Medicaid 1115 Justice Involved Reentry Demonstration Opportunities:

Engaging Key Stakeholders

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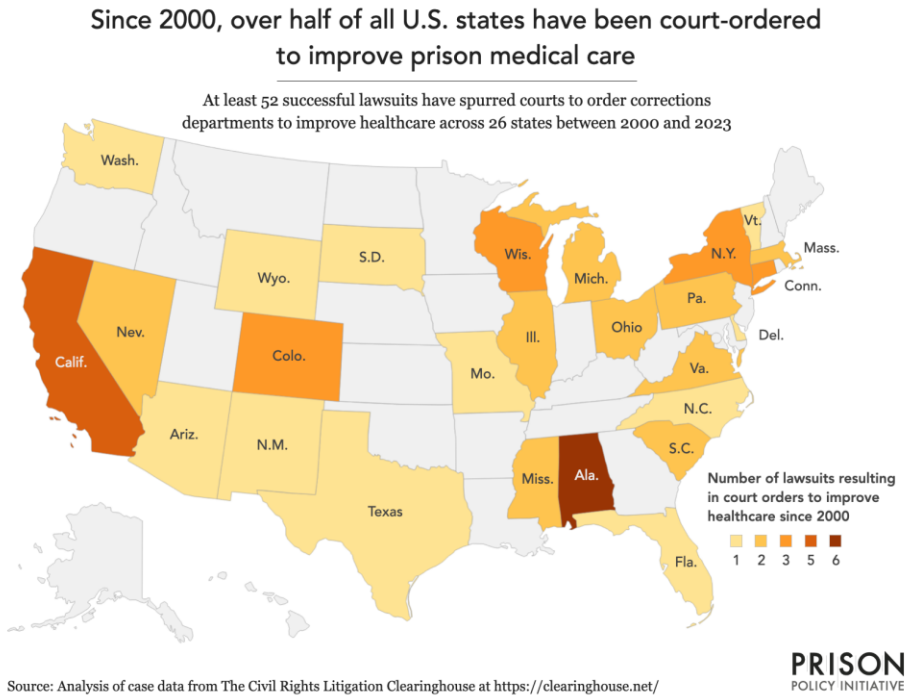
Agenda

01	Setting the Stage
02	Assessing Health and Social Needs
03	Building Collaboration
04	Implementing Enrollment Processes
06	Discussion and Next Steps

Setting the Stage



Justice-Involved Populations: Key Health and Social Statistics

These data underscore the need for pre-release enrollment, care coordination, MOUD access, HCV testing/treatment, and robust HRSN supports (especially housing) within the 90-day pre-release window to reduce overdose, prevent care gaps, and stabilize health at transition[1].

Chronic and Physical Health

- About 51% of state and 43% of federal prisoners report ever having a chronic condition; ~40% report a current chronic condition. Hypertension is the most common (≈29% state; 26% federal).[2]
- Incarcerated people bear a disproportionate infectious-disease burden; ~10% report hepatitis C, and roughly 30% of all people with HCV spend part of each year in correctional facilities.[3]

Behavioral Health Needs

- 43% of state and 23% of federal prisoners have mental health problems.[4]
- Although exact figures are difficult to determine, studies estimate that roughly **65% of the U.S. prison population has an active substance use disorder (SUD)**.[5]
- Only 44% of jails offer MOUD[6].

Overdose and Mortality Risk

- Risk of death, especially overdose, is >10× higher post-release.[7]

Social Determinants of Health

- 15% experienced homelessness before incarceration.[8]
- Formerly incarcerated individuals are 10× more likely to be homeless.[9]

Maternal and Reproductive Health

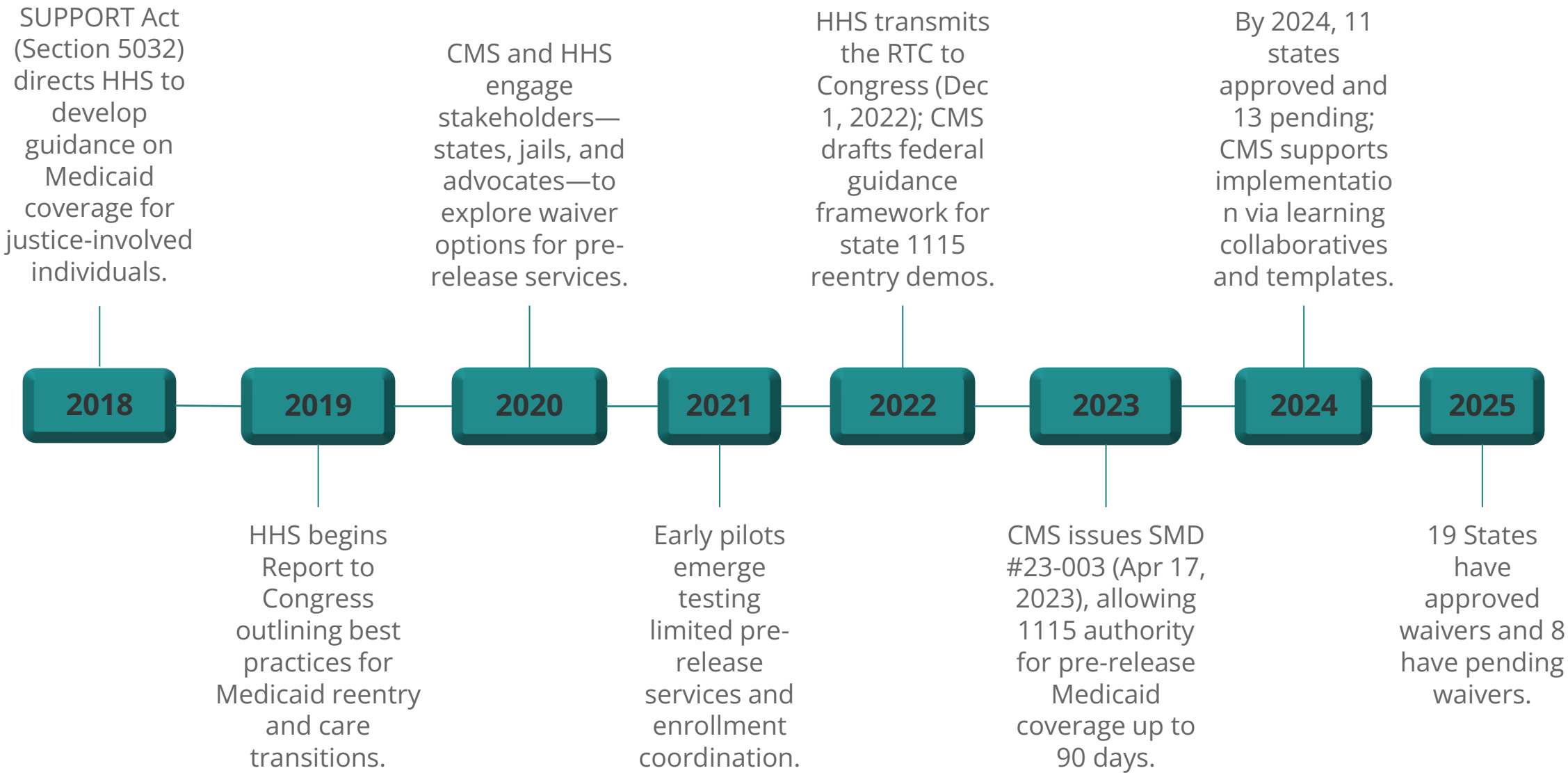
- Hundreds of pregnant people are incarcerated at any time.[10]
- Many receive inadequate prenatal care.[11]

Coverage and Continuity of Care

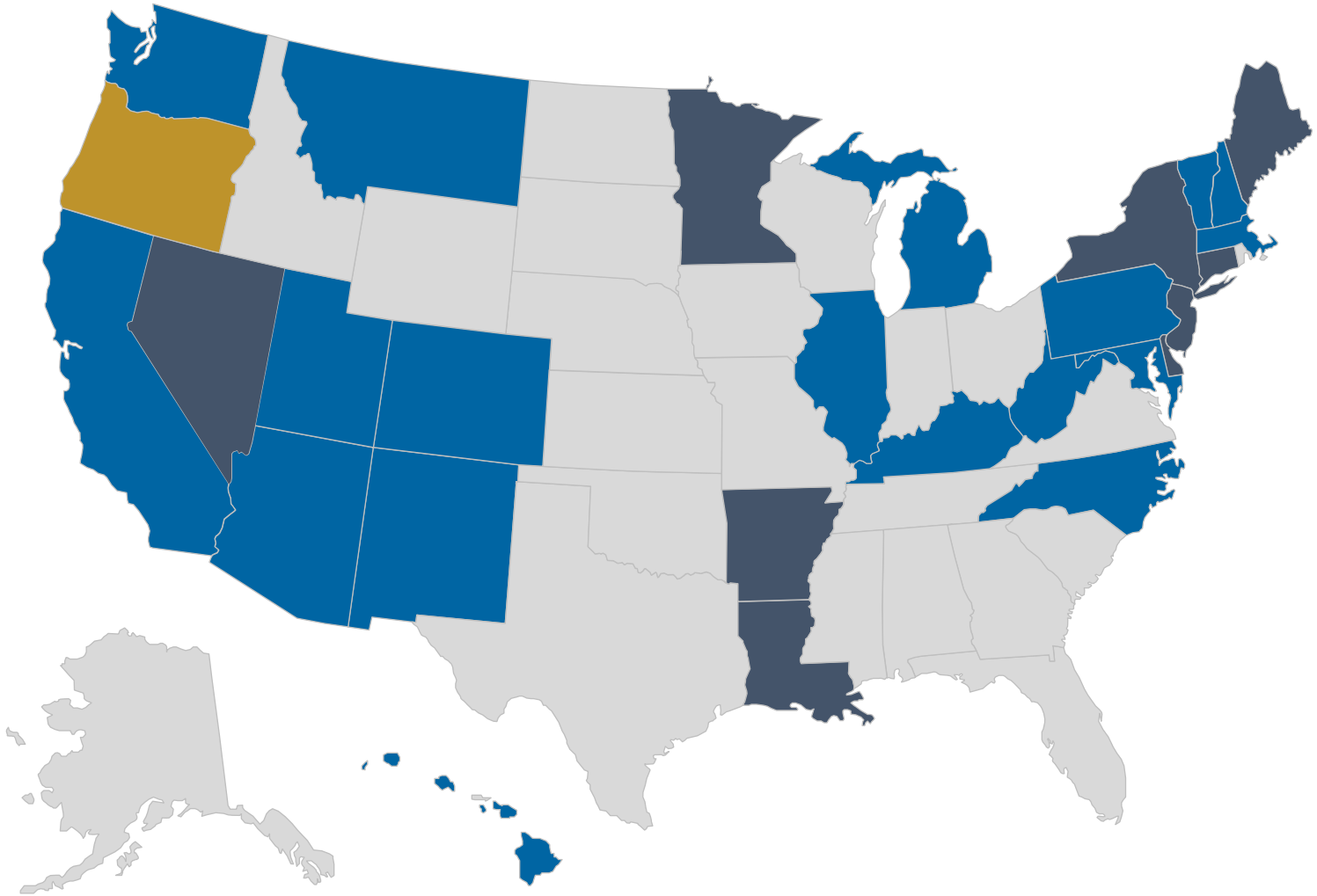
- Many states suspend rather than terminate Medicaid.[12]
- Coverage gaps increase hospitalization and mortality.[13]

Timeline

1115 JUSTICE INVOLVED REENTRY DEMONSTRATION



National Landscape: States approved and pending approval



APPROVED

PENDING APPROVAL

NO WAIVER

APPROVED, BUT NOT MOVING FORWARD

Key Design Features

The demonstration centers on care coordination, continuity of coverage, and access to behavioral health, physical health, and social supports—bridging correctional and community systems to reduce gaps in care and improve post-release outcomes.

Pre-Release Services Up to 90 days before expected release

States may choose to cover services beginning 30 days before release or up to 90 days, with additional hypotheses around outcomes for longer pre-release durations.

Eligible Populations

States have flexibility to define which justice-involved individuals will be eligible (e.g., based on substance use disorder, chronic illnesses, certain Medicaid eligibility groups.

Provider Types

The guidance allows use of **in-reach providers, embedded correctional health providers, or community-based providers**, with required handoffs to community care upon release.

Minimum required services

At least **case management, medication-assisted treatment (MAT), and provision of medications** must be included in the pre-release package. States may propose additional services with justifications.

Eligibility Enrollment Rules

The guidance suggests **suspension**, rather than termination, of Medicaid eligibility during incarceration; also, states should facilitate enrollment or reenrollment before release.

Implementation Planning and Oversight

States must submit an implementation plan (for CMS approval), monitoring & evaluation metrics, and a budget neutrality formulation specific to reentry demonstrations.

State Implementation Plans

The implementation plan outlines key design, as well as actions related to the five milestones included in the State Medicaid Director Letter (SMDL) "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated.

Reentry Demonstration Implementation reporting topics:

SMDL Milestone 1	SMDL Milestone 2	SMDL Milestone 3	SMDL Milestone 4	SMDL Milestone 5	Other Components
Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated.	Covering and ensuring access to the minimum set of pre-release services for individuals who are incarcerated to improve care transitions upon return to the community.	Promoting continuity of care.	Connecting to services available post-release to meet the needs of the reentering population.	Ensuring cross-system collaboration.	Reducing Health Disparities. Reinvestment plan. Consolidated Appropriations Act Population. Appendix: Implementation Phase-In Approach (if applicable).

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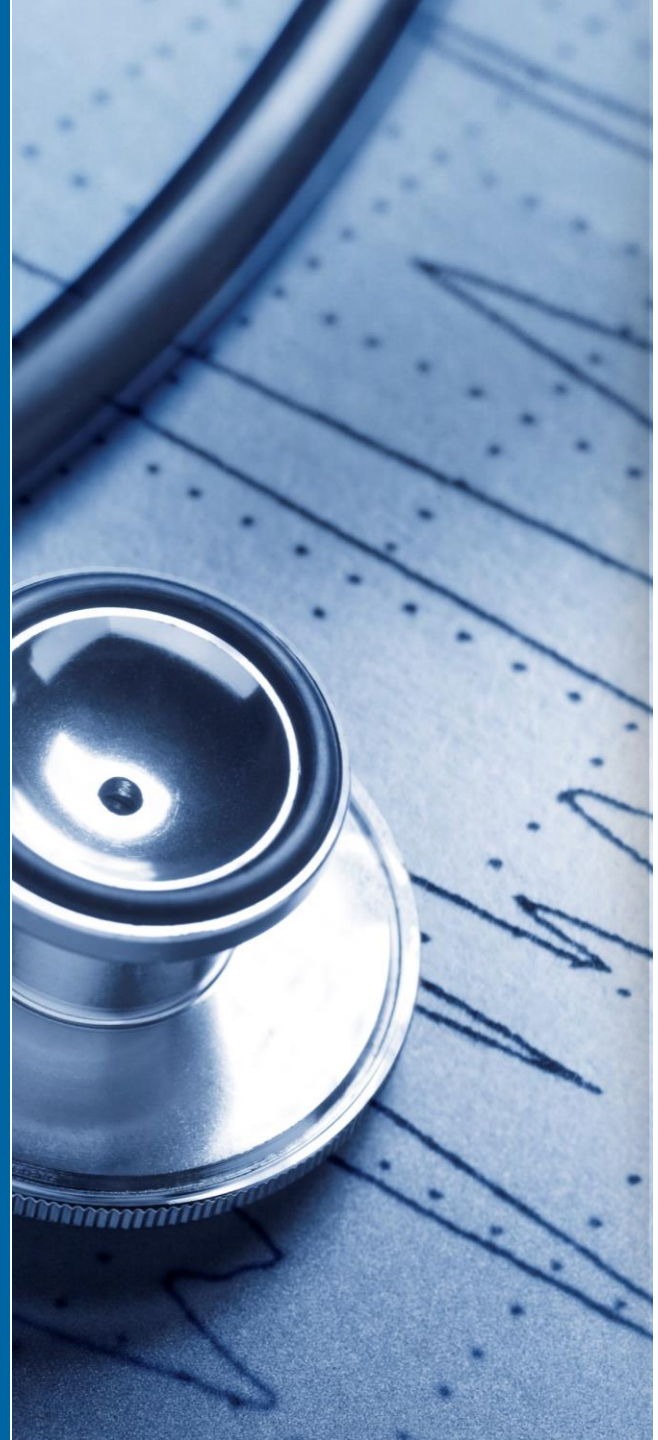
Assessing Health and Social Needs

https://unsplash.com/photos/a-long-hallway-with-chairs-and-a-clock-on-the-wall-sAe3-PWwjAc?utm_source=unsplash&utm_medium=referral&utm_content=creditShareLink

Identifying Comprehensive Health and Social Determinants to Guide Individualized Reentry Planning

Key considerations include conducting timely, person-centered assessments that integrate behavioral, physical, and social needs, ensuring coordination across correctional and community partners to develop individualized care plans that support continuity of coverage and successful reentry.



01

Facilitating Screening and Assessment

02

Creating a Health Risk Assessment that Informs a Reentry Care Plan

03

Data Sharing

04

Data Infrastructure

Screenings at or near intake

Health Screenings

- Initial medical screening within **24–48 hours** of intake to identify urgent and chronic health conditions.
- Assess for communicable diseases (e.g., tuberculosis, hepatitis, HIV, COVID-19) per CDC and NCCHC standards.
- **Chronic disease identification and management** for conditions such as hypertension, diabetes, asthma, and cardiovascular disease.

Behavioral Health Screenings

- **Mental health screening at intake** using validated tools (e.g., Brief Jail Mental Health Screen, PHQ-9, GAD-7).
- **Suicide risk screening** upon booking and periodically thereafter using tools such as the Columbia Suicide Severity Rating Scale (C-SSRS).
- **Substance use disorder (SUD) screening** using validated instruments (e.g., AUDIT, DAST-10, or TCU Drug Screen).

The demonstration opportunity supports the assessment of individuals' whole person needs

.

The core goal is to ensure continuity of care and reduce preventable morbidity and mortality as people transition from incarceration to the community.

Physical Health

Conduct a **comprehensive reentry health assessment within 90 days pre-release**, aligned with the CMS 1115 JI Demonstration framework.

Behavioral Health

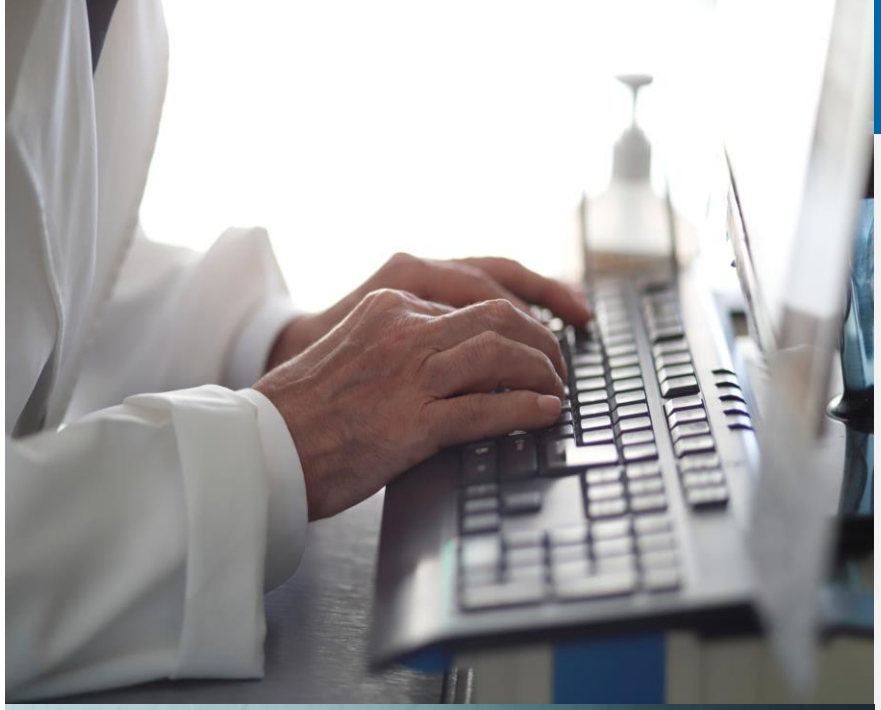
Review and update **behavioral health and SUD treatment plans**, including continuity of medications (e.g., MOUD, psychotropics).

Social Determinants of Health

Screen for Social determinants of health or **health-related social needs (HRSN)** such as housing, food, transportation, and social support.

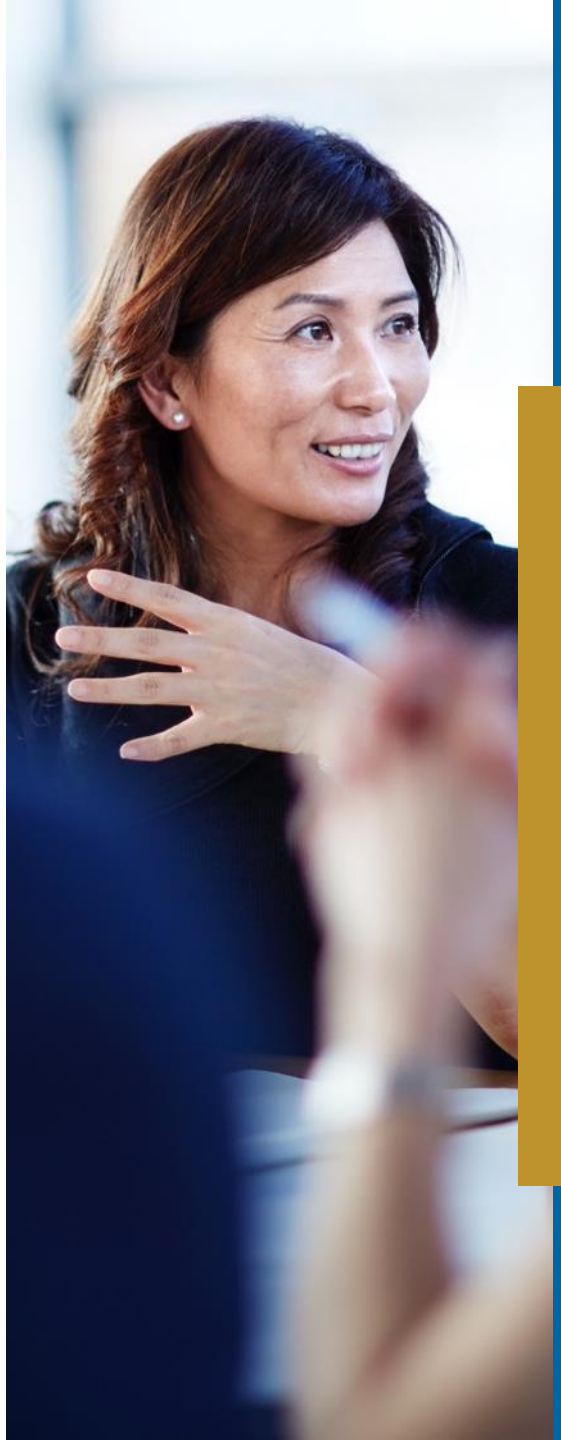
Medication Planning

Ensure **release medication planning**—30-day supply or bridge prescriptions for continuity of treatment.



Assessment Fatigue.

Within the CMS 1115 Justice-Involved context, assessment fatigue is a **critical implementation risk**—especially during the 90-day pre-release period—because justice-involved individuals may already undergo intake, medical, mental health, and eligibility.



01

Streamlined, coordinated assessment workflows across custody, health, and community partners.

02

Use of shared data systems to prevent duplication.

03

Trauma-informed approaches to minimize emotional burden.

04

Phased or tiered screening models (e.g., brief initial screening followed by targeted follow-up assessments).

Creating a Health Risk Assessment and Reentry Care Plan

The HRA and RCP are not just administrative requirements—they are **the operational backbone** of the 1115 JI Reentry Initiative, ensuring that each person leaving incarceration receives **timely, coordinated, and person-centered care** that supports successful reentry and long-term health stability.

- **The Health Risk Assessment (HRA) identifies and documents an individual's current health status, risk factors, and service needs** while in custody, typically as an early step in the reentry process.

- **The Reentry Care Plan** is a **comprehensive, individualized roadmap for continuity of care** as the person transitions from incarceration to the community. It is developed after or informed by the HRA.

Data Sharing

In designing information sharing for the CMS 1115 JI Reentry Initiative, the key is to **balance utility and risk**: enabling enough data exchange to support effective continuity of care, eligibility, billing, and evaluation — while maintaining strict safeguards for privacy, security, legal compliance, and trust.

Grounding your architecture in clear governance, phased implementation, robust technical standards, and cross-agency agreements will be critical to success.

HIPAA & 42 CFR Part 2

Sharing data about behavioral health or substance use requires **special caution** because it is covered by **two overlapping privacy laws.**

State Laws

States may have stricter privacy laws or rules about health, criminal justice, or mental health data.

Data Use Agreements and Memoranda of Understanding

Multiple agencies must establish formal data-sharing agreements that clearly define governance structures, roles, data use parameters, and accountability.

DATA INFRASTRUCTURE

DATA SHARING CONSIDERATIONS FOR CMS 1115 JI REENTRY INITIATIVES

CATEGORY	KEY FOCUS AREAS	SUMMARY OF CORE REQUIREMENTS & CONSIDERATION
Technical & Interoperability Requirements	**Interfacing Across Systems & Timeliness**	• Integrate corrections EHRs, Medicaid eligibility, and community health systems using APIs or data integration layers. • Provide fallback options (batch uploads, secure file transfers) for legacy systems. • CMS supports enhanced federal matching for IT modernization. • Exchange data in near real-time (release dates, care plans, medication histories). Minimize latency to protect care continuity.
Scope, Access Control & Data Minimization	**Role- Based Access & Data Minimization**	• Limit access to authorized users by role (e.g., corrections, Medicaid, clinical staff). • Share only the minimum data necessary for a function (e.g., care coordination). • Avoid wholesale record transfers unless required and consented.
Security, Risk Mitigation & Safeguards	**Encryption, Authentication, Retention Policies & Incident Response**	• Encrypt all data in transit and at rest. • Use multi-factor authentication and layered authorization to limit dataset access. • Define retention timelines and enforce secure deletion or archiving protocols. • Maintain clear cross-agency protocols for breach detection, response, and notification.
Governance, Oversight & Trust	**Governance Committees & Performance Metrics**	• Establish multi-stakeholder oversight bodies (corrections, Medicaid, legal, and community) to set policies and monitor compliance. • Inform individuals about what data is shared, with whom, and for what purpose; engage community and justice-involved stakeholders to build trust. • Track and report on data quality, timeliness, completeness, and outcomes (e.g., post-release continuity of care).

Use Cases & Use Driven Design

Use case—such as release alerts, pre-release care plan transfers, and eligibility data exchange—supports seamless coordination between correctional, Medicaid, and community systems and these processes help:

- Prevent care gaps during the critical transition from custody to community.
- Ensure timely Medicaid activation and reimbursement for allowable pre-release services.
- Improve care coordination and data visibility across sectors through shared dashboards.
- Enable evaluation and accountability by tracking outcomes, utilization, and recidivism.

Release Data Alerts

Send release notifications to care managers or health systems to trigger pre-release planning.

Release Care Plan Transfer

Share health records, medications, and labs with community providers to prevent care gaps.

Eligibility & Enrollment Data Exchange

Coordinate Medicaid suspension/reactivation and share eligibility updates before release.

Claims & Billing Integration

Align billing data to ensure only approved pre-release services are reimbursed.

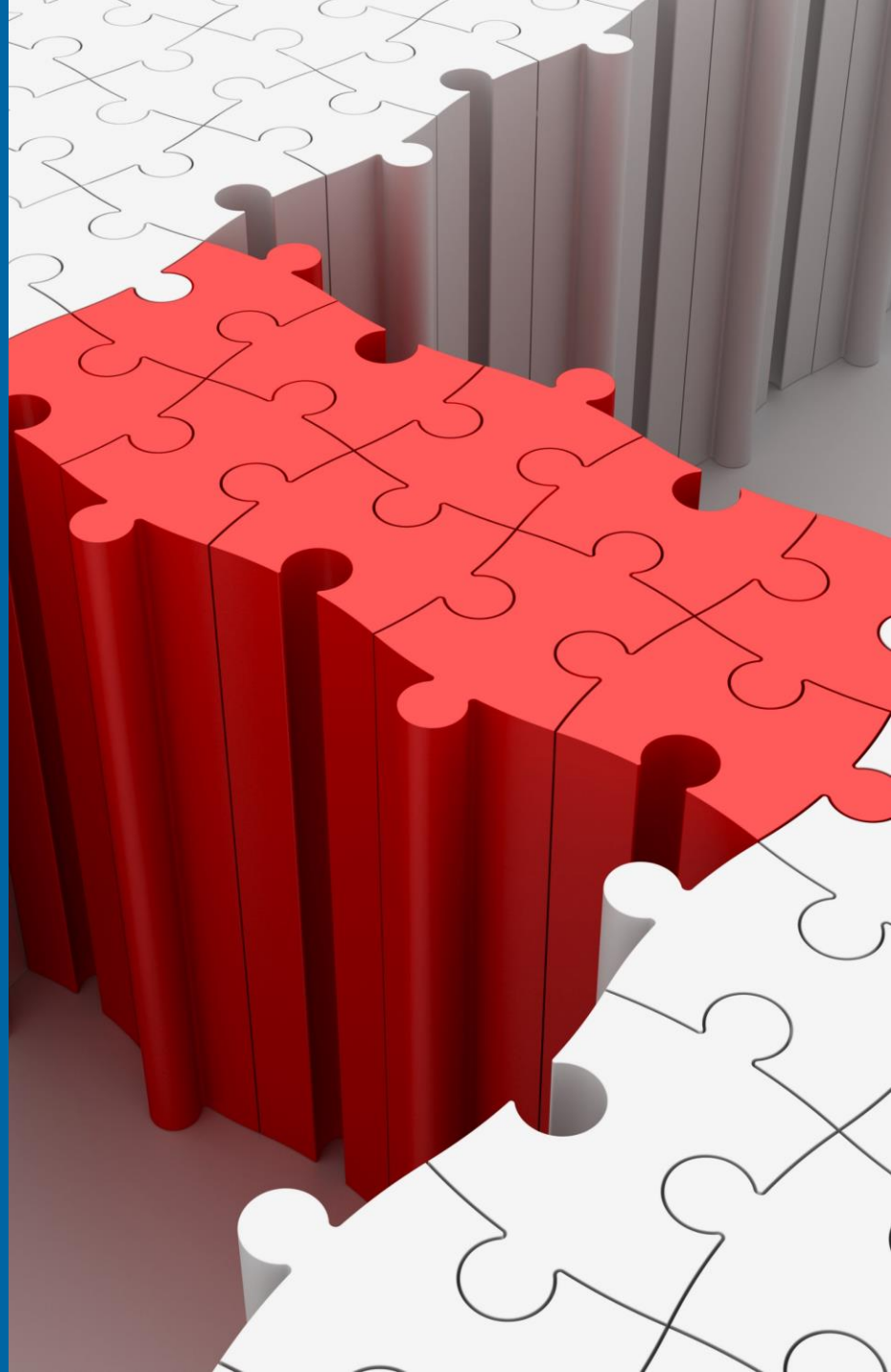
Care Coordination and Case Management

Create shared dashboards for case managers to view and update health, social, and justice data.

Monitoring & Evaluation

Use data for outcomes research, utilization tracking, cost analysis, and recidivism monitoring while preserving privacy.

Building Collaboration



Key Stakeholders

Collaboration between key stakeholders—such as correctional agencies, health departments, managed care plans, community providers, and social service organizations—is essential to the success of a 1115 JI Reentry Initiative because it ensures seamless coordination of care, data sharing, and service continuity as individuals transition from custody to the community.

Carceral Facilities

Carceral facilities are the **entry point for screening, enrollment, and care coordination** during incarceration.

State Medicaid Office

State Medicaid agencies oversee **program design, compliance, and federal reporting** under the Section 1115 waiver. They are responsible for eligibility determination.

Community-Based Providers and Organizations

Community health centers, behavioral health providers, reentry programs, and peer support organizations deliver **continuity of care after release**, bridging the gap between correctional and community systems.

People with Lived Experience

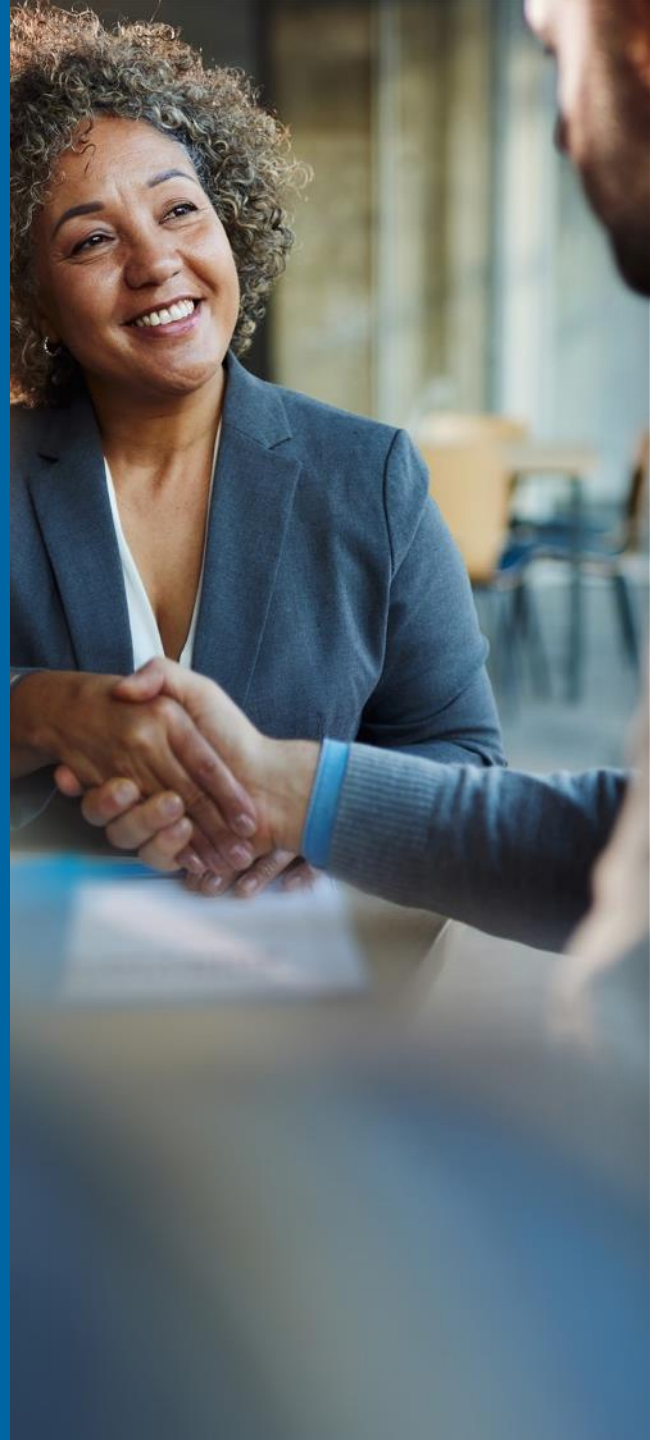
Individuals with lived experience bring **authentic insight and trust-building capacity** to program design, peer navigation, and quality improvement.

Health Plans and Correctional Health Care Companies

Managed care plans and correctional health providers operationalize **clinical integration, data exchange, and reimbursement workflows**.

GOVERNANCE IS THE ORGANIZATIONAL BACKBONE THAT TRANSFORMS CROSS-SECTOR COORDINATION INTO MEASURABLE SUCCESS

Establishing governance structures at both the agency and stakeholder levels is essential for the success and sustainability of a 1115 Justice-Involved (JI) Reentry Initiative as the initiative spans multiple systems—health care, corrections, behavioral health, and social services—that must operate in alignment to achieve shared goals.



Governance Structure

- Coordination Across Complex Systems
- Accountability and Oversight
- Shared Ownership and Collaboration
- Data Sharing and Quality Improvement
- Sustainability and Scalability

Establishing governance structures at both the agency and stakeholder levels is essential for the success and sustainability of a 1115 Justice-Involved (JI) Reentry Initiative because the initiative spans multiple systems—health care, corrections, behavioral health, and social services—that must operate in alignment to achieve shared.

State Level	Local Level	Cross-level Integration
Sets policy, funding, and compliance direction.	Operationalizes workflows and care coordination.	Ensures feedback, data-driven learning, and equity.

State-Level Governance Structure to Foster Collaboration for Effective Implementation

Executive Steering Committee: Provides strategic oversight, funding alignment, and interagency coordination. Members include Medicaid, Corrections, Public Health, MCPs, Governor's Office.

Implementation & Operations Workgroup: Translates policy into practice and coordinates readiness and training. Members include program managers, IT/data leads, MCP representatives and TA partners.

Evaluation & Learning Collaborative: Reviews performance data, drives CQI, and informs CMS reporting. Members: include state evaluators, data analysts, and local CQI leads.

https://unsplash.com/photos/oval-brown-wooden-conference-table-and-chairs-inside-conference-room-GWe0dlVD9e0

Local (County or Regional) Governance Structure.

A **well-designed governance structure** is what separates a well-written 1115 JI Reentry waiver from a truly *operationally sustainable* model.

Local Reentry Steering Committee: Guides county implementation and aligns correctional and community systems. Members include the Sheriff's Office, Health & Human Services, Behavioral Health, MCPs, CBOs, and Lived Experience Reps.

Operational Workgroups:
Eligibility & Enrollment: Medi-Cal activation, data sharing.
Clinical Integration: HRA completion, medication continuity, care plans.
Community Linkages: ECM, housing, and HRSN referrals.
Data & CQI: Reporting and quality improvement cycles.

Community Advisory Council: Brings lived experience, equity perspective, and peer feedback into governance. Members include formerly incarcerated individuals and peer navigators, family members, community-based organizations and advocacy groups.

Cross-Level Integration Mechanisms

Charters & MOUs
Shared Dashboards
Joint Training & TA
Feedback Loops.

Optimization and Sustainability

Transition from pilot to long-term operational structure.
Institutionalize governance through policy, regulation, or permanent funding streams.
Integrate equity and lived experience into CQI.
Establish succession planning and scalable learning collaboratives.

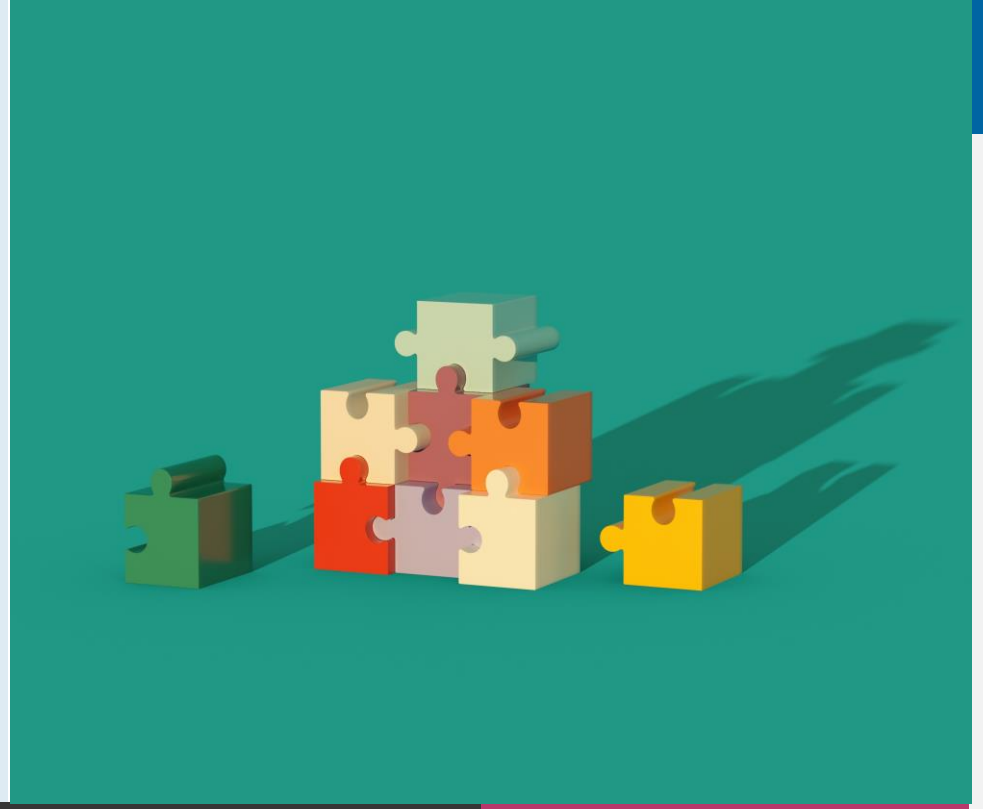
Considerations for Cross-level Integration and Optimization

A strong two-tiered governance structure enables alignment between state strategy and local execution—ensuring effective implementation, operational excellence, and continuous learning for the 1115 JI Reentry Demonstration.

Implementing Enrollment Processes

Strategies for Enrolling Incarcerated Persons in Medicaid for 90-day Pre-Release Services

This is one of the most operationally critical components of the CMS 1115 Justice-Involved Reentry Demonstration. Below is a summary of best-practice recommendations for enrolling incarcerated individuals in Medicaid during the 90-day pre-release period.



Establish Formal Interagency Agreements

Purpose: Clarify roles, data sharing, and workflows among key partners reporting.

Define clear points of contact in both agencies for enrollment coordination.

Identify Eligibility Early

Purpose: Maximize time for eligibility determination and care coordination.

Best Practices:
Screen all new admissions for existing Medicaid coverage status.
Flag individuals 90 days before anticipated release.
Use data-matching systems to verify coverage and avoid duplicate applications.

Implement Dedicated Enrollment Staff or Navigators

Purpose: Ensure consistent, trauma-informed enrollment assistance.

Best Practices:
Train staff in Medicaid rules for suspended vs. terminated coverage, privacy standards, and trauma-informed communication.
Integrate people with lived experience as peer navigators.

People with Lived Experience

Individuals with lived experience bring **authentic insight and trust-building capacity** to program design, peer navigation, and quality improvement.

Health Plans and Correctional Health Care Companies

Managed care plans and correctional health providers operationalize **clinical integration, data exchange, and reimbursement workflows**.

Questions?

Contact Us. We Can Help.

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