Evaluation Design Technical Assistance Guide for Section 1115 Demonstrations: Reentry Demonstrations

This document provides technical assistance for evaluating section 1115 demonstrations that seek to improve outcomes for individuals moving from carceral settings into the community (reentry demonstration initiatives, hereafter referred to as "reentry demonstrations").

It includes a description of the goals (Section 1), an example logic model linking demonstration initiatives to expected outcomes (Section 2), potential data sources and data considerations (Section 3), example hypotheses and research questions (Sections 4 and 5), suggested analytic methods (Section 6), and recommended measures, data sources, and analytic approaches (Tables 2 and 3).

If a state has reentry policies and activities beyond those outlined in the State Medicaid Director Letter (SMDL) #23-003[1] and the Frequently Asked Questions for Reentry Section 1115 Demonstrations (September 2026),[2] these should also be captured in the state's evaluation design. CMS provides evaluation technical assistance guides for several other common demonstration policies.[3] States with multiple policies in their demonstration should consult relevant policy-specific evaluation technical assistance guides to develop comprehensive evaluation designs aligned with special terms and conditions (STCs) requirements.

1. Demonstration goals

In alignment with the goals outlined in the SMDL #23-003, the purpose of a reentry demonstration is to test whether its policies have the following effects for Medicaid beneficiaries:

1. 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
2. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry
3. Improve coordination and communication between correctional systems, Medicaid systems, managed care plans, and community-based providers
4. 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
5. Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and social determinants of health (SDOH)/health-related social needs

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf

[2] https://www.medicaid.gov/federal-policy-guidance/downloads/reentry-faqs-090920264015.pdf

[3] These resources are available to states on the Medicaid.gov website: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources

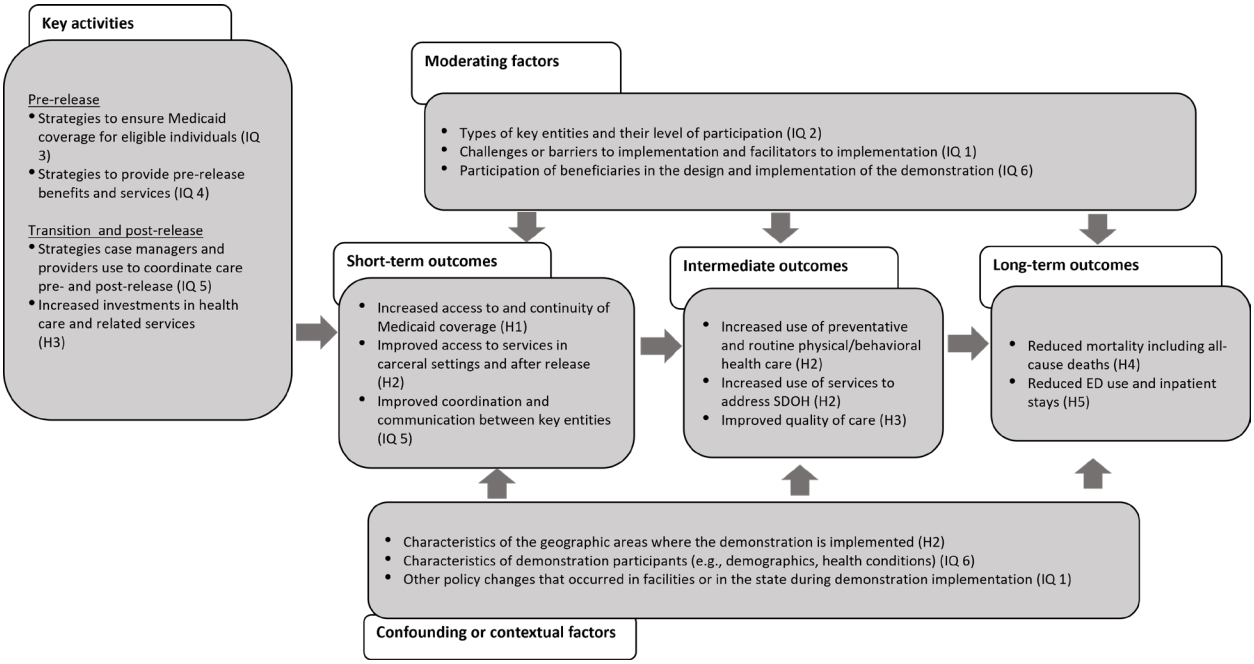
6. Reduce all-cause deaths in the near-term post-release
7. Reduce the number of emergency department (ED) visits and inpatient hospitalizations among recently incarcerated Medicaid beneficiaries[4] through increased receipt of preventive and routine physical and behavioral health care

2. Example logic model for reentry demonstrations

Figure 1 shows an example logic model. It depicts how the demonstration's initiatives are expected to affect outcomes, accounting for moderating, confounding, and contextual factors. For definitions of moderating, confounding, and contextual factors, refer to *Evaluation Design and Reporting for Section 1115 Demonstrations.*[5]

Each state should tailor the logic model to the specific reentry services offered within the section 1115 demonstration. If the reentry demonstration has multiple programs or plans to implement the demonstration differently for distinct populations (for example, youth in correctional facilities), the state can consider developing separate logic models for each program.

Figure 1. Example logic model for reentry demonstrations



Note: Hypothesis and research question numbers in parentheses refer to the research questions in Sections 4 and 5 below. If states are phasing in facilities or additional services over time, they should also consider whether to include the implementation phase as a contextual variable.

H = hypothesis; IQ = implementation question; SDOH = social determinants of health

[4] "Recently incarcerated Medicaid beneficiaries" refers to beneficiaries who were released from a carceral setting within the past year.

[5] This resource is available to states on the Medicaid.gov website: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html

3. Data sources and data considerations

To answer the research questions presented below, the state will need to employ mixed research methods and use multiple data sources, including Medicaid enrollment and claims data, data from correctional facilities (prisons, jails, youth correctional facilities, and/or tribal correctional facilities), and qualitative interviews and/or surveys of providers and participants. The state should consider collecting similar data across all carceral facilities that will eventually participate in the demonstration, even when a facility is not an early implementer. This will enable the state to use the facilities starting implementation later in the demonstration as a source of comparison groups in evaluating the demonstration. If a state is implementing the demonstration at the same time across all facilities, then it should recruit additional comparison facilities and establish data use agreements to collect corrections and pre-release services data (health services and SDOH referrals).[6]

This section describes potential data sources for evaluations of reentry demonstrations (Table 1 and section 3.a) and discusses important data sharing, availability, and quality considerations (sections 3.b and 3.c). A state may need to vary its approach to data collection for different facility types. If the state encounters challenges in identifying a comparison group, or encounters challenges or questions regarding the core data sources, the state should reach out to CMS for further guidance.

Table 1. Potential data sources for Section 1115 reentry demonstration evaluations

Data category	Core data sources
Implementation	Reentry implementation plan; RCR (as applicable)*; annual monitoring reports; provider and beneficiary surveys/interviews
Coverage and services	Medicaid eligibility, enrollment, claims and encounter data; EHR data; HIE data
Corrections data	Facility or department of corrections data; probation or parole data
Case management data	Annual monitoring reports; pre-release case management data; post-release case management and SDOH services data
Vital records data	State mortality records
Comparison group	Data from participating facilities pre-implementation; data from nonparticipating facilities

EHR = electronic health records; HIE = health information exchange; RCR = rapid cycle report; SDOH = social determinants of health
* RCRs document early implementation progress, operational experiences, and lessons learned, and are only applicable if referenced in the demonstration's STCs.

3.a. Data source considerations:

- **Health care services data.** The health care provided to demonstration participants pre- and post-release should be available in the Medicaid claims data; however, states will likely need to partner with pre-release health care providers in facilities not (or not yet) participating in the demonstration to understand what health care services are provided to non-demonstration participants. Many state

[6] If the state is implementing the demonstration across all facilities at the same time, it will want to identify facilities with similar characteristics from which to select a comparison group. States should consider the following facility-level characteristics when identifying comparable facilities: (1) facility type (must be the same type as the demonstration facility being compared); (2) facility size; and (3) facility security level. If the demonstration facility is a jail, states should ideally select a facility from a similar county based on characteristics such as the average socioeconomic status, crime rates, percent of the population at or below the federal poverty level, employment rates, and/or prevalent economic sectors (for example, manufacturing, construction, or food services).

prisons and jails provide health services through contractors rather than providing services directly, so data use agreements should be established with these independent providers. States might have electronic health records (EHRs) or other billing systems that can be leveraged to collect this information. Collecting health care service data for comparison group members who are not enrolled in Medicaid might require payment for the use of an all-payer claims database.

- **State mortality records.** Each U.S. state has a Vital Records Office (often part of the Department of Health or Department of Public Health). These offices are the primary custodians of birth and death records, and they maintain databases of mortality data.
- **Pre-release case management data.** The state will likely need to partner with each facility to collect additional information necessary for evaluating the demonstration, such as Medicaid eligibility screening and determination and services provided pre-release, including case management services and referrals for SDOH. Other data elements that might be useful for ensuring comparison group members are similar to demonstration group members include individuals' demographic information, criminal history, and employment status prior to incarceration. The state might also consider leveraging criminogenic needs and risk assessments, if available, to assess the equivalence of treatment and comparison group members.
- **Post-release case management and SDOH services data**. Important data elements include a record of case management provided and SDOH referrals or services for the demonstration's participants. These might be accessible via a closed-loop social referral platform if used among key entities implementing the demonstration. Collecting these data for the comparison group members will likely be infeasible.
- **Corrections data** from facilities participating in the demonstration and, if applicable, facilities that will serve as a comparison group for the evaluation of demonstration impacts. Potential data elements to collect will include person-level data on the date of incarceration, sentence length, and projected and actual release dates, and facility-level data on the number of people incarcerated. The source, availability, and quality of these data might vary by state and by facility type:
  - Local jails. In most states, jails are managed at the county or local levels and data are maintained by the facility. States should work to establish data use agreements with each local jail that will be part of the demonstration or will serve as a comparison group. Obtaining data from jails can be challenging due to their decentralized and fragmented systems, which often rely on outdated or paper-based recordkeeping. Moreover, because most jail populations consist of individuals awaiting trial or serving short sentences, there is frequent turnover and uncertainty around release dates. Limited staff and resources within jails can further complicate data collection for evaluation purposes. To prepare for these challenges, states should begin by conducting an early assessment of data readiness across participating jails to identify existing systems, data elements, and gaps. Establishing standardized data collection templates and providing technical assistance to support jail staff can improve data quality and consistency. Additionally, building strong relationships with jail administrators and incorporating clear data-sharing protocols into formal agreements will help ensure timely and reliable access to necessary information throughout the evaluation.
  - State prisons. Some data elements necessary for evaluation will be available from the state's Department of Corrections (DOC), such as date of incarceration, projected release date, and actual

release date. The state can enter into a single data use agreement with the DOC to get these data for individuals across state prison facilities.

– Youth correctional facilities.[7] Each state typically has a juvenile justice agency or department that collects and reports data on system-involved youth, court proceedings, and correctional outcomes. The name of the agency that manages these data will vary by state, but common names include the Division or Department of Juvenile Justice or the Division of Youth Services. These agencies are typically housed within larger departments such as the Department of Corrections, Department of Human Services, Department of Children and Families, or the Department of Public Safety.

If the sources above do not provide the necessary incarceration data needed to build a comparison group, states might consider using aggregated databases like those listed below. However, states should be aware of and account for limitations with these data sources, such as significant time lags due to processing delays and, in some cases, fees for acquiring the data.

– The State Verification and Exchange System (SVES) database is a batch query system established by the Social Security Administration (SSA) to provide state and federal agencies with verification of Social Security numbers and benefits information used to establish eligibility for income and health maintenance programs. States can request Prisoner Update Processing System (PUPS) data through SVES, which provides prisoner record information that can be used to establish eligibility or ineligibility for various programs.[8] The data include an individual's initial date of confinement, facility location, and, in cases where the individual has been released, the date that the facility subsequently released them.

– Third-party, private vendors such as Appriss, VINELink, and CLEAR compile data from multiple sources, such as the Bureau of Prisons, public websites for state and local incarceration facilities, and sometimes private data exchanges with facilities. The available data elements vary based on the third-party vendor, but state agencies can purchase this data for a fee and use it to determine incarceration status. States sometimes use this information to determine eligibility for benefits.

– Criminal Justice Administrative Records System (CJARS) is a project to collect and harmonize administrative criminal justice records. The data are not available for all states and years, but for

[7] States implementing the reentry demonstrations in youth correctional facilities should also consider the data required to understand implementation of section 5121 and optional section 5122 of the Consolidated Appropriations Act, 2023. Given the significant overlap with the requirements in the section 1115 reentry demonstration, states should consider collecting the data needed for the evaluation of both initiatives. Section 5121 mandates that states provide screening, diagnostic, and case management services to eligible incarcerated youth (post-adjudication) starting 30 days before release and continuing for at least 30 days after release. Optional section 5122 extends full Medicaid/CHIP benefits to youth pending adjudication.

[8] For example, state child support agencies partner with corrections agencies and use tools like SVES to identify parents with child support orders who become incarcerated and need a modification to their child support order. For states' lessons about partnerships and data, see Aharpour, D, L. Ochoa, J. Stein, and M. Zukiewicz (2020). "*State Strategies for Improving Child Support Outcomes for Incarcerated Parents.*" *ASPE Research Brief*. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Available at https://aspe.hhs.gov/sites/default/files/private/pdf/263901/cs-cj-issue-brief.pdf

states that do submit data to CJARS, the repository might be useful for building comparison groups.[9]

Because the reentry demonstration necessitates cross-system collaboration, obtaining data from both the health care and corrections sectors will be essential to assessing the efficacy of the demonstration. The following are key considerations when planning to obtain data for the demonstration and evaluation:

3.b. Data-sharing considerations:

- **Identify which agencies have the needed data and whether new or amended data-sharing agreements are necessary.** Depending on the facilities engaged in the demonstration and the existing data exchange infrastructure, the state might need to establish or improve approaches to sharing data across the state Department of Corrections, local or county jail systems, and/or the state and local courts. The state should assess if there are existing data exchange agreements between correctional facilities and the courts to suspend or reinstate public benefits based on an individual's incarceration status. If so, the state can build on these existing agreements. If not, the state can reference an example memorandum of understanding (MOU) from other states that have embarked on similar initiatives.[10]
- **Assess whether corrections data will include the identifiers necessary to link individuals across Medicaid and corrections data.** Although correctional agencies generate a unique identifier to track an individual in the correctional system, it might not always include high-quality identifiers that will allow linking across data sets. As a result, the state should coordinate across agencies to ensure the feasibility of linking Medicaid claims data and corrections data using other identifiers such as name, date of birth, and sex, using matching techniques that link identifiers based on similar but inexact matches (probabilistic or "fuzzy" matching).[11,12]
- **Develop secure methods for sharing sensitive information and protecting individual privacy.** The state must establish safe and responsible methods to share health and justice data that uphold privacy and ensure ethical use of that data. Establishing interoperability or real-time, bidirectional data sharing across systems is ideal; however, this requires advanced IT infrastructure, planning, and testing, which takes time to implement. Partners can begin with low-tech solutions such as secure file transfers

[9] For more information on what states are included in the CJARS data library, see CJARS data documentation. Available at: https://cjars.org/documentation/

[10] For more information on the process of identifying potential data elements, partners, and data sharing agreements needed to evaluate reforms, including an example MOU, see Mallik-Kane, K, Jannetta, J. and Hatry, H. *Measuring Progress in Connecting Criminal Justice to Health*. (2018). https://www.urban.org/sites/default/files/publication/97031/measuring_progress_in_connecting_criminal_justice_to_health.pdf

[11] Christen, P. "The Data Matching Process." In: *Data Matching. Data-Centric Systems and Applications*. Springer, Berlin, Heidelberg (2012). https://doi.org/10.1007/978-3-642-31164-2_2

[12] Burns, M. E., et al. "Association between assistance with Medicaid enrollment and use of health care after incarceration among adults with a history of substance use." *JAMA Network Open 5*, no. 1 (2022): e2142688-e2142688. https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2787710

and the use of shared portals to exchange critical data.[13] Once the data are securely shared, access to that data should be restricted to only individuals who need access.

3.c. Considerations about data availability and quality:

- **States can work with their facility and community partners to track the data needed for monitoring and evaluation.** Data needed for evaluations may not be readily available from existing sources. In these cases, participating partners will need to track and share data across the pre- and post-release phases. For example, measuring SDOH, such as housing needs, will likely require self-reported data.
- **States should be prepared for challenges accessing data from corrections partners.** Corrections agencies often use legacy data management systems that make it hard to modify and share data with external partners. This, paired with staffing shortages at facilities and state agencies, might result in states facing additional challenges in obtaining data from corrections agencies, especially if the facility is not participating in the demonstration but will serve as a comparison facility. To limit the burden on corrections agencies, states should develop a short list of the most critical data elements to request, limit the number of data requests made of corrections agencies, and be flexible in how they receive the data from corrections agencies.
- **States should anticipate data quality, availability, and accessibility to differ significantly between prisons and jails.** Jails have a more transient population, with many more people cycling in and out each year compared to prisons. Additionally, local or state agencies manage jails, and the data systems are often separate from the state prison system. As such, there might be more variation in jail data, and it can be more cumbersome to collect the data unless states have a centralized system where local corrections agencies report to the state Department of Corrections.
- **States might need to partner with facilities and pre-release healthcare providers to obtain data on health-related services provided during incarceration.** Many state prisons and most jails provide health services through contractors rather than providing services directly. States should plan for extra time to identify the appropriate partners and to navigate the complexity of obtaining health care data. Obtaining this pre-release health care information is critical for assessing the pre-release benefit package and concepts such as continuity of care.
- **Collecting evaluation data directly from beneficiaries who are incarcerated will likely require clearance by corrections agencies and an institutional review board (IRB).** Different justice agencies have unique requirements for working with people who are incarcerated in their facilities. IRBs protect research subjects and have enhanced protections for some populations, including incarcerated individuals.
- **Consider partnering with corrections entities such as probation or parole to obtain post-release information about participants of the demonstration.** State parole agencies might have data for individuals on parole, but reporting requirements vary by state, and the comprehensiveness of data

[13] For more information on the challenges and potential solutions for effectively sharing data across the corrections and healthcare sectors, see this issue brief: Kaeser, E. *Equitable and Effective Data Sharing to Support Healthy Transitions for Youth During Reentry*. (2024). Network for Public Health Law. https://www.networkforphl.org/resources/equitable-and-effective-data-sharing-to-support-healthy-transitions-for-youth-during-reentry/

might differ by parole officer. For example, parole officers might systematically track and record a parolee's education, employment, and housing status, but not track whether a parolee is following up with substance use disorder treatment and recovery support. Because probation is usually managed at a local level, states might need to coordinate with different entities to obtain community supervision data for individuals on probation.

- **States should consider ways to encourage individuals to participate in data collection activities after release.** People recently released from incarceration face structural challenges that can make engaging in research or evaluation difficult. For example, they might face housing challenges and thus be more transient and harder to reach for follow-up data collection. In addition, individuals released without community supervision often avoid interaction with formal systems, including the health care and justice systems. People who were formerly incarcerated might also hesitate to engage in research or respond to questions about their personal health. Potential strategies to address these challenges include providing incentives for completing data collection activities post-release and gathering ample contact information for the individual and one to three people who would know how to get in touch with them.

Evaluation Data Readiness Activities

Below are suggested data readiness activities the state may undertake prior to or early in demonstration implementation to prepare for evaluation.

1. **Identify all participating facilities and potential comparison facilities.** Document facility characteristics and identify facilities that will implement in later phases to support comparison group selection (see Section 6 for suggested comparison strategies). Identify existing systems and data gaps in data collection processes and capabilities at correctional facilities.
2. **Identify all key entities to be involved in data coordination activities and any external data sources.** Identify partnerships needed to acquire health care service and case management data pre- and post-implementation and assess the feasibility of including external data sources if needed. Maintain ongoing coordination among correctional facilities, Medicaid agencies, reentry partners, and evaluators. Transparent and timely communication fosters engagement and sustained collaboration.
3. **Develop a centralized data governance framework.** Establish clear roles, responsibilities, and decision-making authority for data partners. Define processes for managing data quality, submission timelines, and issue resolution. Use standardized definitions and reporting formats to support comparability. Implement regular audits, feedback loops, and validation checks to monitor completeness, accuracy, and timeliness.
4. **Establish data-sharing and data use agreements.** Leverage existing agreements where possible. Include the independent evaluator in DUAs to allow access to the data for evaluation. Review federal and state privacy laws (e.g., HIPAA, 42 CFR Part 2) to ensure all data-sharing and linkage activities comply with applicable regulations. Engage legal counsel early to avoid downstream delays.
5. **Begin building out or enhancing data capabilities and standards between correctional facilities, Medicaid agencies, and other community resources.** Develop systems for consistent, person-level and facility-level tracking to facilitate pre- and post-release data collection. Establish secure methods for sharing sensitive information that includes identifiers needed to link individuals across datasets. Consider creating master person indices or adopting probabilistic matching approaches to facilitate merging data across sources.
6. **Plan for direct data collection from participants, where needed.** Begin process for obtaining IRB approvals and/or facility clearances and develop strategies to encourage participation.
7. **Begin collecting baseline data, where possible.** Collect pre-implementation data from participating facilities and data from comparison facilities, as feasible. For demonstrations operating in youth correctional facilities, consider also collecting data on the provision of services as required by the 2023 Consolidated Appropriations Act Section 5121.
8. **Pilot test data processes before full implementation.** Conduct small-scale pilots to test data transfer protocols, linkage procedures, and quality controls before expanding statewide. The state may draw on key lessons learned from its RCR, if applicable, to identify those data processes.
9. **Provide technical assistance and training to facility staff.** Offer training on data entry, reporting standards, and evaluation requirements. Consistent training promotes accuracy, reduces burden, and builds support for the evaluation .

4. Research questions related to demonstration implementation

To understand how implementation may have shaped demonstration outcomes, the state should specify a set of implementation questions focused on essential demonstration operations. These questions should inform the testable hypotheses in the next section and provide context for interpreting the findings. Table 2 maps the example questions below to recommended measures, data sources, and analytic approaches. The state can tailor these questions and add state-specific implementation

question(s) based on input from key entities involved in the demonstration,[14] including potential demonstration participants. Because implementation may differ substantially across jails, prisons, youth correctional facilities, and tribal correctional facilities, the state should examine variation by facility type where appropriate.

The state should consider findings from its RCR when conducting implementation analyses and interpreting evaluation findings. Evaluation findings related to implementation should build upon, rather than duplicate, information reported in the RCR.

Primary Implementation Question 1: How did implementation evolve from the initial implementation plan, including the phase-in of facilities and services? What changes, challenges, and adaptations occurred during implementation?[15]

Primary Implementation Question 2: How did key entities collaborate to operationalize the demonstration? What roles did they play, how did those roles or levels of participation change over time, and what challenges or barriers affected their collaboration and implementation?

Primary Implementation Question 3: What strategies did the state use to ensure Medicaid coverage for eligible individuals pre-release? How did this vary by facility or facility type?[15]

Primary Implementation Question 4: How did the state implement and operationalize provision of pre-release benefits and services? How did implementation or operational strategy vary across facilities or populations? For states providing coverage for more than 30 days before release, how did the additional time affect planning and service delivery, and what barriers and facilitators affected implementation?

Primary Implementation Question 5: How did the state coordinate care across systems, including correctional facilities, Medicaid agencies, managed care plans, and community providers? What strategies, mechanisms, and data processes supported continuity of care (for example, shared EHRs, warm handoffs, joint care plans) and connections to post-release services, and what barriers and facilitators affected these efforts? How have partnerships and coordination efforts differed by facility type?

Primary Implementation Question 6: How did beneficiaries experience the demonstration, including opportunities to inform the demonstration design or implementation? What barriers or challenges did beneficiaries experience when participating in the demonstration, including challenges accessing scheduled or referred services, and what suggestions do they have for improving the demonstration? How did this vary by facility and beneficiary characteristics?

5. Hypotheses and research questions for reentry demonstrations

The following hypotheses and research questions are consistent with CMS's expectations for evaluating the effects of reentry demonstrations. The state should also add hypotheses and research questions

[14] Key entities may include representatives from the corrections system, pre-release health care providers, community-based providers, managed care plan staff, Medicaid agency staff, and people with lived experience.

[15] For states with reentry demonstrations approved in September 2026 or later, Primary Implementation Questions 1 and 3 will be addressed in the RCR and therefore are not required in the interim or summative evaluation reports. However, the state should consider relevant RCR findings when conducting subsequent evaluation analyses and interpreting demonstration outcomes.

designed to evaluate state-specific aspects of the demonstration, with input from key entities. Table 3 presents Hypotheses 1 through 5 and corresponding research questions, along with suggested outcome measures, measure stewards, and data sources. In instances where the state is testing services beyond the minimum benefit package or providing coverage for a period over 30 days prior to a beneficiary's expected release date, the state should discuss any relationship identified between the provision and timing of particular services and salient post-release outcomes, including: utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient, and effective reentry planning; enabled pre-release management and stabilization of clinical, physical, and behavioral health conditions; and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage of pre-release services.

In addition to the hypotheses and research questions listed below, the state should evaluate demonstration costs. The document titled *Evaluation Design Technical Assistance Guide for Section 1115 Demonstrations: Assessing Demonstration Costs* provides research questions, measures and data sources, and analytic methods for assessing costs in conjunction with demonstration goals and outcomes.[16]

Hypothesis 1: The reentry demonstration will increase Medicaid coverage and the continuity of Medicaid coverage for individuals in carceral settings just prior to release.

Primary Research Question 1.1: How did the implementation of the demonstration impact Medicaid enrollment and continuity of coverage for participants?

Primary Research Question 1.2: How did Medicaid enrollment differ by beneficiary characteristics and facility type?

Hypothesis 2: The reentry demonstration will improve access to services and service uptake in carceral settings and after release.

Primary Research Question 2.1: How has the availability of pre-release services changed with the implementation of the demonstration?

Primary Research Question 2.2: How has the demonstration affected individuals' access to and uptake of pre-release and post-release services, including services that address SDOH?[17] If the state increased coverage beyond 30 days pre-release, what were the benefits associated with offering pre-release services for a longer length of time?

Primary Research Question 2.3: How do measures of access to and uptake of benefits differ by beneficiary characteristics and facility type?

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[16] This resource is available to states on the Medicaid.gov website: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html.

[17] Beneficiary subgroups might include subgroups by disability, immigration status, or geography, or other characteristics or populations that are important to the state's demonstration. Subgroups by facility type might include jails, prisons, youth correctional facilities or tribal correctional facilities.

Hypothesis 3: The reentry demonstration will improve the quality of care and maximize successful reentry for soon-to-be-released individuals and those transitioning into Medicaid upon release by increasing investments in health care and related services (such as those detailed in the state's reinvestment plan).

Primary Research Question 3.1: To what extent has the reentry demonstration improved the quality of care for individuals soon-to-be-released or recently released?

Primary Research Question 3.2: How did beneficiaries' experiences of the quality of care pre- and post-release differ by beneficiary characteristics and facility type?

Hypothesis 4: The demonstration will reduce all-cause deaths in the near-term post-release.

Primary Research Question 4.1: How did all-cause deaths in the near-term post-release change during the demonstration?

Primary Research Question 4.2: How did changes in all-cause deaths near-term differ by beneficiary characteristics?

Hypothesis 5: The demonstration will reduce emergency department (ED) visits and inpatient hospitalizations among recently released Medicaid beneficiaries.

Primary Research Question 5.1: How did ED utilization among recently released Medicaid beneficiaries change during the demonstration?

Primary Research Question 5.2: How did the use of inpatient care among recently released Medicaid beneficiaries change during the demonstration?

Primary Research Question 5.3: How did changes in the use of ED and inpatient care differ by beneficiary characteristics?

6. Methods for testing demonstration hypotheses

CMS expects the state to adapt the suggested research questions in Section 5 with appropriate modifications for the state-specific demonstration. The research questions address the evaluation hypotheses, in alignment with the anticipated goals of reentry demonstrations.

For each of the outcome measures in Table 3, states should use the most rigorous comparison strategy and associated analytic approach feasible to obtain estimates of causal demonstration impacts. When methodological prerequisites prevent an outcome measure from being feasible or estimable, the state should identify an alternative outcome measure to address the research question where possible. From more to less rigorous, these approaches include the following:

1. A difference-in-differences regression model (1) comparing beneficiaries participating in the reentry demonstration to people released from comparable facilities that are not [yet] participating in the reentry demonstration (for example, due to a phased roll out of the demonstration), (2) comparing beneficiaries participating in the reentry demonstration to similar beneficiaries in other states without

a reentry demonstration, or (3) comparing providers involved in the demonstration to providers from comparable facilities that are not [yet] involved in the reentry demonstration.[18]

2. An interrupted time series regression model (if multiple pre-demonstration data points on outcome measures are available) or a pre-post comparison (if multiple pre-demonstration data points on outcome measures are unavailable or of poor quality). For interrupted time series analyses, the state should identify the timing of actual demonstration implementation and assess whether outcomes changed immediately following implementation, whether longer-term trends changed, or both.
3. Descriptive trend analyses over the course of the demonstration (if data on outcome measures are unavailable or are of poor quality in the pre-demonstration period and in non-demonstration states). The state should examine how observed trends align with the timing of demonstration implementation, including any phased roll out of facilities or services.

The state should also conduct sensitivity analyses, as appropriate for the analytic approach, to assess the robustness of findings. These may include testing alternative implementation dates, excluding periods when implementation was still ramping up, using alternative pre-demonstration trend specifications, or conducting placebo tests using dates before implementation.

[18] It is preferable to compare participating facilities to facilities that are not currently participating but will eventually participate because facilities that do not participate might be systematically different from those that do. However, if this is not feasible (for example, if all participating facilities implement the demonstration at the same time), then the state can compare demonstration facilities with otherwise comparable facilities that are not planning to participate in the demonstration. Facilities selected for other-state comparisons should have similar beneficiary population characteristics and pre-demonstration outcome trends and should not be implementing similar service delivery changes concurrent with the demonstration. If an other-facility comparison is not feasible, the state should consider conducting interrupted time series analyses (if multiple pre-demonstration data points are available) or a pre-post comparison (if multiple pre-demonstration data points are not available) within their own state. More considerations on choosing a suitable comparison group are available at https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/comparison-grp-eval-dsgn.pdf and https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/outofstate-comp.pdf. While the latter resource focuses on identifying out-of-state comparison groups, many of the same principles apply when selecting within-state comparison groups.

Table 2: Suggested data sources, measures, and analytic approaches for research questions related to demonstration implementation

Note: CMS expects that the state will work with its evaluators and demonstration partners to choose among and adapt the suggested approaches to addressing relevant research questions based on data availability. All analytic approaches suggested in Table 2 are descriptive or narrative and do not use comparison groups.

Data sources	Measures and analytic approach
Primary Implementation Question 1: How did implementation evolve from the initial implementation plan, including the phase-in of facilities and services? What changes, challenges, and adaptations occurred during implementation?	
• Administrative data on participating facilities, providers, and partners • Monitoring reports • Implementation status self-assessment table from RCR • Interviews with carceral staff, state Medicaid agency staff, case management staff, and pre-release and community-based health care and SDOH providers	Descriptive quantitative and qualitative analysis of the following: • Changes to the plan for phasing in facilities and/or services • The trends in the number of participating facilities, providers, partners, or services • The experiences of key entities phasing in new facilities and/or services • Other policy changes that occurred in facilities or in the state during demonstration implementation
Primary Implementation Question 2: How did key entities collaborate to operationalize the demonstration? What roles did they play, how did those roles or levels of participation change over time, and what challenges or barriers affected their collaboration and implementation?	
• Administrative data on participating facilities, providers, and partners • Monitoring reports • Reentry RCR IM1: Ability to provide the approved pre-release services package • Interviews with carceral staff, state Medicaid agency staff, case management staff, and pre-release and community-based health care and SDOH providers • Interviews with individuals with lived experience consulted during the demonstration development and implementation	Descriptive quantitative and qualitative analysis of the following: • The roles of key entities in the demonstration and how roles have changed over time, including whether and why any entities discontinued participation • The experiences of key entities implementing the demonstration
Primary Implementation Question 3: What strategies did the state use to ensure Medicaid coverage for eligible individuals pre-release? How did this vary by facility or facility type?	
• Reentry RCR IM2: Ability to identify and enroll eligible beneficiaries and IM4: Ability to track services • Interviews with carceral staff, state Medicaid agency staff, case management staff, people with lived experience, and pre-release and community-based health care and SDOH providers • Survey of pre- and post-release health care providers	Descriptive qualitative analysis of the following (overall and by facility type): • Whether and how states assessed eligibility, supported applications, and suspended and reestablished Medicaid coverage (including practices and procedures) • How the state's IT infrastructure and data sharing affected its ability to assess eligibility and enroll or suspend coverage

Data sources	Measures and analytic approach
Primary Implementation Question 4: How did the state implement and operationalize provision of pre-release benefits and services? How did implementation or operational strategy vary across facilities or populations? For states providing coverage for more than 30 days before release, how did the additional time affect planning and service delivery, and what barriers and facilitators affected implementation?	
• Reentry RCR IM1: Ability to provide the approved pre-release services package • Interviews with carceral staff, state Medicaid agency staff, case management staff, and pre-release health care and SDOH providers	Descriptive qualitative analysis of the following (overall and by facility type): • Challenges or barriers (technological, interpersonal, structural, etc.) and strategies used to overcome them • Technical assistance provided during implementation and the changes made in response to the technical assistance
Primary Implementation Question 5: How did the state coordinate care across systems, including correctional facilities, Medicaid agencies, managed care plans, and community providers? What strategies, mechanisms, and data processes supported continuity of care (for example, shared EHRs, warm handoffs, joint care plans) and connections to post-release services, and what barriers and facilitators affected these efforts? How have partnerships and coordination efforts differed by facility type?	
• Reentry RCR IM3: Ability to coordinate care pre- and post-release and IM5: Ability to validate and share data among cross-system partners • Records of data use agreements (DUAs) and memoranda of understanding (MOUs) • Interviews with state Medicaid agency staff, case management staff, pre-release and community-based health care and SDOH providers • Case management data systems • Interviews with beneficiaries • Beneficiary survey[a]	Descriptive qualitative analysis of the following: • Roles of case managers and care coordinators • Changes to the processes for providing case management pre- and post-release • Changes to IT infrastructure to facilitate continuity of case management • Reported provider experience of partnerships between key entities responsible for care coordination • Reported beneficiary experience with care coordination Descriptive quantitative analysis of the following: • The number of contacts between pre-release and post-release case management staff • Number of DUAs or MOUs established between providers in carceral and community settings
Primary Implementation Question 6: How did beneficiaries experience the demonstration, including opportunities to inform the demonstration design or implementation? What barriers or challenges did beneficiaries experience when participating in the demonstration, including challenges accessing scheduled or referred services, and what suggestions do they have for improving the demonstration? How did this vary by facility and beneficiary characteristics?	
• Interviews with beneficiaries • Beneficiary survey[a]	Descriptive qualitative analysis of the following (overall and by beneficiary and facility subgroups): • Beneficiary experience and participation, including any opportunities to help design the demonstration or influence its implementation • Barriers to participation before and after release and ideas for improvement Descriptive quantitative analysis of beneficiaries' participation (overall and by beneficiary and facility subgroups)

[a] States might find it helpful to reference and adapt questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) data maintained by the Agency for Healthcare Research and Quality.

CAHPS = Consumer Assessment of Healthcare Providers and Systems; EHR = electronic health record; FFS = fee-for-service; HIE = health information exchange; IM = implementation milestone; MAT = medication assisted treatment; RCR = rapid cycle report; SDOH = social determinants of health.

Table 3: Suggested outcome measures, measure stewards, and data sources for hypotheses and associated research questions

Note: The outcome measures listed below are suggestions; the state may include other outcomes of interest.

Outcome measure(s)	Measure steward, endorsement	Data source(s)
Hypothesis 1: *The reentry demonstration will increase Medicaid coverage and the continuity of Medicaid coverage for individuals in carceral settings just prior to release.*		
Primary Research Question 1.1: How did the implementation of the demonstration impact Medicaid enrollment and continuity of coverage for participants?		
Percentage of incarcerated individuals newly enrolled in Medicaid out of all individuals incarcerated in the facility.	None	Pre-release case management data; Medicaid eligibility data; corrections data
Differences in continuity of Medicaid enrollment by service use, length of incarceration, or redetermination requirements.	None	Medicaid eligibility data; claims data
Primary Research Question 1.2: How did Medicaid enrollment differ by beneficiary characteristics and facility type?		
Subgroup analysis by beneficiary characteristics and facility type[a]		
Hypothesis 2: *The reentry demonstration will improve access to services and service uptake in carceral settings and after release.*		
Primary Research Question 2.1: How has the availability of pre-release services changed with the implementation of the demonstration?		
Ratio of pre-release providers to incarcerated individuals	None	Provider data; corrections data
Number of full-time equivalent physical and behavioral health providers qualified to deliver SUD services in correctional facilities	None	
Provider-reported availability of pre-release services	None	Provider survey
Beneficiary-reported access to services	AHRQ	Beneficiary survey
Primary Research Question 2.2: How has the demonstration affected individuals' access to and uptake of pre-release and post-release services, including services that address SDOH? If the state increased coverage beyond 30 days pre-release, what were the benefits associated with offering pre-release services for a longer length of time?		
Receipt of case management before release	None	Case management/coordination data
Receipt of MAT services before release	None	Pre-release health data; Medicaid claims
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)	CMS (CMIT#672)[b]	
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	CMS (CMIT#672)[b]	
Receipt of 30-day supply of prescription medication upon release	None	
Receipt of social service referrals for SDOH pre-release	None	
Receipt of preventive care and office visits within 6 months of release	None	
Receipt of behavioral health care within 6 months of release	None	

Outcome measure(s)	Measure steward, endorsement	Data source(s)
Receipt of MAT within 6 months of release (among participants who had a claim for MAT pre-release)	None	Post-release health data; Medicaid claims
Continuity of Pharmacotherapy for Opioid Use Disorder	University of Southern California (CMIT#164)[b]	Pre- and post-release health data; Medicaid claims
Receipt of social services for SDOH post-release	AHRQ	Case management/coordination data; beneficiary survey[c]
Primary Research Question 2.3: How do measures of access to and uptake of benefits differ by beneficiary characteristics and facility type?		
Subgroup analysis by beneficiary characteristics and facility type[a]		
Hypothesis 3: *The reentry demonstration will improve the quality of care and maximize successful reentry for soon-to-be-released individuals and those transitioning into Medicaid upon release by increasing investments in health care and related services (such as those detailed in the state's reinvestment plan).*		
Primary Research Question 3.1: To what extent has the reentry demonstration improved the quality of care for individuals soon-to-be-released or recently released?[d]		
Self-reported experience of quality of care	None	Interviews with individuals incarcerated or formerly incarcerated in participating facilities; Surveys of formerly incarcerated population
Utilization of any of these services within 30 days of release (primary care, behavioral health, family planning services and supplies, or SDOH services)	None	Medicaid claims
Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	NCQA (CMIT#394)[b]	
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	SAMHSA (CMIT#750)[b]	
Primary Research Question 3.2: How did beneficiaries' experiences of the quality of care pre- and post-release differ by beneficiary characteristics and facility type?		
Subgroup analysis by beneficiary characteristics and facility type[a]		
Hypothesis 4: *The demonstration will reduce all-cause deaths in the near-term post-release.*		
Primary Research Question 4.1: How did all-cause deaths in the near-term post-release change during the demonstration?		
All-cause mortality rate within 7 days post-release	None	Vital records
All-cause mortality rate within 30 days post-release	None	
All-cause mortality rate within 6 months post-release	None	
All-cause mortality rate within 12 months post-release	None	
Overdose-related deaths within 30 days post-release	None	
Suicide-related deaths within 30 days post-release	None	
Primary Research Question 4.2: How did changes in all-cause deaths near-term differ by beneficiary characteristics?		
Subgroup analysis by beneficiary characteristics[a]		
Hypothesis 5: *The demonstration will reduce emergency department (ED) visits and inpatient hospitalizations among recently released Medicaid beneficiaries.*		
Primary Research Question 5.1: How did ED utilization among recently released Medicaid beneficiaries change during the demonstration?		

Outcome measure(s)	Measure steward, endorsement	Data source(s)
ED visits within 30 days post-release	None	Medicaid claims
ED visits within 6 months post-release	None	
ED visits within 12 months post-release	None	
Primary Research Question 5.2: How did the use of inpatient care among recently released Medicaid beneficiaries change during the demonstration?		
Inpatient admissions within 30 days post-release	None	Medicaid claims
Inpatient admissions within 6 months post-release	None	
Inpatient admissions within 12 months post-release	None	
Primary Research Question 5.3: How did changes in the use of ED and inpatient care differ by beneficiary characteristics?		
Subgroup analysis by beneficiary characteristics[a]		
Additional state-specific hypotheses and/or research question(s) determined jointly with key entities, including potential demonstration participants[e]		
To be determined	To be determined	To be determined

[a] Beneficiary subgroups might include subgroups by disability, immigration status, or geography (e.g., urban, suburban, rural), or other characteristics or populations that are important to the state's demonstration. Subgroups by facility type might include jails, prisons, youth correctional facilities, or tribal correctional facilities.

[b] The CMS Measures Inventory Tool (CMIT) numbers identify measures in CMS's measure inventory. All but one of the measures referenced by CMIT number in this guide are included in the 2026 Adult Core Set (available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-adult-core-set.pdf) or the 2026 Child Core Set (available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-child-core-set.pdf). For Continuity of Pharmacotherapy for Opioid Use Disorder (CMIT #164), see the CMS Measures Inventory Tool (https://cmit.cms.gov/cmit/#/FamilyView?familyId=164).

[c] States might find it helpful to reference and adapt questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey maintained by the Agency for Healthcare Research and Quality (AHRQ). While AHRQ used a 12-month follow-up period, states should consider following up with beneficiaries 3 to 6 months after release, both because this is such a critical time period for returning individuals and because it may be increasingly more difficult to reach and survey individuals farther out from release.

[d] States with reentry demonstrations operating in youth correctional facilities should consider collecting data on the provision of services as required by the 2023 Consolidated Appropriations Act Section 5121. For example, states might want to collect data on youths such as their adjudication status, age, and child welfare involvement. Similarly, states might want to also track the provision of the required pre-release screening and diagnostic services, and the required post-release services 30 days after release.

[e] CMS encourages states to develop additional research questions specific to the state's demonstration in collaboration with key entities.

AHRQ = Agency for Healthcare Research and Quality; CMIT = The CMS Measure Inventory Tool; CMS = Centers for Medicare & Medicaid Services; CAHPS = Consumer Assessment of Healthcare Providers and Systems; ED = emergency department; HER = electronic health record; FFS = fee-for-service; HIE = health information exchange; MAT = medication assisted treatment; NCQA = National Committee for Quality Assurance; SDOH = social determinants of health.