

Re-Entry from Incarceration

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As of 2020, there were approximately 1.8 million adults incarcerated in jails and prisons in the United States. Incarcerated adults are at higher risk of many health issues, including HIV, substance use, and mental health conditions. A 2017 U.S. Department of Justice study, for example, found that 58% of state prisoners and 63% of sentenced individuals at jails met clinical criteria for a substance use disorder.

Re-entry from incarceration is an important – and vulnerable – time. Recently-released adults face substantial health risks, with higher utilization of emergency departments, higher risk of overdose, and higher risk of mortality; one study found that, during the two weeks immediately post-release, individuals were 129 times more likely to experience a fatal overdose than the general population.

Access to healthcare – including substance use and mental health services – can help mitigate these challenges, along with employment, housing, mentorship, education, and other community-based services. Ideally, planning for re-entry would begin at the time of intake into the jail or prison and continue throughout the entire period of incarceration.

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Medicaid's Role in the Re-Entry Process

Per the Social Security Act's "inmate exclusion" policy, Medicaid cannot provide coverage for people who are incarcerated. To effectuate this policy, states typically terminate or suspend Medicaid coverage when a member is incarcerated, and then re-enroll or re-activate coverage when the member is released. States have also launched initiatives to newly enroll individuals in Medicaid as part of the re-entry process; many people leaving incarceration are eligible for Medicaid because they have no or very low income.

The "inmate exclusion" policy leads to significant challenges, including:

- **Gaps in coverage and care during re-entry.** Medicaid enrollment or reactivation can take time to complete and finding a provider can take even longer. This can lead to gaps in coverage and delays in access to crucial healthcare services like substance use treatment or prescription drugs.
- **Challenges providing streamlined re-entry planning.** "In-reach services," or care coordination services that are provided inside jails and prisons, can smooth the re-entry process by identifying health-related needs, establishing connections to community-based primary care and behavioral health services, and facilitating the transfer of medical records before release. Some state Medicaid agencies have required their managed care organizations to provide in-reach services. States with fee-for-service delivery systems, however, have limited ability to use Medicaid to fund this type of care.

Opportunities for Federal Action

- **Allow states to provide Medicaid coverage up to 90 days before re-entry from incarceration.** Allowing pre-release coverage would prevent gaps in care and create a pathway for Medicaid to help fund care coordination services before release. Congress and CMS should create a state option to provide pre-release coverage up to 90 days before release.
- **Provide clarity on how changes to the “inmate exclusion” policy would apply to pre-trial populations.** The majority of individuals who are in jail have not yet received a trial or sentence, so they do not have a set release date. This complicates the interpretation of proposed legislation and Section 1115 waiver requests that would allow Medicaid coverage up to a certain number of days pre-release. CMS should clarify how states could provide pre-release coverage to individuals who do not yet have a release date. Potential solutions could include allowing states to provide coverage for all individuals who have not yet been sentenced or allowing states to provide coverage for up to the first 90 days of a pre-trial stay in jail.
- **Provide planning and implementation grants to support crucial systems work.** In order to provide timely enrollment, state Medicaid programs must build data exchanges and shared processes with jails and prisons. This work can be time consuming and costly, especially in county-based jail systems that may use many different systems. Federal policymakers should create planning and implementation grants to support this work.
- **Provide clear guidelines on braiding funding.** The Department of Justice, the Department of Labor, the Substance Abuse and Mental Health Services Administration, and other federal agencies provide grants to support re-entry services. Federal agencies should provide clear guidelines on how to braid grant funding with Medicaid funds to support comprehensive re-entry services, and consider aligning guidance and reporting requirements between these types of grants.
- **Support comprehensive crisis response systems.** Crisis response systems – including mobile crisis teams and crisis stabilization centers – can help people who are experiencing a behavioral health crisis get connected to health care instead of the justice system. Read NAMD’s recommendations on crisis response here.

Supporting State Innovation

Many states have already launched efforts to support people who are re-entering from incarceration. Six states (AZ, CA, KY, MT, UT, and VT) have submitted Section 1115 waivers requesting that CMS allow Medicaid coverage for 30 or 90 days before release; CMS has not yet responded to these waiver requests. Many states use their managed care organizations (MCOs) to provide pre-release services: Arizona, for example, contractually requires MCOs to identify high-risk members prior to release and set up post-release health care appointments. Connecticut, a fee-for-service state, provides pharmacy vouchers during re-entry so that individuals can access necessary prescriptions while their Medicaid applications are being processed.

You can read more about state actions to support people who are re-entering from incarceration in NAMD’s Medicaid Forward: Behavioral Health report.