



**ASPE**  
ASSISTANT SECRETARY FOR  
PLANNING AND EVALUATION

## REPORT TO CONGRESS

# Health Care Transitions for Individuals Returning to the Community from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group

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A Report to Congress

Required by Section 5032 of the Substance Use-Disorder Prevention  
that Promotes Opioid Recovery and Treatment for Patients and  
Communities Act (SUPPORT Act; Pub.L. 115-271)

U.S. Department of Health and Human Services  
Office of the Assistant Secretary for Planning and Evaluation

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## Office of the Assistant Secretary for Planning and Evaluation

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# Executive Summary

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## Introduction and Background

Individuals returning to the community after incarceration in prison or jail<sup>a</sup> have a variety of significant needs, including those related to access to health coverage and continuity of health care. These needs are especially important because justice-involved individuals have disproportionately high rates of serious mental illness (SMI), substance use disorder (SUD), and infectious and other chronic physical health conditions.<sup>2-4</sup> Mortality among returning community members is significantly elevated in the

*An estimated **80%** of returning community members have chronic medical, psychiatric, or substance use disorders.<sup>1</sup>*

post-release period; especially in the week after release, when overdose, suicide, and homicide are the leading causes of death.<sup>5,6</sup> Poor health status is associated with higher costs to the health care and criminal justice systems and, in some studies, increased rates of recidivism.<sup>7,8</sup> Black and low-income individuals are overrepresented in the justice system, and negative outcomes during reentry may

perpetuate existing disparities.

In states that expanded Medicaid eligibility under the Affordable Care Act (ACA), most returning community members are eligible for Medicaid. However, Medicaid plays a very limited role during incarceration due to a federal inmate exclusion that prohibits use of Medicaid funds to cover most services provided to people while incarcerated in prison and jails.

Section 5032 of the 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (Pub.L. 115-271) (hereinafter referred to as SUPPORT Act) requires the Secretary of HHS to convene a stakeholder group of representatives of “managed care organizations, Medicaid beneficiaries, health care providers, the National Association of Medicaid Directors, and other relevant representatives from local, state, and federal jail and prison systems” to discuss best practices for states to help inmates released from public institutions transition to the community with health care (hereinafter referred to as the Stakeholder Group). This report summarizes the identified practices of that Stakeholder Group and, as required by Section 5032 of the SUPPORT Act, informs design of a demonstration opportunity “under Section 1115 of the Social Security Act (42 U.S.C. 1315) to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under Title XIX of such Act.”<sup>9</sup> This content comes from the stakeholder meeting unless otherwise cited. The Stakeholder Group is governed by the Federal Advisory Committee Act (Pub.L. 92-463) which sets forth standards for the formation and use of advisory committees.

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<sup>a</sup> Jails are administered by local law enforcement and hold those with shorter sentences (usually 1 year or less) and those awaiting trial. Prisons are state or federal facilities where people who have been found guilty of breaking a state or federal law, respectively, are sent to serve sentences typically longer than 1 year.

## Challenges

Returning community members face multiple challenges which can hinder their ability to obtain health coverage and successfully transition their health care. These challenges include inability to access and afford medications and treatment—including medications for opioid use disorder (MOUD), medications for other SUDs, and medications for chronic and infectious conditions—which can contribute to post-release morbidity and mortality. Other challenges include limited electronic data sharing of health records between justice system and community providers, limited post-release resources (especially in low-income and rural areas), systemic health system biases against justice-involved individuals, and a variety of pressing health-related social needs, including obtaining housing, accessing food, securing employment, and reestablishing interpersonal relationships. Some reentrants must also navigate bureaucratic hurdles to reinstate Medicaid payment for benefits or reapply for Medicaid. Others, especially those in states that did not expand Medicaid eligibility to the adult group, may not be eligible for Medicaid and may be unable to access and afford insurance provided by employers or through the federal Health Insurance Marketplaces or state-based Marketplaces. Even when returning community members do obtain Medicaid coverage, some services that are particularly relevant to individuals with mental health diagnoses and SUD—such as rehabilitative services and case management—are optional benefits under state plans and thus may not be covered.

## Promising Practices

State and local jurisdictions, often with federal support, can implement practices to support access to coverage and health care during reentry. These practices occur within correctional facilities and in the community. Because some justice-involved individuals cycle in and out of correctional institutions, community-based practices may be simultaneously pre- and post-incarceration, representing a key opportunity to connect with and support individuals while they are not in a carceral facility.

A review of relevant literature and discussion among stakeholders identified promising practices at the state and local levels to connect returning community members to health care. These practices include universal screening for SUD during intake, expanded access to MOUD within correctional settings, in-reach care coordination and discharge planning, community navigators and peer support specialists, culturally competent models of care, cross-sector care coordination, assistance with access to medication post-release, crisis diversion programs and partnerships, telehealth, and information sharing between correctional health care providers and community providers.

Other practices relate specifically to health coverage, which is often a prerequisite to accessing health care in the United States. Promising practices to promote coverage include expansion of Medicaid eligibility to adults up to 133 percent of the federal poverty level (referred to as the adult group), suspension (rather than termination) of Medicaid coverage upon incarceration, designation of correctional facilities as qualified entities for presumptive eligibility, data sharing across agencies to automate suspension and reinstatement, pre-release application assistance, and Medicaid Health Homes for returning community members.

## 1115 Demonstration

Under Section 1115 of the Social Security Act, states are given the ability to apply to the Federal Government to implement time-limited experimental or pilot projects within their Medicaid programs. States have employed 1115 demonstrations to support justice-involved individuals in several ways, including targeting Medicaid eligibility, behavioral health services, or case management to returning community members; and providing this population with transitional care during reentry. As of October 2022, 11 states have submitted Section 1115 demonstration applications to HHS to demonstrate and test innovative approaches to providing Medicaid coverage for certain services provided to incarcerated individuals for a limited period prior to release. These applications are under review as of October 21, 2022.<sup>b</sup>

An 1115 demonstration through which states can receive federal matching in Medicaid payments for pre-release services provided to individuals who would receive Medicaid coverage for the services if not incarcerated has the potential to improve care transitions. Key policy considerations for such a demonstration include the scope of benefits provided pre-release, the ideal length of time for pre-release payment for services, strategies for addressing social supports, meaningful engagement of justice-involved individuals in the design of the demonstration, opportunities to address health disparities, and strategies for monitoring and evaluating the demonstration outcomes.

Several key design elements may help support state uptake of the 1115 demonstration opportunity. Factors such as the ability to customize the target population of the model, support for data infrastructure, strategic partnership opportunities, inclusion of pre-arrest diversion activities, and 1115 demonstration budget neutrality considerations, may generate additional state interest in an 1115 demonstration opportunity.

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<sup>b</sup> The 11 states include: Arizona, California, Kentucky, Massachusetts, Montana, New Jersey, New York, Oregon, Utah, Vermont, and West Virginia.

## Section 1. Introduction

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In October 2018, the SUPPORT Act was signed into law. Section 5032(a) of this Act requires the Secretary of HHS to “convene a stakeholder group of representatives of managed care organizations, Medicaid beneficiaries, health care providers, the National Association of Medicaid Directors, and other relevant representatives from local, state, and federal jail and prison systems” to develop best practices for states to help inmates released from public institutions transition to the community with health care (such as by ensuring continuity of health insurance or Medicaid enrollment).<sup>10</sup> The Medicaid Reentry Stakeholder Group, a designated Federal Advisory Committee governed by Federal Advisory Committee rules, was established in July 2020 and convened virtually in August 2021.<sup>11,c</sup>

Section 5032(b) of the SUPPORT Act further states that the best practices identified by the stakeholder group will be summarized in a report and form the basis of “opportunities to design demonstration projects under Section 1115 of the Social Security Act (42 U.S.C. 1315) to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under Title XIX of such Act.”<sup>9</sup> During the August meeting, the stakeholder group discussed considerations for a new 1115 demonstration, including systems for providing assistance and education for Medicaid enrollment and providing payment for health care services for the subject beneficiaries “with respect to a period (not to exceed 30 days) immediately prior to the day on which such individuals are expected to be released.”<sup>9</sup>

This report summarizes the challenges and practices that were identified by the stakeholders, as required under Section 5032 of the SUPPORT Act, along with relevant information from supplementary literature (including an annotated bibliography and unpublished issue briefs) prepared in advance of the meeting. The report presents issue background (Section 2), major challenges associated with health care transitions for returning community members (Section 3), promising health care-related practices (Section 4), promising health coverage-related practices (Section 5), and key considerations for an 1115 demonstration opportunity (Section 6). Much of the content in this report comes directly from the stakeholder meeting transcript; this is identified throughout the report as stakeholder statements and perspectives. Content from the supplementary literature is cited with full references. The Stakeholder Group is governed by the Federal Advisory Committee Act which sets forth standards for the formation and use of advisory committees.

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<sup>c</sup> See **Appendix A** for full list of Stakeholder Group participants.

## Section 2. Background

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Reentry to the community after incarceration in prison or jail (jointly referred to in this report as “correctional facilities”) is a transitional period. Health care transitions (including those related to health coverage, care, and medications) are critical aspects of this process. Persons with justice system involvement carry a disproportionately high disease burden, including high rates of SMI, SUD, and infectious and other chronic physical health conditions.<sup>2-4</sup> SUD is especially prominent among individuals in jails (in which stays range from several hours to a year or more), compared to individuals in prisons (in which stays are typically longer and where chronic health conditions are more common). According to data from the Bureau of Justice Statistics, more than half of state prisoners (58 percent) and sentenced jail inmates (63 percent) in 2011-2012 met the criteria for drug dependence or abuse, and more than a third of state and federal prisoners (37 percent) and jail inmates (44 percent) in 2007-2009 reported previously being diagnosed with a mental health disorder.<sup>d</sup> Half of individuals in state and federal prisons (50.5 percent) and local jails (50.2 percent) reported ever having a chronic condition, including cancer, high blood pressure, diabetes, heart-related problems, kidney-related problems, arthritis, asthma, and cirrhosis of the liver. Overall, an estimated 80 percent of returning community members have chronic medical, psychiatric, or substance use disorders.<sup>1</sup> Additionally, although HIV prevalence is declining among incarcerated individuals, it remains higher than in the general population.<sup>e,f</sup> More recently, from March through June 2020, federal and state prisoners were 5.5 times more likely than the non-institutionalized population to test positive for COVID-19.<sup>12</sup>

Given these substantial health needs, access to and continuation of care during reentry is crucial. However, returning community members (also referred to in this report as “reentrants”) face multiple health-related challenges which can hinder their ability to obtain coverage and successfully transition care. These challenges are extensive, varied, and include inability to access and afford medications and treatment, limited electronic data sharing of health records between justice system and community providers, limited post-release resources (especially in low-income and rural areas), and systemic health system biases against justice-involved individuals. Additionally, the immediate post-release period is a time of multiple pressing needs, including for obtaining housing, food, and employment and navigating interpersonal relationships; health care is just one of many. Furthermore, challenges in meeting basic needs such as nutrition, housing and employment can make it difficult to obtain, afford and access health care. From a coverage perspective, some reentrants must navigate bureaucratic hurdles to reinstate Medicaid payment for benefits or reapply for Medicaid. Others, especially those in states that did not expand Medicaid eligibility to the adult group, are not eligible for Medicaid and may be unable to access and afford insurance provided by employers or through the federal Health Insurance Marketplaces or state-based Marketplaces.

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<sup>d</sup> These are the most recent years for which these data are available.

<sup>e</sup> See <https://bjs.ojp.gov/content/pub/pdf/hivp20st.pdf>.

<sup>f</sup> See <https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics>.



The consequences of lack of health care and/or inadequate transition of care during the reentry period can be severe. During the early post-release period, mortality rates are significantly increased among returning community members, especially from overdose, suicide, and homicide.<sup>5,6</sup> A study of more than 76,000 persons released from Washington State Department of Corrections found that death rates among these reentrants were 3.6 times higher than expected (based on the mortality rates for the non-institutionalized population within the state), with overdose as the leading cause of death. Opioids were involved in 15 percent of all deaths, and risk of death (from any cause) was particularly high in the first week after release.<sup>13</sup> When individuals do not get needed health care during reentry, the consequences impact not only themselves but the communities to which they have returned. Untreated health conditions and poor health status have been found to be associated with increased rates of recidivism and higher associated costs to the health care and criminal justice systems.<sup>7,8</sup> Studies in Florida and Washington State have found that Medicaid enrollment upon release was associated with a 16 percent reduction in recidivism among former inmates with severe mental illness.<sup>14,15</sup> Furthermore, inadequate health care transitions during reentry also perpetuate racial and socioeconomic health disparities, due to overrepresentation of Black, Latino, and low-income individuals within the justice system.<sup>16</sup> When reentering individuals cannot and do not access needed health care, the detrimental consequences--to health and beyond--are concentrated within low-income communities and communities of color.

To understand the health care-related challenges facing reentering community members, and to develop effective strategies within and beyond the policy realm to connect these individuals with coverage and care, the broader policy context is key. Beginning in January 2014, the ACA created a new pathway to Medicaid coverage for millions of individuals in the states that elected to expand eligibility.<sup>g</sup> Prior to the ACA, Medicaid eligibility was generally limited to specific categories of low-income individuals, including children, pregnant women, parents of dependent children, the elderly, and persons with disabilities. Under the ACA, states can choose to expand eligibility to most low-income adults under 133 percent of the federal poverty level. Because people who are incarcerated are disproportionately low-income, expanded eligibility creates a significant pathway to Medicaid for the justice-involved population.<sup>16</sup>

Although individuals may enter prison and jail with Medicaid enrollment (and others are eligible, though unenrolled), the role of Medicaid for incarcerated individuals is extremely limited. Under the federal inmate exclusion, established in 1965 when Congress first authorized the Medicaid program, Medicaid funds cannot be used to pay for services provided to an “inmate of a public institution,” which includes people incarcerated in prison and jails (both pre- and post-sentencing), with very limited exceptions.<sup>h</sup> As a result of this prohibition, enacted in part to prevent cost-shifting from state and local government to the Federal Government, prisons and jails are responsible for provision and payment of health care services for individuals in their custody. Correspondingly, the type, quality, and quantity of services vary significantly among locations, based on resource availability.

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<sup>g</sup> As of January 31, 2022, 39 states (including the District of Columbia) have adopted Medicaid expansion.

<sup>h</sup> The exception to this policy is if the inmate is receiving services as an inpatient in a medical institution, which generally means in a medical facility outside of the public institution for an expected period of 24 hours or more.

In the absence of federal requirements, states differ in how they treat an individual’s Medicaid coverage upon their entry into institutional custody. Historically, most states enacted policies to terminate enrollment upon entry, in order to prevent inappropriate Medicaid billing while in custody.<sup>17</sup> In 2016, the Centers for Medicare & Medicaid Services (CMS) released guidance encouraging states to facilitate continuity of enrollment in Medicaid by keeping individuals enrolled but placing them into a limited benefits status to ensure that the only services that can be paid are permissible.<sup>18,i</sup> In January 2021, CMS released subsequent guidance for states in implementing the SUPPORT Act.<sup>19</sup> Section 1001 of the SUPPORT Act prohibits states from terminating Medicaid enrollment based on incarceration for “eligible juveniles.”<sup>j</sup>

Although policies vary from state to state, the process for reinstating payment for Medicaid benefits post-release is generally quicker in so-called “suspension states,” in which an individual’s coverage is either suspended upon incarceration *or* is maintained but with coverage limited to allowable inpatient services. In contrast, in “termination states,” enrollment is terminated upon entry (except for eligible juveniles) and individuals must reapply for Medicaid post-release.

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<sup>i</sup> These are the most recent years for which these data are available.

<sup>j</sup> Eligible juveniles are individuals under age 21 and individuals enrolled in the mandatory eligibility group for former foster care children.

## Section 3. Challenges

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When incarcerated individuals return to the community, their disease burden and existing health challenges are often compounded by a variety of challenges related to accessing health care and health coverage. Understanding these obstacles—many of which are described below—provides a foundation for developing strategies to facilitate connection to coverage, promote access to and continuity of care, and improve health status before and after release. This content comes from the stakeholder meeting unless otherwise cited. The Stakeholder Group is governed by the Federal Advisory Committee Act which sets forth standards for the formation and use of advisory committees.

### I. Health Care

Given the high rates of SUD among the incarcerated population, provision of treatment within prisons or jails supports successful transition back to the community. One example is MOUD. MOUD is an approach to opioid use treatment that combines the use of Food and Drug Administration-approved medications (i.e., buprenorphine, methadone, or naltrexone) for opioid use disorder (OUD) that can be prescribed in combination to reduce opioid craving and use, risk of overdose, and other negative health outcomes. Providing MOUD in combination with counseling and behavioral therapies is considered by medical experts to be an evidence-based best practice, and the Substance Abuse and Mental Health Services Administration (SAMHSA) describes it as a “whole-patient” approach to treating SUDs.<sup>20</sup> There is a strong base of correlational evidence showing that when methadone or buprenorphine is provided both during custody and after release, individuals with OUD have significantly lower rates of opioid overdose and mortality.<sup>21,22</sup> However, this treatment approach is underutilized in criminal justice settings. As of 2018, only 14 states offered methadone or buprenorphine in any of their jail or prison facilities, 39 offered injectable naltrexone prior to release, and one (Rhode Island) offered all three medications.<sup>23</sup> Barriers to more widespread use of MOUD in prisons and jails include concerns about cost and liability, facility policies that prohibit the use of controlled substances, and lack of trained medical providers. (Providers must receive a waiver from the SAMHSA to be able to prescribe buprenorphine, and methadone may only be dispensed in SAMHSA-certified opioid treatment programs.) Additionally, misunderstanding around use of MOUD can present a barrier to its use, as some medical and criminal justice officials may perceive it as substituting one addictive drug for another.<sup>20</sup>

Access to medications post-release can be extremely difficult for reentering individuals, many of whom have health conditions for which a consistent medication regimen is necessary, including maintenance medications for chronic physical health conditions and MOUD. Stakeholders noted that although some states (including Arizona, Connecticut, Massachusetts, and Rhode Island) provide individuals with a limited supply of their medications upon release, this is not a consistently adopted practice. When individuals do receive a limited medication supply, it is typically for less than 30 days, and they risk running out before they are able to see a provider, obtain a refill, and secure the necessary funds to pick up the prescription. The high rate of overdose in the immediate post-release period may be due, in part, to the inability of returning community members to access MOUD during reentry.

Continuity of care for returning community members can also be hindered by limited data sharing between health care providers in the criminal justice system and those in the community. Stakeholders discussed that because most areas lack data infrastructure for sharing medical records between these providers, health care providers in the community often have a limited understanding of reentrants' medical histories, current medication lists, and comprehensive health care needs. The lack of interface between medical records pre- and post-release contributes to discontinuity of care, discontinuation of medication, duplicative care, and missed opportunities for health care coordination and intervention.

*“Let's remember the competing priorities that these men and women have around housing insecurity, employment, clothing, links with social services, family reunification. There's a smorgasbord of issues.”*

*-Stakeholder*

Transition of care is further complicated by the fact that returning community members face a variety of pressing--and at times, competing--needs. These include securing housing, food, and employment; navigating interpersonal relationships; and, after long periods of incarceration, adjusting to a changed society. Individuals may delay or avoid applying for health coverage or seeking health care as they focus on other immediate post-release needs. Additionally, those that do seek to access health care may face systemic barriers such as lack of transportation, inflexible work schedules,<sup>24</sup> and few health resources, which can be an especially acute concern in rural areas. For reentrants with low health literacy and/or SMI, navigating the health care system can be even more challenging.

Finally, stigma towards justice-involved individuals and biases within the health care system also present barriers for reentrants seeking care. Formerly incarcerated individuals face the stigma of having a criminal record along with intersecting stigmas related to behavioral health conditions, poverty, unemployment, and housing instability.<sup>1</sup> Collectively, experiencing stigma and discrimination from health care providers can build and reinforce distrust of the medical system among justice-involved individuals and present further barriers to seeking needed medical care during reentry. Additionally, research has found that many health care providers report feeling that they lack cultural competency in dealing with individuals who have been incarcerated.<sup>25</sup>

## II. Health Coverage

Reentering individuals also face specific challenges related to accessing health coverage. Access to coverage can promote continuity of care, reduce the number of hospitalizations, and lower the mortality rate among recently released individuals.<sup>26</sup>

Because most justice-involved individuals are low-income, Medicaid is the predominant form of health coverage for this population. One analysis found that in the year following release from state and federal prison, 45 percent of reentrants had no reported income, and among those that did, the median annual income was \$10,090.<sup>27</sup> However, an initial challenge to obtaining Medicaid is meeting eligibility criteria. In states that expanded Medicaid eligibility under the ACA, nearly all adults with incomes less than 133 percent of the federal poverty guidelines (calculated as approximately \$18,075 for an

individual in 2022) are eligible for coverage.<sup>28</sup> However, in the 12 states<sup>k</sup> that have not adopted expansion, in addition to being below the income threshold, individuals must fall into one or more of the following categories to qualify for Medicaid: children, pregnant women, parents of dependent children, the elderly, and persons with disabilities. In these non-expansion states, many individuals who are low-income (as is true for most individuals leaving prison and jail) lack Medicaid eligibility because they do not meet at least one of the categorical requirements. This is especially true for non-disabled, non-elderly men, who comprise a significant share of the justice-involved population. Reentrants who are ineligible for Medicaid face challenges obtaining other forms of health insurance, as private Marketplace coverage may be unaffordable. Additionally, a criminal record can present barriers to securing employment, especially employment that provides health insurance benefits.

In states that have implemented Medicaid expansion for the adult group, many individuals are eligible for Medicaid when they enter prison or jail. According to a 2014 report from the U.S. Government Accountability Office, officials from New York and Colorado--both states that expanded eligibility--estimated that 80 percent and 90 percent of state prison inmates, respectively, were likely Medicaid-eligible.<sup>29</sup> However, the federal statutory inmate exclusion prohibits federal financial participation for nearly all care furnished to beneficiaries while they are incarcerated. The policy does *not* exclude incarcerated individuals from Medicaid eligibility, but it prohibits Medicaid payments for benefits and services while incarcerated (with the exception of care provided to Medicaid-eligible incarcerated individuals who are inpatients in a medical institution). As such, in some cases, states place individuals in a suspension status and in others a state may terminate an individual's Medicaid enrollment when they are incarcerated.<sup>l</sup>

There is substantial variation in how states approach this issue; as of January 2019, 41 states plus the District of Columbia suspend (versus terminate) Medicaid upon incarceration in jail, and 42 states plus the District of Columbia suspend upon incarceration in prison.<sup>30</sup> In some of these states, suspensions are for a short period of time only (e.g., 30 days) before proceeding to termination, or they apply only to specific prisons and jails. In the remaining states, enrollment is terminated when an individual is incarcerated in a prison or jail. In cases when enrollment has been terminated, reentering individuals must reapply for Medicaid to obtain coverage post-release. Reentrants may find it difficult to complete the application due to lack of a steady mailing address, documentation, proof of residency, and/or other information that is necessary to verify their eligibility.<sup>31</sup> This population may also have low health literacy, which can make the Medicaid application process more difficult and daunting. Given these challenges, termination of enrollment presents a barrier to securing health care coverage immediately following release and increases the likelihood of gaps or lapses in coverage and care.

Even when Medicaid is suspended during incarceration, returning community members face barriers to reinstating and using their coverage upon release. Among the more than 40 states that suspend

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<sup>k</sup> As of January 2022, the following states have not adopted Medicaid expansion: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

<sup>l</sup> Section 1001 of the SUPPORT Act prohibits states from terminating Medicaid enrollment for "eligible juveniles." Eligible juveniles are individuals under age 21 and individuals enrolled in the mandatory eligibility group for former foster care children.

Medicaid, just over half (23 states) have electronic, automated data sharing systems in place between the criminal justice system and state Medicaid agency. In some of these states, the data system alerts the Medicaid agency when an enrollee has been incarcerated and when they have been released, to facilitate automatic suspension and reinstatement of Medicaid. However, multiple stakeholders stated that even in many so-called “suspension states,” reentrants can experience lapses in coverage during reentry due to bureaucratic delays to reinstate coverage, limited communication between the relevant systems, and variation in practices at the local level. Timing of reinstatement and the associated gaps in coverage and care can be especially challenging for individuals leaving jail, many of whom experience frequent short-term stays in jail and therefore cycle in and out of Medicaid.

*“Until we recommend that there be investments in states and local governments to be able to **automate both enrollment and suspension**, we’re never going to achieve the seamless transitions that we’re hoping for.”*

-Stakeholder

Returning community members who obtain Medicaid also face challenges related to coverage for needed services. Stakeholders noted that some services that are particularly relevant to individuals with mental health diagnoses and SUDs are optional benefits under Medicaid and may not be covered. These include clinic services, rehabilitative services (such as counseling and recovery support), personal care, and case management. Stakeholders also discussed that two promising approaches for supporting this population (crisis diversion facilities and peer support services) could be

challenging for reentrants to access if the benefit is not covered in their state.

Among older reentrants, Medicare is another important coverage option. However, even when Medicare eligibility requirements are met, the time-limited Initial Enrollment Period can present challenges. Individuals must enroll during the 7-month period starting 3 months prior to turning 65 and ending 3 months after turning 65, or else they are subject to a monthly late enrollment penalty for the duration of their Part B coverage (and/or Part A coverage if the individual is ineligible for premium-free Part A). Justice-involved individuals may be unaware of this enrollment window or may be unable to complete enrollment documents during this time due to long periods of incarceration. In the proposed rule titled “Medicare Program; Implementing Certain Provisions of the Consolidated Appropriations Act, 2021 and Other Revisions to Medicare Enrollment and Eligibility Rules”, published in the Federal Register on April 27, 2022 (87 FR 25090), CMS proposed a special enrollment period (SEP) for formerly incarcerated individuals. The SEP, as proposed, would be available beginning on or after January 1, 2023, and be available for 6 months following the individual’s release from incarceration. Additionally, Medicare Part A--which covers hospital, skilled nursing facility, home health services (for individuals not enrolled in Part B)--is available premium-free to individuals with disabilities under age 65 who have received Social Security Disability benefits for 24 months, have End Stage Renal Disease, or they or their spouse is 65 and older and have worked and paid taxes under the Federal Insurance Contributions Act for at least 10 years. Individuals with a substantial criminal justice system history may not meet this requirement, further increasing their out-of-pocket expenditures, as individuals eligible for and enrolled in Medicare Part A without sufficient eligible work history would be required to pay a monthly premium.

The next two sections describe two categories of practices (those related to health care [Section 4] and those related to health coverage [Section 5]) that workgroup members identified as promising approaches to address the challenges described above.

## Section 4. Care-Related Practices

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Local, state, and federal entities have developed and implemented a variety of practices in response to the health care challenges faced by returning community members. These occur during incarceration (“institution-based practices”), before and after incarceration (“community-based practices”), or in some cases, in both institutional and community settings. Because some justice-involved individuals cycle in and out of correctional institutions, community-based practices should not solely be viewed as post-release strategies; rather, they may be simultaneously pre- and post-incarceration, representing an important opportunity to connect with and support individuals while they are not in a carceral facility.

The following practices may be helpful in facilitating linkage to health care and promoting health for returning members, but they are not directly focused on applying to or gaining health coverage. The approaches in this section include screening for and treating SUD; conducting “in-reach” into correctional facilities; developing and supporting tailored reentry plans; and building connections with community-based clinics, physicians, and navigators.

### I. Institution-Based Practices

Institution-based coverage practices are those that take place within the correctional institution. In all instances, the partnership between the jail or prison and other community partners is key.

#### Substance Use Disorder Treatment

##### Universal Screening for SUD during Intake to Correctional Facilities

Intake screening for SUD is a promising practice--instituted by the Rhode Island Department of Corrections (RIDOC) prison system and Middlesex County Sheriff’s Office in Massachusetts, among others--given the high rates of SUD in the justice-involved population and the known benefits of early engagement in treatment. Screening can be used to determine whether an individual presents with signs of prescription drug use, recreational use of illicit drugs, SUD, dependence, and active withdrawal, and whether they are in ongoing treatment for SUD.<sup>32</sup> If needed, further testing can be completed by facility staff or a community testing partner to establish the full extent of the inmate’s behavioral health needs.<sup>32</sup> Screenings set the groundwork for an appropriate reentry plan and can expedite institution-based treatments while also presenting an opportunity to divert people with behavioral conditions linked to drug use to treatment facilities.

##### Implementation of Policies that Facilitate MOUD

Provision of MOUD in jails and prisons has been shown to increase the use of community-based treatments and decrease drug use post-release.<sup>33</sup> To increase provision of MOUD to incarcerated individuals with OUD, correctional facilities can apply to register as federally regulated opioid treatment programs, which allows their staff to provide methadone and buprenorphine. (Naltrexone does not require such a designation.) Medical staff can also obtain a waiver that allows them to administer buprenorphine. The New Jersey Department of Corrections operates two state correctional facilities as



registered correctional treatment centers, allowing them to provide addiction treatment to inmates. In conjunction with Gateway Foundation, a national SUD treatment provider, the facilities also offer clinical and behavioral therapy for participants.

Correctional facilities can also partner with community-based registered opioid treatment programs and MOUD providers to administer MOUD within their facilities. RIDOC has partnered with a statewide community vendor that provides MOUD within correctional facilities and post-release to individuals who were identified to have OUD upon intake screening.<sup>21</sup> In addition, this model enables individuals with pre-existing MOUD prescriptions to continue their regime uninterrupted upon arrival to RIDOC.<sup>21</sup> A retrospective analysis showed that after implementation of the model there was a decline in fentanyl overdose deaths for reentrants in the post-release period and increased participation in MOUD in the community for those that began or continued MOUD during incarceration.<sup>21</sup>

### **Cognitive Behavioral Therapy for SUD**

Due to high rates of co-occurring mental illness with substance use among justice-involved individuals, substance use screenings should be paired with mental health screenings. One treatment approach is the pairing of medically managed withdrawal with cognitive behavioral therapy (CBT)--an evidence-based form of psychotherapy--to support sustained sobriety and encourage behavioral changes. Both Kentucky's Department of Corrections and Philadelphia's Department of Prisons maintain "whole-person care" during and after incarceration by offering CBT and relapse prevention support groups.<sup>20</sup>

## **In-reach**

### **In-reach Care Coordination and Discharge Planning**

In-reach occurs when community-based professionals--such as case managers, social workers, or other supportive personnel--come into correctional facilities and provide in-person assistance such as care coordination, discharge planning, and/or cross-sector coordination. Cross-sector coordination integrates support across multiple sectors including health, housing, and employment. In this collaborative effort, in-reach staff inform community-based staff of the needs of soon-to-be-released individuals. In-reach care coordinators undergo necessary training to be awarded the security clearance to work in jails and prisons.<sup>34</sup> In some states, including New York and Rhode Island, peer navigators with histories of justice system involvement participate in the in-reach process and assist with pre-release discharge planning. Compared to remote care coordination and cross-sector coordination, in-reach is associated with greater engagement in care following release.<sup>31,34</sup>

In-reach care coordination can include comprehensive care (CC) case plans, which are specific and individualized plans developed by jail or prison staff, community-behavioral health treatment providers, and/or probation and parole agencies that guide successful reentry. The CC case plan model addresses criminogenic risk and behavioral health needs based on screenings and assessment results and includes referrals and connections to ongoing treatment or recovery support services in the community.<sup>32</sup> This work typically begins through in-reach and continues in the community once an individual is released. The National Reentry Resource Center hosted a series of webinars in 2018 that highlighted multiple

agencies' approaches to case planning; the Franklin County Sheriff's Office in Greenfield, Massachusetts reported that in 2017, 62 percent of their case planning participants reentered the community with a scheduled primary health care appointment.<sup>35</sup>

Medicaid managed care organizations (MCOs) are also involved in pre-release discharge planning in states including New Mexico and Ohio. Through New Mexico's jail-focused Supporting Incarcerated Individuals Transitioning to the Community, care coordinators provide education about Medicaid benefits and help develop a care plan for returning community members. Through Ohio's prison-focused Medicaid Pre-Release Enrollment Program, all Medicaid MCOs are required to deliver pre-release care coordination services. These services include social worker and nurse-led care management as well as Peer-to-Peer Medicaid Guides who lead classes about the benefits of Medicaid enrollment. In both states, in-reach care coordination may be provided remotely using videoconference technology or other platforms, though federal matching funds cannot be claimed for these MCO in-reach services provided while the individual is incarcerated.<sup>36</sup>

Discharge planners employed by the Connecticut Department of Corrections conduct detailed screenings to identify inmates with serious physical or mental health needs and then work with the individual for 60-90 days prior to release to coordinate care.<sup>37</sup> The planners ensure that the reentrant has immediate health care and medication at the time of reentry by providing prescriptions, initiating connections to providers and community-based health centers, and coordinating medical appointments.<sup>37</sup>

## **II. Community-Based Practices**

Community-based coverage practices are those that focus on organizations and agencies whose work mainly occurs outside of correctional facilities but who may partner with facilities and corrections departments.

### **Care Coordination and Peer Support**

#### **Community Navigators and Peer Support Specialists**

Stakeholders emphasized that post-release care coordinators and peer support specialists can effectively engage reentrants and support effective reentry from a public institution to the community. Several stakeholders note that care coordination is most beneficial when initiated pre-release, but care coordination after release is also key to maintaining continuity of care and encouraging the use of primary care services (rather than emergency services). Peer support specialists are individuals with a personal history of SUD, mental illness, or criminal justice system involvement who help engage recently released people in their recovery and reentry process. The specialist can draw on their shared lived experiences to motivate the reentrant and provide referrals to community clinics, social service resources, and a range of reentry services and supports.

## Culturally Competent Models of Care

Professionals who work with justice-involved individuals often note that they frequently are hesitant to engage with the health care system, possibly reflecting a mistrust rooted in poor care experiences before, during, and after incarceration.<sup>34</sup> Additionally, and not unrelatedly, many providers report a lack of cultural competence in working with formerly incarcerated patients.<sup>25</sup> Culturally competent clinics, programs, and models of care can help build trust between patients and providers and support greater engagement in health care. Transitions Clinic Network (TCN) draws upon known best practices for engaging reentrants by providing cross-sector care coordination, requiring cultural competency training for health care staff members, and employing community health workers with histories of incarceration. TCN also partners with providers and staff that are educated on the justice system and places clinics in neighborhoods with high populations of formerly incarcerated people. This model has proven successful at providing primary care post-release and has expanded to 13 states and Puerto Rico.<sup>m,n</sup> Similarly, the Michigan Prisoner Reentry Initiative, a statewide coordinated care program, employs community health workers to help reentrants access health care and social services in the community.<sup>38</sup> A recent analysis found recidivism rates dropped from 46 percent to 21.8 percent for participants who had been on parole for 2 years at one program site.<sup>38</sup>

***“We know these are** men and women that have heard, “no.” They've heard no to resources, they've heard no to help, they've heard no to equity, they've heard no to health equity. We're yes at [Transitions Clinic Network]. **Yes, I'll listen. Yes, I'll help. Yes, I understand. Yes, I care.** Yes, I'll go to your appointment with you. And I can't tell you how much that alone, that support comes into effect, in keeping people from my community in care.”*

-Stakeholder

## Cross-Sector Care Coordination

To address the complex and intersecting reentry needs faced by returning community members, correctional facilities can support cross-sector care coordination. This approach involves building relationships and communicating among a variety of sectors, including health, housing, justice, and labor.<sup>31,34</sup> One such example, described by several stakeholders, is the care coordination provided by community health workers within TCN. These health workers help coordinate care that addresses reentrants' health-related social needs, such as assistance finding housing, food, and employment and addressing legal issues or probation requirements. They may also refer reentrants to community agencies and accompany them to medical and non-medical appointments to encourage attendance and provide support.

<sup>m</sup> TCN operates in Alabama, Arkansas, California, Connecticut, Louisiana, Massachusetts, Minnesota, North Carolina, New York, Puerto Rico, Rhode Island, Texas, Washington State, and Wisconsin.

<sup>n</sup> Many Transition Clinics are located in HRSA supported health centers.

## **Establishment of Medical-Legal Partnerships to Meet Reentrants' Comprehensive Needs**

Returning community members are faced with many needs, including not only accessing medical care and medications but also securing housing, obtaining employment, and accessing food. A medical-legal partnership is a health care delivery model that formally includes lawyers on a care team to address legal issues that drive poor health and contribute to population health inequities. Stakeholders from Chicago and Hawaii recommended state-led medical-legal partnerships that help reentrants expunge their records, access Supplemental Nutrition Assistance Program and housing benefits, and secure other immediate needs. This non-traditional, whole-person approach aims to allow reentrants more time to connect with health care providers, engage in treatment, and increase continuity of care.

### **Medication Supports**

#### **Assistance with Access to Post-Release Medication**

Consistent access to medication is important for treatment effectiveness. However, individuals may experience challenges accessing needed medication upon their return to the community, particularly while they wait for their Medicaid coverage to be activated or reinstated. Some states supply reentrants with a post-release prescription or supply of medication (paid for with sources other than federal Medicaid funds) to ensure continuous access to medication. A state-funded medication supply may be more advantageous, as one study found that 40-60 percent of returning community members fill the prescriptions they receive at discharge.<sup>37</sup> Connecticut's prescription voucher program provides reentrants with both a prescription and a prescription voucher to ensure the prescription cost is covered. The voucher can also help assuage pharmacists' concerns about payment if the individual's Medicaid coverage is pending.<sup>37</sup>

For returning community members with OUD, uninterrupted access to MOUD is especially important to treatment efficacy.<sup>32</sup> Reentrants with OUD face higher risk of drug overdose due to reduced tolerance to opioids and disruption of social supports while incarcerated. States including Kentucky, Massachusetts, Connecticut, Arizona, and Rhode Island supply a limited quantity of medication upon release, such as extended-release naltrexone. Since 2015, most prisons within the Kentucky Department of Corrections system have offered extended-release naltrexone to inmates receiving SUD treatment, including for a minimum of 6 months after their release. This model has led to significant improvements in health care costs, rates of relapse, overdose, and recidivism.<sup>20</sup> Upon their release, inmates in the Philadelphia Department of Prisons receive a two-dose supply of naloxone in the form of Narcan, a standing order prescription for Narcan, and training to ensure safe keeping and usage.<sup>20</sup>

#### **MOUD Centers of Excellence**

Centers of Excellence for individuals with OUD use evidence-based practices to provide treatment and care coordination.<sup>39</sup> RIDOC established 12 community-located Centers of Excellence in MOUD to ensure continuity of care and to maintain treatment post-release. To create this network, the state repurposed existing outpatient facilities located throughout the state. Reentrants can choose their preferred center to enable continued treatment regardless of location post-release.<sup>20</sup>

## Crisis Diversion

### Development of and Investment in Crisis Diversion Programs and Partnerships

Crisis diversion programs aim to redirect justice-involved individuals away from incarceration and into community treatment programs. A stakeholder explained the operation of crisis diversion programs, in which community-based professionals work alongside clinical staff members and law enforcement, specifically parole officers, to oversee and check-in on reentrants as frequently as daily. The goals of crisis diversion facilities, such as those developed in Middlesex County, Massachusetts and Tucson, Arizona and presented by stakeholders, are to reduce recidivism and hospitalizations while improving health outcomes and delivery of behavioral health care in the community. Typically, individuals can access crisis diversion services on a walk-in basis, as well as through interactions with law enforcement (who may take an individual in crisis to such a facility). Once there, the stakeholder continued, they receive crisis stabilization and outpatient services, as well as case management and access to reentry services. These facilities are shown to reduce overall spending, particularly through reduced use of emergency facilities and jails and prisons. According to a stakeholder, the facilities are ideally located “in an area of the county that's not service-rich, because we want to help lift those traditional barriers to access, especially for communities of color, to help address health disparities that currently exists.”

Stakeholders described a co-responder model in Middlesex County, Massachusetts where a clinician working within the police department responds to emergency calls with officers to quickly administer care for people with SUD and behavioral health concerns. This strategy may be effective at reducing reentry to correctional facilities and emergency departments.

## Data Sharing and Infrastructure

### Use of Telehealth to Expand Care for Individuals with Access Barriers

Returning community members can face multiple barriers to accessing health care, including limited health resources (particularly in rural areas) and lack of transportation, childcare, and/or employment flexibility to allow them to attend in-person appointments. One stakeholder highlighted that imbalance of need for care and capacity of care available is frequently seen in rural area and on American Indian/Alaska Native tribal lands. Increased use of telehealth can be used to expand capacity in rural areas and improve access to care for all reentrants. Telehealth has expanded globally since the beginning of the COVID-19 pandemic and serves as a vital means to deliver care and overcome access barriers. Telehealth and telemedicine appointments allow for individuals to meet virtually with community-based providers and present opportunities to conduct in-reach care coordination remotely into correctional facilities. One stakeholder suggested that improved broadband capabilities across rural communities could facilitate telehealth use for this population.

### Information Sharing between Correctional Health Care Providers and Community Providers

Data sharing is critically important to improving the health care-related transition for returning community members. Sharing information on the health care provided during incarceration with community-based clinics and physicians can be an important part of treating chronic illnesses and

behavioral health conditions, because it allows for treatment continuity, reduces duplicative care, and facilitates communication about the individual's health needs. A stakeholder explained that representatives from organizations like TCN use shared information to act as advocates for clients in the community. Data sharing is vital to building relationships between the individual and community providers and between the correctional system and the state Medicaid agency and MCOs. With the appropriate technological infrastructure in place, correctional facilities can update MCOs with anticipated upcoming release dates to prepare for enrollment and reentry. Sharing of relevant information also reduces duplicative efforts of collecting the same information multiple times.

## Section 5. Coverage-Related Practices

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Health coverage is often a prerequisite to accessing health care in the United States, and lack of coverage can be a substantial barrier to care. For low-income individuals with justice system involvement, Medicaid is a significant coverage option. To support connection to coverage upon release from incarceration, and to address coverage-related challenges faced by returning community members, local, state, and federal entities have implemented a number of strategies. These strategies may be focused on the correctional institution itself or involve external organizations and agencies; they may also be initiated while the returning community member is incarcerated or be activated upon release. All strategies must adhere to the federal inmate exclusion policy, which prohibits Medicaid payment of most benefits and services provided to people incarcerated in prison and jails. The promising practices discussed in this section offer potential ways for the local, state, and Federal Government to improve access to health coverage, with the ultimate goal of promoting continuity of care during reentry and improving health.

### I. Institution-Based Practices

#### Medicaid Eligibility and Coverage

##### **Expansion of Medicaid Eligibility to Cover Adults up to 133 percent of the Federal Poverty Level**

Efforts to connect returning community members to Medicaid require that these individuals are eligible for Medicaid. One way to increase access to Medicaid is by expanding eligibility criteria. Under the ACA, states can expand Medicaid eligibility to most adults with incomes below 133 percent of the federal poverty level. Thirty-nine states (including the District of Columbia) have opted to expand eligibility.<sup>40</sup> This expansion can benefit states and community members during incarceration (when qualifying inpatient services occur) and after release.<sup>36</sup> Because states fund correctional budgets without a federal match, whereas Medicaid is jointly financed by state and federal funds, Medicaid payment for qualifying inpatient services<sup>41</sup> can reduce state expenditures. States that assist with Medicaid applications during incarceration can also help ensure that individuals have coverage upon their return to the community.

##### **Suspension, Rather than Termination, of Medicaid upon Incarceration**

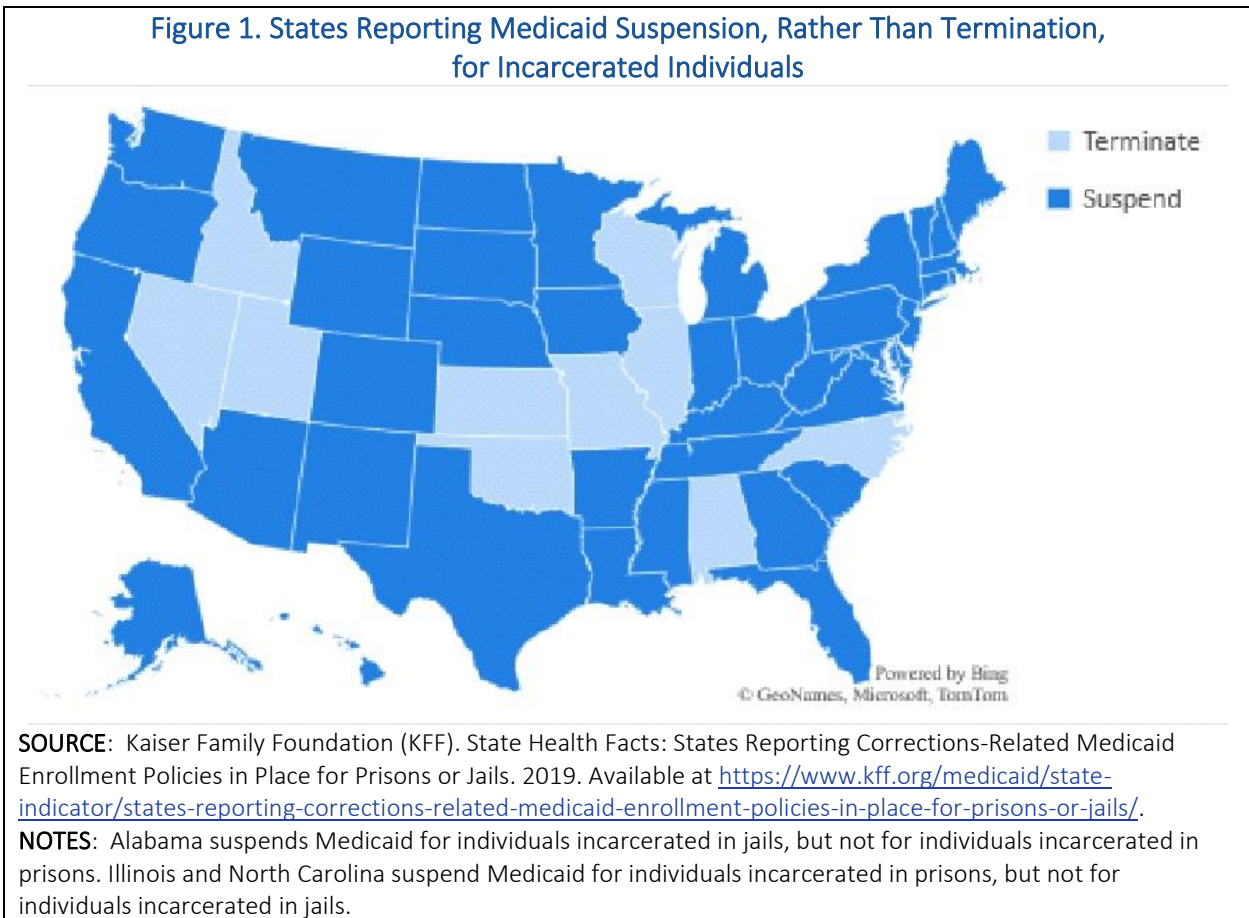
When a Medicaid-enrolled individual becomes incarcerated, Medicaid generally cannot be used to pay for benefits and services delivered to that individual. States can determine how to operationalize this requirement: some suspend Medicaid, which can be reinstated upon release, while others terminate enrollment and require a new application and eligibility determination post-release.<sup>9</sup> As of 2019, 42 states including the District of Columbia suspend Medicaid in jail and 43 states including the District of Columbia suspend Medicaid in prison. Medicaid suspension allows for easier reinstatement of coverage

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<sup>9</sup> Section 1001 of the SUPPORT Act prohibits states from terminating Medicaid enrollment for “eligible juveniles.” Eligible juveniles are individuals under age 21 and individuals enrolled in the mandatory eligibility group for former foster care children.

upon release and quicker engagement with health care services after returning to the community.<sup>42,43</sup> However, stakeholders explained that suspension policies are implemented differently across states, and returning community members can still experience administrative challenges with reinstatement of coverage. In Colorado, for example, the state passed a law allowing Medicaid suspensions but as of 2015, the state’s benefits management system was not able to process suspension requests.<sup>44</sup> Several stakeholders noted that to be effective, policies allowing for Medicaid suspension must be supported by systems and practices that facilitate this practice.

**Figure 1. States Reporting Medicaid Suspension, Rather Than Termination, for Incarcerated Individuals**



### Designation of Correctional Facilities as Qualified Entities for Presumptive Eligibility

States can designate correctional facilities as “qualified entities” that can screen individuals for Medicaid eligibility and immediately but temporarily allow access to Medicaid for those who appear to be eligible based on attested information, while the individual’s application is being processed. This practice, known as presumptive eligibility, allows individuals to immediately access Medicaid without the need to wait for full application completion, verification, and processing.<sup>45</sup> While applicable to both jails and prisons, stakeholders find that this strategy is particularly useful in jails where individuals may be held for only a short period of time. Submission of a full Medicaid application is not a condition of eligibility for presumptive eligibility. However, stakeholders explained that for maximum benefit, states should ensure follow-up to complete the full application, which can be done in person, online, or by phone,



mail or other commonly available electronic means, after the return to the community. Maryland implemented presumptive eligibility through a state plan amendment to facilitate enrollment immediately prior to release for individuals who were incarcerated. Once released, these individuals are immediately able to access Medicaid and are directed to a local health department to complete the full application, at their discretion.<sup>36</sup>

## Data and Information Sharing

### Data Sharing and Communication Across Agencies to Automate Suspension and Reinstatement of Medicaid

Relationships and communication across the state Medicaid agency, correctional facilities, MCOs, and community providers can help promote continuity of both health coverage and care by allowing stakeholders to effectively plan for an individual's upcoming release. Lessons learned from pre-release programs in Maryland, New Mexico, and Ohio included the importance of stakeholder buy-in, clear and frequent communication across partners, and improving data sharing capabilities.<sup>36</sup>

Data sharing can also facilitate automatic suspension and reinstatement of coverage when an individual is enrolled and released.<sup>34</sup> Information sharing agreements between the justice system and Medicaid must adhere to certain parameters, including obtaining enrollee consent and following privacy and confidentiality standards. Stakeholders stated that local, state, and federal investment in data quality and infrastructure can support successful implementation of this strategy, particularly at the county level and in rural areas. In North Carolina, the Prison-Based Medicaid Enrollment Assistance Program relies on data exchange between the Department of Public Safety and the Division of Medicaid Assistance to identify incarcerated individuals eligible for Medicaid and provide notifications upon release, saving the state prison system an estimated \$10 million per year.<sup>46</sup> In Arizona, the state Medicaid agency operates a data exchange system through which participating jails send information daily on all individuals who were either booked or released that day. The system uses these data to automate suspension and reinstatement of Medicaid and to inform MCOs and community providers about newly enrolled/reenrolled individuals.<sup>37</sup>

## Pre-release Application Assistance

### Application Assistance Prior to Release from Incarceration

States and localities can provide a variety of types of reentry supports including navigators, peer specialists, discharge planners, and reentry counselors. These teams and individuals can assist with Medicaid applications, including gathering any necessary documentation to verify eligibility after the application is submitted, at the point of initial facility intake through to discharge.<sup>37,43,47</sup> This assistance can help reduce challenges associated with the application process, such as low health literacy levels.<sup>42</sup> Assisting individuals in applying for Medicaid at intake can also be beneficial when community members are released at odd hours or may post bond and not be offered application assistance or other coverage-related services at discharge. For example, in Cook County, Illinois, justice, health, and community-based organizations developed a program with buy-in from jail staff to conduct an abbreviated application

process (10 minutes instead of 30) at intake.<sup>47</sup> States can also establish special populations enrollment units within the state’s Medicaid agency, as was done in Ohio, to accelerate the processing of Medicaid applications originating from correctional facilities.<sup>37</sup>

### **Allowance of Alternative Forms of Documentation for Medicaid Applications**

Incarcerated individuals and those returning to the community may lack necessary documentation, such as proof of income and state residency, that Medicaid may require to verify eligibility. Allowing use of alternative forms of documentation, such as an inmate identification number or jail release letter, can help with timely eligibility determinations.<sup>44,47</sup> Cook County’s program allows jail identification to be used as identity verification, which is particularly important when other forms of documentation are unavailable.<sup>47</sup>

### **Medicaid Inpatient Benefit**

#### **Utilization of Medicaid Benefits for Individuals Who need Inpatient Services while Incarcerated**

While the promising practices described above help connect individuals to coverage upon their return to the community, some states have explored opportunities to provide coverage during incarceration. Although Medicaid cannot pay for most services for incarcerated individuals, states may use Medicaid funds for coverable services provided to Medicaid-eligible inmates who are inpatients in a “medical institution” (including hospitals, nursing facilities, and intermediate care facilities for individuals with an intellectual disability) for 24 hours or longer provided that the minimum quality standards including patient/resident rights can be met.<sup>17,p</sup> Some states have processes in place to ensure Medicaid payment for eligible beneficiaries who receive inpatient services in a medical institution while incarcerated, which can provide cost savings to the state and is more readily accessed when states suspend rather than terminate Medicaid as well as provide Medicaid application assistance at intake. For individuals without coverage prior to entry, Arizona, Connecticut, and Massachusetts have procedures in place to assist with applying for Medicaid and processing their Medicaid applications during an inpatient stay.<sup>43</sup>

## **II. Community-based practices**

### **Medicaid Health Homes**

#### **Coverage of Medicaid Health Home Services for Returning Community Members**

Under the optional Medicaid “Health Homes” benefit at Section 1945 of the Social Security Act, states can cover certain services for Medicaid beneficiaries with at least two chronic conditions (including SUDs), with at least one chronic condition and who are at risk of having another, or with at least one serious and persistent mental health condition. The services that states can cover under this benefit are CC management, care coordination and health promotion, comprehensive transitional care from inpatient to other settings, patient and family support, and referral to community and social support

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

services (if relevant). This benefit can be especially helpful for returning community members who disproportionately experience physical and behavioral health problems. States can opt to add this Health Home benefit to their state Medicaid plan. New York implemented a criminal justice pilot program under the state’s health home state plan option. As part of the program, the Department of Health and the Division of Criminal Justice Services share data to identify eligible individuals and coordinate a warm handoff at discharge to connect returning community members to health home care managers.<sup>48</sup>

## Medicaid Licensing and Standards

### **Additional Guidance on Crisis Diversion Facilities and Crisis Current Procedural Terminology (CPT) Codes**

One stakeholder highlighted the need for additional state and federal action on crisis services, licensing, and payment. Community-based crisis diversion facilities are receiving and stabilization centers that serve all individuals in need. These facilities are one component of broader crisis care and can be an important resource for law enforcement officers, who are often responsible for responding to individuals experiencing mental health crises.<sup>49</sup> This stakeholder noted that while some states offer technical assistance on facility licensure, additional clarity on payment and other technical implementation challenges would be beneficial. The stakeholders cited additional needed guidance on and standards for CPT codes--used in medical coding and billing--related to certain crisis services. While such CPT codes exist, states and providers may use them inconsistently. For example, the same code may be used for crisis services provided in a group home or in a high acuity crisis center staffed by clinicians, which would incur significantly different costs. Clarity and standardization around these codes could facilitate greater use of codes and ability to reimburse for important crisis services.

## Non-Medicaid Coverage Supports

### **Development of Processes to Screen for Eligibility and Facilitate Enrollment in Other Programs and Types of Coverage**

Returning community members may be eligible for other programs like Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medicare, or U.S. Department of Veterans Affairs (VA) health care and benefits. In order to connect returning community members to all relevant supports, jails and prisons can implement screening processes for these programs. These processes may cover the entire incarcerated population or a subgroup and be conducted at intake or prior to release. Identifying veterans is especially beneficial as veterans can enroll in VA health insurance coverage while incarcerated and be set up to receive treatment upon release.<sup>50</sup>

### **Support for Older Returning Community Members through Application and Enrollment Assistance Programs**

Programs such as State Health Insurance Assistance Programs (SHIPs) and the SSI/SSDI Outreach, Access, and Recovery (SOAR) program are targeted enrollment programs that can help connect older returning community members to health care coverage and other supports. SHIPs provide health insurance

counseling to Medicare-eligible individuals.<sup>51</sup> SOAR is a SAMHSA program that can provide eligibility determinations, application documentation, and application assistance to those seeking help with enrollment in Social Security benefits.<sup>q,r</sup> These programs can help reduce barriers to coverage for older returning or recently released community members. They may also help individuals navigate Medicare-specific challenges such as financial penalties associated with enrolling outside of the Initial Enrollment Period.<sup>52</sup>

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<sup>q</sup> See <https://aspe.hhs.gov/reports/aging-reentry-health-coverage-barriers-medicare-medicaid-older-reentrants>.

<sup>r</sup> See <https://soarworks.samhsa.gov/sites/default/files/article/upload-files/2022-05/SOAR%20Works%20for%20CJ.pdf>.

## Section 6. 1115 Demonstration Considerations

Medicaid Section 1115 demonstrations offer opportunities to improve health—including health care transitions—for justice-involved individuals. Under Section 1115 of the Social Security Act, states are given the ability to apply to implement time-limited experimental or pilot projects (typically for a duration of 5 years) within their Medicaid programs. These projects allow states to test policies that typically would not be allowed under federal rules. Demonstrations must be likely to promote Medicaid objectives and be budget neutral to the Federal Government, and are approved in the Secretary’s discretion.<sup>53</sup> States must also conduct comprehensive monitoring and evaluation activities of all approved demonstrations.

States have employed 1115 demonstrations to support justice-involved individuals in several ways. Examples of approved demonstrations include providing presumptive eligibility for individuals in prisons and jails; targeting Medicaid eligibility, behavioral health services, or case management to returning community members; and providing this population with transitional care during reentry.<sup>54</sup> Currently CMS has under review 11 applications to demonstrate and test approaches to coverage for services during a limited period prior to release. These requests vary with respect to the time period for which coverage for Medicaid-eligible incarcerated individuals may be provided (typically 30 or 90 days prior to release), the eligible populations, and the package of covered services. For example, the Arizona request is for a period of 30 days prior to release; it targets inmates with serious behavioral and physical health conditions at high risk of experiencing homelessness upon release, and covers housing-related case management, tenancy supports, linkages with physical and behavioral health providers, and medication. The Vermont request is for 90 days prior to release, available to all inmates, and includes the full set of Medicaid State Plan benefits. Additional details about pending 1115 demonstration requests related to the inmate exclusion are provided in **Table 1**.<sup>55</sup>

**Table 1. Publicly Available Pending Section 1115 Demonstrations Requesting Authority for Coverage of Incarcerated Individuals, as of September 2022**

| State      | Eligibility Criteria  | Services Provided Pre-release  | Coverage Initiation   |
|------------|---|--|---|
| Arizona    | Incarcerated individuals who are Medicaid-eligible with serious behavioral and physical health conditions at high risk of experiencing homelessness upon release. | Housing-related case management, tenancy supports, linkages with physical and behavioral health providers, medication and peer supports.     | 30 days prior to release.   |
| California | Incarcerated individuals who are Medicaid-eligible with complex health care needs, SUD, or mental health diagnosis, and all incarcerated youth.                   | Enhanced care management, linkages with behavioral and physical health providers, durable medical equipment and 30-day supply of medication. | 90 days prior to release for adults and throughout the period of incarceration for youth. |

**Table 1 (continued)**

| State         | Eligibility Criteria   | Services Provided Pre-release   | Coverage Initiation   |
|---------------|--|---|---|
| Kentucky      | Incarcerated individuals who are Medicaid-eligible with a SUD diagnosis.   | SUD treatment services, medication management, MCO selection, case management and peer support services.  | Throughout entire period of incarceration (including pretrial).*  |
| Massachusetts | Incarcerated individuals who are Medicaid-eligible with a chronic condition, mental health condition, or SUD; Youth who are Medicaid-eligible staying in a Department of Youth Services (DYS) juvenile justice facility.   | Certain medical, behavioral health, and pharmacy services for adults, including 30-day supply of medication.<br><br>Full Medicaid State Plan benefits for youth in DYS facilities.  | 30 days prior to release for adults and throughout period of incarceration for youth. Continuous eligibility provided for 1 year after an adult or youth leaves a carceral setting. |
| Montana       | Incarcerated individuals who are Medicaid-eligible with SUD, SMI, or serious emotional disturbance.  | Limited community-based clinical consultation services, in-reach care management services, behavioral health services and a 30-day supply of medication.  | 30 days prior to release.   |
| New Jersey    | Incarcerated individuals who are Medicaid-eligible with behavioral health diagnoses.   | Up to 4 behavioral health care management visits to arrange a post-discharge appointment, provide needed referrals, and conduct a brief housing assessment along with other services to support continuity of care.   | 60 days prior to release for adults.  |
| New York      | Incarcerated individuals who are Medicaid-enrolled with 2 or more qualifying chronic diseases (such as COPD and diabetes), or one single qualifying condition of either Hepatitis C, HIV/AIDS, SMI, intellectual/developmental disabilities, sickle cell disease or a SUD and who are scheduled to be discharged from a jail or prison within 30 days. | Targeted set of in-reach services including care management and discharge planning, clinical consultant services, peer services, sexual and reproductive health information and connectivity, medication management plan development, and delivery of certain high priority medication. | 30 days prior to release or within 30 days of incarceration if there is a reasonable expectation of discharge within that period.   |

**Table 1 (continued)**

| State         | Eligibility Criteria  | Services Provided Pre-release   | Coverage Initiation  |
|---------------|---|---|--|
| Oregon        | All Incarcerated individuals who are Medicaid-eligible; Youth who are Medicaid-eligible entering county or juvenile detention facilities. | Limited state Medicaid benefits and pre-release transition services for Medicaid members in prison, including care coordination, navigation services, prescription drugs.<br><br>Full Medicaid State Plan benefits for youth entering county or juvenile detention facilities, as well as individuals in jails, local correctional facilities, or tribal jails. | 90 days prior to release for adults in prison and youth in closed correctional facilities.<br><br>Throughout period of incarceration for youth in county or juvenile detention facilities, and adults in jail or tribal correctional facilities. |
| Utah          | Incarcerated individuals who are Medicaid-eligible with chronic physical or behavioral health condition, mental illness, or an OUD.       | Full set of Medicaid State Plan benefits, except adults with dependent children and medically frail individuals (who would receive a non-traditional benefit package inclusive of some state plan benefits, with specific service limitations).   | 30 days prior to release.  |
| Vermont       | All Incarcerated individuals who are Medicaid-eligible.   | Full set of Medicaid State Plan benefits.   | 90 days prior to release.  |
| West Virginia | Incarcerated individuals who are Medicaid-eligible with a known or suspected SUD.   | Services to support transitioning member to their chosen MCO, community-based clinical consultation services, in-reach care management services, HIV/Hepatitis C screening and treatment, and 30-day supply of medication.  | 30 days prior to release.  |

**SOURCE:** KFF analysis of Section 1115 demonstration requests posted to Medicaid.gov; additional state content added by RTI International; additional content provided by CMS.

**NOTES:** Demonstrations would apply to incarcerated individuals in state and county correctional facilities in all states in table except for Montana and West Virginia, where the demonstration would only apply to individuals incarcerated in state prisons.

\* In Kentucky, members would be covered through fee-for-service Medicaid during incarceration, then transitioned to an MCO 30 days prior to release.

## I. Key Considerations

Several considerations are key to the design of an 1115 demonstration, through which states could receive federal matching in Medicaid payments for services provided to individuals who would be eligible for Medicaid payment for the services if not incarcerated up to a set period of time pre-release. The inmate exclusion generally prohibits use of federal Medicaid funds for services provided to incarcerated individuals, with the exception of services provided while the beneficiary is an inpatient in a medical institution. This statutory provision, in place since the establishment of Medicaid in 1965 to

prevent cost-shifting from state and local government to the Federal Government, essentially restricts individuals in prisons and jails from utilizing Medicaid coverage. An 1115 demonstration could provide expenditure authority for a set period of time for pre-release services, so that individuals could utilize Medicaid coverage as they prepare to return to the community.

The advantages of an 1115 demonstration to provide coverage for a predetermined amount of time pre-release include promoting “in-reach” into prison and jails and facilitating the establishment of connections to community-based care prior to release. These connections may reduce gaps in care during the reentry period, support care continuity, and support other social determinants of health such as obtaining housing.<sup>56</sup> However, some stakeholders expressed concerns about allowing Medicaid coverage pre-release. Concerns primarily centered on whether such a demonstration would incentivize local and state criminal justice systems to keep individuals in correctional facilities, due to decreased local and state costs of incarceration. Citing the Americans with Disabilities Act, one stakeholder stated that incentives should be toward “provid[ing] services to people in a community-based environment, rather than a facility.” Another stakeholder agreed that the focus should be on reforming incarceration, not shifting health care costs.

An 1115 demonstration opportunity should also consider the length of time during which pre-release Medicaid reimbursement for health care services is allowable. The Health and Economic Recovery Omnibus Emergency Solutions Act or HEROES Act (H.R. 6800), passed by the U.S. House of Representatives but not the Senate, would have allowed for Medicaid payments for health care for incarcerated individuals during the 30-day period preceding date of release. Discussion of such an 1115 demonstration typically includes a 30-day pre-release period, but several states have applied for demonstrations with pre-release periods longer than 30 days (see **Table 1**). Some stakeholders noted that 30 days may be insufficient for coordinating and transitioning care, particularly for individuals with SUD. If sentences are reduced, an individual may be released earlier than anticipated and without the expected 30-day period for Medicaid coverage. Furthermore, one stakeholder expressed that “when people are in recovery [from SUD], 30 days is a very, very small period of time.” They noted that based on their experience providing care for individuals with OUD, a 90-day coverage period would be more appropriate from a treatment perspective.

Demonstration design also requires consideration of the scope of covered Medicaid pre-release benefits. As seen in **Table 1**, the currently submitted demonstration applications vary greatly in the scope of pre-release benefits included in the 1115 demonstration application. Some states propose limiting benefits to a set of services including reentry support, enhanced case management, behavioral health services, and a 30-day medication supply. In contrast, other states propose providing the full set of Medicaid State Plan benefits to eligible individuals.<sup>55</sup> Multiple stakeholders recommended that an 1115 demonstration cover the full set of benefits as well as all optional benefits, which include recovery supports, supportive housing and employment and rehabilitation supports. Stakeholders noted the importance of coverage for physical and behavioral health services, including crisis services. The workgroup also discussed which population(s) should be eligible for benefits under the 1115 demonstration. Multiple stakeholders noted that many individuals enter prisons and jails with behavioral health symptoms but without prior behavioral health diagnosis. If the demonstration limits



eligibility to individuals with specific diagnoses, such as SMI, this relies on the correctional facilities to appropriately identify these individuals. Individuals who may benefit from services but have not been diagnosed would likely be ineligible for needed benefits.

Stakeholders also emphasized the need to address social supports and health-related social needs within the demonstration opportunity. Housing and food security were specifically mentioned as integral to reentry success. One stakeholder noted that Arizona has included emergency bridge housing as a crisis benefit within their 1115 demonstration application. They explained that housing should be viewed through a “crisis lens,” because lack of housing--or a gap in a stable living situation--requires assistance at the speed of a crisis response. Social supports could be addressed in the demonstration through future state and federal partnerships; stakeholders suggested as one potential example increased interaction at the federal level between CMS and the U.S. Department of Housing and Urban Development to potentially incorporate housing support into 1115 demonstrations.

*“Communities with histories of incarceration should be required to be included in the process of the development of the waiver and the implementation.”*

-Stakeholder

Finally, several stakeholders encouraged centering and engaging justice-involved individuals in the demonstration design process. Earlier in the meeting, stakeholders had previously discussed the importance of involving individuals with lived experience in direct service provision, through peer navigator or clinical roles. However, stakeholders also noted the value of bringing in communities with histories of justice involvement from the onset of demonstration design and engaging them throughout the process, to ensure that the opportunity is person-centered and well-tailored to the needs of this population. As one stakeholder noted, this work would be strengthened by “having people with lived experience at the table at the very beginning.”

## II. Facilitators of State Uptake

Stakeholders noted that several key design elements may help support state uptake of the 1115 demonstration opportunity. The first of these elements is the ability to customize the target population of the model based on the state’s demographics, priorities, and financial resources. Target populations may include individuals in corrections settings with SUD or SMI, older incarcerated individuals, and/or those with chronic health conditions. An open-ended, non-prescriptive approach to the model design will allow CMS to “meet the states where they’re at” in terms of what is beneficial and achievable over the course of the demonstration.

Another potential facilitator of state uptake of the 1115 demonstration is flexible federal funding that considers budget neutrality from a broad perspective. Stakeholders expressed the opinion that if budget neutrality calculations could consider savings across systems

*“I would like to see the ability for states to support diversion activities so that we’re not just thinking about... how we ensure a warm handoff when someone leaves a correctional setting, but how to prevent them from becoming incarcerated in the first place.”*

-Stakeholder

(including corrections, public health, SUD, and mental health budgets) as a result of investment in the Medicaid program, states would have greater ability to invest in the 1115 demonstration.

Many stakeholders raised the importance of data infrastructure for coordination between Medicaid and corrections systems, while also noting that many states and localities lack a robust system for cross-agency communication. States may be more enthusiastic about an 1115 demonstration if it includes the ability to invest in data infrastructure, data collection, and communications systems. One stakeholder noted that this type of efficient communication is especially important in county jails, where stays are typically much shorter than in prisons and individuals often cycle in and out of custody. Other stakeholders noted the importance of supporting investment in training for correctional staff and community partners. Enrollment efforts within prisons and jails require staffing, resources, and expertise that may be outside the budget of these correctional institutions. States will likely be interested in funding to support this work, as well as additional financing to support enrollment training efforts.

Multiple stakeholders expressed that building intentional and strategic partnerships is key to garnering state buy-in. One stakeholder noted the importance of partnering with the criminal justice system when designing the demonstration, specifically sheriffs who oversee local jails, and ensuring collaboration from the onset. As this individual explained, without a collaborative partnership, “a sheriff is not going to like to be told by a health agency what they have to do inside their facility.” Another stakeholder expressed the importance of partnering with American Indian/Alaska Native tribes, especially given tribal status as sovereign nations. Although states are currently required to notify tribes and facilitate feedback on 1115 demonstration changes, this stakeholder recommended that states prioritize ongoing, collaborative communication and engagement. When states complete their demonstration application, they should explain “how they’re going to *engage* with the tribes, rather than consult the tribes.”

Finally, incorporation of pre-arrest diversion into the 1115 demonstration presents a major opportunity for state uptake and population impact, by diverting individuals to appropriate community-based services instead of correctional facilities. Most states currently engage in some form of diversion activities, including community-based crisis diversion and treatment centers, but it can be difficult to secure Medicaid payment for these services and facilities.<sup>5</sup> An increased focus on this work would accomplish the dual purpose of encouraging state uptake of the 1115 demonstration and addressing root causes of incarceration to promote the health and safety of individuals and communities.

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<sup>5</sup> See <https://aspe.hhs.gov/reports/approaches-early-jail-diversion-collaborations-innovations>.

## Section 7. Conclusion

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Health care and health coverage are important and impactful aspects of the reentry process. The importance of access to and continuity of health care throughout reentry is underscored by the high rates of serious health concerns (including SMI, SUD, and chronic and infectious health conditions) among the justice-involved population. Successful care transitions following incarceration benefit returning community members and the broader communities to which they return. Conversely, lack of care or gaps in care harm these individuals and communities, which are predominantly low-income and disproportionately comprised of Black and Hispanic individuals. Successful reentry is therefore a matter of—and a means of promoting—health equity.

*“Maybe now, as we move forward, we will have an understanding that **healthcare is reentry.**”*

-Stakeholder

Health transitions during reentry require coordination among corrections systems and community agencies. Promising care-related practices raised by stakeholders include SUD screening and treatment, including provision of MOUD; post-release medication prescription and/or supply; in-reach discharge planning and care coordination; peer support navigators; data sharing between correctional system and community providers; and crisis diversion

services and facilities. Promising coverage-related practices include increased access to Medicaid through expanding eligibility, suspending Medicaid upon incarceration, and designating correctional facilities as qualified entities for presumptive eligibility; data sharing between the criminal justice system and Medicaid agencies; automated reinstatement of Medicaid upon release; Medicaid health homes for justice-involved beneficiaries; and enrollment assistance for SSI, SSDI, Medicare, and VA health care and benefits.

Looking ahead, an 1115 demonstration to allow Medicaid payment for pre-release care offers a significant potential opportunity to promote access to and continuity of health coverage and care for returning community members. In doing so, the demonstration could also seek to address the critically important goals of reducing health disparities and promoting equity in health coverage, access to care, and health outcomes. The justice-involved population carries a disproportionate burden of health challenges, perpetuated by deeply rooted systemic factors. Medicaid Section 1115 demonstration authority presents an opportunity to work towards current priorities for the Center for Medicaid and CHIP Services, including coverage and access, equity, and innovation in whole-person care.

Based on stakeholder discussion, key considerations for demonstration design include the scope of benefits provided pre-release, who would be eligible, the length of time for pre-release coverage for services, and strategies for addressing social supports. In addition, there should be meaningful engagement of justice-involved individuals in the design, attention to addressing health disparities, and thoughtful attention to data collection, implementation, monitoring, and evaluation of the demonstration outcomes.

Stakeholders also identified areas for further research and discussion, including disparities among different racial and ethnic groups, the divide between urban and rural areas, health coverage and access to care among the juvenile justice population, utilization of and outcomes associated with post-release Medicaid coverage, and the differences between jails and prisons that may require different reentry approaches.

The challenges associated with the transition back to the community after prison and jail are multifaceted. Promising practices to address these challenges recognize this complexity. Reentry success requires support both pre- and post-release, within and beyond the correctional facility, and related to health care access and health coverage. An 1115 demonstration to improve care transitions for Medicaid-eligible individuals preparing for release from prison or jail provides an important pathway to test and learn from promising approaches to reentry practices and supports that serve to promote health of individuals, health of communities, and health equity.

## Section 8. References

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## Appendix A. Stakeholder Group Attendees

| Stakeholder                     | Affiliation  |
|---------------------------------|--|
| Tracy Johnson, Ph.D.            | Colorado Medicaid  |
| Jennie Simpson, Ph.D.           | Texas Health and Human Services Commission   |
| Sarah Somers                    | National Health Law Program (NHELP)  |
| Sherrie Arriazola Martinez      | Safer Foundation   |
| Dr. Shira Shavit                | Transitions Clinic Network   |
| Jack Rollins                    | National Association of Medicaid Directors (NAMD)  |
| Daniel J. Mistak                | Community Oriented Correctional Health Services (COCHS)  |
| Jonas Thom                      | CareSource   |
| David Ryan                      | Middlesex County, Massachusetts Sheriff's Office   |
| Angela Sauer                    | Washington State Department of Corrections   |
| Dr. Kisha N Davis, M.D., M.P.H. | Aledade Inc., Medicaid and CHIP Payment and Access Commission (MACPAC; CHIP the Children's Health Insurance Program) |
| Warren Ferguson, M.D.           | Health and Criminal Justice Program at UMass Medical School  |
| Rodney K. Robinson              | Bureau of Indian Affairs, Office of Justice Services   |
| Jacey Cooper                    | California Department of Healthcare Services   |
| April Hamilton                  | New York Department of Health  |
| Blaire Bryant                   | National Association of Counties (NaCo)  |
| Margie Balfour, M.D., Ph.D.     | Connections Health Solutions; University of Arizona  |
| Cathy Thompson, Ph.D.           | Federal Bureau of Prisons  |
| Caprice Knapp, Ph.D.            | North Dakota Department of Human Services  |
| Scott Taberner                  | Massachusetts Behavioral Health Justice Involved Initiative  |
| Joseph Calderon                 | Lead Community Health Worker, Transitions Clinic Network   |

## Appendix B. List of Acronyms

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The following acronyms are mentioned in this report.

|        |   |
|--------|---|
| ACA    | Affordable Care Act                                       |
| AIDS   | Acquired Immunodeficiency Syndrome                        |
| CBT    | Cognitive Behavioral Therapy                              |
| CC     | Comprehensive Care  |
| CHIP   | Children’s Health Insurance Program                       |
| CMS    | Centers for Medicare & Medicaid Services                  |
| COPD   | Chronic Obstructive Pulmonary Disease                     |
| CPT    | Current Procedural Terminology                            |
| DYS    | Massachusetts Department of Youth Services                |
| FR     | Federal Register  |
| H.R.   | U.S. House of Representatives                             |
| HHS    | U.S. Department of Health and Human Services              |
| HIV    | Human Immunodeficiency Virus                              |
| KFF    | Kaiser Family Foundation                                  |
| MCO    | Managed Care Organization                                 |
| MOUD   | Medications for Opioid Use Disorder                       |
| OUD    | Opioid Use Disorder                                       |
| Pub.L. | Public Law  |
| RIDOC  | Rhode Island Department of Corrections                    |
| SAMHSA | Substance Abuse and Mental Health Services Administration |

|             |  |
|-------------|--|
| SEP         | Special Enrollment Period  |
| SHIP        | State Health Insurance Assistance Program  |
| SMI         | Serious Mental Illness   |
| SOAR        | SSI/SSDI Outreach, Access, and Recovery  |
| SSDI        | Social Security Disability Insurance   |
| SSI         | Supplemental Security Income   |
| SUD         | Substance Use Disorder   |
| SUPPORT Act | Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act |
| TCN         | Transitions Clinic Network   |
| U.S.C.      | United States Code   |
| VA          | U.S. Department of Veterans Affairs  |