
SMD# 23-003

**RE: Opportunities to Test
Transition-Related Strategies to
Support Community Reentry and
Improve Care Transitions for
Individuals Who Are Incarcerated**

April 17, 2023

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) is issuing the following guidance for designing demonstration projects under section 1115 of the Social Security Act (the Act) (42 U.S.C. § 1315) to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution (hereinafter referred to as incarcerated individuals, except when quoting from statute) and who are otherwise eligible for Medicaid. This letter also provides guidance to interested states about development and submission of the associated section 1115 demonstration application.

This guidance continues to implement section 5032 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) (Pub. L. No. 115-271), Promoting State Innovations to Ease Transitions Integration to the Community for Certain Individuals. As mandated in section 5032, the Department of Health and Human Services (HHS) convened a stakeholder group to develop best practices for states to ease health care-related transitions for incarcerated individuals to the community and to develop a Report to Congress (RTC). On December 1, 2022, HHS transmitted the RTC to Congress.¹ Additionally, section 5032 directs the Secretary of HHS, through the Administrator of CMS, to issue this State Medicaid Director Letter (SMDL) regarding opportunities to design demonstration projects under section 1115 of the Act to improve care transitions for incarcerated individuals exiting a public institution and who are otherwise eligible for Medicaid, and to base this guidance on best practices identified in the RTC.

As provided in section 1115 of the Act, the Secretary of HHS may waive certain provisions of section 1902 of the Act and/or provide authority for federal matching of expenditures that otherwise would not be eligible for federal financial participation (FFP) under section 1903 of the Act, where the Secretary determines that the demonstration project is *likely to assist in promoting the objectives of Medicaid*. While CMS reviews every section 1115 demonstration

¹ <https://aspe.hhs.gov/sites/default/files/documents/d48e8a9fdd499029542f0a30aa78bfd1/health-care-reentry-transitions.pdf>.

application individually and based on its merits, CMS anticipates that a demonstration that increases access to coverage or covered services for low-income individuals and does not restrict access to coverage or care, generally will be likely to assist in promoting the objectives of Medicaid. Demonstrations consistent with the approach described in this guidance will test innovative approaches to coverage and quality to improve care transitions, starting pre-release, for individuals who are incarcerated, thereby facilitating improved continuity of care once the individual is released. Further, improving care transitions will likely help these individuals access high-quality, evidence-based, coordinated, and integrated care during reentry.

This guidance encourages states to implement an innovative service delivery system to facilitate successful reentry transitions for Medicaid-eligible individuals leaving prisons and jails and returning to the community. It is informed by best and promising practices described in the RTC and offers states an opportunity to apply for demonstration authority to receive FFP for expenditures for certain pre-release health care services furnished to individuals who are incarcerated and otherwise eligible for Medicaid. Such expenditures otherwise would not qualify for FFP, but will receive FFP under this demonstration opportunity to improve care transitions and increase the likelihood that individuals participating in the demonstration will access needed care upon release from incarceration. This continuity of care will likely result in associated improvements in health outcomes. For simplicity, this demonstration opportunity will be referred to as the “Reentry Section 1115 Demonstration Opportunity” throughout this letter.

Background²

Incarceration in the United States

The United States has the highest incarceration rate of any country in the world.³ On any given day, using the most recently available data, generally from 2020 or 2021, 1.9 million individuals were incarcerated nationwide in federal and state prisons (facilities for the confinement of individuals convicted of a serious crime, usually for a sentence over one year in length, or a felony), local jails (short-term confinement facilities that typically hold individuals awaiting trial or other proceedings, as well as convicted offenders serving sentences of one year or less) and other correctional settings.^{4,5} Approximately 1.2 million individuals were held in federal or state

² This document contains links to non-United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.

³ https://www.prisonstudies.org/sites/default/files/resources/downloads/world_prison_population_list_13th_edition.pdf.

⁴ <https://www.prisonpolicy.org/reports/pie2022.html>.

⁵ Government data on incarcerated individuals has lagged in recent years, an issue made worse by the COVID-19 pandemic (<https://www.prisonpolicy.org/reports/pie2022.html>), and data are generally limited on the health care services available in carceral settings, as well as how much prisons and jails spend on that health care. Throughout

prisons as of the end of 2020, and 549,100 were held in local jails as of mid-year 2020.^{6,7} In 2020, there was a notable reduction of 15 percent of individuals incarcerated in federal or state prisons, and a reduction of 25 percent of individuals incarcerated in local jails, that is largely attributable to COVID-19 delaying court trials and sentencing of individuals.^{8,9} A 2020 analysis of data from 2010 to 2017 showed an increase in the average length of stay in jails to a 26-day national average, an increase of 22 percent.¹⁰ Increases in length of stay may be attributable to factors such as high bail costs and individuals who committed more serious crimes staying in jails longer.¹¹

A 2021 county-level analysis identified a strong association between jail incarceration and increases in premature death rates from infectious diseases, chronic lower respiratory disease, drug use, and suicide.¹² In addition, pregnant women in a carceral system primarily designed for men bring specific challenges for addressing these women's health care needs.¹³ It is also noteworthy that from 2011 to 2012, approximately 37 percent of people in state and federal prisons and 44 percent of people incarcerated in jails had a history of mental illness.¹⁴ A November 2020 issue brief based on 2017 data identified that individuals who are incarcerated have higher rates of mental illness and chronic and other physical health care needs, including hypertension, asthma, tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hepatitis B and C, arthritis, and sexually transmitted diseases, than the general population.¹⁵ Further, according to a 2020 report, although the exact rate of substance use disorders (SUD) in individuals who are incarcerated is difficult to determine, it may be as high as 65 percent in prisons nationally.¹⁶ In some states, it is even higher. For example, Minnesota reported in 2019 that approximately 90 percent of the state's incarcerated population had been diagnosed with an SUD.¹⁷

this SMDL, we have tried to cite the most recently available data on these topics, which, at times, has necessitated reporting on research and data that were compiled a number of years ago.

⁶ <https://bjs.ojp.gov/content/pub/pdf/p20st.pdf>.

⁷ <https://bjs.ojp.gov/library/publications/jail-inmates-2020-statistical-tables>.

⁸ <https://bjs.ojp.gov/content/pub/pdf/p20st.pdf>.

⁹ <https://bjs.ojp.gov/library/publications/jail-inmates-2020-statistical-tables>.

¹⁰ <https://www.pewtrusts.org/en/research-and-analysis/articles/2020/03/27/why-hasnt-the-number-of-people-in-us-jails-dropped>.

¹¹ <https://datacollaborativeforjustice.org/work/confinement/understanding-trends-in-jail-populations-2014-2019-a-multi-site-analysis/>.

¹² <https://www.publichealth.columbia.edu/public-health-now/news/incarceration-strongly-linked-premature-death-us>.

¹³ [https://jaapl.org/content/early/2020/05/13/JAAPL.003924-20#:~:text=Incarcerated%20women%20frequently%2\[...\]20risk,and%20low%20birth%20weight%20infants](https://jaapl.org/content/early/2020/05/13/JAAPL.003924-20#:~:text=Incarcerated%20women%20frequently%2[...]20risk,and%20low%20birth%20weight%20infants).

¹⁴ <https://www.bjs.gov/content/pub/pdf/imhrprj1112.pdf>.

¹⁵ <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/medicaid-role-health-people-involved-justice-system>.

¹⁶ <https://www.drugabuse.gov/download/23025/criminal-justice-drugfacts.pdf?v=25dde14276b2fa252318f2c573407966>.

¹⁷ https://mn.gov/doc/assets/Substance%20Use%20Disorder%20Treatment_tcm1089-413914.pdf.

Health Needs and Outcomes for Justice Involved Individuals Re-Entering the Community

Formerly incarcerated individuals with physical and mental health conditions and SUDs¹⁸ typically have difficulty succeeding upon reentry because of obstacles present immediately at release, such as high rates of poverty and/or high risk of poor health outcomes.¹⁹ They face stigma and legal barriers when seeking to obtain housing, education, employment, government benefits, and health care access, and can be confronted with negative community perceptions and corresponding lack of support that hinder successful reentry.²⁰ Additionally, without access to affordable health care services post-release, individuals who were formerly incarcerated often do not seek outpatient medical care, including needed SUD or mental health treatment and are at significantly increased risk for emergency department (ED) use and hospitalization.^{21,22} Individuals reentering the community from correctional facilities are also at a greater risk of overdose death as compared to the general population, especially in the first two weeks post-release.^{23,24} Studies have also concluded that individuals with SUD or substance-related criminal charges who are reentering the community are at greater risk of criminal re-involvement and recidivism, underscoring that addressing public health needs may help advance public safety outcomes.^{25,26}

People from racial and ethnic minority groups are disproportionately represented among the carceral population. Black people are incarcerated in state prisons at nearly five times the rate of white people, and Latino people are incarcerated in state prisons at 1.3 times the rate of non-Latino white people.²⁷ The rates of incarceration for Black people in jails from 2010-2019 was more than three times that of white people.²⁸ Racial disparities in incarceration further exacerbate health disparities for Black people, Indigenous people, and people of color upon release.²⁹

Individuals who are part of the lesbian, gay, bisexual, transgender, queer, and other sexual minority (LGBTQ+) community are disproportionately represented in the carceral system. Individuals who are transgender are incarcerated at a rate of more than twice that of the

¹⁸ Throughout the SMDL, we use the term “behavioral health conditions” to encompass mental health conditions and SUDs.

¹⁹ <https://www.aafp.org/about/policies/all/incarceration.html>.

²⁰ <https://www.apa.org/pi/ses/resources/indicator/2018/03/prisons-to-communities>.

²¹ <https://bmcmernmed.biomedcentral.com/articles/10.1186/1471-227X-13-16>.

²² <https://www.aafp.org/about/policies/all/incarceration.html>.

²³ <https://www.kff.org/medicaid/issue-brief/how-connecting-justice-involved-individuals-to-medicare-can-help-address-the-opioid-epidemic/>.

²⁴ Binswanger I.A., Stern M.F., Deyo R.A., et al. Release from prison--a high risk of death for former inmates. *New England Journal of Medicine*, 2007 Jan 11; 356(2):157-165.

²⁵ <https://ascpjournals.biomedcentral.com/articles/10.1186/s13722-019-0136-6>.

²⁶ <https://www.kff.org/medicaid/issue-brief/how-connecting-justice-involved-individuals-to-medicare-can-help-address-the-opioid-epidemic/>.

²⁷ <https://www.sentencingproject.org/publications/color-of-justice-racial-and-ethnic-disparity-in-state-prisons/>.

²⁸ <https://bjs.ojp.gov/content/pub/pdf/ji19.pdf>.

²⁹ <https://www.aafp.org/about/policies/all/incarceration.html>.

population as a whole, while sexual minorities are incarcerated at a rate of three times that of the population as a whole.³⁰ Many people who are LGBTQ+ experience significant discrimination in carceral settings, which can negatively impact their health and well-being.³¹

Additionally, individuals who have communication disabilities, may, upon release, experience barriers to services. Also, individuals with limited English proficiency face barriers related to services that are not available in multiple languages.³² For instance, the Federal Bureau of Prisons notes that Spanish-speaking women who are incarcerated experienced a barrier to participating in its trauma program that is currently only available in English.^{33,34}

Health Needs and Outcomes for Justice Involved Youth

Youth who are incarcerated have a very high incidence of adverse childhood experiences, with as many as 90 percent of such youth having experienced trauma. They are also at higher risk for having experienced sexual and physical abuse and for having behavioral health disorders.^{35,36} Further, they are often multi-system involved, with a significant overlap between youth in foster

³⁰ <https://transequality.org/sites/default/files/docs/resources/TransgenderPeopleBehindBars.pdf>.

³¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8430972/>.

³² Providers have an obligation to comply with nondiscrimination requirements under various federal civil rights laws, including Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act 1973, and Section 1557 of the Affordable Care Act. Individuals with disabilities are entitled to communication that is as effective as communication for people without disabilities, including through the provision of auxiliary aids and services. See 45 C.F.R. 84.52(d)(1); 45 C.F.R. 85.51(a); 28 C.F.R. 35.160; 45 C.F.R. 92.102; 28 C.F.R. 35.104. Additionally, covered entities must take reasonable steps to provide meaningful access to individuals, with limited English proficiency, including through the provision of interpreting services and translations. See 45 C.F.R. 80 as interpreted by *Lau v. Nichols*, 414 U.S. 563 (1974); 45 C.F.R. 92.101; 45 C.F.R. 92.101(b)(2).

³³ <https://oig.justice.gov/reports/2018/e1805.pdf>.

³⁴ Additional resources for supporting language and disability access needs as part of an individual's reentry to the community can be found at the following: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: <https://thinkculturalhealth.hhs.gov/clas>; Guide to Developing a Language Access Plan: <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan-508c.pdf>; Providing Language Services to Diverse Populations: Lessons from the Field: <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Lessons-from-the-Field.pdf>; Modernizing Health Care to Improve Communication Accessibility for Individuals who are Blind or Low-vision: <https://www.cms.gov/files/document/omh-visual-sensory-disabilities-brochure-508c.pdf>; Modernizing Health Care to Improve Communication Accessibility for Individuals Who Are Deaf or Hard of Hearing: <https://www.cms.gov/files/document/audio-sensory-disabilities-brochure-508c.pdf>; Modernizing Health Care to Improve Physical Accessibility Primer for Providers: <https://www.cms.gov/files/document/cmsmodernizinghealthcare.pdf>; Resource Inventory: <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH-Modernizing-Health-Care-Physical-Accessibility.pdf>; Plans, providers, and state/local governments may find the following resource to be helpful: <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Brief-Physical-AccessibilityBrief.pdf>.

³⁵ Baglivio M, Epps N, Swartz K, Huq M, Sheer A, Hardt N. The prevalence of adverse childhood experiences (ACE) in the lives of juvenile offenders. *Journal of Juvenile Justice*, 2014; 3(2):1-23.

³⁶ Underwood L.A., Washington A. Mental Illness and Juvenile Offenders. *International Journal of Environmental Research and Public Health*, 2016 Feb 18; 13(2):228.

care and those involved in the juvenile justice system. Depending on how broadly multi-system involvement is defined, it is possible that as high as 50 percent of youth referred to the juvenile justice system are also involved with the child welfare system.³⁷ The length of stay in youth correctional facilities is typically short, with a median period of 64 days in 2019.³⁸ Like adult carceral facilities, youth correctional facilities are variable in terms of health care provided, from very robust and comprehensive care to limited care.³⁹ As with adults in the carceral system, there is a disproportionate rate of incarceration for youth of color.⁴⁰

Linkages to care for youth who move between the correctional and foster care systems are extremely important to promote continuity of care and treatment, particularly for youth with mental health needs and SUD. Providing screening for physical and behavioral health needs while incarcerated and facilitating linkages to physical and behavioral health care in the community will support youth who are incarcerated in transitioning more successfully back to the community.⁴¹ Emerging research shows that youth do better emotionally, physically, and educationally when placed in home-based family settings and the use of more restrictive congregate care placements are limited, when possible and appropriate.^{42,43} Attachment disruptions from primary caregivers may underlie some youths' mental health issues; thus, studies have shown that it is fundamental to incarcerated youths' mental health and well-being to build strong relationships with a caregiver.⁴⁴ Correctly diagnosing SUD in youth is critical and may be complicated by youth self-medicating for emerging mental health symptoms/disorders, such as anxiety and depression, in order to "fit in" with peers and avoid stigma associated with having mental health needs.⁴⁵ Female youth who are incarcerated have higher rates of unintended pregnancies than same-age peers, so providing family planning services is critical as well.⁴⁶

³⁷ Thomas D., Siegel G., Wachter A., Deal T., Rackow A., Vessels L., Halemba G., Hurst H. When Systems Collaborate: How Three Jurisdictions Improved their Handling of Dual-Status Cases. Pittsburgh, PA. National Center for Juvenile Justice; 2016. Available at: <http://www.ncjj.org/pdf/Juvenile%20Justice%20Geography,%20Policy,%20Practice%20and%20Statistics%202015/WhenSystemsCollaborateJJGPSCaseStudyFinal042015.pdf>.

³⁸ <https://www.ojjdp.gov/ojstatbb/corrections/qa08405.asp?qaDate=2019>.

³⁹ Gallagher C.A., Dobrin A. Can Juvenile Justice Detention Facilities Meet the Call of the American Academy of Pediatrics and National Commission on Correctional Health Care? A National Analysis of Current Practices. *Pediatrics*, 2007 Apr; 119(4):991-1001.

⁴⁰ Developmental Services Group, Inc. Disproportionate Minority Contact. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, US Department of Justice; 2014. Available at: https://www.ojjdp.gov/mpg/litreviews/Disproportionate_Minority_Contact.pdf.

⁴¹ American Academy of Pediatrics. Health Care for Youth in the Juvenile Justice System. *Pediatrics*, 2011; 128(6):1219–1235. Available at: <https://publications.aap.org/pediatrics/article/128/6/1219/31060/Health-Care-for-Youth-in-the-Juvenile-Justice>.

⁴² <https://theacademy.sdsu.edu/wp-content/uploads/2016/03/alternatives-congregate-care-feb-2016.pdf>.

⁴³ Children's Bureau (2015). A National Look at the Use of Congregate Care in Child Welfare. Retrieved from: https://www.acf.hhs.gov/sites/default/files/documents/cb/cbcongregatecare_brief.pdf.

⁴⁴ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6703996/>.

⁴⁵ https://childmind.org/article/mental-health-disorders-and-substance-use/#full_article.

⁴⁶ <https://childsafety.losangelescriminallawyer.pro/juvenile-delinquency-and-teen-pregnancy.html>.

Health Care in Carceral Settings

All carceral authorities are constitutionally obligated to provide needed health care for inmates in their custody, regardless of the carceral setting (i.e., local or state jail, state or federal prison). However, the provision of health care within carceral systems is widely variable. The standard of adequate care⁴⁷ may be defined at the state, county, or facility level. Even initial health care screenings and provision of life-sustaining or life-prolonging services are implemented very differently across states, counties, and facilities.⁴⁸ Despite the high rates of chronic physical and mental illnesses and SUD among individuals who are incarcerated, access to health care services in prisons and jails can be limited. In 2017, of the 5,100 prisons and jails in the United States, fewer than 30 offered methadone or buprenorphine, two common, safe, and effective medication assisted treatment (MAT) medications for SUD.⁴⁹ Health care in a carceral environment varies in practice in almost every way, including the services provided (e.g., assessment; care management; and delivery of preventive, acute, or palliative care), setting (e.g., availability of onsite care, coordination of services while in custody), the providers who render services (e.g., contracted vendors or state agency staff), as well as the number and type of licensed and unlicensed professionals per facility (e.g., enrollment status in the state Medicaid program, registry in the National Plan and Provider Enumeration System), or state scope of practice and provider prescribing authority. This variation leaves some carceral settings only providing the most basic care for acute illnesses and injuries.

The costs of health care provided to individuals who are incarcerated also vary widely. In 2015, the typical state spent \$5,700 annually on health care services for an individual incarcerated in a state prison, with California spending the most on health care at approximately \$20,000 per individual per year, and Louisiana spending the least at \$2,100 per individual per year.⁵⁰

While data are available on the costs of health care provided in state prisons, data about health care costs in jails are not readily accessible.⁵¹ Local jail funding may be derived from a patchwork of local governmental agencies and sources, and these revenue streams are not always reflected in jails' operating budgets and public disclosures. Further, disaggregating the portion of the jail funding dedicated to health care is made more complicated by lack of clarity around the full costs to operate jails. A 2015 survey of jails indicated that anywhere from 1 percent to more than 53 percent of total jail costs were paid by another government agency, and a majority of these costs, which were outside of jail budgets, tend to be for employee benefits and health care for incarcerated individuals.⁵²

⁴⁷ In *Estelle v. Gamble*, 429 U.S. 97 (1976), the Court stated that the government has an obligation to provide medical care for those whom it is punishing by incarceration, and that deliberate indifference to serious medical needs of prisoners is proscribed by the Eighth Amendment's prohibition of cruel and unusual punishment.

⁴⁸ <https://www.ojp.gov/pdffiles1/nij/grants/189735.pdf>.

⁴⁹ <https://store.samhsa.gov/sites/default/files/d7/priv/pep19-matusecjs.pdf>.

⁵⁰ <https://www.pewtrusts.org/en/research-and-analysis/articles/2017/12/15/prison-health-care-spending-varies-dramatically-by-state>.

⁵¹ <https://www.vera.org/downloads/publications/price-of-jails.pdf>.

⁵² <https://www.vera.org/downloads/publications/price-of-jails.pdf>.

The average overall annual cost of holding a person in jail in 2017 was about \$34,000, according to a 2021 report.⁵³ In comparison, the average annual cost of holding a person in a state prison in 2020 was roughly \$31,580⁵⁴, and the average annual cost of holding a person in a federal facility in 2020 was \$39,158.⁵⁵ The portion of a jail's budget spent on health care can vary widely by county even within the same state, such as in Virginia, where local jails spend anywhere from 2.5 to 33 percent of their budgets on health care.⁵⁶ Although health expenses for incarcerated individuals are often paid through a jail budget, about half of the reporting jails in a 2015 survey indicated that another county agency paid at least a portion of an incarcerated individual's medical costs and that this practice is most prevalent in large counties.⁵⁷ The aforementioned information points to the inadequacy and variability of available data on jail-related health care expenditures. The data on health care spending in both jails and prisons also highlights the disparities in health care investments, depending on the state and/or the local jurisdiction in which an individual is incarcerated.

There is also limited information on the availability of health care services in carceral settings and insufficient information on the quality of those services. Further, little beyond anecdotal or isolated local data are available regarding the transition process for individuals, including youth, exiting the carceral system and linkages with health care services in the community. Data on necessary elements for a successful transition are not readily available, particularly related to jails where people may cycle in and out relatively rapidly, with little time for transition planning.

Medicaid Eligibility in Carceral Settings

Incarceration status does not render an individual ineligible for Medicaid, as it is not a factor of eligibility. Individuals who are held involuntarily in a public institution may be eligible for and enrolled in Medicaid, but federal Medicaid funds may not be used to pay for services for such individuals while they are incarcerated, except when they are inpatients in a medical institution as provided in paragraph (A) following the last paragraph of section 1905(a) of the Act, hereinafter referred to as the inmate payment exclusion. Qualifying inpatient stays would be in facilities, such as hospitals, nursing homes, psychiatric residential treatment facilities or other medical institutions for an expected duration of 24 hours or more⁵⁸, in which there is an admission of the individual to the facility as an inpatient. In 2016, CMS provided guidance to states regarding facilitating access to covered Medicaid services during and after a stay in a

⁵³ [https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/01/local-spending-on-jails-tops-\\$25-billion-in-latest-nationwide-](https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/01/local-spending-on-jails-tops-$25-billion-in-latest-nationwide-data#:~:text=The%20average%20annual%20cost%20of,capital%20challenges%20to%20local%20budgets.)

[data#:~:text=The%20average%20annual%20cost%20of,capital%20challenges%20to%20local%20budgets.](https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/01/local-spending-on-jails-tops-$25-billion-in-latest-nationwide-data#:~:text=The%20average%20annual%20cost%20of,capital%20challenges%20to%20local%20budgets.)

⁵⁴ <https://nicic.gov/state-statistics/2020/2020-national-averages.>

⁵⁵ <https://www.federalregister.gov/documents/2021/09/01/2021-18800/annual-determination-of-average-cost-of-incarceration-fee-coif.>

⁵⁶ <https://www.pewtrusts.org/en/research-and-analysis/reports/2018/01/jails-inadvertent-health-care-providers.>

⁵⁷ <https://www.vera.org/downloads/publications/price-of-jails.pdf.>

⁵⁸ 42 CFR 435.1010 Definitions relating to institutional status and <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf>.

correctional institution, including states' authority to suspend, rather than terminate Medicaid eligibility for individuals who are incarcerated. Suspending rather than terminating eligibility maintains enrollment for Medicaid-eligible individuals who become incarcerated, while complying with the inmate payment exclusion.⁵⁹ Since then, section 1001 of the SUPPORT Act prohibited states from terminating Medicaid eligibility for eligible juveniles.⁶⁰ Suspending rather than terminating an individual's Medicaid coverage during incarceration facilitates timely reinstatement of coverage upon release from a public institution. Timely reinstatement of coverage upon release from incarceration directly impacts when care is received and is a contributing factor for early identification of treatable medical conditions, continuity of care, reduction of medical crises, and mortality, and ensuring individuals who were incarcerated have the resources required for successful reentry into the community.^{61,62}

For states that adopted the Affordable Care Act's Medicaid expansion for the adult group, most incarcerated individuals are eligible for Medicaid. Many states are seeking to put in place policies and processes to ensure that Medicaid-eligible individuals are enrolled prior to release and able to receive Medicaid-covered benefits and services as quickly as possible after release.⁶³ States that maintain enrollment during incarceration with suspended coverage also use this strategy to facilitate claiming of FFP in expenditures for services provided to incarcerated beneficiaries while they are inpatients in a medical institution.⁶⁴

Summary of Section 5032 Stakeholder Group Meeting and Report to Congress on Best Practices

On August 20, 2021, HHS convened a meeting of a federal advisory committee established under section 5032 of the SUPPORT Act. This group included representatives from managed care organizations, Medicaid beneficiaries, health care providers, the National Association of Medicaid Directors, and other representatives from local, state, and federal jail and prison systems, as required by the statute. The group did not produce consensus recommendations. Rather, stakeholders identified promising practices, as well as areas for consideration, to promote seamless transitions to the community and inform CMS' development of the required SMDL and Reentry Section 1115 Demonstration Opportunity. The stakeholder input also provided insight on reentry planning for individuals in the carceral system.

⁵⁹ See April 28, 2016, State Health Official Letter # 16-007 "RE: To Facilitate successful reentry for individuals transitioning from incarceration to their communities" found at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf> and January 19, 2021, State Medicaid Director Letter # 21-002 "RE: Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions (Section 1001 of the SUPPORT Act)" found at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf>.

⁶⁰ <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf>.

⁶¹ <https://counciloncj.org/issue-brief-1/>.

⁶² <https://counciloncj.org/harp-issue-brief-2/>.

⁶³ <https://www.commonwealthfund.org/publications/issue-briefs/2019/jan/state-strategies-health-care-justice-involved-role-medicaid#:~:text=Medicaid%20expansion%20makes%20most%20individuals,is%20effective%20prior%20to%20release.>

⁶⁴ <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/08/how-and-when-medicaid-covers-people-under-correctional-supervision>.

The RTC, which was informed by the section 5032 stakeholder group feedback, identified challenges related to the transition of individuals reentering the community. These challenges include individuals receiving needed health care when there are competing needs for other social supports, continuity of care, access to care including access to post-release MAT, stigma, and understanding the scope of covered benefits and costs, among others. The RTC noted that prisons, jails, and health care providers face challenges in data sharing and cross-systems communication and coordination for transitioning individuals. Additionally, the RTC describes how sharing information on the health care provided during incarceration with community-based clinics, physicians, and other providers can be an important part of treating chronic illnesses and behavioral health conditions, because it allows for treatment continuity, reduces duplicative care, and facilitates communication about the individual's health needs. The report also describes data sharing challenges between correctional systems and state Medicaid agencies, as well as managed care organizations, that include additional non-health data such as anticipated or updated release dates and reentry information, and Medicaid enrollment. The RTC further describes best and promising practices for health care, eligibility, enrollment, and coverage-related practices, and key considerations for a section 1115 demonstration opportunity.

CMS considered the feedback and insight provided by stakeholders in the design of this Reentry Section 1115 Demonstration Opportunity.

Reentry Section 1115 Demonstration Opportunity

As noted above, section 1115(a) of the Act authorizes the Secretary of HHS to waive certain statutory provisions and to match expenditures that otherwise would not qualify for federal matching in order to permit states to conduct experimental, pilot, or demonstration projects that, in the judgment of the Secretary, are likely to assist in promoting the objectives of title XIX of the Act. While CMS will consider each section 1115 demonstration application on its own merits, the Reentry Section 1115 Demonstration Opportunity discussed in this SMDL is intended to help states submit proposals that would advance the goals of the Medicaid statute to provide medical assistance to vulnerable and low-income populations and ensure high quality care for communities and populations served. States are encouraged to submit applications for demonstrations that would test innovative practices that are likely to assist in promoting the objectives of Medicaid. In this demonstration opportunity, states may provide coverage for certain Medicaid services to incarcerated individuals who are soon to be released from incarceration, consistent with the statutory directive in section 5032 of the SUPPORT Act.

While states' applications may propose to make certain carceral health care services that are currently paid exclusively with state and/or local dollars eligible for FFP, the Reentry Section 1115 Demonstration opportunity is not intended to shift current carceral health care costs to the Medicaid program. Section 5032(b) of the SUPPORT Act makes clear that the purpose of this demonstration opportunity is "to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX." This demonstration opportunity does not absolve carceral authorities of their constitutional obligation to ensure needed health care is furnished to inmates in their custody and is not intended as a means to transfer the financial burden of that obligation from a federal, state, or local carceral authority to the Medicaid program. Accordingly, CMS

does not expect to approve state proposals to receive federal Medicaid matching funds through the Reentry Section 1115 Demonstration Opportunity for any existing carceral health care services that are currently funded with state and/or local dollars unless states agree to reinvest the total amount of new federal matching funds received for such services under the demonstration into activities and/or initiatives that increase access to or improve the quality of health care services for individuals who are incarcerated (including individuals who are soon-to-be released) or were recently released from incarceration, or for health-related social services that may help divert individuals from criminal justice involvement. Consistent with this expectation, states will need to commit at the time of the demonstration approval to a reinvestment plan, and will develop and submit the plan for CMS approval during the post-approval period. The plan will outline how the federal matching funds under the demonstration will be reinvested throughout the demonstration period. Additional information regarding the reinvestment plan requirements are provided on pages 32-33.

In general, to meet the statutory purpose of improving care transitions for soon-to-be released incarcerated individuals who are otherwise eligible for coverage, the services covered under this demonstration opportunity should aim to improve access to community resources that address the health care and health-related social needs of this population, with the aims of improving health outcomes and reducing ED visits and inpatient hospital admissions for both physical and behavioral health (mental health and SUD) issues once they are released and return to the community. A brief summary of the Reentry Section 1115 Demonstration Opportunity expected features, described in detail below, is provided in Appendix 1.

Overarching Demonstration Goals

CMS expects that demonstration applications for the Reentry Section 1115 Demonstration Opportunity will address the following goals:

- **Increase coverage, continuity of coverage, and appropriate service uptake** through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release;
- **Improve access to services** prior to release and improve transitions and continuity of care into the community upon release and during reentry;
- **Improve coordination and communication** between correctional systems, Medicaid systems, managed care plans, and community-based providers;
- **Increase additional investments in health care and related services**, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful reentry post-release;
- **Improve connections between carceral settings and community services** upon release to address physical health, behavioral health, and health-related social needs (HRSN);⁶⁵
- **Reduce all-cause deaths** in the near-term post-release; and

⁶⁵ As discussed in a letter to State Health Officials issued on January 7, 2021, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>, addressing Social Determinants of Health can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid program. While “social determinants of health” is a broad term that relates to the health of all people, HRSN relates more specifically to an individual’s adverse conditions reflecting needs that are unmet and contribute poor health.

- **Reduce number of ED visits and inpatient hospitalizations** among recently incarcerated Medicaid beneficiaries through increased receipt of preventive and routine physical and behavioral health care.

Quality and Health Equity

Health equity means the attainment of the highest level of health for all individuals, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.⁶⁶

The Reentry Section 1115 Demonstration Opportunity supports CMS' vision to serve the public as a trusted partner and steward, dedicated to expanding coverage, advancing quality and health equity, and improving health outcomes. By design, this Reentry Section 1115 Demonstration Opportunity focuses on providing coverage for high-quality services furnished to certain incarcerated individuals, a group of individuals who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. States' demonstration designs should be cognizant of and include proposed approaches for improving quality of coverage and care for all Medicaid demonstration beneficiaries, thereby reducing disparities and improving health equity for eligible Medicaid beneficiaries.

Based on the recommendations in the RTC, CMS strongly encourages states contemplating submitting a demonstration application to engage individuals with lived experience who were formerly incarcerated in both the design and implementation of a state's Section 1115 Reentry Demonstration proposal. Inclusion of people with lived experience has been identified as an important feature by the section 5032 stakeholder group, gathering practical insight and perspective that recognizes the voices of those who could be served by the demonstration. Such engagement increases the potential for this section 1115 demonstration opportunity to improve care transitions and quality of care to best meet individuals' needs, regardless of their backgrounds or circumstances.

Breadth of Carceral Settings

Section 5032 of the SUPPORT Act makes no distinction between incarcerated individuals exiting federal, state, and local prisons and jails. The Reentry Section 1115 Demonstration Opportunity offers flexibility to states to provide coverage for certain pre-release services furnished to individuals in state and/or local jails, prisons, and/or youth correctional facilities. The types of carceral settings included, e.g. state prisons, local jails, etc., as well as limitations relating to the ability of individual carceral facilities in the state to participate, are at the state's discretion to propose. States may outline a phased approach to adding additional carceral facilities throughout the life of the proposed demonstration.

When an individual is incarcerated in a federal prison, the federal Bureau of Prisons (BOP) is responsible for providing and paying for all physical and behavioral health care. Federal

⁶⁶ <https://www.cms.gov/pillar/health-equity>.

prisoner health care costs are the responsibility of a federal agency and not the state in which the federal prison is located. Additionally, since many federal prisoners are incarcerated outside of their home state, they often will need to apply for and enroll in Medicaid in a different state than where they are incarcerated in order to ensure coverage upon release. States may process applications from incarcerated individuals, prior to release, who apply for Medicaid coverage in the state in which they will reside, with the effective date of eligibility the date the individual arrives in their state of residence. CMS encourages state Medicaid agencies to assist individuals who are incarcerated in federal prisons in their states by directing them to Medicaid application information for the state in which they intend to reside upon release so that federal prison social workers can help federal prisoners submit a Medicaid application prior to release. CMS expects states to refrain from including federal prisons as a setting in which demonstration-covered pre-release services are provided under the demonstration, given the existing role of BOP, as another federal agency, in providing and paying for all health care for federal prisoners during incarceration.

Eligible Individuals

The SUPPORT Act indicates that this demonstration opportunity includes “certain individuals who are soon to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX[.]”

The section 5032 stakeholder group recommended that the individuals eligible for demonstration coverage should include individuals who are incarcerated with a broad array of chronic health conditions that may be related to physical and/or behavioral health. Available data indicate that individuals incarcerated in jails and prisons have a higher likelihood of having a wide variety of chronic conditions, including but not limited to behavioral health conditions such as SUD and/or mental illness.⁶⁷ Further, lack of treatment for these chronic conditions often leads to poor health outcomes and more frequent ED and inpatient hospital use post-release.

CMS encourages states interested in the Reentry Section 1115 Demonstration Opportunity to propose a broadly defined demonstration population that includes otherwise eligible, soon-to-be former incarcerated individuals. States have the flexibility to target the population(s) covered by the demonstration, for example, to individuals with specific conditions, and should establish identification criteria. As states develop criteria and processes for identification of individuals who may be included in the Reentry Section 1115 Demonstration Opportunity, including those with specific conditions, states should be mindful of establishing identification criteria for individuals who may have a condition that is currently undiagnosed.

Medicaid Eligibility and Enrollment

Section 5032(b)(1) requires that the demonstration opportunity provide “assistance and education for enrollment under a State plan under the Medicaid program[.]” Consistent with this provision, in order to ensure individuals are able to access services in the period in which pre-release demonstration services are available, demonstration states should work with their correctional

⁶⁷ <https://bjs.ojp.gov/content/pub/pdf/mpsfjji1112.pdf>.

facility partners to start the application process and assist incarcerated individuals who are not already enrolled in Medicaid to apply for Medicaid upon the individual's incarceration, throughout the period of incarceration and no later than 45 days before the individual's expected date of release. In addition, section 5032(c) clarifies that nothing under title XIX of the Act or any other provision of law precludes a state from reclassifying or suspending (rather than terminating) the eligibility of an individual for medical assistance under title XIX of the Act while such individual is an inmate of a public institution.

CMS expects that demonstration states will make pre-release outreach well in advance of the 30-day pre-release period, along with eligibility and enrollment support, available to all individuals incarcerated in the facilities in which the demonstration is functioning. Without outreach and support to assist all interested individuals to apply for Medicaid coverage or renewal, it is generally not possible to assess who "may be eligible" for Medicaid and limit outreach and enrollment support to a subset of individuals who are incarcerated.

Consistent with CMS' priority to expand access to "quality, affordable health coverage and care"⁶⁸ and the recommendation of the section 5032 stakeholder group, CMS does not expect to approve a Reentry Section 1115 demonstration unless the state suspends, rather than terminates, an individual's Medicaid eligibility, when an individual becomes incarcerated for the duration of their incarceration. Ensuring enrollment in health coverage is an essential component of improving care transitions between carceral settings and the community. A straightforward strategy to better ensure enrollment for newly released, Medicaid-eligible individuals is to adopt a suspension approach, instead of termination, so the individual does not have to submit a new application upon release. The state's priority in implementing a suspension strategy is to support maintenance of enrollment for Medicaid beneficiaries. Consistent with that goal, CMS encourages states to submit applications that describe alternative policies and procedures to ensure that only allowable benefits are covered and paid for during incarceration while also providing coverage and payment for full benefits as quickly as possible upon release. While recognizing the importance of suspension (rather than termination), we understand that some states that are not currently using a suspension approach will need time and resources to modify systems to make changes to their eligibility and enrollment systems. Therefore, depending on a state's readiness and its demonstration proposal, we will offer a glide path of up to two years from demonstration approval for the state to make system changes to effectuate eligibility/benefit suspension. A state may request CMS approval for a 90/10 enhanced federal matching rate for the design, development, and implementation of certain Medicaid systems (or improvements to such systems) to support eligibility determinations and enrollment (including suspension strategies).

CMS previously released sub-regulatory guidance that outlines permissible suspension strategies, including benefits and eligibility suspension approaches, and how a state may effectuate these

⁶⁸ <https://www.cms.gov/cms-strategic-plan>.

suspension approaches.^{69,70} Under a benefits suspension, an eligible individual continues to be enrolled in Medicaid, but Medicaid coverage is limited to services furnished to the individual while admitted to a medical institution for at least a 24-hour inpatient stay,⁷¹ in accordance with the inmate payment exclusion. One way to effectuate a benefits suspension is for the state to make edits in their Medicaid Management Information System (MMIS) to limit payable benefits to only services furnished while the beneficiary is an inpatient, for the duration of the incarceration.

The eligibility suspension strategy involves the state suspending the individual's eligibility so that they are no longer eligible to receive Medicaid benefits for the duration of the incarceration; the state must lift an eligibility suspension when an eligible incarcerated person becomes an inpatient in a medical institution so that Medicaid may pay for services furnished to the beneficiary as an inpatient, which are not subject to the inmate payment exclusion.⁷² There are several ways a state can effectuate an eligibility suspension. States may make eligibility systems edits to place the individual in a "suspended" eligibility status or the state may make MMIS edits to place the individual in a "no pay" or other status that ensures claims are not paid for the eligible individual. If an individual is determined eligible for Medicaid while incarcerated and the individual otherwise satisfies the definition of an eligible individual, the state must treat this individual as it would an eligible individual who was enrolled in Medicaid at the time of incarceration and place the individual in a suspended eligibility or benefits status, except during periods when the individual is an inpatient in a medical institution, as discussed above.

Recognizing the brief timeframe that some individuals will remain in jail and the potential uncertainty about when they will leave, presumptive eligibility (PE) can be a useful tool for quickly connecting individuals with coverage for a temporary period of time. CMS encourages states to consider utilizing PE for individuals who are anticipated to have short-term stays and enroll individuals who are likely eligible under a state's Medicaid eligibility guidelines for a temporary period of time. Permitting local jails and prisons to serve as qualified entities would allow them to make determinations of PE prior to a person's release, providing immediate access to health coverage upon reentry while the individual applies for Medicaid or waits to learn if they qualify for Medicaid. While states may not require an individual to fill out a full Medicaid application to receive a PE determination or before a PE period begins, individuals should be informed that filing a full Medicaid application is necessary for coverage to continue, and states may require that local jails or prisons serving as qualified entities assist individuals determined presumptively eligible in completing a full Medicaid application during the PE period prior to release. For individuals with longer-term stays, it is preferable for states to work with their correctional facility partners to assist individuals who are not already enrolled in Medicaid to apply for Medicaid no later than 45 days prior to the individual's expected date of release.

⁶⁹ <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf>.

⁷⁰ <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf>.

⁷¹ 42 C.F.R. § 435.1010.

⁷² When a state effectuates an eligibility suspension, a state is not required to conduct regular annual renewals or redetermine eligibility based on changes in circumstances. If a state is not conducting regular annual renewals or determining eligibility based on changes in circumstances while eligibility is suspended, the state may need to complete a renewal or redetermination at the time an inmate becomes an inpatient.

Scope of Health Care Services

Section 5032 does not define the scope of health care services to be provided to demonstration-eligible individuals prior to release through the section 1115 demonstration opportunity. The section 5032 stakeholder group recommended including sufficient services in the demonstration opportunity to promote successful health care transitions. Stakeholders had differing perspectives on how broad the pre-release package of covered services should be, particularly given that incarcerated individuals often lack access to needed health care services in carceral settings. Some section 5032 stakeholder group members thought that broad Medicaid coverage (e.g., coverage for full state plan benefits) was necessary to provide needed health care that may not be provided adequately or at all by the carceral system. Other members thought the coverage should focus on the services necessary to transition people to care in the community once out of prisons and jails and should not supplant the obligations of prisons and jails to provide needed health care. Still other members highlighted the importance of providing supports to address HRSN, such as bridge housing assistance and employment supports, noting that without support to obtain housing and a job, it is difficult for individuals returning to the community to address their underlying health issues.

With the wide variation in section 5032 stakeholder group members' perspectives about an appropriate pre-release benefit package and the respective roles and responsibilities of the Medicaid program and carceral system regarding health care, CMS anticipates that interested states may propose a range of benefit designs in their applications for the Reentry Section 1115 Demonstration Opportunity. However, CMS expects that state proposals for benefit designs will be sufficiently robust to be likely to improve care transitions as contemplated in section 5032 of the SUPPORT Act and as discussed in this letter, including by covering at least the minimum set of pre-release services discussed below.

The goal of the pre-release benefit package design is to support the proactive identification of both physical and behavioral health needs and develop a plan to address health and HRSN for soon-to-be released incarcerated individuals who otherwise meet Medicaid eligibility criteria and Reentry Section 1115 Demonstration Opportunity eligibility criteria. The benefit package, therefore, should promote coverage and quality of care to improve transitions for individuals being released from jails or prisons and returning to their communities. It should also address the overarching demonstration goals described above, which were informed by available research and the section 5032 stakeholder group and are discussed in greater detail in the RTC. While states may propose to exceed the minimum benefit package described below, states should collaborate with their participating carceral facilities to ensure the feasibility of providing all proposed benefits in the state's benefit package to incarcerated beneficiaries, which provide stabilizing services that will enhance public health outcomes and support reentry.

CMS recognizes that many individuals exiting prison and jail systems, including youths, may not have received sufficient health care to address all of their physical and/or behavioral health care needs while incarcerated; however, the purpose of this demonstration opportunity is to provide short-term Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions. Therefore, the demonstration benefit package should be designed to improve identification of health and HRSN and connection to providers with the

capacity to meet those needs in the community, during the period immediately before the individual's expected release. Demonstration-covered services also may help improve the health of demonstration beneficiaries prior to reentry, support improved health outcomes upon release, and increase the likelihood of a successful transition to the community. Once beneficiaries are released, the coverage for which the individual is otherwise eligible must be provided consistent with all requirements applicable to such coverage.

Minimum Benefits for the Reentry Section 1115 Demonstration Opportunity

As part of the Reentry Section 1115 Demonstration Opportunity, CMS does not expect to approve a state's proposal unless the pre-release benefit package includes at least: 1) case management to assess and address physical and behavioral health needs and HRSN; 2) MAT services for all types of SUD as clinically appropriate, with accompanying counseling; and 3) a 30-day supply of all prescription medications that have been prescribed for the beneficiary at the time of release⁷³, provided to the beneficiary immediately upon release from the correctional facility. States may propose to cover these benefits under the demonstration or describe to CMS in the demonstration application how the state otherwise ensures that they will be provided to eligible beneficiaries, such as, through the state plan immediately upon release (e.g., 30-day supply of prescription medications), through another state-only program or by the carceral system directly (e.g., MAT).

It is important to note that, to the extent the state chooses to provide prescribed drug coverage under demonstration authority in a manner that would provide less coverage for prescribed drugs than under the optional Medicaid benefit described at section 1905(a)(12), consistent with sections 1902(a)(54) and 1927 (the Medicaid Drug Rebate Program), the state may not seek federal nor supplemental state specific rebates under section 1927 of the Act for any of the pre-release drugs provided under the demonstration. This would apply to MAT drugs and the 30-day supply of medications upon release (as clinically appropriate based on the medication dispensed and the indication), if those drugs are covered through section 1115 expenditure authority prior to the individual formally being released from incarceration, as well any additional pre-release covered outpatient drugs, such as hepatitis C drugs. Therefore, in order for states to be permitted under this demonstration opportunity to seek rebates, they must include all covered outpatient drugs pre-release and meet the Medicaid Drug Rebate program section 1927 requirements. States may include utilization management tools consistent with their approved Medicaid state plan.

As noted in the background section of this letter, compared to the general population, individuals who are incarcerated have a higher incidence of chronic physical and behavioral health conditions and disease burden, including high blood pressure, asthma, cancer, arthritis, and

⁷³ The 30-day supply of prescription medications should be dispensed as clinically appropriate based on the medication and the indication.

infectious diseases, such as tuberculosis, hepatitis C, and HIV, to name a few.⁷⁴ Youth incarceration is independently associated with worse adult physical and mental health.⁷⁵ CMS strongly encourages states to cover pre-release services, such as family planning services and supplies for both men and women, and screening for common health conditions within the incarcerated population, such as blood pressure, diabetes, Hepatitis C, and HIV.

Benefit #1: Case Management to Assess and Address Physical and Behavioral Health Needs, and HRSN

Case management is expected to be a major component in the Reentry Section 1115 Demonstration Opportunity and should be provided to all beneficiaries in the demonstration. As stakeholders emphasized in the RTC, case management is a lynchpin for the successful transition of reentering individuals. Medicaid case management facilitates services that assess and meet an individual's health needs, including behavioral health needs and HRSN.⁷⁶

Case management services include the following activities: 1) comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services; 2) development (and periodic revision) of a specific care plan based on the information collected through the assessment; 3) referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed supportive and stabilizing services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and 4) monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary.⁷⁷ Case management assists individuals in getting connected to services and providers, not only for physical and behavioral health needs, but also for HRSN. For instance, if the state includes youth and/or youth correctional facilities in the demonstration, a case manager might also work with state children and youth agencies for children who are involved with the foster care system.

Pre-release case management is expected to actively build a bridge to post-release Medicaid services, addressing needs beyond merely identifying and listing out potential services and resources. The pre-release case manager is expected to connect individuals to needed services by setting up appointments with post-release community providers and ensuring a warm hand-off to the post-release case manager, if different, for follow up on receipt of services once the individual is released from incarceration.

⁷⁴ <https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/incarceration#:~:text=Studies%20have%20shown%20that%20when,%2C%20hepatitis%20C%20and%20HIV.>

⁷⁵ [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5260153/.](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5260153/)

⁷⁶ <https://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/downloads/moratoriumsummary.pdf>.

⁷⁷ [https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.169.](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.169)

Case managers are not expected to provide services to a particular individual on a daily basis throughout the entire pre-release period during which a beneficiary is receiving demonstration coverage. Instead, case managers should use that period of time to develop a connection with the individual, assess their needs, plan effectively for any Medicaid or demonstration-covered services and supports that the reentering individual may receive on a pre-release basis, and arrange for any covered services that the beneficiary may need post-release (including scheduling initial post-release appointments with providers, as appropriate). Building trust between case managers and their clients occurs over time and through learning about the incarcerated individual's lived experience prior to and during incarceration, as well as aspirations for and obstacles to their clients' future success upon release back into the community.

A key function of the case manager is to perform a comprehensive assessment by gathering and assimilating information from an array of sources, likely documented in multiple systems and across different formats, to ascertain the health needs of an individual who is incarcerated. The assessment may include any past medical history, medical records, assessments, screenings, diagnostic services, information available from the corrections system, interviews with the individual, and information from health plans, state Medicaid agencies and providers, or other sources that may be available to the case manager.⁷⁸

Another key function of the case manager is the incorporation of the information from the comprehensive assessment into an actionable person-centered care plan that engages the individual at the center of decision making. States may need to work with their correctional agency partners to establish agreements to share data and information to facilitate the ability of the case manager to effectively create a person-centered care plan and to successfully make connections to enable the beneficiary to obtain needed services both pre- and post-release. The person-centered care plan should encompass all needs related to physical and behavioral health, and primary and specialty treatment to be provided either pre-release, or post-release in the community. This includes addressing in the person-centered care plan, as appropriate, family planning services and supplies for both men and women, and screening and lab work for common health conditions (blood pressure, diabetes, mental health conditions, Hepatitis C and HIV).

The role of case managers and the person-centered care plan are to examine past needs and services, and to document and facilitate current and future needs and services. In this Reentry Section 1115 Demonstration Opportunity, case management is provided pre-release, and will consider the delivery of services pre and post-release by:

- Ensuring needs identified in the care plan include services which will be received during the post-release period, and facilitating those future services by
 - Helping individuals to identify providers of services post-release;
 - Making referrals for and scheduling appointments for services post-release; and

⁷⁸ This list is a sampling of potential sources and is neither an exhaustive nor a list of sources that necessarily must be consulted. Case managers and information custodians should take care to observe all applicable legal requirements concerning the protection of personally identifiable information and protected health information, including obtaining consent or an authorization from the individual, where appropriate.

- Transitioning between pre- and post-release case managers, when another case manager will assume case management longer-term through post-release coverage (Medicaid or other) via a warm handoff process;
- Ensuring the state's approved Reentry Section 1115 Demonstration benefit package of services is provided to individuals who are eligible during the pre-release period (e.g., MAT) as appropriate, and attempting to coordinate receipt of these services with the individual's receipt of other services provided directly by the carceral authority or otherwise that are not part of the approved Section 1115 Reentry Demonstration project; and
- Communicating with correctional health care providers about health care conditions that have been identified and that may require treatment prior to release, whether such treatment is covered under the demonstration or by the carceral health care delivery system or otherwise.

Additionally, the person-centered care plan should address social, educational and other underlying needs, such as vocational services or employment. Many Medicaid beneficiaries face challenges related to HRSN,⁷⁹ which can be particularly challenging for individuals who were formerly incarcerated as they rebuild their lives in the community. HRSN can have an impact on health, including but not limited to access to nutritious food, affordable and accessible housing, convenient and efficient transportation, safe neighborhoods, strong social and familial connections, quality education, and opportunities for meaningful employment. There is a growing body of evidence that indicates that these challenges can lead to poorer health outcomes for beneficiaries and higher health care costs, and can exacerbate health disparities.⁸⁰ To help ensure that beneficiaries' HRSN are met, states are strongly encouraged to establish partnerships and communication lines with state and local social service agencies to promote access to affordable housing and nutrition opportunities for beneficiaries returning to the community.

To illustrate how a case manager may address HRSN in the carceral setting, an individual may be having difficulty securing safe and stable housing. A case manager can assist in identifying a community-based provider whose area of expertise involves helping individuals connect to safe and stable housing. The case manager will make the connection to the providers to enable the individual to understand housing options, or other supportive services essential to success during reentry, as well as follow-up with the individual to ensure the connections are effective.

While the person-centered care plan is created in the pre-release period and is part of the case management pre-release service to assess and address physical and behavioral health needs and HRSN, the scope of the plan extends beyond release and should include the full array of Medicaid-covered services and other needed supports. As previously indicated, some of the services identified in the person-centered care plan may be provided pre-release, while others will be provided post-release. The case manager creates linkages by arranging for and scheduling appointments for services pre-release and post-release in the community. Because the scope of the person-centered care plan includes both pre- and post-release periods, it may include a vast array of services and items for comprehensive physical and behavioral health care as appropriate, such as: physical exams, consultation, lab work, screening for suicide risk,

⁷⁹ <https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/incarceration>.

⁸⁰ <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>.

screening for overdose risk, MAT, peer support services, medications; linkages with housing, employment, and/or other HRSN providers; connection to integrated care models such as Medicaid health homes for individuals with chronic conditions; linkages to long-term services and supports needed to remain in the community upon release; and other health care services, supplies, and appliances beneficiaries may need upon release (e.g., wheelchair, walker, glucose meter and diabetic test strips, etc.).

Case managers will need to:

- develop a relationship characterized by respect, dignity, and trust with each individual who is incarcerated and assigned to the case manager;
- assess the individual comprehensively by acquiring and synthesizing information regarding their needs;
- offer information in an easy to understand and actionable person-centered care plan;
- make linkages to services pre-release, with other linkages to post-release services; and
- provide a warm hand-off to post-release case managers who will provide services under the Medicaid state plan or other waiver or demonstration authority.

States and managed care plans, if applicable, should consider training requirements and competencies for case managers to address the medical and social complexities and challenges individuals who are currently or were recently incarcerated may experience and lay the foundation for a trust relationship such as:

- trauma-informed approaches, which recognize individuals' life experiences within and outside of incarceration, as individuals who are incarcerated have significantly higher rates of trauma and adverse childhood experiences than the general population;⁸¹
- person-centered care planning, which puts the individual at the center of the conversation and includes them in decision-making;
- intrapersonal and person-centered approach to acknowledging cultural experiences and environments, recognizing how individuals' past, current, and future cultural experiences and environments inform individuals' needs;
- support for individuals' communication needs related to language or disability,⁸² which is essential for building understanding, safety, and trust, as well as ensuring quality in person-centered care planning and coordination;
- knowledge, experience, and understanding of complex physical and behavioral health needs and health-related social needs, and individuals with undiagnosed conditions or needs that may not have been treated or met;
- understanding of the unique needs of the incarcerated population they will be serving, as well as the additional hurdles these individuals are likely to face upon reentry, based on chronic

⁸¹ Wolff N, Shi J. Childhood and adult trauma experiences of incarcerated persons and their relationship to adult behavioral health problems and treatment. *Int J Environ Res Public Health*, 2012 May; 9(5):1908-26. Available at: <https://www.mdpi.com/1660-4601/9/5/1908>.

⁸² Web-based training resources that may be useful for cultural competency/cultural humility skills as case managers work with individuals with limited English proficiency, individuals with disabilities, and individuals from LGBTQ+ communities are available at: <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/webbasedtraining>. States can also consider staff with similar needs who may be able to better engage individuals and build a strong rapport.

health conditions, complex health-related circumstances, interaction with the foster care system, the stigma associated with incarceration, and the supportive services necessary to address underlying employment, housing, and other underlying needs; and

- skills related to making a trust connection and building a strong rapport with reentering individuals, based on respect.

Individuals who are incarcerated may be moving or returning to communities far from where they have been incarcerated. As such, case managers will need to be knowledgeable or inform themselves about community resources in the areas to which individuals are returning in order to arrange for needed services. Case managers who provided pre-release services, depending on the state's proposal, may continue to provide post-release case management under the Medicaid state plan authority or other waiver or demonstration authority. They may also need to coordinate with other case managers in the communities where incarcerated individuals will be moving to facilitate a smooth transition and warm hand off if there will be more than one case manager involved with an incarcerated individual's transition to the community. States will need to ensure appropriate case management coverage is available to work with formerly incarcerated individuals post-release. CMS is available for state technical assistance to add state plan coverage for targeted case management or to provide case management under other Medicaid authorities, as may be needed.

Planning for post-release services begins with case management through this demonstration, but reassessment, monitoring and follow-up will likely continue after the individual is released from incarceration, through the post-demonstration Medicaid benefits to which the beneficiary is entitled. Whether case management is provided in fee-for-service or through a managed care plan, CMS expects case managers to work with the individual on an ongoing basis post-release to help ensure access to care, continuity of care, and receipt of needed services post-release. Case managers working with reentering individuals who will be enrolled in a managed care plan should also ensure that they educate the individuals on how to access covered services, including how to determine whether a provider is in the plan's network.

Since many incarcerated individuals, upon reentry, will be required to meet conditions of parole or probation, case managers may need to facilitate effective communication with parole or probation officers to coordinate health care services, as well as address HRSN in the community.

Benefit #2: Medication Assisted Treatment (MAT)

For purposes of this demonstration opportunity, MAT includes medication in combination with counseling/behavioral therapies, as appropriate and individually determined, and should be available for all types of SUD as clinically appropriate, not just OUD. CMS also recognizes that in many instances, prisons and jails are not providing MAT or are only providing limited forms of MAT. Despite these limitations, CMS expects that MAT coverage will be accessible to demonstration beneficiaries with SUD. MAT may be covered as a demonstration benefit under the Reentry Section 1115 Demonstration Opportunity, or it may be provided under existing state-only programs or by the carceral system. In cases where MAT benefits may be limited or not easily accessible, such as when provided by a state-only program or by the carceral system

directly, demonstration coverage may be used to enhance the benefit to help ensure robust coverage and access to MAT services for beneficiaries for whom they are appropriate.

As noted earlier in the background section of this letter, rates of SUD among individuals who are incarcerated are extremely high. Additionally, many individuals are incarcerated for crimes involving drugs or drug use.⁸³ Data also show that MAT is underutilized in the carceral system for a variety of reasons, including pressure from other incarcerated individuals while in a carceral setting; stigma; and perceptions that using MAT to treat an SUD is just trading one drug for another drug, that individuals who are incarcerated may not be able to continue treatment post-release or will be likely to resume drug use to cope with environmental stress after release, and that correctional facilities may not have capacity to provide or cannot afford to provide MAT.⁸⁴

In addition to greater access to illegal drugs once released, individuals may be returning to settings and communities in which they were using drugs prior to incarceration, as well as encountering new or aggravated life stressors due to the obstacles to securing services and supports to address underlying needs. High rates of death from opioid overdose shortly after release from incarceration are well documented, with a 2018 study of individuals released from North Carolina prisons from 2000 to 2015 experiencing overdose deaths during the period two weeks post-release at a rate that was 40 times higher than overdose deaths in the general North Carolina population.⁸⁵ In two Washington state studies, drug overdose was the most common cause of death and was responsible for over a quarter of deaths after release from prisons, with the greatest risk of death immediately after release from prison.⁸⁶

Given these alarming statistics, the importance of providing MAT coverage for the carceral population with SUD is critical to ensuring the quality of care for reentering individuals and the likelihood of successful transitions to the community. Medicaid coverage is available for all U.S. Food and Drug Administration (FDA) approved medications for opioid use disorder (MOUD), including buprenorphine, methadone, and naltrexone as well as acamprosate and naltrexone for alcohol use disorder. All of these approved MOUD and alcohol use disorder medications have been shown to be safe and effective when used in accordance with their FDA-approved labeling. Patients on naltrexone who discontinue its use or relapse after a period of abstinence may have a reduced tolerance to opioids. Therefore, taking the same, or even lower doses of opioids than used in the past can cause life-threatening consequences. CMS encourages states to cover the full array of FDA-approved medications, including buprenorphine and methadone. States should encourage providers, including those practicing in correctional

⁸³ <https://nida.nih.gov/publications/drugfacts/criminal-justice>.

⁸⁴ https://store.samhsa.gov/sites/default/files/d7/priv/pep19-matbriefcjs_0.pdf.

⁸⁵ Ranapurwala, S. et al., Opioid overdose mortality among former North Carolina inmates: 2000-2015. *American Journal of Public Health*, 2018 Sept; 108(9):1207–1213. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6085027/>.

⁸⁶ <http://www.hca.wa.gov/assets/program/SOR-workgroup-meetingmaterials-202009.pdf>

facilities, to utilize the medication that is most appropriate for each individual, with a focus on MAT induction, stabilization, and maintenance of treatment, including post-release.⁸⁷

The Reentry Section 1115 Demonstration Opportunity may present an opportunity to increase provision of MAT within the carceral system. In line with research demonstrating the effectiveness of MAT,^{88,89} CMS expects state Medicaid agencies participating in this demonstration opportunity, along with their correctional agency partners, to use all available levers in their states to increase the availability of MAT as clinically appropriate within prisons and jails to appropriate individuals.

Benefit #3: 30-day supply of all prescription medications provided to the beneficiary immediately upon release from the correctional facility

States and stakeholders have shared that a prison or jail providing a prescription for medication that an individual is taking is often inadequate to ensure near real-time receipt of the medication in the community when a person is released from incarceration, and therefore is often inadequate to ensure adherence to a prescribed course of medical treatment. Providing a 30-day supply of prescription medication that has been prescribed for a beneficiary immediately upon release (as clinically appropriate based on the medication dispensed and the indication) can reduce one barrier to meeting ongoing medical needs upon reentry and may prevent unnecessary use of an ED and/or inpatient hospitalization.

Provision of medication upon release may be as either a pre-release demonstration service or as a post-release Medicaid service furnished outside the scope of this demonstration. Some states may choose to cover the medications through section 1115 expenditure authority prior to the individual formally being released from incarceration. In other states, the individual may receive the medications under their state plan Medicaid benefit package as they are leaving the carceral facility. Regardless of the approach selected by the state, CMS expects the Reentry Section 1115 Demonstration Opportunity to facilitate the provision of a 30-day supply of any prescription medication(s) (as clinically appropriate based on the medication dispensed and the indication) for physical and behavioral health conditions, including MAT prescription(s), at the point of release.

Flexibility for Additional Physical and Behavioral Health Services

Due to the variability in health care services currently provided in jails and prisons, the Reentry Section 1115 Demonstration Opportunity allows state Medicaid agencies to scope a proposed common benefit package across carceral facilities to best accomplish the demonstration goals by improving care transitions for incarcerated individuals. In addition to the services of case management, MAT coverage for all types of SUD, and 30 days of prescription medication upon release⁹⁰, we recognize that there may be other important physical and behavioral health services

⁸⁷ <https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/naltrexone>.

⁸⁸ <https://pubmed.ncbi.nlm.nih.gov/30797392/>.

⁸⁹ <https://www.ncbi.nlm.nih.gov/books/NBK538936/>.

⁹⁰ The 30-day supply of prescription medications should be dispensed as clinically appropriate based on the medication and the indication.

that states may request to cover on a pre-release basis, such as family planning services and supplies, behavioral health or preventive services, including those provided by peer supporters/ community health workers with lived experience, or treatment for Hepatitis C. CMS is also open to states requesting section 1115 expenditure authority to provide medical supplies, equipment, and appliances prior to the individual formally being released from incarceration, so that individuals transition to the community with needed items, such as walkers, diabetic supplies, etc. Because of operational variations between states, some individuals may be able to receive these items immediately upon release as part of their state plan or other waiver or demonstration project benefit package as they are leaving the carceral facility.

States may also wish to leverage existing and new initiatives to improve health outcomes for individuals who are incarcerated returning to the community, similar to the *Strategies to Address the Opioid Epidemic (SUD)*⁹¹ and/or *Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance (SMI/SED)*⁹² section 1115 demonstration opportunities. There are also many models and best and promising practices to draw upon that are in place in public and private health systems. One best practice for reentry supports includes relying on trained peers or community navigators who have similar lived experiences as recently released beneficiaries who can act as mentors to help navigate health and reentry challenges. Having a trained peer supporter can provide another long-lasting, trusting relationship post-release. Individuals may feel more comfortable relaying a personal challenge, health concern, or environmental issue or conflict, including a relapse, to a peer rather than a medical professional or parole or probation officer.⁹³

Models like the Transitions Clinic Network leverage community health workers who are part of the integrated care team to further promote high quality, equitable health care and cultural responsiveness in clinics that serve reentering individuals in the neighborhoods most impacted by incarceration.⁹⁴ Additionally, “hub-and-spoke”⁹⁵ and OTPs are two examples of evidence-based model options for prison and jails. Prisons and jails can contract with providers in the community or become certified OTPs. Hub and spoke models rely on “hub” providers to act as responsible providers who facilitate and/or provide treatment with shared resources and

⁹¹ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>.

⁹² <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>.

⁹³ <https://nationalreentryresourcecenter.org/resources/formerly-incarcerated-peer-mentoring-can-offer-chance-give-back>.

⁹⁴ <https://transitionsclinic.org/>.

⁹⁵ Department of Justice (DOJ), Bureau of Prisons (BOP) is working with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Administration to implement Opioid Treatment Programs (OTP) in federal institutions and is also working to implement a “hub and spoke” model that will allow all BOP-managed institutions to directly provide all three U.S. Food and Drug Administration approved MOUD medications. Hubs will provide direct oversight of the program, ensuring that individuals have access to medications, while some medications are provided by community providers. For more information, see: <https://www.ojp.gov/first-step-act-annual-report-april-2022>.

responsibilities extending to “spoke” interdisciplinary community team members such as physical and behavioral health providers and care coordinators.⁹⁶

Reentering individuals may also benefit from integrated provider delivery models, such as health homes,^{97,98} to provide whole person primary, acute, and behavioral health care, and long-term services and supports to members with chronic conditions in the community under one umbrella. Health homes can be especially helpful for returning community members who disproportionately experience physical and behavioral health problems including SUD.⁹⁹ Under the optional Medicaid “Health Homes” benefit at section 1945 of the Act, states can cover certain services for Medicaid beneficiaries with at least two chronic conditions (including SUDs), with at least one chronic condition and who are at risk of having another, or with at least one serious and persistent mental health condition. The services that states can cover under this benefit are comprehensive care management, care coordination and health promotion, comprehensive transitional care from inpatient to other settings, patient and family support, and referral to community and social support services (if relevant). States can opt to add this Health Home benefit to their state Medicaid plan.

States that want to add pre-release services beyond the minimum benefit package should base these additional services on the needs of the carceral populations they are proposing to serve and the carceral settings included in their demonstration. Such services would be otherwise coverable state plan services, if not for the inmate payment exclusion. These states should provide justification in their section 1115 demonstration applications for how such services would be likely to promote the objectives of the Medicaid program and facilitate meeting the demonstration goals, consistent with section 5032 of the SUPPORT Act.

Pre-Release Services Providers

During the pre-release period, states may choose to cover in-person health care services, services delivered to individuals who are incarcerated via telehealth, or use some combination of both modalities. CMS expects Medicaid agencies to work with the respective correctional systems and facilities to ensure access to demonstration-covered health care services and to facilitate access into correctional facilities for community health care providers, including case managers, in person and/or via telehealth. State Medicaid agencies should also collaborate with correctional entities to ensure the availability of appropriate technology that may be needed for health care services that are delivered via telehealth, as well as procedures to ensure appropriate privacy during telehealth visits, consistent with any applicable federal and state confidentiality, privacy, and security requirements. This privacy is critical in facilitating a trusting relationship between individuals who are incarcerated and their health care providers during the pre-release service delivery period and is expected to help ensure better health outcomes upon release.

⁹⁶ <https://store.samhsa.gov/sites/default/files/d7/priv/pep19-matusecjs.pdf>.

⁹⁷ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib112719.pdf>.

⁹⁸ <https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/guide-medicaid-health-home-design-implementation/index.html>.

⁹⁹ <https://aspe.hhs.gov/sites/default/files/documents/d48e8a9fdd499029542f0a30aa78bfd1/health-care-reentry-transitions.pdf>.

While provision of “in reach” pre-release services by community-based providers is the preferred approach to build trust with individuals who are incarcerated and strengthen the connection to the community upon release, CMS recognizes the operational complexities inherent in providing services to an incarcerated population, and that many states have provider shortages, which are particularly acute in rural areas. States may choose to rely on carceral health care providers for delivery of some or all of the pre-release services.

Generally, states that rely on carceral health care providers to furnish pre-release services authorized through the demonstration must ensure that they comply with Medicaid provider participation policies set by the state Medicaid agency.

The demonstration’s evaluation efforts will be expected to include an examination of pre-release carceral and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community.

Pre-release Timeframe

Section 5032(b) of the SUPPORT Act states that, “the Secretary of Health and Human Services, through the Administrator of the Centers for Medicare & Medicaid Services, shall issue a State Medicaid Director letter, based on best practices developed under subsection (a)(1), regarding opportunities to design demonstration projects under section 1115 of the Social Security Act (42 U.S.C. 1315) to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX of such Act, including systems for, with respect to a period (not to exceed 30 days) immediately prior to the day on which such individuals are expected to be released from such institution - (1) providing assistance and education for enrollment under a State plan under the Medicaid program under title XIX of such Act for such individuals during such period; and (2) providing health care services for such individuals during such period.” For the reasons outlined below, the Reentry Section 1115 Demonstration Opportunity can include flexibility for states to offer coverage for certain pre-release services for up to 90 days before the incarcerated individual’s expected date of release.

The section 5032 stakeholder group and a number of states have suggested that 30 days prior to release is not a sufficient period of time to begin supporting incarcerated individuals to best enable their successful transition back to their communities. They point out that 30 days may be insufficient for coordinating and transitioning care, particularly for individuals with SUD. However, Congress has expressed its judgment in section 5032(b) of the SUPPORT Act that this demonstration opportunity should provide coverage for health care services furnished to demonstration beneficiaries for a period that specifically does not exceed 30 days prior to the expected date of release. Although that time limitation does not apply to the Secretary’s general authority to approve demonstration projects and associated expenditure authorities under section 1115 of the Act, we must abide by Congress’ determination that demonstration projects under the opportunity described in section 5032(b) of the SUPPORT Act to improve care transitions for certain soon-to-be released individuals must not begin to cover services subject to the inmate payment exclusion before the date that is 30 days immediately prior to the individual’s expected release date.

CMS welcomes state proposals to provide demonstration coverage for certain pre-release services for a period up to 90 days immediately prior to the individual's expected release date, but such demonstrations must have a demonstration purpose and related experimental hypotheses that go beyond improving care transitions for soon-to-be released individuals. That is, the demonstration must not be limited in its test to the matter that Congress directed should be evaluated during a period not to exceed 30 days immediately prior to the expected release date, but should include one or more additional tests that the Secretary has discretion to approve under section 1115 of the Act with respect to the period over 30 days and up to 90 days immediately prior to the expected released date.

Under Secretarial authority at section 1115 of the Act, and in keeping with the objective of the Medicaid program to furnish medical assistance, CMS will consider state requests that exceed the 30-day period for pre-release services, for up to a 90-day pre-release period.

Administrative Information Technology (IT)

State Medicaid agency IT system expenditures¹⁰⁰ incurred in the implementation of the Reentry Section 1115 Demonstration Opportunity may be eligible for enhanced FFP. For states interested in receiving such funding, CMS reminds states of the following:

- Approval for enhanced match requires the submission and approval of an Advanced Planning Document (APD). A state may submit an APD requesting approval for a 90/10 enhanced federal match for the design, development, and implementation of their Medicaid Enterprise Systems (MES) initiatives that contribute to the economic and efficient operation of the program. This can include technology that supports data sharing between state Medicaid agencies, state correctional agencies and participating correctional facilities, such as systems to support eligibility determinations and enrollment (including suspension strategies).
- Interested states should refer to 45 CFR Part 95, Subpart F – Automatic Data Processing Equipment and Services-Conditions for FFP for the specific provisions contained therein related to APD submission.
- As a condition of receiving enhanced federal funding for technology, 42 CFR § 433.112(b)(12) requires alignment with, and incorporation of, industry standards adopted by the Office of the National Coordinator for Health IT in 45 CFR part 170, subpart B. Subpart B contains potentially helpful standards for coordination care between carceral settings and community providers (e.g., direct messaging, the Fast Healthcare Interoperability Resource application programming interface, public health standards including electronic case reporting for more granular overdose reporting and/or COVID reporting, and syndromic surveillance standards to potentially coordinate Hepatitis C or HIV care coordination, etc.).
- States may also request a 75/25 enhanced federal match for ongoing operations of CMS-approved systems. Interested states should refer to 42 CFR Part 433, Subpart C – Mechanized Claims Processing and Information Retrieval Systems for the specific provisions contained therein related to systems approval.

¹⁰⁰ <https://www.medicaid.gov/medicaid/data-systems/health-information-exchange/federal-financial-participation-for-hit-and-hie/index.html>.

State Medicaid agency expenditures that may be eligible for this enhanced administrative match include, but are not limited to, the following examples:

- Establishing State Medicaid Agency systems and/or improving data integration with other electronic data sources and/or systems to support eligibility determination, enrollment (including suspension), and case management of Medicaid beneficiaries, as well as connections between carceral settings, state Medicaid agencies, state correctional agencies, Medicaid providers, and other systems (e.g., housing or other HRSN data systems/sources);
- Developing and implementing software applications that facilitate communication among Medicaid providers and correctional staff involved with care furnished to incarcerated beneficiaries;
- Adding additional data fields and data matching logic for Medicaid program components such as eligibility and enrollment, services, prior authorization or claims processing in addition to new fields that may be added through this demonstration such as length of incarceration, expected dates of discharge from incarceration, and other data elements specific to the carceral environment;
- Adding new or existing system processes or enhancements for routine file exchanges and updates, and processes for matching, notification, and delivery of files to facilitate the necessary data exchanges to identify individuals and deliver services as well as tracking of participation in the demonstration and delivery of services; and
- Implementing or improving MES accessibility technologies for users with disabilities.

If there are questions related to IT topics and IT system expenditures, CMS encourages states to contact their MES State Officer.

States are also asked to consider the technical requirements for coordinating care between carceral settings and community providers and public health entities. The electronic health records (EHR) used by correctional health providers may not necessarily be certified to criteria in the Office of the National Coordinator for Health Information Technology's (ONC) Health IT Certification Program (Certification Program),¹⁰¹ which is a voluntary certification program established to provide for the certification of health IT. Requirements for certification are established by standards, implementation specifications and certification criteria adopted by the Secretary of Health and Human Services. Given the variance in capabilities of EHRs in carceral settings, and the need to coordinate care with community providers post-release, states may wish to consider multiple approaches:

1. States may consider requiring or recommending that participating correctional health providers use EHRs that have been certified to criteria within the ONC Certification Program, such as EHRs that meet the definition in 45 C.F.R. § 170.102 for "2015 Edition Base EHR."

¹⁰¹ <https://www.healthit.gov/topic/certification-ehrs/about-onc-health-it-certification-program>.

2. States may consider requiring or recommending that participating correctional health providers are able to perform certain activities related to coordinating care irrespective of the certification status of any carceral EHR system, such as:
 - a. Ability to electronically share a core set of clinical and demographic information about each patient with community providers, as defined by the most appropriate edition of the United States Core Data for Interoperability (USCDI).¹⁰²
 - b. Ability to bi-directionally share data with public health entities and community providers for purposes of activities related to coordinating care for HIV (including Pre-Exposure Prophylaxis or PreP testing) and Hepatitis C.
 - c. Ability to share necessary clinical information with community providers for establishing or continuing MAT post-release.
 - d. Ability to share necessary clinical information with Medicaid SUD treatment providers post-release.
 - e. Ability to share necessary clinical information with Medicaid behavioral health providers post-release.
 - f. Ability to share results of screening for HRSN with appropriate community providers and public assistance agencies.
3. States may consider requiring or recommending that correctional health providers and community providers connect to some national networks to facilitate activities related to coordinating care, such as:
 - a. Connecting to the eHealth Exchange¹⁰³ to facilitate the exchange of data across disparate systems, including pharmacy and lab data;
 - b. Connecting to the Centers for Disease Control and Prevention Immunization Gateway¹⁰⁴ to facilitate the exchange of immunization data across jurisdictions; or in the future, when available under the Trusted Exchange Framework and Common Agreement (TEFCA), by participating as a signatory to a Framework Agreement (as that term is defined by the Common Agreement for Nationwide Health Information Interoperability as published in the Federal Register and on ONC's website¹⁰⁵) in good standing (that is, not suspended) and enabling secure, bi-directional exchange of information to occur, in production, for every patient encounter, transition or referral, and record stored or maintained, in accordance with applicable law and policy.

Transitional, Non-Service Expenditures

CMS will consider requests for time-limited support in the form of FFP for certain new expenditures through section 1115 demonstration authority to support necessary changes required by states, correctional facilities, and health care providers to implement and expand

¹⁰² <https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi>.

¹⁰³ <https://ehealthexchange.org/>.

¹⁰⁴ [https://www.cdc.gov/vaccines/programs/iis/iz-gateway/overview.html#:~:text=The%20Immunization%20Gateway%20\(IZ%20Gateway,provider%20organization%2C%20and%20consumer%20applications](https://www.cdc.gov/vaccines/programs/iis/iz-gateway/overview.html#:~:text=The%20Immunization%20Gateway%20(IZ%20Gateway,provider%20organization%2C%20and%20consumer%20applications).

¹⁰⁵ <https://www.healthit.gov/topic/interoperability/policy/trusted-exchange-framework-and-common-agreement-tefca>.

service provision and coordination with community providers, to support the implementation of the Reentry Section 1115 Demonstration Opportunity. Examples include the following:

- Development of new business and operational practices and related health IT to support the coordination of pre- and post-release services that would improve alignment in documentation and billing between Medicaid and the carceral setting;
- Hiring and training of staff to assist with working effectively and appropriately with justice-involved individuals receiving services authorized under the demonstration; and
- Outreach, education, and stakeholder convening to advance collaboration between correctional facilities, Medicaid agencies, and other organizations involved in supporting and planning for the Reentry Demonstration.

CMS recognizes there are significant upfront and/or one-time non-service costs required to bring necessary linkages to Medicaid operations and IT capabilities into the carceral settings. FFP for such expenditures authorized through a Reentry Section 1115 Demonstration must be new spending. In their applications, states should clearly describe the specific transitional, non-service activities necessary to support the successful implementation of the Reentry Section 1115 Demonstration, and should justify the projected expenditures associated with each activity. In order to justify approval, states should document how these expenditures are new as a result of implementation activities necessary for the Reentry Section 1115 Demonstration and not an offset of existing or otherwise planned expenditures. When incurred expenditures support both Reentry Section 1115 Demonstration and non-Demonstration activities, states must apply cost allocation principles consistent with federal regulations at 45 CFR Part 75 in order to properly identify the amounts that may be claimed for FFP. As with other components of a state demonstration application, CMS will review each request for expenditure authority individually and on its merits. If authorized, such expenditures will be subject to any limitations, as well as regular reporting, monitoring, and evaluation requirements, to be described in the relevant expenditure authorities and demonstration STCs.

Data-Sharing, Confidentiality, Privacy, and Security Considerations

CMS understands data related to carceral status, release and reentry details, Medicaid eligibility, and the health care needs of individuals who are incarcerated and returning to the community may reside in fragmented systems, including non-electronic systems. This may present some challenges in data sharing for purposes of case management and collection of data for this Reentry Section 1115 Demonstration Opportunity. States are reminded, and should be cognizant, of the laws and regulations regarding confidentiality, access, storage, and handling of certain information, including but not limited to: Section 1902(a)(7) of the Act;¹⁰⁶ 42 CFR Part 431, Subpart F; 42 CFR Part 2;¹⁰⁷ and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security, Breach Notification, and Enforcement Rules (the HIPAA

¹⁰⁶ <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-431/subpart-F>.

¹⁰⁷ For more information about the requirements in 42 CFR Part 2 regarding confidentiality of SUD patient records, see: <https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs>.

Rules).^{108,109} These laws and regulations should not be barriers for health care personnel to coordinate patient care among organizations or for audit, monitoring, and/or evaluation activities, but they may require the data to be used and safeguarded in accordance with the applicable rules, and may require patient consent or authorization under certain circumstances. To operationalize data sharing for this demonstration opportunity, CMS recommends that state Medicaid agencies engage their partner corrections agencies early on to establish vehicles, such as appropriate and comprehensive consent/authorization forms, if required, for information sharing and Memoranda of Understanding to facilitate information sharing with appropriate information protections and compliance with, as applicable, 42 CFR Part 2; the HIPAA Rules; 42 CFR Part 431, Subpart F;¹¹⁰ and any other applicable requirements under federal and state law for data sharing, confidentiality, privacy, and security.

Reinvestment Plan

As noted above, CMS does not expect to approve state proposals to receive federal Medicaid matching funds through the Reentry Section 1115 Demonstration Opportunity for any existing carceral health care services that are currently funded with state and/or local dollars unless the state agrees to reinvest the total amount of federal matching funds received for such services under the demonstration into activities and/or initiatives that increase access to or improve the quality of health care services for individuals who are incarcerated (including individuals who are soon-to-be released) or were recently released from incarceration, or for health-related social services that may help divert individuals from criminal justice involvement. Any investment in carceral health care must add to and/or improve the quality of health care services and resources for individuals who are incarcerated and those who are soon to be released from carceral settings, and not supplant existing state or local spending on such services and resources.

Interested states should develop and submit as part of their implementation plan a reinvestment plan for CMS review and approval outlining how the funds will be reinvested.

The reinvestment plan should align with the goals of the Reentry Section 1115 Demonstration Opportunity. It should detail the state's plans to increase access to or improve the quality of health care services, as well as address HRSN of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions. States have flexibility to identify particular activities and/or initiatives in their reinvestment plan, based on the focus of the state's proposal and the needs of individuals in their state. Reinvestment funds should be used to support the successful transition of beneficiaries to the community, e.g. investments to facilitate the provision of pre-release services, such as case

¹⁰⁸ 45 CFR Parts 160 and 164. For more information on the HIPAA Rules, see: <https://www.hhs.gov/hipaa/for-professionals/index.html>.

¹⁰⁹ 42 CFR Part 2 currently imposes different requirements for SUD treatment patient records protected by Part 2 than the HIPAA Rules impose for protected health information (PHI). These statutory and regulatory schemes apply to different types of entities and create dual obligations and compliance challenges for HIPAA covered entities and business associates that maintain PHI and Part 2 records, and thus are subject to both sets of rules.

¹¹⁰ <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-431/subpart-F>.

management, or expansion of community-based capacity, e.g. increasing or improving mental health and SUD services. The reinvestment plan should describe the activities and/or initiatives the state has selected to invest in and a timeline for implementation. For example, the reinvestment plan could include investments aimed at achieving the following:

- Improved access to behavioral and physical health care services in the community. This may result in expansion of Medicaid services such as adding or expanding mobile crisis services, trained peer supports, Medicaid health homes, and long-term services and supports to beneficiaries with chronic conditions and complex health-related circumstances.
- Improved access to and/or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the Reentry Section 1115 Demonstration Opportunity.
- Improved health information technology and data sharing.
- Increased community-based provider capacity that is particularly attuned to the specific needs of and able to serve justice-involved or individuals at risk of justice involvement.
- Expanded or enhanced community-based reentry services and supports, including services and supports to meet the HRSN of the justice-involved population.

The state's share of expenditures for new, enhanced or expanded pre-release services approved under the demonstration can be considered an allowable reinvestment. CMS would not approve a reinvestment plan under which funds would be used to build prisons, jails, or other carceral facilities or pay for prison or jail-related improvements other than those for direct and primary use in meeting the health care needs of individuals who are incarcerated. States seeking to reinvest funds in activities in jails or prisons should describe in their reinvestment plan, which is subject to CMS review and approval, whether privately-owned or -operated carceral facilities would receive any of the reinvested funds and, if so, the safeguards the state proposes to ensure that such funds are used for the intended purpose and do not have the effect of increasing profit or operating margins for privately-owned or -operated carceral facilities.

Demonstration Milestones

The Reentry Section 1115 Demonstration Opportunity offers states flexibility to design demonstrations that are aimed at making significant improvements on a number of milestones with associated actions. When submitting proposals for the Reentry Section 1115 Demonstration Opportunity, states will be expected to commit to a number of actions to improve care transitions for reentering individuals, including by helping eligible individuals gain or maintain Medicaid enrollment and access high quality covered services. These commitments should be linked to state actions that build on the demonstration goals described earlier in this letter. They should include actions to ensure continuity of coverage and care, to cover and ensure access to the minimum set of pre-release services for individuals who are incarcerated, to facilitate better transitions and address physical and behavioral health conditions, to ensure access to services post-release to meet the needs of the reentering population, and to ensure cross-system collaboration. The milestones and associated actions are:

1. *Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated*

- Implement a state policy for a suspension strategy during incarceration (or implement an alternative proposal to ensure that only allowable benefits are covered and paid for during incarceration, while ensuring coverage and payment of full benefits as soon as possible upon release), with up to a two-year glide path to fully effectuate.
 - Ensure that any Medicaid-eligible person who is incarcerated at a participating facility but not yet enrolled is afforded the opportunity to apply for Medicaid in the most feasible and efficient manner and is offered assistance with the Medicaid application process in accordance with 42 CFR § 435.906 and § 435.908. This could include applications online, by telephone, in person, via mail or common electronic means in accordance with 42 CFR § 435.907. All individuals enrolled in Medicaid during their incarceration must be provided notice of any Medicaid eligibility determinations and actions pursuant to 42 CFR § 435.917 and § 431.211.
 - Ensure that all individuals at a participating facility who were enrolled in Medicaid prior to their incarceration are offered assistance with the Medicaid renewal or redetermination process requirements in accordance with 42 CFR § 435.908 and § 435.916. All individuals enrolled in Medicaid during their incarceration must be provided notice of any Medicaid eligibility determinations and actions pursuant to 42 CFR § 435.917 and § 431.211.
 - Implement a state requirement to ensure that all Medicaid-enrolled individuals who are incarcerated at a participating facility have Medicaid and/or managed care plan cards or some other Medicaid and/or managed care enrollment documentation (e.g., identification number, digital documentation, instructions on how to print a card, etc.) provided to the individual upon release, along with information on how to use their coverage (coordinated with the requirements under milestone #3 below).
 - Establish processes to allow and assist all individuals who are incarcerated at a participating facility to access and complete a Medicaid application, including providing information about where to complete the Medicaid application for another state, e.g., relevant state Medicaid agency website, if the individual will be moving to a different state upon release.
2. *Covering and ensuring access to the minimum set of pre-release services for individuals who are incarcerated to improve care transitions upon return to the community*
- Implement state processes to identify individuals who are incarcerated who qualify for pre-release services under the state's proposed demonstration design (e.g., by chronic condition, incarceration in a participating facility, etc.).
 - Cover and ensure access to the minimum short-term, pre-release benefit package, including case management to assess and address physical and behavioral health needs and HRSN, MAT services for all types of SUD as clinically appropriate with accompanying counseling, and a 30-day supply of medication (as clinically appropriate based on the medication dispensed and the indication) provided to the beneficiary immediately upon release, to Medicaid-eligible individuals identified as participating in the Reentry Section 1115 Demonstration Opportunity. In addition, the state should specify any additional services that the state proposes to cover for beneficiaries pre-release. The state should describe the Medicaid benefit category or authority for each proposed service.

- Develop state process to ensure case managers have knowledge of community-based providers in communities where individuals will be returning upon release or have the skills and resources to inform themselves about such providers for communities with which they are unfamiliar.

3. *Promoting continuity of care*

- Implement a state requirement that individuals who are incarcerated receive a person-centered care plan prior to release to address any physical and behavioral health needs, as well as HRSN and consideration for long term services and supports (LTSS) needs that should be coordinated post-release, that were identified as part of pre-release case management activities and the development of the person-centered care plan.
- Implement state policies to provide or facilitate timely access to any post-release health care items and services, including fills or refills of prescribed medications and medical supplies, equipment, appliances or additional exams, laboratory tests, diagnostic, family planning, or other services needed to address the physical and behavioral health care needs, as identified in the course of case management and the development of the person-centered care plan.
- Implement state processes to ensure, if applicable, that managed care plan contracts reflect clear requirements and processes for transfer of the member's relevant health information for purposes of continuity of care (e.g., active prior authorizations, care management information or other information) to another managed care plan or, if applicable, state Medicaid agency (e.g., if the beneficiary is moving to a region of the state served by a different managed care plan or to another state after release) to ensure continuity of coverage and care upon release (coordinated with the requirements under milestone #1 above).
- Implement state processes to ensure case managers coordinate with providers of pre-release services and community-based providers, if they are different providers. Implement a state policy to require case managers to facilitate connections to community-based providers pre-release for timely access to services upon reentry in order to provide continuity of care and seamless transitions without administratively burdening the beneficiary, e.g., identifying providers of post-release services, making appointments, having discussions with the post-release case manager, if different, to facilitate a warm handoff and continuity of services. A simple referral is not sufficient. Warm hand-offs to a post-release case manager and follow-up are expected, consistent with guidance language in the case management section.

4. *Connecting to services available post-release to meet the needs of the reentering population*

- Develop state systems to monitor individuals who are incarcerated and their person-centered care plans to ensure that post-release services are delivered within an appropriate timeframe. We expect this generally will include a scheduled contact between the reentering individual and the case managers that occurs within one to two days post-release and a second appointment that occurs within one week of release to ensure continuity of care and seamless transition to monitor progress and care plan implementation. These short-term follow-ups should include the pre-release and post-release (if different) case managers, as possible, to ensure longer term post-release case management is as seamless as possible. In keeping with the person-centered care plan

and individual needs, CMS is providing these general timeframes as suggestions, but recognizes that depending on the beneficiary's individualized needs and risk factors, a case manager may determine that the first scheduled contact with the beneficiary should occur, for example, within the first 24 hours after release and on a more frequent cadence in order to advance the goals of this demonstration.

- Develop state processes to monitor and ensure ongoing case management to ensure successful transitions to the community and continuity of care post-release, to provide an assessment, monitor the person-centered care plan implementation and to adjust it, as needed, and to ensure scheduling and receipt of needed covered services.
- Develop state processes to ensure that individuals who are receiving services through the Reentry Section 1115 Demonstration Opportunity are connected to other services needed to address LTSS and HRSN, such as housing, employment support, and other social supports as identified in the development of the person-centered care plan.
- Implement state policies to monitor and ensure that case managers have the necessary time needed to respond effectively to individuals who are incarcerated who will likely have a high need for assistance with navigating the transition into the community.

5. *Ensuring cross-system collaboration*

- Establish an assessment outlining how the state's Medicaid agency and participating correctional system/s will confirm they are ready to ensure the provision of pre-release services to eligible beneficiaries, including but not limited to, how facilities participating in the Reentry Section 1115 Demonstration Opportunity will facilitate access into the correctional facilities for community health care providers, including case managers, in person and/or via telehealth, as appropriate. A state could phase in implementation of pre-release services based on the readiness of various participating facilities and/or systems.
- Develop a plan for organizational level engagement, coordination, and communication between the corrections systems, community supervision entities, health care providers and provider organizations, state Medicaid agencies, and supported employment and supported housing agencies or organizations.
- Develop strategies to improve awareness and education about Medicaid coverage and health care access among various stakeholders, including individuals who are incarcerated, community supervision agencies, corrections institutions, health care providers, and relevant community organizations (including community organizations serving the reentering population).
- Develop systems or establish processes to monitor the health care needs and HRSN of individuals who are exiting carceral settings, as well as the services they received pre-release and the care received post-release. This includes identifying any anticipated data challenges and potential solutions, articulating the details of the data exchanges, and executing related data-sharing agreements to facilitate monitoring of the demonstration, as described below.

Implementation, Monitoring, and Evaluation

CMS expects a state with an approved Reentry Section 1115 Demonstration to submit an implementation plan, a monitoring protocol, quarterly/annual monitoring reports, a mid-point

assessment report, an evaluation design, and interim/summative evaluation reports, consistent with typical expectations and requirements for a section 1115 demonstration project. States with an approved Reentry Section 1115 Demonstration will be expected to complete all implementation activities necessary to achieve the milestones discussed in this letter and included in the approved Special Terms and Conditions (STC) governing the state's demonstration project. The monitoring and evaluation expectations will align with the goals and milestones of the approved demonstration project, including state-specific policy nuances that the state requests and CMS approves. CMS will provide individual state technical assistance on the monitoring and evaluation expectations.

Implementation Plan

A state with an approved Reentry Section 1115 Demonstration will develop an implementation plan per CMS guidance that describes the activities and associated timelines for achieving the demonstration milestones. Among other things, a state will be expected to identify for each milestone what it anticipates to be the key implementation challenges and the state's specific plans to address these challenges. Similarly, a state should note in its implementation plan how it will drive positive changes in health care quality for all demonstration beneficiaries, thereby reducing disparities and improving health equity. The state must also describe in the implementation plan its approach to ensure that coverage and payment for full benefits is in place as soon as possible upon release. A state may submit this plan as part of its application, during the approval process with CMS, or as a post-approval protocol. As a state develops its implementation plan, and as mentioned in the RTC, the state may wish to engage individuals who were incarcerated with lived experience in the planning, design, and implementation of the Reentry Section 1115 Demonstration Opportunity. If a state plans to phase in implementation of its demonstration, it should describe its approach in the implementation plan, including how it will leverage the phased approach to support creating comparison groups in the evaluation. Regardless of whether the implementation plan is submitted as part of a state's application or as a post-approval protocol, FFP for services provided during individuals' stays in carceral settings will be contingent upon CMS approval of the state's implementation plan.

As a state's implementation of an approved Reentry Section 1115 Demonstration progresses, the state will be expected to include information in its section 1115(a) demonstration monitoring reports that details the state's progress toward meeting the milestones, specifically in the context of the timeframes specified in the state's implementation plan.

The implementation plan must also include a reinvestment plan. The reinvestment plan should align with the goals of the Reentry Section 1115 Demonstration Opportunity specified in section 5032(b) of the SUPPORT Act, as discussed earlier in this document.

Monitoring Protocol and Quarterly and Annual Monitoring Reports

Consistent with 42 CFR § 431.428, states must undertake monitoring of their section 1115 demonstrations. The goal of monitoring is to identify risks associated with demonstration implementation, and proactively identify any needed mid-course corrections. To support monitoring activities, a state with an approved Reentry Section 1115 Demonstration will be

expected to include information in its demonstration quarterly and annual monitoring reports that, among other things, details performance measures representing key indicators of progress toward meeting the milestones for the demonstration. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals eligible for pre-release services, participating pre-release services providers, utilization of applicable pre-release and post-release services (e.g., primary, behavioral, MOUD, case management), provision of health or social service referral pre-release, participants with established care plans at release, and take-up of data system enhancements among participating carceral settings. Additionally, the state will be expected to report quality of care and health outcomes metrics known to be important for closing key quality and health equity gaps in Medicaid/CHIP (e.g., the National Quality Forum (NQF) “disparities-sensitive” measures) and prioritizing key outcome measures and their clinical and non-clinical (i.e., social) drivers of health. In coordination with CMS, the state is expected to select such measures for reporting in alignment with a critical set of health equity-focused measures that CMS is finalizing as part of its upcoming guidance on the Health Equity Measure Slate. Not all measures on the list will be applicable based on a state’s demonstration design. The state and CMS will collaborate to determine the appropriate measures the state will report. The monitoring reports will also be expected to include qualitative information that will align with the milestones outlined above, including but not limited to the state’s progress on data development and exchange.

CMS will provide guidance to each participating state to develop a monitoring protocol that will describe the plan for how and what the state will report in quarterly and annual monitoring reports. The information will include, but not be limited to, agreed upon performance measures, measure concepts, and qualitative narrative summaries. The state will also describe its plans for collecting and reporting stratified data throughout the life-cycle of the demonstration. States that utilize managed care plans for this demonstration must ensure that all managed care plan contracts include sufficient requirements for plans to provide all required information and data. Any deviations from CMS’ guidance the state wishes to make will be documented in the monitoring protocol. A timeframe for submitting the monitoring protocol and quarterly and annual monitoring reports will be included in the STCs of each demonstration.

Mid-point Assessment

Between years two and three of the demonstration implementation, we will expect an independent assessor to use data reported by the state to inform a mid-point assessment describing the state’s progress in meeting the milestones and performance measure targets. A state at risk of not meeting the milestones will be expected to describe the mid-course corrections it will undertake, including any modifications to its demonstration implementation. For example, the mid-point assessment should include an examination of how the state is progressing on data development and exchange, as a critical component to successfully monitoring and evaluating the demonstration. The mid-point assessment should indicate if the state is on track as per its implementation plan, any challenges the state is encountering, and how the state is planning to overcome those challenge and apply lessons learned. Furthermore, FFP for demonstration expenditures may be withheld if a state is not making adequate progress on meeting the milestones as evidenced by the approved performance measures. Additionally,

achievement of the milestones will be taken into consideration by CMS if a state is to request an extension of its demonstration.

Evaluation Design and Interim and Summative Evaluation Reports

A state will also be expected to conduct independent and robust interim and summative evaluations. To guide the evaluation efforts, the state will develop an evaluation design, with technical assistance from CMS, to be submitted within 180 days of the demonstration approval. The evaluation design will include detailed analytic plans and data collection and reporting details, and will be subject to CMS approval. The evaluation design should be mixed-methods and might include how the state will test whether the demonstration improved care transitions for individuals who are released from incarceration, including but not limited to, whether and how the demonstration improves coverage and quality of care. Outcomes of interest could include, but are not limited to, measurement of cross-system communication and collaboration, connections between carceral settings and community services, provision of preventive and routine physical and behavioral health care, and avoidable ED visits and inpatient hospitalizations, as well as all-cause deaths. Furthermore, the state should conduct a comprehensive cost analysis to support developing estimates of implementing the demonstration, including covering associated services. In instances where the state is testing services beyond the minimum benefit package identified above and/or providing coverage for a period over 30 days and up to 90 days immediately prior to a beneficiary's expected release date, the state should incorporate additional hypotheses to describe those tests.

CMS underscores the importance of the state undertaking well-designed provider, carceral facility, and/or beneficiary surveys and/or interviews to assess, for instance, key implementation challenges for case managers, providers and carceral facilities and their understanding of beneficiary experience, as well as to directly explore beneficiary understanding of and experience with transitioning out of the carceral setting. To the extent feasible, the state will be expected to collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, geography, and sexual orientation and gender identity). Such stratified data analyses will provide an understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration's various policies might support reducing such disparities. Additionally, if a state plans to phase in implementation across different carceral facilities, the state and its evaluator should leverage that approach in evaluation to create comparison groups.

The state will be required to submit the interim evaluation report one year before expiration of the demonstration or when the state submits a proposal to extend the demonstration in accordance with transparency requirements at 42 CFR § 431.412(c). The state will be required to submit the summative evaluation report within eighteen months after the demonstration period ends.

Budget Neutrality

CMS will continue to require, as a condition of section 1115 demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program

with the demonstration cannot exceed what the federal government’s Medicaid costs in that state likely would have been without the demonstration. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 demonstration approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the “without waiver” (WOW) costs).

CMS is available to provide technical assistance to states to facilitate understanding and application of the budget neutrality approach.¹¹¹

Submission Process for Section 1115 Demonstration Projects

States may submit a new section 1115 demonstration application or amend an existing section 1115 demonstration in order to seek section 1115 expenditure authority under the Reentry Section 1115 Demonstration Opportunity.

To facilitate CMS’ review of applications for Reentry Section 1115 Demonstrations, state proposals should address the key elements discussed in the greater detail above, including a description of the carceral settings, individuals who are eligible for the demonstration, pre-release services to be included in the demonstration, and the timeframe for delivery of pre-release services. States should also identify for each milestone what they expect to be the key implementation challenges and at a high level how they intend to address these challenges, with the expectation that they will be further described in the implementation plan.

States should follow the usual process for submitting a section 1115 demonstration proposal in accordance with the transparency requirements outlined in 42 CFR § 431.412 for new demonstrations or in accordance with the state’s STCs for proposals to amend an existing demonstration to add authorities for the Reentry Section 1115 Demonstration Opportunity. This includes completing public notice and tribal consultation, as applicable, prior to submission to CMS in accordance with the applicable notice requirements for section 1115 proposals. For more information about the section 1115 demonstration application process, states may contact their CMS Section 1115 Project Officer or refer to the “1115 Application Process” webpage on Medicaid.gov at <https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-application-process/index.html>.

¹¹¹ States may wish to review recent demonstration approvals for an explanation of specific budget neutrality considerations. While CMS reviews each demonstration application individually, these approvals may be helpful reference documents. See: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-ca-10142022.pdf>; <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ma-masshealth-cal.pdf>.

Conclusion

CMS encourages states to apply for the Reentry Section 1115 Demonstration Opportunity to improve care transitions for Medicaid beneficiaries exiting carceral facilities, including by providing demonstration coverage for time-limited pre-release services, and acknowledges that several states currently have proposals pending with CMS that include requests for authority to provide coverage for pre-release services. CMS believes that provision of pre-release services to eligible individuals who are incarcerated may not only improve the health and reentry outcomes of individuals who are leaving carceral facilities, but may also benefit the Medicaid program and society at large through potential reduced drug-related deaths, decreased use of EDs and hospitalizations, and reductions in health disparities experienced by people of color. States with proposals already pending should review those proposals against the guidance in this letter, and should continue to engage with CMS about the state's proposed approach and any changes the state may wish to make to its proposal. Questions regarding this guidance may be directed to Alissa DeBoy, Director, Disabled and Elderly Health Programs Group, at Alissa.Deboy1@cms.hhs.gov. We look forward to continuing our work together on these important issues.

Sincerely,

/s/

Daniel Tsai
Deputy Administrator and Director

Appendix 1 - Summary of Elements in Reentry Section 1115 Demonstration Opportunity

- *Quality* – states should consider how the demonstration design could advance quality (including but not limited to health equity) through its approaches to promoting access to coverage, care, transitions to the community, and quality of services, and addressing HRSN.
- *Carceral Settings* – states may include state and/or local jails, prisons, and/or youth correctional facilities for pre-release services. States may include individuals in federal prisons in the Reentry Section 1115 Demonstration Opportunity to help federal prisoners submit Medicaid application(s). However, CMS expects states to refrain from including federal prisons as a setting in which pre-release services are provided under the demonstration.
- *Eligible Individuals* – states may include individuals currently incarcerated who are otherwise Medicaid eligible, soon-to-be former incarcerated individuals. States have the flexibility to target the population.
- *Medicaid eligibility and enrollment* – states will be expected to suspend and not terminate eligibility, but will have a glide path of up to two years to implement this fully.
- *Scope of “Health Care” Services* – states will be expected to include case management to assess and address physical and behavioral health needs and HRSN, MAT services for all types of SUD as clinically appropriate, and a 30-day supply of all prescription medications (as clinically appropriate based on the medication dispensed and the indication) provided to the beneficiary immediately upon release from the correctional facility, as a minimum scope of services and may propose to cover additional services.
- *Pre-release Timeframe* – states generally will be expected to cover demonstration services beginning 30 days immediately prior to the individual’s expected date of release; however, CMS will consider approving demonstration authority to begin coverage as early as 90 days prior to the expected release date, depending on the state’s demonstration purpose and design. In the event the state requests a pre-release service coverage timeframe longer than 30 days, the state should incorporate into its statement of the demonstration purpose one or more elements to be tested in addition to improving care transitions. If CMS approves a coverage timeframe longer than 30 days, relevant hypotheses that the longer timeframe is needed to test will be required to be incorporated into the state’s evaluation design.
- *Administrative Information Technology (IT) System Costs* – state Medicaid agency IT System costs may be eligible for enhanced FFP through an APD, including IT systems that support data sharing between state Medicaid agencies and participating correctional facilities.
- *Transitional, Non-Service Expenditures* – states may request time-limited support in the form of FFP for certain new expenditures through section 1115 demonstration authority for necessary changes required by states, correctional facilities, and health care providers to implement and expand service provision and coordination with community providers, such as development of new business or operational practices, workforce development and outreach, education, and stakeholder convening.
- *Reinvestment Plan* – states are expected to include in the implementation plan, a reinvestment plan that outlines the aggregate amount of federal matching funds that is being requested and where reinvestments will be made, as discussed in this letter.