Medicaid and CHIP MAC Learning Collaboratives

The Coverage Learning Collaborative

Operational Planning for a Section 1115 Reentry Demonstration

September 25, 2023
2:00- 3:30 PM ET

Agenda

- Context Setting
- Medicaid Enrollment, Eligible Populations, and Eligible Facilities
- Services: Scope, Delivery, and Billing/Claiming
- Reinvestment Plan, Readiness Assessments, Implementation Plan, Monitoring, and Evaluation
- Supporting Internal and External Partnerships
- Infrastructure Building and IT System Financing

Context Setting

Section 1115 Reentry Demonstration Opportunity

On April 17, 2023, CMS released a State Medicaid Director Letter (SMDL) that describes a section 1115 demonstration opportunity to support community reentry and improve care transitions for justice-involved populations.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SMD# 23-003

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

April 17, 2023

Dear State Medicaid Director:

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

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

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

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

The SMDL implements section 5032 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, which directed the U.S. Department of Health and Human Services (HHS) to issue guidance on how states can design section 1115 reentry demonstrations to provide services to justice-involved individuals prior to release to support their reentry into the community.

Source: Center for Medicare and Medicaid Services, State Medicaid Director Letter #23-003, "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who are Incarcerated, April 17, 2023, available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf.

Background on 1115 Reentry Demonstration Opportunity

Historically, states have been unable to draw down Medicaid funding to provide health care services to individuals when they are incarcerated due to restrictions in federal Medicaid law (known as the "inmate exclusion").

Restrictions on Medicaid-Funded Services for Inmates of a Public Institution

- Medicaid regulations at 42 CFR § 435.1010 define an inmate of a public institution as "a person living in a public institution" and define a public institution as "an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control."
  - A correctional institution is considered a public institution and may include state or federal prisons, local jails, detention facilities, or other penal settings (e.g., boot camps, wilderness camps).
  - CMS considers an individual of any age to be an inmate if the individual is in custody and held involuntarily through operation of law enforcement authorities in a public institution.
- Individuals who are held involuntarily in a public institution may be eligible for and enrolled in Medicaid, but federal Medicaid funds may not be used to pay for services for such individuals while they are incarcerated.
- The payment exclusion does not apply to inpatients in a medical institution (e.g., hospitals, nursing homes).*

The SMDL outlines the opportunity for states to receive federal financial participation (FFP) for expenditures for certain pre-release health care services provided to individuals who are incarcerated and otherwise eligible for Medicaid prior to their release.

*More information on institutional settings that do and do not qualify for Medicaid funds can be found here: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf

Goals for Section 1115 Reentry Demonstrations

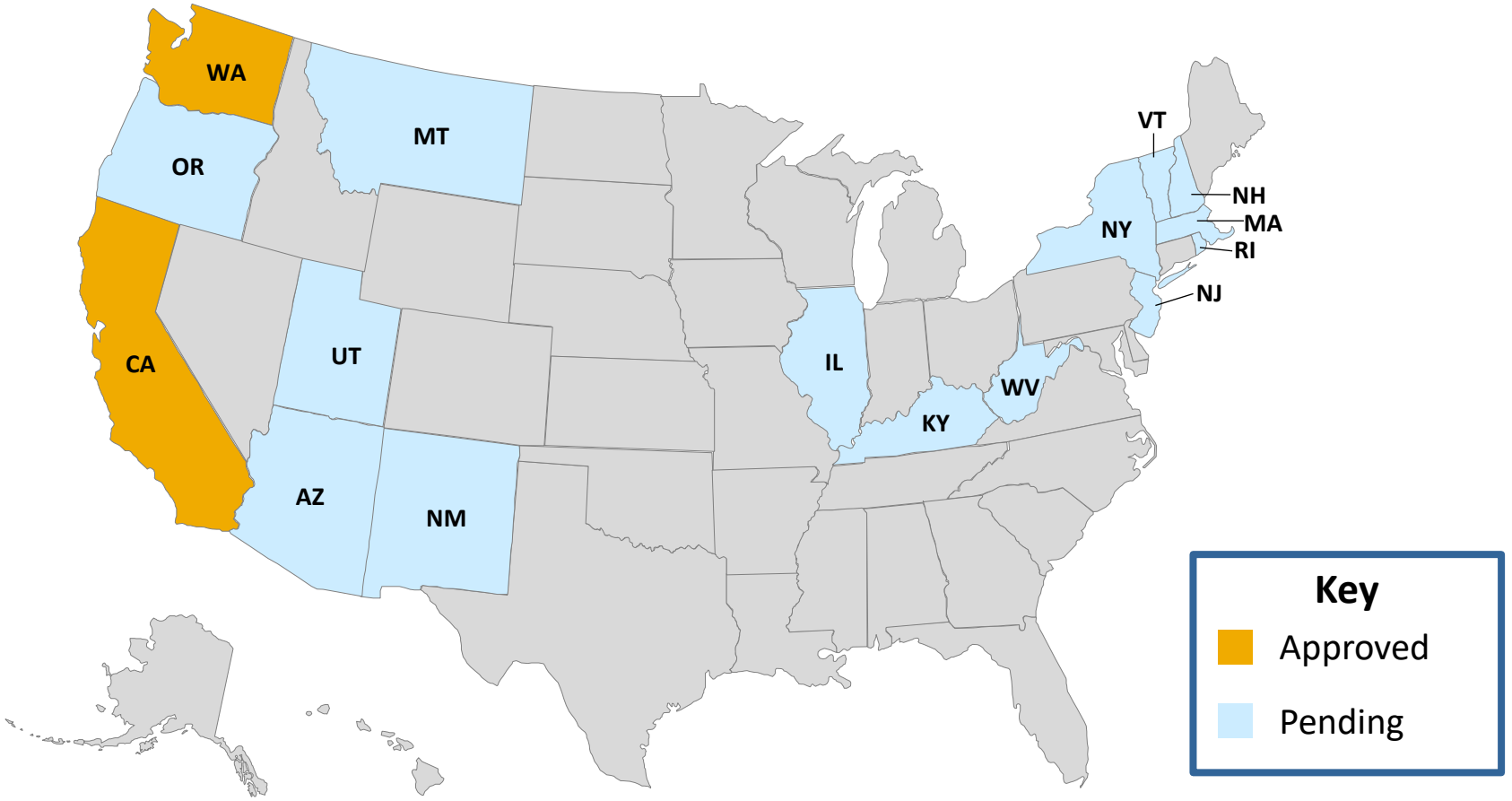
This demonstration opportunity is intended to help state health and correctional systems support reentry into the community for individuals leaving incarceration.

Specifically, 1115 reentry demonstrations seek to:

- Increase coverage, continuity of coverage, and appropriate service uptake;
- Improve access to services;
- Improve coordination and communication;
- Increase additional investments in health care and related services;
- Improve connections between carceral settings and community services;
- Reduce all-cause deaths; and
- Reduce number of emergency department (ED) visits and inpatient hospitalizations.

Approved & Pending 1115 Reentry Demonstration Requests

As of July 2023, 16 states have submitted section 1115 reentry demonstration requests. Demonstration projects have been approved in California and Washington.



See Appendix for links to states' requested and approved section 1115 reentry demonstrations.

Medicaid and CHIP MAC Learning Collaboratives

Objectives

Many states with pending or approved section 1115 reentry demonstrations, as well as states that are evaluating whether to pursue a demonstration, have requested technical assistance to better understand the operational considerations for implementing this initiative.

The purpose of this presentation is to support states by:

- ❑ **Reviewing section 1115 reentry demonstration features available under the SMDL**
- ❑ **Reviewing requirements and state policy options**
- ❑ **Outlining operational considerations to support state implementation planning**

Medicaid Enrollment, Eligible Populations, and Eligible Facilities

Medicaid Enrollment and Suspension

Demonstration Requirements: Enrollment

- Under the SUPPORT Act, all states are required to have processes in place to facilitate enrollment and suspension for Medicaid-eligible children under age 21.
- A threshold operational requirement for implementing a reentry demonstration, and a condition for CMS demonstration approval, is enrolling eligible but unenrolled individuals of any age in Medicaid and not terminating individuals in Medicaid coverage upon their incarceration if they are already enrolled. This includes restoring coverage upon release. States should:
  - Work with correctional facility partners to start the application process and help incarcerated individuals apply for Medicaid.
  - Assist with applications upon incarceration and no later than 45 days before the individual's expected date of release.

Demonstration Requirements: Suspension

- Once enrolled, states are expected to suspend and not terminate eligibility.
  - Suspending (rather than terminating) eligibility supports the goals of ensuring states limit coverage and payment to authorized Medicaid benefits and services during incarceration and making coverage and payment for full Medicaid benefits and services available as soon as possible upon release. Strategies to implement suspension are described in the SMDL.
  - States that do not have the capacity or infrastructure to conduct suspension now may propose alternative policies and procedures while they implement suspension. A glide path of up to two years to implement this fully may be permitted.

Medicaid Enrollment and Suspension: Operational Considerations

Current State Assessment: States should consider conducting a current state assessment to understand the extent to which:

- State Medicaid agencies have standardized pre-release Medicaid and non-termination/suspension operational processes in place, including coordination with correctional facilities;
- Given SUPPORT Act requirements, there are gaps in the current processes in youth correctional facilities; and
- Existing eligibility and enrollment systems will need to be updated to accommodate new non-termination/suspension processes.

Eligibility and Enrollment Processes:

- These processes can be facilitated by a correctional facility worker, state Medicaid eligibility and enrollment worker, or community-based in-reach application assister.
- Application processes should be set up so that they are standardized and at a regular frequency to ensure timely enrollment.
- Non-termination/suspension processes require regular data transfer (e.g., daily batched file transfer or a portal) between correctional facilities and the state to communicate when an individual is incarcerated and already enrolled in Medicaid and when the person is released into the community.
- States must have a process to complete an eligibility renewal or redetermination if an inmate receives inpatient care.

Additional Considerations:

- The state may also need to provide regular technical assistance support to both correctional facility staff and state Medicaid eligibility and enrollment workers.
- Depending on the state, a state may need to secure legislative authority making it mandatory to establish pre-release enrollment and suspension processes and develop and issue guidance.
- The state and correctional facilities may develop education and outreach programs, including leveraging peer supports, to highlight the importance of enrolling in Medicaid.

Eligible Populations

Demonstration Requirements

- Medicaid- and CHIP-eligible individuals (both currently enrolled or not currently enrolled) who are currently incarcerated may be included as eligible populations in this demonstration.
  - *For example*: States may determine that all Medicaid-eligible individuals can receive pre-release services.
- States have the flexibility to target subsets of the incarcerated population and could establish identification criteria.
  - *For example*: States may define the target population to include individuals with specific conditions, such as a substance use disorders (SUDs), serious mental illnesses (SMIs), and/or chronic conditions.
- Eligible enrollees can be either pre- or post-adjudication (in other words, individuals who are incarcerated both prior to and post their sentencing).

Eligible Populations: Operational Considerations

Defining No Additional Eligibility Criteria

- If a state does not establish additional eligibility criteria, it will be easier for the correctional facility and the state to implement since existing eligibility rules and processes will apply. This approach is also likely to increase the number of individuals who will be eligible to receive pre-release services.

Defining Additional Eligibility Criteria

If a state elects to establish eligibility criteria for pre-release services, then it will need to:

- Define those criteria in detail;
- Consider establishing a screening process whereby the correctional facility or another entity that is identified by the state screens individuals (leveraging its own existing screening process but also incorporating additional state-established eligibility criteria, if not aligned); and
- Establish a data transfer process (e.g., daily batched file) whereby the correctional facility shares with the state who is screened and found eligible for pre-release services.

Eligible Populations: Additional Considerations

Examples of Approved and Proposed State Eligibility Criteria

California (Approved): Medicaid eligible adults with 1) mental illness; 2) SUD; 3) a chronic condition; 4) intellectual/developmental disability (I/DD); 4) traumatic brain injury (TBI); 5) HIV/AIDS; or 6) are pregnant or postpartum. All Medicaid/CHIP eligible youth (no behavioral health/chronic condition criteria).

Kentucky (Proposed): Medicaid eligible individuals who meet SUD criteria through assessment completed by Department of Correction staff and have a confirmed SUD diagnosis.

New York (Proposed): Individuals with a history of SUD, serious mental illness (SMI), HIV/AIDS, Hepatitis C, sickle cell disease, and/or chronic disease.

Washington (Approved): All Medicaid eligible individuals

Additional Considerations

- Regardless of whether a state uses eligibility criteria or not, a state needs to establish a process whereby Medicaid enrollees are flagged as eligible to receive pre-release services.
- Based on information received, a state needs to establish an indicator/aid code or other tracking process to limit billing/claiming only for the approved targeted pre-release services.
- Eligibility criteria and screening processes should be designed such that they minimize the risk of overlooking individuals with undiagnosed conditions.

Eligible Facilities

Demonstration Requirements

- States may include individuals in state and/or local jails, prisons, and/or youth correctional facilities for pre-release services.
- States have the discretion to propose the types of carceral settings for participation.
- Federal facilities are not eligible to participate in the reentry demonstration; states may assist federal prisoners to apply for Medicaid in the state in which they are intending to reside upon release.
- Individuals residing in supervised community residential facilities, aka "halfway houses", may receive Medicaid-funded services if the individual has freedom of movement and association while residing at the facility. In those circumstances, individuals residing in halfway houses will not be subject to the inmate payment exclusion.

Examples of Approved and Proposed Eligible Facilities

Washington (Approved): state prisons, county jails, and youth correctional facilities

West Virginia (Proposed): state prisons and regional jails

Montana (Proposed): state prisons

Illinois (Proposed): Cooke County jail

Note: See Appendix for links to approved and pending section 1115 reentry demonstrations.

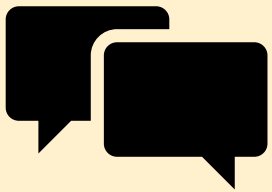
Eligible Facilities: Operational Considerations

State Prisons. Operationalizing in state prisons is relatively easier than operationalizing in local or county jails because individuals incarcerated in prisons are post adjudication and the state will generally have a release date that it can work with to start delivering pre-release services to support reentry.

Local Jails/Correctional Facilities. Operationalizing in local jails/correctional facilities is relatively more complex compared to operationalizing in state prisons because the average length of stay is less than 30 days and there is typically no predetermined release date to coordinate against (although some states incarcerate individuals in jails post their sentencing/adjudication).

- States that operationalize pre-release services in jails/correctional facilities should consider establishing a short-term model where services are provided based on the individual's intake date and length of stay for the individual.
- Many individuals who are in county jails have a higher need for pre-release services because of the cycle of release, hospitalization, and re-incarceration.

- Regardless of the facilities in which the reentry demonstration will operate, a state may wish to consider passing legislation to mandate correctional facility participation.
- States may propose a phased approach to adding carceral facilities over the course of the demonstration.
- States are required to conduct a readiness assessment of carceral settings before implementing the demonstration in those locations. (See subsequent slides.)



Questions?

Services: Scope, Delivery, and Billing/Claiming

Overview: Mandatory Minimum Covered Services

Minimum Pre-release Benefit Package	Current State Considerations
Case management to assess and address physical and behavioral health needs and health-related social needs (HRSNs)	▪ Some, but not all, correctional facilities currently provide reentry case management, but most do not conduct any follow-up post-release into the community.
Medication-Assisted Treatment (MAT) services, as clinically appropriate, with accompanying counseling for all types of SUD	▪ Some, but not all, correctional facilities currently provide MAT to incarcerated individuals. ▪ New requirements for coverage of MAT for both opioid use disorders and alcohol use disorders will likely require correctional facilities that do offer some form of MAT to expand the scope of services.
A **30-day supply of all prescription medications**, as clinically appropriate based on the medication dispensed and the indication, provided to the individual immediately upon release from the correctional facility	▪ Some, but not all, correctional facilities have pharmacies on-site; some correctional facilities use mail-in pharmacy providers and/or community-based pharmacies. ▪ While some correctional facilities already provide medications in-hand upon release, the vast majority only provide prescriptions.

Deeper Dive on Case Management

Case Management

- Case management includes the activities coverable under the Medicaid targeted case management services benefit.
- Pre-release case management should build a bridge to post-release physical health, behavioral health, and HRSN services.
- The case manager may be different between pre- and post-release services; a warm hand-off is necessary to ensure continuity of services.

Deeper Dive on Case Management

Operational Considerations

- States will need to establish detailed policy and operational guidance that describes:
  - Expectations for conducting pre-and post- release case management, establishing post-release closed loop referrals, and ensuring smooth linkages to physical, behavioral, and HRSN services.
  - Processes for promoting and ensuring collaboration between case managers and providers of pre- and post-release services.
- States will need to determine the model for who will provide the pre-release case management (e.g., Medicaid managed care plans, fee-for-service in-reach community-based providers, correctional facility providers, a combination).
- Regardless of the model, a state will need to establish clear policy and operational expectations for assigning a case manager and ensuring continuity of case management across the pre- and post-release periods.
  - *For example:* If the pre- and post-release case manager are different, the state needs to ensure a warm handoff between the two case managers.

Managed Care Plan Enrollment. If a state elects to use plans for conducting pre-release case management, a state will need to develop:

- An operational process for: (1) enrolling individuals into the plan; and (2) communicating updates to the plan; and
- Policies and amended managed care contracts that clearly outline expectations.

Additional Covered Services

Additional Covered Services

States may consider covering additional services, such as:

- Family planning services and supplies
- Services provided by peer supporters and/or community health workers with lived experience
- Behavioral health rehabilitative or preventive services
- Treatment for Hepatitis C

Operational Considerations

- Additional services should be based on the needs of the carceral populations.
- States should provide justification for such services and must assess the effectiveness of the additional services in their monitoring and evaluation processes.

California and Washington received approval to cover the following additional pre-release services:

- Physical and behavioral health clinical consultation services
- Laboratory and radiology services
- Medications and medication administration during the pre-release period
- Durable medical equipment to have in-hand upon release
- Community health workers

Providers of Pre-Release Services

Providers of Pre-Release Services

- States may allow providers to be in-reach community-based providers and/or correctional facility providers.
  - In reach pre-release services by community providers is preferred by CMS in order to ensure continuity of coverage during the post-release period.
- Services can be provided in-person and/or via telehealth.
- States relying on carceral health care providers to furnish pre-release services are expected to ensure the providers comply with Medicaid provider participation requirements set by the state.

Providers of Pre-Release Services

Operational Considerations

- In-Reach Community Providers
  - Leveraging community providers for the delivery of pre-release services can contribute to continuity of care if individuals continue to see the same provider post-release.
  - Community providers may not have experience working in correctional environments and/or addressing the needs of justice-involved individuals (e.g., addressing trauma and criminogenic risk factors) and may need training and support.
- States will need to work with correctional facilities to ensure there are smooth security processes, private interview rooms, and assistance to ensure individuals are able to see the provider via telehealth or in-person.
- States will need to conduct a current state assessment within their correctional facilities to understand what services are currently being provided and which providers are delivering those services.

State Medicaid agencies will need to begin working with correctional facilities as early into the process as possible to establish working relationships and assess implementation needs.

Billing/Claiming

Demonstration Requirements

Delivery System: States will need to determine whether they deliver services through fee-for-service, managed care, or a combination.

Rates: States may also determine rates for pre-release services and whether those rates will be different than those currently being offered through the State Plan.

For example:

- Tiered rates for in-reach providers
- Bundled payments for care management activities
- Combination of both above approaches

Operational Considerations

- Generally, correctional facilities do not have experience billing Medicaid, nor do they have electronic health records (EHRs) with existing Medicaid billing/claiming capabilities.
- This will be a new operational process that correctional facilities will need to set up for their providers to understand billing/claiming requirements and for their systems to process Medicaid claims.

An Example of a Proposed Approach for Operationalizing Billing/Claiming by Service and Workforce Type Approach

For each service, the state should assess whether it will be delivered via an in-reach community-based provider, via a correctional facility, or both.

Service	Example Workforce Approach	Example Billing/Claiming Approach
Case Management	State will leverage in-reach case managers through Medicaid managed care.	Case manager will be enrolled as a Medicaid provider and be paid via managed care plan.
MAT*	Combination of in-reach community-based providers and correctional facility providers	In-reach and correctional facility providers will be enrolled as Medicaid providers and bill Medicaid agency for the provision of services.
30-Day Supply of Medication	State may leverage existing correctional facility pharmacies, if a facility has one, or community-based pharmacies that will need to coordinate with the correctional facility.	Community-based and correctional facility providers will be enrolled as Medicaid pharmacies and bill Medicaid agency for the provision of prescriptions.

**A state could use a combination of in-reach community-based and correctional facility providers based on who is currently providing MAT in correctional facilities and where new MAT provider capacity is needed*

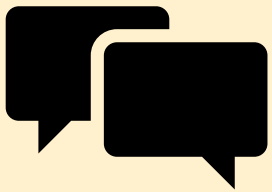
Pre-Release Timeframe

Demonstration Requirements

- States generally will be expected to cover demonstration services beginning 30 days immediately prior to the individual's expected date of release.
- CMS will consider approving demonstration authority to begin coverage up to 90 days prior to the expected release date.
- If a state requests a pre-release service timeframe longer than 30 days, the state must justify the longer timeframe and plan to evaluate novel hypotheses that align with the justification.

Operational Considerations

- States should conduct a current state assessment to better understand average length of stay in correctional facilities.
- 90 days allows more time to set up pre-release services. However, this timeframe will likely only be available for individuals who are in prisons since inmates in prisons have longer average lengths of stay.
- Many individuals in jails and youth correctional facilities have short lengths of stays (e.g., 30 days or less) and unpredictable release dates. As such, these individuals will likely receive a more limited set of targeted reentry services that should start at intake.
- Developing a process to provide reentry services to individuals with short-term stays will require partnership between the state and correctional facilities to ensure reentry services are provided in a timely manner.



Questions?

Reinvestment Plan, Readiness Assessments, Implementation Plan, Monitoring, and Evaluation

Reinvestment Plan

Demonstration Requirements

- To receive approval for reentry demonstrations, CMS expects states to reinvest the total amount of federal matching funds received for existing carceral health care services that are currently funded with state and/or local dollars.
- Reinvestments should support improved access to and quality of health care and health-related social services for individuals who are incarcerated or were recently released from incarceration.
- Reinvestments in carceral health care should supplement and not supplant existing state or local spending on such services and resources.

Operational Considerations

- States are expected to include a reinvestment plan in the implementation plan that:
  - Specifies the amount of federal matching dollars for services that are currently being funded in correctional facilities with state or local dollars to pay for existing services; and
  - Describes the proposed reinvestments.
  - Examples of reinvestments include but are not limited to:
    - Improved access to behavioral and physical health care services in the community;
    - Improved health information technology and data sharing; and
    - Increased community-based provider capacity.
- The state's share of expenditures for new, enhanced, or expanded pre-release services approved under the demonstration can be considered an allowable investment.
- CMS will not approve a reinvestment plan under which funds are used to build prisons, jails, or other carceral facilities; used for non-health related improvements for such facilities; or increases the profits of private carceral facilities.

Readiness Assessment

Demonstration Requirements

All participating facilities must demonstrate readiness to conduct the following prior to participating in the reentry demonstration:

- ❑ Pre-release application and enrollment processes for individuals not enrolled in Medicaid or CHIP prior to incarceration and who do not otherwise become enrolled during incarceration;
- ❑ Screening process to determine eligibility for pre-release services;
- ❑ Provision of pre-release services prior to the expected date of release for the authorized timeframe (e.g., 90 days), which includes, but is not limited to, meeting Medicaid provider participation requirements and establishing billing and claiming processes;
- ❑ Coordination across partners who furnish services to enrollees;
- ❑ Reentry planning, pre-release care management, and assistance with care transitions to the community;
- ❑ Operational processes needed to implement Medicaid and CHIP requirements (e.g., suspension, notices, fair hearings);
- ❑ Data exchange to support care coordination and transition activities;
- ❑ Data reporting to support program monitoring, evaluation, and oversight; and
- ❑ Staffing and project management to support facility participation in the reentry demonstration.

CMS expects these criteria for readiness to be documented in the Reentry Initiative Implementation Plan. If a facility is otherwise ready but is not prepared to implement a data exchange and/or follow data reporting requirements, a state will develop a reliable workaround, as well as an agreement and reasonable timeline for the facility to achieve the expected level of readiness.

Readiness Assessment

Operational Considerations

- States will need to establish initial readiness assessment infrastructure based on required readiness elements.
- Required expectations and criteria for what will satisfy readiness should be clearly articulated to correctional facilities well in advance of assessments.
- For example:
  - For determining readiness to submit Medicaid applications: the correctional facility will need to explain to the state: how individuals will be identified as being uninsured and needing to submit an application; which entity will assist in completing and submitting the application; by what frequency applications will be submitted; through what modality; and how follow-up/trouble-shooting will occur.
  - For determining readiness to screen eligibility for pre-release services (if applicable): the facility will need to demonstrate which staff will lead the screening process, what screening tools will be used; who is responsible for submitting the screening information to the state; and who is responsible for follow-up/troubleshooting.
- A correctional facility's readiness needs to be clearly communicated, in advance of its go-live timeframe, to external implementing partners (e.g., managed care plans and community-based providers).

Reentry Demonstration Initiative Implementation Plan

Demonstration Requirements

States must submit an implementation plan, subject to CMS approval. CMS is developing an implementation plan template for states to use.

Operational Considerations

- This implementation plan is due to CMS after approval of the reentry demonstration (based on an agreed upon timeframe). States may not draw down federal financial participation for pre-release services until CMS approves the state's implementation plan.
- The implementation plan must describe:
  - The implementation settings, the time period that services are available, and the phase-in implementation approach;
  - Current state processes for meeting the below milestones (including data and infrastructure needs), and mitigation plans to address anticipated implementation challenges associated with each milestone:
    1. Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated;
    2. Covering and ensuring access to the expected minimum set of pre-release services for individuals who are incarcerated, to improve care transitions upon return to the community;
    3. Promoting continuity of care;
    4. Connecting to services available post-release to meet the needs of the reentering population; and
    5. Ensuring cross-system collaboration.
  - Strategies to improve health care quality for all beneficiaries, thereby reducing disparities.
  - Reinvestment plan for federal matching funds received for existing carceral health care services that are currently funded with state and/or local dollars.

Monitoring

States will be required to conduct systematic monitoring of their demonstrations to track key metrics and identify implementation challenges and any need for mid-course corrections.

Demonstration Requirements

- SMDL #23-003 outlines monitoring metrics that states must track, which at a minimum include:
  - Administration of screenings to identify individuals eligible for pre-release services;
  - Participating pre-release services providers;
  - Utilization of applicable pre-release and post-release services;
  - Provision of health or social service referral pre-release;
  - Participants with established care plans at release;
  - Uptake of data system enhancements among participating carceral settings; and
  - Quality of care and health outcomes metrics, including disparities-sensitive measures, which are needed to close disparities and gaps in quality of care in Medicaid/CHIP.
- Monitoring reports will also include a qualitative component, which will allow states to provide narrative information on metric trends, milestone progress, and operational updates.

Source: Center for Medicare and Medicaid Services, State Medicaid Director Letter #23-003, "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who are Incarcerated, April 17, 2023, available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf.

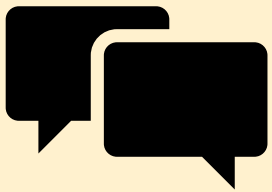
Evaluation

States will be required to conduct robust evaluation of the demonstration.

Demonstration Requirements

- The evaluation will test whether an 1115 reentry demonstration expands Medicaid coverage through increased enrollment of eligible individuals and efficient high-quality pre-release services that promote continuity of care into the community post-release.
- Outcomes of interest could include but are not limited to:
  - Cross-system communication and collaboration
  - Connections between carceral settings and community services
  - Provision of preventive and routine physical and behavioral health care
  - Avoidable ED visits and inpatient hospitalizations
- As part of the evaluation, states should conduct a comprehensive cost analysis to estimate the cost of implementing the demonstration.
- To the extent possible, states should collect data to support analyses that are stratified by populations of interest. This information can be used to help identify disparities in access to/quality of care and health outcomes as well as to better understand how the demonstration may reduce such disparities.
- If a state is including services beyond the minimum benefit package and/or providing coverage for a period greater than 30 days prior to an enrollee's release date, the state should incorporate additional hypotheses to test the additive impact of those features.

Source: Center for Medicare and Medicaid Services, State Medicaid Director Letter #23-003, "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who are Incarcerated, April 17, 2023, available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf.



Questions?

Supporting Internal and External Partnerships

Internal Medicaid Agency Engagement

Standing up a reentry demonstration is operationally complex because it requires policy-making and operational implementation that intersects with every aspect of the Medicaid program, including:

- Eligibility and enrollment
- Benefit design
- Provider enrollment
- Provider and pharmacy billing/claiming
- Rate-setting
- Managed care delivery system, as applicable

Coordinating across state Medicaid agency teams and subject matter experts will be essential for planning and implementation.

- States should seek to establish intra-agency coordination and communication processes as early into implementation as possible.
- For example, states should convene, or leverage, standing cross-agency meetings to disseminate information and troubleshoot as implementation challenges arise.
- Cross-agency coordination can also help with aligning messaging with external stakeholders.

Early Engagement with Correctional Partners

- Robust collaboration between state Medicaid agencies and officials responsible for overseeing correctional facilities is required to implement pre-release services.
- States will be standing up a Medicaid program within correctional facilities that likely do not have any historical experience working with Medicaid. For this reason, correctional agency leadership needs to be engaged early and frequently.
  - States will need to provide resources to help correctional partners better understand Medicaid program requirements.
  - Correctional facilities should understand that the reentry demonstration is not a grant funded program but rather one that requires providers to enroll in Medicaid and bill through existing Medicaid pathways.
  - States should identify champions with correctional agencies who support the objectives of the reentry demonstration and who can bring along other correctional facility partners.
- States should consider establishing memorandums of understanding between the state and the correctional facility that outline expectations and roles and responsibilities for implementing pre-release services.

External Partner Engagement

- **Engaging with external partners early and frequently will help to cultivate relationships between states and critical entities who are jointly committed to the success of the reentry demonstration.**
- **Examples of critical external partners include but are not limited to:**
  - Prison, jail, and youth correctional center leadership
  - Probation and parole officers
  - Community-based physical and behavioral health providers
  - Community-based organizations, including those that have:
    - Experience working with individuals who are justice involved and/or
    - Focus on connecting individuals to health-related social needs such as housing and nutrition
  - Managed care plans, as appropriate
  - Consumer advocates
  - Individuals with lived experience

Infrastructure Building and IT System Financing

Transitional, Non-Service Expenditures

Federal Guidance

- States may request time-limited support in the form of FFP for certain new expenditures required by states, correctional facilities, and health care providers to implement and expand service provision and coordination with community providers.
- Examples include:
  - Development of new business or operational practices and related health IT
  - Workforce growth and development
  - Outreach, education, and stakeholder convening

Operational Considerations

- States need to define:
  - The specific transitional, non-service activities needed to successfully implement the reentry demonstration, including a budget justification and documentation that these are new expenditures association with the demonstration
  - The qualified entities that may receive time-limited capacity building funds
- States will need to establish a distribution infrastructure which may include an application process and subsequent reporting infrastructure for the state to assess how the funds were used and how they have helped to advance readiness for delivering pre-release services.

To develop a projection for a capacity-building funding request, states will need to:

- Communicate early with correctional facilities to assess willingness/ readiness to participate as well as evaluate facility needs for implementation
- Estimate capacity building costs for hiring staff, building IT systems, developing protocols, and other activities to support start-up cross-system planning and implementation

Administrative Information Technology (IT) Systems Costs

State Medicaid agency IT system costs that meet required criteria through an Advanced Planning Document may be eligible for enhanced FFP.

- This may include IT systems that support data sharing between the Medicaid and correctional agencies, carceral facilities, Medicaid providers, and other systems (e.g., housing or other HRSN data systems/sources).
- Enhanced FFP may be claimed for new systems or improvements to existing systems.
- If states have questions related to IT topics and IT systems expenditures, CMS encourages states to contact their Medicaid Enterprise Systems State Officer.

California will leverage an existing provider screening portal (referred to as the Screening Portal), which will be modified specifically for the purpose of collecting and sharing: (1) Medicaid enrollment information; and (2) pre-release service eligibility data between correctional facilities and the Medicaid agency.

Source: California Department of Health Care Services. Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative (June 2023). https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-Stakeholder-Comment-June-2023.pdf

Questions and Wrap Up

If you have any questions or would like technical assistance to address state-specific challenges, please contact your state project officer.

If you have any updates to your contact information or would like more information about the Coverage LC, please contact MACLC@mathematica-mpr.com.

Appendix

Approved and Pending Section 1115 Reentry Demonstrations: Status and Hyperlinks (as of August 2023)

State	Demonstration Status
Arizona	Pending
California	Approved
Illinois	Pending
Kentucky	Pending
Massachusetts	Pending
Montana	Pending
New Hampshire	Pending
New Jersey	Pending
New Mexico	Pending
New York	Pending
Oregon	Pending
Rhode Island	Pending
Utah	Pending
Vermont	Pending
Washington	Approved
West Virginia	Pending