HMA

HealthManagement.com

Lessons Learned from Implementing 1115 Justice-Involved Reentry Initiatives

Written By
Julie White, MSW

Table of Contents

EXECUTIVE SUMMARY

Section 1115 justice-involved reentry demonstrations represent the most important Medicaid policy shift in correctional health in decades. The Centers for Medicare & Medicaid Services (CMS) 2023 State Medicaid Director Letter opened a pathway for states to cover a limited package of Medicaid services during the 90 days before release for otherwise eligible individuals leaving carceral settings. The policy does **not** repeal the inmate payment exclusion; rather, it creates a demonstration-based exception for carefully defined pre-release services intended to improve continuity of care and reduce post-release overdose, avoidable emergency department use, hospitalization, and mortality. Effective January 1, 2025, CMS implemented new Medicaid and the Children's Health Insurance Program (CHIP) requirements for incarcerated youth under the Consolidated Appropriations Act of 2023.

California and Washington have emerged as the two most instructive early-adopter states operationally, but they chose materially different implementation architectures. California embedded reentry within California Advancing and Innovating Medi-Cal (CalAIM), tied pre-release services to Medi-Cal fee-for-service claims, linked release to Enhanced Care Management and county "Behavioral Health Links," and used the statewide Providing Access and Transforming Health (PATH) investment vehicle to build implementation capacity. Washington embedded reentry within Medicaid Transformation Project 2.0, made Reentry Targeted Case Management mandatory, used managed care more explicitly for post-release coordination, and created a third-party-administrator claims-clearinghouse support model for facilities. California was the first state approved and the first to go live; Washington was the second state to implement and the first to do so through managed-care organizations.

The central strategic lesson from both states is that reentry policy succeeds only when designed as **a cross-system operating model**, not as a Medicaid benefit add-on. Governance, legal authorities, release-date visibility, consented data exchange, managed-care participation, county behavioral-health alignment, and provider network readiness are as influential as benefit design. Health Management Associates (HMA's) public toolkits and commentary align with this experience: successful reentry initiatives require breaking down silos across policy, contracting, systems/IT, and operations, while using disciplined data reporting to satisfy oversight and show impact.

Operationally, the hardest implementation work is not clinical protocol but workflow reliability, including:

- Identifying who is within the release window
- Confirming Medicaid status or completing enrollment
- Assigning a care manager
- Generating a reentry care plan
- Scheduling community appointments
- Ensuring medication continuity
- Executing a warm handoff
- Creating a billable data trail across facilities, plans, county agencies, and community providers

California's public guidance reflects three care-management models—in-reach, embedded, and mixed—while Washington's policy guide standardizes a more prescriptive Reentry Targeted Case Management structure with mandatory and optional benefits. Both states signal that flexibility in local workflow can coexist with strict state minimum standards.

The evidence base justifies investment and tempers expectations. The post-release period is associated with sharply elevated overdose and mortality risk. Medicaid expansion and improved coverage continuity have been associated with lower mortality and, in some settings, lower recidivism. However, the recidivism findings are not consistent. States should therefore avoid overselling near-term crime effects and instead build evaluation frameworks that first track process reliability, clinical continuity, and utilization outcomes before estimating longer-term downstream public safety and cost impacts.[1]

The practical implication is clear: the next generation of reentry support should combine policy design, implementation management, managed-care strategy, correctional operations, data architecture, and evaluation into a single integrated service line. California provides the strongest public proof point for scaled implementation. while Washington provides the strongest public proof point for phased launch discipline, managed-care integration, and pragmatic operational supports, including a claims clearinghouse and cohort-based rapid response.[2]

MEDICAID REENTRY POLICY CONTEXT

Section 1115 demonstrations allow the Health and Human Services (HHS) Secretary to approve state Medicaid pilots that are likely to advance Medicaid objectives. In April 2023, CMS issued State Medicaid Director Letter (SMD) 23-003, which established the current reentry demonstration opportunity under the SUPPORT Act. CMS positioned these demonstrations to improve care transitions for certain Medicaid-eligible incarcerated individuals who are approaching release. The broader federal policy baseline remains unchanged: incarceration does not make a person ineligible for Medicaid, but federal Medicaid funds generally cannot pay for services provided during incarceration unless the person is an inpatient in a medical institution. This restriction is known as the inmate payment exclusion. Reentry demonstrations create targeted exceptions to test whether pre-release services can improve outcomes.

The federal policy rationale is grounded in a substantial health-risk literature. People leaving incarceration face elevated overdose risk—especially in the first two weeks after release—and heightened risks of death, relapse, and disengagement from care. A meta-analysis found markedly elevated drug-related death risk immediately after release. A 2023 retrospective cohort study documented fatal and nonfatal opioid overdose risk after prison release. A New York City jail-release study found a post-release mortality rate far higher than the in-jail rate, with opioid overdose the leading cause of death among people who died within six weeks.[3]

Recent quasi-experimental research suggests Medicaid has an impact, though its effects vary by context. A 2024 Journal of the American Medical Association (*JAMA)* Health Forum study found that Rhode Island's Medicaid expansion was associated with reductions in all-cause mortality and overdose mortality among formerly incarcerated people, though benefits were not evenly distributed across racial groups. A 2022 *Journal of Policy Analysis and Management* paper found Medicaid expansion associated with lower recidivism for certain violent and public-order offenses among multi-time reoffenders. By contrast, a National Bureau of Economic Research (NBER) study of simplified Medicaid enrollment for people leaving incarceration in South Carolina found increased Medicaid enrollment and healthcare utilization without a detectable reduction in one-year or three-year recidivism, underscoring that context, service mix, and local implementation likely mediate downstream public safety outcomes.

The youth policy environment has also shifted. CMS's juvenile-justice guidance implementing sections 5121 and 5122 of the Consolidated Appropriations Act of 2023 made new Medicaid and CHIP requirements for incarcerated youth effective January 1, 2025. CMS explicitly warned states not to design those processes in ways that delay release or increase justice-system involvement. This creates an increasingly important operational distinction: adult reentry still depends heavily on state 1115 design, while youth implementation has a partially mandatory federal floor.[4]

As of 2026, CMS's reentry demonstration web page shows a rapidly expanding field of approved states, including California and Washington, confirming that what began as a novel demonstration category is quickly becoming a mainstream Medicaid transformation agenda. That broader diffusion matters for HMA because clients increasingly need implementation playbooks, not just waiver-writing support.[5]

CALIFORNIA AND WASHINGTON IMPLEMENTATION PROFILES

California's Justice-Involved Reentry Initiative is part of CalAIM. California became the first state to approve a targeted set of Medicaid services up to 90 days prior to release for eligible adults and youth in state prisons, county jails, and youth correctional facilities. California's foundational policy guide describes a broad pre-release package centered on care management, physical- and behavioral-health clinical consultation, medications for addiction treatment, medication administration, laboratory and radiology services, peer support, and community health worker services, with pre-release claims paid through Medi-Cal fee-for-service using Medi-Cal Rx and the California Medicaid Management System (CA-MMIS). California also built reentry on top of earlier statutory and operational work on Medi-Cal suspension and pre-release enrollment.

California's first public impact report showed what scaled implementation looks like in practice. By February 1, 2026, all 31 state prison facilities and 33 county jails and youth correctional facilities in 13 counties had gone live, and facilities had screened and identified 34,956 eligible individuals and delivered more than 159,000 billable pre-release services and prescriptions. California has also required that all correctional facilities must go live by October 1, 2026. Public implementation narratives highlight daily or recurring multidisciplinary release-planning meetings, growing emphasis on Behavioral Health Links and Enhanced Care Management handoffs, and strong collaboration between the California Department of Corrections and Rehabilitation (CDCR), county partners, managed-care plans, and community-based providers.

By contrast, Washington's Reentry Demonstration Initiative is nested inside Medicaid Transformation Project 2.0. CMS approved the renewal of Washington's waiver in June 2023 through June 2028, and Health Care Authority (HCA) built the reentry initiative as a phased cohort model. Washington's public materials identify mandatory benefits including Reentry Targeted Case Management, evaluation and medication for substance use disorder, medications at release, Apple Health benefits for certain pre-adjudication youth, and clinical assessment/evaluation for certain post-adjudication youth. Optional benefits include adult clinical assessment, pre-release medications, laboratory and radiology services, services by providers with lived experience, and medical equipment and supplies at release. Washington's guide also formalizes milestone-based participation, readiness assessment, and post-launch reporting expectations.

Washington's implementation architecture is especially notable for three reasons:

1. HCA formed a Reentry Advisory Workgroup in 2021 and tasked it with payment, managed-care communication, booking-and-release data exchange, and health-record transmission issues;
2. HCA uses statewide booking-and-release data from Department of Corrections (DOC) and the Washington Association of Sheriff's and Police Chiefs (WASPC) to suspend eligibility and drive release-related workflows;
3. Washington created a third-party-administrator support model: Community Health Partnership Services serves as a claims clearinghouse and offers technical and administrative support to participating facilities.

These are highly transferable operational choices for other states seeking to reduce facility-level administrative burden.[6]

Public Washington results are less mature than California's, but there are useful signals. HCA states that Cohort 1 and Cohort 2 facilities were live by March 1, 2026. A 2025 HCA news release reported that eight facilities went live on July 10 of 2025, four were launched November 1 of 2025, 11 were planned for January of 2026, and 23 were committed for July 2026—a total of 56 facilities. The same release describes early promising reports from rapid-response calls: needed treatment, sustained recovery support, successful warm handoffs, increased Medicaid enrollment among newly identified eligible people, and effective communication with Managed Care Organizations (MCOs).

Table 1. Comparative Implementation

Dimension	California	Washington
Demonstration home	CalAIM Section 1115 demonstration[7]	Medicaid Transformation Project 2.0 Section 1115 waiver[8]
Core pre-release window	Up to 90 days prior to release[9]	Up to 90 days prior to release[10]
Payment model	Pre-release services billed in Medi-Cal fee-for-service; pharmacy via Medi-Cal Rx, clinical services via CA-MMIS[11]	Facility/provider billing supported by HCA policy guide; optional free claims-clearinghouse support through CHPS[12]
Care-management structure	Flexible: in-reach, embedded, or mixed care-management models[13]	Standardized Reentry Targeted Case Management is mandatory[14]
Managed-care role	Managed Care Plans (MCPs) central for post-release ECM, warm handoffs, and community linkage	Washington is the first implementing state using MCOs in this way; MCO communication and warm handoffs are explicit design features
Capacitating infrastructure	PATH is a five-year, $1.85 billion statewide infrastructure initiative spanning ECM, Community Supports, and justice-involved services[15]	Washington made available up to $303 million in reentry capacity-building funding to facilities and providers[16]
Public implementation scale	31 state prisons plus 33 county/youth facilities in 13 counties live by February 1, 2026[17]	56 facilities publicly described as phased launch/commitment set in late 2025; Cohort 1 and 2 live by March 1, 2026[18]
Publicly reported service output	34,956 eligible people identified; over 159,000 billable services and prescriptions delivered[19]	Early results reported qualitatively: treatment delivered, warm handoffs achieved, increased Medicaid enrollment[20]
Youth implementation	Included in statewide design for youth correctional facilities[21]	Green Hill and Echo Glen launched youth-focused reentry on March 1, 2026[22]

STRATEGIC PLANNING LESSONS

The first lesson is that **governance must be formal, cross-functional, and durable**. California's public materials repeatedly credit deliberate coordination between the Department of Health Care Services (DHCS), CDCR, county agencies, MCPs, county behavioral-health agencies, and community organizations with turning policy into workflow. Washington similarly created a Reentry Advisory Workgroup years before launch and used it to work through communication with MCOs, booking-and-release data, and health-record transmission. In both states, the most effective governance function was not merely steering, but active issue resolution on release-date changes, claims setup, contracting, pharmacy access, and escalation protocols.

The second lesson is that **stakeholder engagement must start before benefit design is finalized**. HMA's public analysis emphasizes early engagement with managed-care organizations, and both states' experiences support that view. In California, Kern Family Health and other public partners describe weekly or monthly forums focused on operational issues such as provider questions, warm handoffs, contracting, and billing. In Washington, HCA built learning-series webinars on provider enrollment, MCO contracting and credentialing, client eligibility and enrollment, benefits, and data exchange—evidence that stakeholder education itself was treated as implementation infrastructure.[23]

The third lesson is that **financing strategy must distinguish startup capacity from ongoing service payment**. California's PATH initiative is a statewide infrastructure investment vehicle rather than a one-to-one operating budget for reentry services. California's public guidance makes clear that capacity funds can be used for planning, staffing, IT, and closing operational gaps while actual reentry services are funded through Medi-Cal claims. Washington similarly uses milestone-based capacity-building applications and budgets, while still requiring facilities to stand up billable workflows and giving them the option to use the Community Health Partnership Services (CHPS) clearinghouse for claims support. States that blur this distinction risk funding the build but not the business model, or vice versa.

The fourth lesson is that **data-sharing is not a compliance side issue; it is core dependency**. California's guide emphasizes consented data-sharing with MCPs and community providers, and its impact report frames effective information exchange as necessary for care coordination and behavioral-health linkage. Washington's public materials go even further by identifying real-time booking/release notification, transmission of health records through the Clinical Data Repository, MCO incarceration-location information, and same-day pharmacy access as strategic design priorities. The practical takeaway is that states should architect reentry around a minimum viable dataset and minimum viable event architecture: booking, expected release date, actual release date, Medicaid status, care-plan status, appointment status, medication status, and warm-handoff completion.

The fifth lesson is that **legal and compliance decisions must be translated into clear operational rules**. California's pre-release enrollment brief shows how statutory suspension requirements, pre-release application duties, and waiver goals translate into county workflows. Washington's eligibility guidance similarly reflects the legal shift from termination to suspension, with DOC completing applications for prison populations and variable jail workflows depending on local resource capacity. The most avoidable implementation failures are legal-operational translation failures: unclear consent forms, unclear release-date authorities, unclear Health Insurance Portability and Accountability (HIPAA)/42 CFR Part 2 boundaries, or ambiguous responsibility for post-release appointment scheduling and pharmacy continuity.

The sixth lesson is that **equity must be designed structurally, not rhetorically**. California explicitly grounds the initiative in disproportionate behavioral-health burden and racial disproportionality in incarceration, while Washington's early rural, Tribal, and juvenile launches suggest an equity-oriented sequencing strategy. However, the Rhode Island mortality study is a reminder that coverage expansions alone do not guarantee equitable outcomes; racial disparities in benefit realization can persist. Equity planning for reentry therefore needs stratified measures from day one: enrollment completion, time-to-first-visit, medication continuity, warm-handoff completion, Emergency Department (ED) use, overdose, and reincarceration by race/ethnicity, age, gender, geography, facility type, and disability/behavioral-health status.

OPERATIONAL DESIGN

Operational implementation begins with a simple truth: a reentry demonstration is a chain, and the chain breaks where the release-adjacent workflow is weakest. The operational sequence across both states is broadly similar:

California and Washington differ in local flexibilities and financing mechanics, but not in the essential sequence.[24]

High-Value Operational Considerations

Screening and enrollment workflows. California's enrollment brief and Washington's policy guide both indicate that enrollment reliability is foundational. California stresses early identification, application assistance, application submission and troubleshooting, and cross-agency monitoring; Washington requires eligibility support, screening, and release-date notification, with differing workflows for prisons, jails, juvenile rehabilitation, and juvenile detention. The strongest design choice in both states is reducing dependency on a person's final release day by moving eligibility and planning upstream.[25]

Staffing and training. California's three care-management models are a useful design pattern because they let states accommodate different facility realities while still enforcing a minimum care-management standard. Washington's learning-series approach, together with mandatory Reentry Targeted Case Management (rTCM) and formal readiness assessments, shows the value of state-managed implementation curriculum.

Care coordination and community provider networks. Both states emphasize warm handoffs, but California's documentation is especially clear that the receiving post-release entity may be an ECM provider, MCP, county behavioral-health provider, or another community-based provider, depending on release destination and benefit pathway. Washington's use of MCOs and same-day pharmacy access points to a particularly important lesson: reentry is only as strong as the destination network. Network adequacy for reentry should therefore be measured differently from ordinary Medicaid network adequacy—by time-to-first-appointment, capacity for post-release priority scheduling, and acceptance of warm-handoff protocols.[26]

IT and EHR integration. Facilities need not solve full interoperability on day one, but they do need a minimum interoperable operating model: event-based release information, consent capture, problems/medications/allergies, appointments, and handoff confirmation. California's and Washington's public materials both point to the same operational truth: booking, release, and care-transition information must move faster than legacy correctional or Medicaid systems were originally designed to move. A practical HMA strategy is staged maturity: file exchange first, event notifications second, record-sharing third, and closed-loop referral confirmation fourth.

OUTCOMES, METRICS, AND COMPARATIVE TABLES

California has the strongest publicly reported process and service metrics to date. By February 1 of 2026, California reported 64 facilities live, 34,956 eligible individuals identified, and more than 159,000 billable pre-release services and prescriptions delivered. California explicitly says analyses of claims and utilization data are still in early stages, which means the state's strongest current evidence is process success and service penetration rather than final impact on mortality, utilization, or recidivism.[27]

Washington's public reporting is earlier-stage and more qualitative, but it still reveals what should be measured. HCA highlighted increased Medicaid enrollment among newly recognized eligible individuals, successful warm handoffs, needed treatment delivery, and strong plan-facility communication as leading indicators. This is exactly the right evaluation sequence for an early implementation period: first prove that the process chain works; then estimate clinical continuity; then evaluate utilization, mortality, and reincarceration.[28]

The literature suggests that states should keep four evaluation layers distinct. The first is process reliability: Was the person identified, enrolled, assessed, planned for, and handed off? The second is clinical continuity. Were medications, Medications for Opioid Use Disorder/ Medications for Alcohol Use Disorder (MOUD/MAUD), and first visits completed? The third is near-term utilization and safety: ED use, hospitalization, overdose, and death. The fourth is longer-term social and justice outcomes: housing stability, treatment engagement, and recidivism. This tiered structure prevents the common mistake of judging a new program only by rearrest or reincarceration before the operational foundation is mature.

Table 2. Recommended Metrics Dashboard

Metric Domain	Suggested Measure	Why It Matters	California Public Status	Washington Public Status
Enrollment continuity	Share of eligible releases with active Medicaid/Apple Health at release	Prevents coverage gap at highest-risk moment	Pre-release screening and enrollment infrastructure is publicly emphasized; person-level release activation rates not yet published[29]	HCA reports increased Medicaid enrollments as an early result; percentage not yet published[30]
Reentry workflow reliability	Share with completed screening, assessment, reentry care plan, and warm handoff	Best predictor of whether the model is functioning	Warm-handoff and care-plan expectations are explicit; public completion rates not yet published[31]	rTCM warm handoff is mandatory; public completion rates not yet published[32]
Medication continuity	Share leaving with medications in hand; share with uninterrupted MOUD/MAUD	Strongly linked to post-release stability	Medication continuity is built into design; person-level rates not yet published[33]	Medications at release are mandatory; same-day pharmacy access was an early system focus[34]

Metric Domain	Suggested Measure	Why It Matters	California Public Status	Washington Public Status
Service utilization	7-, 30-, and 90-day outpatient follow-up; ED visits; inpatient stays	Captures whether community linkage is replacing crisis care	Claims/utilization analyses underway[35]	Public utilization rates not yet published
Safety outcomes	Overdose, all-cause mortality, suicide, infectious disease treatment completion	Aligns with federal rationale for reentry	Not yet published in reentry-specific state results	Not yet published in reentry-specific state results
Public-safety outcomes	6-, 12-, and 24-month rearrest, reconviction, reincarceration	Important but lagging indicator	Public leaders report perceived reduction in returns to custody; formal rates not yet published[36]	Recidivism reduction is an explicit goal; formal rates not yet published[37]
Cost impacts	Per Member Per Month (PMPM) medical spend post-release; ED/inpatient avoidance; Medicaid churn reduction	Required for sustainability and policy scaling	Not yet publicly estimated	Not yet publicly estimated

Evidence on Likely Impact

The best available external evidence supports the direction of travel. Medicaid expansion in Rhode Island was associated with reductions in all-cause and overdose mortality for formerly incarcerated people. Medicaid expansion has also been associated with reduced recidivism for some offense categories among multi-time reoffenders. At the same time, simplified Medicaid enrollment in South Carolina improved coverage and utilization without changing recidivism, which means states should not assume that coverage alone changes criminal-justice outcomes. Program design must ensure community treatment access, medication continuity, and actual care engagement.[38]

A 2025 *JAMA Network Open* study of Wisconsin prison releases adds an important operational nuance: even among people who enrolled in Medicaid within a month of release, prescription continuity for chronic medications was only 51.7 percent overall, and continuity strongly tracked whether the person had a post-release outpatient visit. Put simply, enrollment is necessary but insufficient. The operational target is **enrollment plus encounter plus medication continuity**.[39]

RECOMMENDATIONS, RISKS, AND POLICY IMPLICATIONS

In the **short term**, states and facilities should stabilize governance, enrollment, consent, release-date visibility, and warm-hand-off reliability. In the **mid-term**, they should strengthen provider networks, standardize performance dashboards, reduce claims friction, and build stratified equity reporting. In the **long term**, they should integrate reentry with managed-care accountability, value-based payment, community supports, and broader justice-system diversion and behavioral-health strategies. This sequencing is more realistic than trying to optimize every policy and operational variable simultaneously.[40]

Table 3. Prioritized Implementation Checklist

Time Horizon	Priority Action	What "Good" Looks Like
Short term	Stand up a cross-agency command structure	State Medicaid, corrections, county behavioral health, plans, providers, and IT meet on fixed cadence with issue log and escalation rules
Short term	Make release-date and Medicaid-status data usable	Daily or near-real-time file/event exchange; clear source of truth for expected and actual release dates
Short term	Standardize screening, consent, and care-plan templates	Minimal local variation in forms and thresholds; operational clarity on HIPAA/42 CFR Part 2 and sharing permissions
Short term	Launch a warm-handoff protocol	Named sender and receiver, documented acceptance, appointment booked, medication plan confirmed
Mid term	Reduce billing friction	Readiness-tested claims workflow, denial tracking, provider enrollment support, and clear remediation pathway
Mid term	Build destination capacity	Priority appointments, pharmacy continuity, behavioral-health slotting, and network maps segmented by release geography
Mid term	Implement a tiered dashboard	Process, continuity, utilization, safety, equity, and justice outcomes reported monthly or quarterly
Long term	Tie reentry to managed-care accountability	Contractual expectations for post-release engagement, community capacity investment, and data exchange performance
Long term	Evaluate impact and recalibrate benefit design	Use claims, encounter, justice, and mortality data to refine service package and target population

Table 4. Risk and Mitigation

Risk	Why It Matters	Mitigation
Unreliable release-date data	Prevents timely enrollment, medication planning, and appointment scheduling	Build event-driven release notifications; use daily reconciliation; require facility escalation for date changes[41]
Incomplete consent or unclear data authority	Blocks handoffs and record exchange	Standardize forms; train staff; create legal-operational quick reference; audit consent quality[42]
Community network bottlenecks	Enrollment without access will not improve outcomes	Reserve priority post-release slots; map high-volume release destinations; contract for reentry capacity[43]
Billing complexity and claim lag	Undercuts provider participation and obscures true activity	Use readiness testing, denial analytics, and clearinghouse support; build simple provider guidance[44]
Workforce turnover	Weakens care continuity and institutional memory	Develop role-based training, launch playbooks, supervision, and backup staffing models
Equity blind spots	Benefits may accrue unevenly across race, geography, age, and facility type	Stratify dashboard measures; review disparities routinely; target corrective action where uptake lags[45]
Overemphasis on recidivism too early	Can mischaracterize success or failure before operations mature	Sequence evaluation: process first, continuity second, utilization/safety third, justice outcomes fourth[46]

Policy Implications

For policymakers, the strongest implication is that 1115 reentry should not remain a niche waiver concept. The combination of federal policy support, growing multi-state adoption, and a well-established risk profile in the post-release period makes reentry a plausible long-term axis of Medicaid benefit modernization. The California and Washington experiences suggest that scaling should begin with disciplined operational conditions: minimum data standards, minimum handoff standards, minimum pharmacy standards, and transparent readiness criteria.[47]

For managed care, the implication is equally significant. Washington's experience shows the feasibility of using MCOs as active reentry partners rather than merely passive post-release payers, and California's design makes clear that MCPs cannot be peripheral if ECM and community linkage are to work. CMS and states should therefore move toward explicit managed-care expectations for release transitions, including turnaround times for outreach, post-release appointment requirements, data exchange obligations, and reentry-specific network strategies.[48]

ENDNOTES

[1] Merrall ELC, Kariminia A, Binswanger IA, et al. Meta-Analysis of Drug-Related Deaths Soon After Release from Prison. *Addiction*. Sep;105(9):1545-54. doi: 10.1111/j.1360-0443
[2] California Department of Health Care Services. From Incarceration to Care: California's Medi-Cal Reentry Initiative Impact Report. March 2026. Available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Documents/CA-Reentry-Initiative-Impact-Report-March-2026.pdf.
[3] Merrall ELC, Kariminia A, Binswanger IA, et al. Meta-Analysis of Drug-Related Deaths Soon After Release from Prison. *Addiction*. Sep;105(9):1545-54. doi: 10.1111/j.1360-0443
[4] U.S. Department of Health & Human Services Guidance Portal. Provision of Medicaid and CHIP Services to Incarcerated Youth.
Available at: https://www.hhs.gov/guidance/document/provision-medicaid-and-chip-services-incarcerated-youth.
[5] Medicaid. Reentry Section 1115 Demonstrations. Demonstration Opportunity. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/reentry-section-1115-demonstration-opportunity.
[6] Washington State Health Care Authority. Reentry from a Carceral Setting. Available at: https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp/reentry-carceral-setting.
[7] Medicaid. CMS Approves Amendment to California's CalAIM Section 1115 Demonstration. December 16, 2024. Available at: https://content.govdelivery.com/accounts/USCMSMEDICAID/bulletins/3c7aeb0.
[8] Washington State Health Care Authority. What We're Working on. Available at: https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp/what-were-working.
[9] California Department of Health Care Services. From Incarceration to Care: California's Medi-Cal Reentry Initiative Impact Report. March 2026. Available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Documents/CA-Reentry-Initiative-Impact-Report-March-2026.pdf.
[10] Washington State Health Care Authority. Reentry from a Carceral Setting. Available at: https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp/reentry-carceral-setting.
[11] California Department of Health Care Services. Policy and Operational Guide for Planning and Implementing the Justice-Involved Reentry Initiative. May 2026. Available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Documents/CalAIM-JI-Policy-and-Operations-Guide-Foundational-Guidance.pdf.
[12] Washington State Health Care Authority. Reentry Initiative Policy and Operations Guide: Medicaid Transformation Project (MTP 2.0). Available at: https://www.hca.wa.gov/assets/program/reentry-initiative-policy-and-operations-guide.pdf.
[13] California Department of Health Care Services. Policy and Operational Guide for Planning and Implementing the Justice-Involved Reentry Initiative. May 2026. Available at:

https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Documents/CalAIM-JI-Policy-and-Operations-Guide-Foundational-Guidance.pdf.

[14] Washington State Health Care Authority. Reentry Initiative Policy and Operations Guide: Medicaid Transformation Project (MTP 2.0). Available at: https://www.hca.wa.gov/assets/program/reentry-initiative-policy-and-operations-guide.pdf.

[15] California Department of Health Care Services. PATH JI Initiative. Available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/Path-JI.aspx.

[16] Washington State Health Care Authority. Reentry from a Carceral Setting. Available at: https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp/reentry-carceral-setting.

[17] California Department of Health Care Services Impact Report. March 2026. Available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Documents/CA-Reentry-Initiative-Impact-Report-March-2026.pdf.

[18] Washington State Health Care Authority. Washington State Recognized for Groundbreaking Reentry Program. November 20, 2025. Available at: https://www.hca.wa.gov/about-hca/news/news-release/washington-state-recognized-groundbreaking-reentry-program.

[19] California Department of Health Care Services. From Incarceration to Care: California's Medi-Cal Reentry Initiative. March 2026. Available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Documents/CA-Reentry-Initiative-Impact-Report-March-2026.pdf.

[20] Washington State Health Care Authority. Washington State Recognized for Groundbreaking Reentry Program. November 20, 2025. Available at: https://www.hca.wa.gov/about-hca/news/news-release/washington-state-recognized-groundbreaking-reentry-program.

[21] California Department of Health Care Services. Justice-Involved Reentry Initiative. Available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/home.aspx.

[22] Washington State Health Care Authority. Young People Exiting Green Hill, Echo Glen Will be Eligible for Expanded Health Care Coverage. Available at: https://www.hca.wa.gov/about-hca/news/news-release/young-people-exiting-green-hill-echo-glen-will-be-eligible-expanded-health-care-coverage.

[23] Health Management Associates (HMA). Improving Healthcare for Justice-Involved Populations: Key Insights on Medicaid Section 1115 Reentry Demonstrations. August 22, 2024. Available at: https://www.healthmanagement.com/blog/improving-healthcare-for-justice-involved-medicaid-1115-reentry/.

[24] California Department of Health Care Services. Strategies for Conducting Pre-Release Medi-Cal Enrollment in County Jails. August 9, 2022. Available at: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/Issue-Brief-Strategies-PreRelease-MediCal-Enrollmentin-County-Jails-8-18-22.pdf.

[25] Ibid

[26] California Department of Health Care Services. Policy and Operational Guide for Planning and Implementing the Justice-Involved Reentry Initiative. May 2026. Available at:

https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Documents/CalAIM-JI-Policy-and-Operations-Guide-Foundational-Guidance.pdf.

[27] California Department of Health Care Services. From Incarceration to Care: California's Medi-Cal Reentry Initiative Impact Report. March 2026. Available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Documents/CA-Reentry-Initiative-Impact-Report-March-2026.pdf.

[28] Washington State Health Care Authority. Washington State Recognized for Groundbreaking Reentry Program. November 20, 2025. Available at: https://www.hca.wa.gov/about-hca/news/news-release/washington-state-recognized-groundbreaking-reentry-program.

[29] California Department of Health Care Services. Strategies for Conducting Pre-Release Medi-Cal Enrollment in County Jails. August 9, 2022. Available at: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/Issue-Brief-Strategies-PreRelease-MediCal-Enrollmentin-County-Jails-8-18-22.pdf.

[30] Washington State Health Care Authority. Washington State Recognized for Groundbreaking Reentry Program. November 20, 2025. Available at: https://www.hca.wa.gov/about-hca/news/news-release/washington-state-recognized-groundbreaking-reentry-program.

[31] California Department of Health Care Services. Policy and Operational Guide for Planning and Implementing the Justice-Involved Reentry Initiative. May 2026. Available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Documents/CalAIM-JI-Policy-and-Operations-Guide-Foundational-Guidance.pdf.

[32] Washington State Health Care Authority. Reentry Initiative Policy and Operations Guide: Medicaid Transformation Project (MTP 2.0). Available at: https://www.hca.wa.gov/assets/program/reentry-initiative-policy-and-operations-guide.pdf.

[33] California Department of Health Care Services. Policy and Operational Guide for Planning and Implementing the Justice-Involved Reentry Initiative. May 2026. Available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Documents/CalAIM-JI-Policy-and-Operations-Guide-Foundational-Guidance.pdf.

[34] Washington State Health Care Authority. Reentry Initiative Policy and Operations Guide: Medicaid Transformation Project (MTP 2.0). Available at: https://www.hca.wa.gov/assets/program/reentry-initiative-policy-and-operations-guide.pdf.

[35] California Department of Health Care Services. From Incarceration to Care: California's Medi-Cal Reentry Initiative Impact Report. March 2026. Available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Documents/CA-Reentry-Initiative-Impact-Report-March-2026.pdf.

[36] Ibid

[37] Washington State Health Care Authority. Reentry Initiative Policy and Operations Guide: Medicaid Transformation Project (MTP 2.0). Available at: https://www.hca.wa.gov/assets/program/reentry-initiative-policy-and-operations-guide.pdf.

[38] Perera PS, Miller VE, Fitch KV, et al. Medicaid Expansion and Mortality Among Persons Who Were Formerly Incarcerated. *JAMA Netw Open*. 2024 Sep 3;7(9):e2429454. doi: 10.1001/jamanetworkopen.2024.29454

[39] Dague L, McNamara C, Westergaard R, Look KA, Burns M. Continuity of Prescription Medication Use Among Adults Leaving State Prison. *JAMA Netw Open.* 2025 Feb 3;8(2):e2461982. doi: 10.1001/jamanetworkopen.2024.61982

[40] Health Management Associates (HMA). Improving Healthcare for Justice-Involved Populations: Key Insights on Medicaid Section 1115 Reentry Demonstrations. August 22, 2024. Available at: https://www.healthmanagement.com/blog/improving-healthcare-for-justice-involved-medicaid-1115-reentry/.

[41] Washington State Health Care Authority. Reentry Initiative Policy and Operations Guide: Medicaid Transformation Project (MTP 2.0). Available at: https://www.hca.wa.gov/assets/program/reentry-initiative-policy-and-operations-guide.pdf.

[42] Ibid

[43] California Department of Health Care Services. Policy and Operational Guide for Planning and Implementing the Justice-Involved Reentry Initiative. May 2026. Available at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Documents/CalAIM-JI-Policy-and-Operations-Guide-Foundational-Guidance.pdf.

[44] Washington State Health Care Authority. Reentry from a Carceral Setting. Available at: https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp/reentry-carceral-setting.

[45] Perera PS, Miller VE, Fitch KV, et al. Medicaid Expansion and Mortality Among Persons Who Were Formerly Incarcerated. *JAMA Netw Open*. 2024 Sep 3;7(9):e2429454. doi: 10.1001/jamanetworkopen.2024.29454

[46] Packham A, Slunsky D. Accessing the Safety Net: How Medicaid Affects Health and Recidivism. National Bureau of Economic Research. Available at: https://www.nber.org/papers/w31971.

[47] Medicaid. Reentry Section 1115 Demonstrations. Demonstration Opportunity. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/reentry-section-1115-demonstration-opportunity.

[48] Washington State Health Care Authority. Washington State Recognized for Groundbreaking Reentry Program. November 20, 2025. Available at: https://www.hca.wa.gov/about-hca/news/news-release/washington-state-recognized-groundbreaking-reentry-program.

HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With multidisciplinary consultants coast to coast, HMA's expertise, services, and team are always within client reach.

HealthManagement.com