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Kennedy, Rachel

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NARROWING THE "MEDICAID INMATE EXCLUSION POLICY" TO IMPROVE CONTINUITY OF CARE FOR THE REENTRY POPULATION

Rachel Kennedy

About the Author

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Introduction

Every year in the United States, over 600,000 people are released from prison and over 9,000,000 enter and exit jail.[1] Many of these individuals have complex and chronic physical and mental health conditions. The Bureau of Justice Statistics found that in 2016, forty percent of incarcerated people in state prisons reported having an active chronic health condition, forty-three percent had a history of mental health issues, and fourteen percent met the threshold for serious psychological distress.[2] Nationally, a person with serious mental illness is three times more likely to be found in a jail or prison than a hospital.[3] Upon reentry to their communities, many individuals are left unsupported in vulnerable positions, without health insurance or transitional medical care.[4] The consequences for those with acute medical needs and mental health disorders—particularly those with substance use disorders—can be severe.[5] Though countless policies, practices, and dynamics underlie this concerning status quo, this Article focuses on one in particular: the "Medicaid Inmate Exclusion Policy" (MIEP).[6]

The MIEP prohibits the use of federal dollars to cover Medicaid expenses for incarcerated individuals.[7] Scholars and legislators have argued that repealing the MIEP would improve the quality of health care

1. *Incarceration & Reentry*, Off. of the Assistant Sec'y for Plan. & Evaluation (ASPE), https://aspe.hhs.gov/topics/human-services/incarceration-reentry-0 [https://perma.cc/E4MH-XDWH].
2. Laura M. Maruschak et al., *Medical Problems Reported by Prisoners*, Bureau of Just. Stat. (2021); Laura M. Maruschak et al., *Indicators of Mental Health Problems Reported by Prisoners*, Bureau of Just. Stat. (2021).
3. E. Fuller Torrey et al., *More Mentally Ill Persons in Jails and Prisons Than Hospitals*, Nat'l Sheriffs Ass'n, Treatment Advoc. Ctr. (2010); *See* John Hult, *Majority of Prison Drugs Used for Mental Illness*, Argus Leader (Nov. 28, 2015, 7:22 p.m.), https://www.argusleader.com/story/news/2015/11/28/majority-prison-drugs-used-mental-illness/76457896 [https://perma.cc/X3DD-DPUK] (since the 1950s, the number of psychiatric beds in the United States has dropped by ninety-five percent, the number of people with mental illness in the criminal legal system has jumped by 400 percent).
4. *See, e.g.*, Access to Medicaid Coverage and Care for Adults Leaving Incarceration, MACPAC (2023) ("Medicaid-eligible adults leaving incarceration often experience delays obtaining Medicaid coverage upon release. They may also lack access to needed medications and connections to community-based providers to initiate or continue their care after release."); *see generally infra* Part I.
5. *See* Ingrid A. Binswanger et al., *Release from Prison – A High Risk of Death for Former Inmates*, 356 New Eng. J. Med. 157 (2007).
6. *See* 42 U.S.C. § 1396d.
7. *See id.* (a limited exception, which not all states have implemented, exists for incarcerated patients who are admitted to a Medicaid-participating hospital for twenty-four hours or longer; *see* Mira Edmonds, *The Reincorporating of Prisoners into the Body Politic*, 28 Geo. J. on Poverty L. & Pol'y 279 (2021); *see also* Pew Charitable Trusts, State Prisons and the Delivery of Hospital Care (2018) (discussing state-owned corrections-only hospitals that are ineligible for Medicaid participation).

provided during incarceration and continuity of care upon release.[8] However, federal legislative efforts to repeal or amend the MIEP have failed.[9] Recent state-based agency efforts, on the other hand, have had promising success.[10] This Article surveys these various MIEP-related legislative and regulatory efforts and analyzes their potential to narrow the scope of the MIEP to improve quality of health care for incarcerated people and continuity of care upon reentry. Ultimately, this Article recommends leveraging state regulatory law to improve continuity of care as a potential stepping stone to repealing or amending the MIEP. This Article proceeds in four parts. Part I highlights the dismal state of correctional health care to provide context for incarcerated people's health care needs during incarceration and upon release. Part II provides background on Medicaid and the MIEP's impact on incarcerated and formerly incarcerated people. Part III discusses policy efforts at the federal and state levels to curb the MIEP's effects through various legislative and regulatory mechanisms—namely, Section 1115 demonstration projects. Part IV hones in on the strengths and weaknesses of Section 1115 demonstration projects and concludes with high-level recommendations.

I. Incarceration: "A Catalyst for Worsening Health"[11]

The health care provided in jails and prisons is severely inadequate—resulting in unknown scores of preventable deaths, causing medical professionals to urge for higher standards of care, and giving rise to thousands of lawsuits.[12] In one class action lawsuit, the New York City Department of Correction (DOC) was held in contempt in 2022 following 1,909 documented instances of failing to provide incarcerated individuals with access to medical appointments or services in a two-month period.[13] That year, nineteen people died in New York City

8. Kevin Fiscella et al., *The Inmate Exception and Reform of Correctional Health Care*, 107 AM. J. PUB. HEALTH 384 (2017). *See also* Jason S. Schnittker, *An Outdated Federal Law Bars Inmates from Medicaid After Release. A Recent Effort to Fix That Failed*, PENN LEONARD DAVIS INST. OF HEALTH ECON. (2023) (discussing failed legislation from 2021); Aaron Littman, *Free-World Law Behind Bars*, 131 YALE L.J. 1385 (2022). *See generally*, Edmonds, *supra* note 7.
9. *See infra* Part III.A–B.
10. *See infra* Part III.C.
11. Lauren Brinkley-Rubinstein, *Incarceration as a Catalyst for Worsening Health*, 1 HEALTH & JUST. 3 (2013).
12. *See* Marcella Alsan et al., *Health Care in U.S. Correctional Facilities – A Limited and Threatened Constitutional Right*, 388 NEW ENG. J. MED. 847, 848 (2023) (discussing research suggesting that approximately 13,000 cases have been filed in the U.S. alleging inadequate health care between 1985 and 2022); *see, e.g.*, Josiah D. Rich et al., *The Need for Higher Standards in Correctional Healthcare to Improve Public Health*, 30 J. GEN. INTERNAL MED. 503 (2015); Tirzah Christopher, *There is Little Scrutiny of 'Natural' Deaths Behind Bars*, NPR (Jan. 2, 2024, 5:00 AM), https://www.npr.org/2024/01/02/1219667393/there-is-little-scrutiny-of-natural-deaths-behind-bars [https://perma.cc/4A4N-V692].
13. *See* BROOKLYN DEFENDER SERVICES ET AL., NYS SUPREME COURT HOLDS NYC DEPARTMENT OF CORRECTION IN CONTEMPT OF COURT FOR FAILING TO ENSURE THAT

jails—the highest number in nearly a decade.[14] Among those who died was a thirty-one-year-old woman named Mary Yehudah, whose suspected cause of death was untreated diabetes, and a twenty-five-year-old man named Dashawn Carter, whose suspected cause of death was suicide.[15] According to a DOC report, Mr. Carter had a known history of mental illness and missed seventy-six medical appointments while incarcerated due to the DOC's failure to escort him to the jail's clinic.[16]

Failure to provide accessible medical services is not limited to New York City; a nationwide survey found that departments of correction failed to deliver medical exams for chronic diseases to twenty percent of people incarcerated in prisons and seventy percent of people incarcerated in jails.[17] Further, a 2023 cross-sectional national study found that the use of prescription medications is "consistently lower in jails and state prisons compared with community settings," particularly for chronic conditions such as diabetes, asthma, hypertension, hepatitis B or C, HIV, depression, and severe mental illness.[18] The availability of necessary health care is particularly sparse for people with substance use disorders. Opioid use disorder often goes "largely untreated" during incarceration, and access to medications for opioid use disorder (MOUD) "lag[] behind that in the community."[19] By one estimate, up to eighty-five percent of incarcerated people in state prisons required substance use treatment, but only thirteen percent received it.[20]

In addition to the general inaccessibility of health care in jails and prisons, the carceral setting itself also contributes to negative health outcomes. As just one example, physical conditions of confinement, such as overcrowding and poor ventilation, contribute to the risk of infectious

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Incarcerated New Yorkers Have Access to Medical Care in NYC Jails (2022); *see also* Jonah E. Bromwich, *Medical Care at Rikers is Delayed for Thousands, Records Show*, N.Y. Times (Feb. 1, 2022), https://www.nytimes.com/2022/02/01/nyregion/rikers-island-medical-care.html [https://perma.cc/99XH-E8UE].

14. Jan Ransom & Jonah E. Bromwich, *Tracking the Deaths in New York City's Jail System*, N.Y. Times (Oct. 19, 2023), https://www.nytimes.com/article/rikers-deaths-jail.html [https://perma.cc/QD7Q-JHYX].
15. *See id.*
16. Melissa Cintrón Hernández et al., Second Report and Recommendations on 2022 Deaths in New York City Department of Correction Custody (2022).
17. Andrew P. Wilper et al., *The Health and Health Care of US Prisoners*, 99 Am. J. of Pub. Health 666 (2009).
18. Jill Curran et al., *Estimated Use of Prescription Medications Among Individuals Incarcerated in Jails and State Prisons in the US*, JAMA Health Forum (2023).
19. Ebony N. Russ et al., Prison & Jail Reentry & Health (2021). *See also How Is Opioid Use Disorder Treated in the Criminal Justice System?* Nat'l Inst. on Drug Abuse (Dec. 2021), https://nida.nih.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-opioid-use-disorder-treated-in-criminal-justice-system [https://perma.cc/3CFN-6337]; Christy K. Scott et al., *The Impact of the Opioid Crisis on U.S. State Prison Systems*, 9 Health & Just. 17 (2021).
20. Josiah D. Rich et al. *How Health Care Reform Can Transform the Health of Criminal Justice-Involved Individuals*, 33 Health Aff. 462 (2014).

diseases[21]—which became devastatingly apparent during the COVID-19 pandemic.[22] General confinement and solitary confinement also cause physical and psychological harm to individuals.[23] A growing body of research refers to the combination of post-traumatic stress disorder, social sensory deprivation, and antisocial personality traits experienced by incarcerated people as "post incarceration syndrome."[24] People with such conditions face an increased risk of developing "chronic physical conditions compared to the general population, impacting almost every biological system in the body."[25]

With such inadequate care and exacerbating conditions,[26] it is of little surprise that incarceration has been referred to as "a catalyst for worsening health."[27] And the consequences of inadequate care persist after release. Upon reentry, formerly incarcerated individuals—who are often low-income[28] and disproportionately suffer from chronic disease

21. *See, e.g.*, Morgan Maner et al., *Infection Disease Surveillance in U.S. Jails*, 17 PLoS ONE (2022).
22. *See, e.g.*, *Impact of COVID-19 on State and Federal Prisons, March 2020–February 2021*, BUREAU OF JUST. STAT. (2022), https://bjs.ojp.gov/press-release/impact-covid-19-state-and-federal-prisons-march-2020-february-2021 [https://perma.cc/UZ3U-UP32] ("Almost 2,500 persons held in state and federal prisons died of COVID-19-related causes from March 2020 to February 2021."); *see also* Abigail I. Leibowitz et al., *Association Between Prison Crowding and COVID-19 Incidence Rates in Massachusetts Prisons, April 2020–January 2021*, 181 JAMA INTERNAL MED. 1315 (2021); Edmonds, *supra* note 7, at 299 ("By December 2020, there had been at least 276,235 reported COVID-19 cases among prisoners nationally, meaning one in five U.S. prisoners had tested positive for COVID-19 – more than four times the rate in the general population." (citation omitted)).
23. Justin D. Strong et al., *The Body in Isolation: The Physical Health Impacts of Incarceration in Solitary Confinement*, 15 PLoS ONE (2020); *see generally* Brinkley-Rubinstein, *supra* note 11.
24. MACPAC, *supra* note 4, at 70; Dominique Farrell, *Why People Leave Prison 'More Broken' Than When They Entered*, GBH (Sept. 25, 2023), https://www.wgbh.org/news/local/2023–09–25/why-people-leave-prison-more-broken-than-when-they-entered [https://perma.cc/F37D-6BUK].
25. CANADIAN MENTAL HEALTH ASS'N., THE RELATIONSHIP BETWEEN MENTAL HEALTH, MENTAL ILLNESS, AND CHRONIC PHYSICAL CONDITIONS, https://ontario.cmha.ca/documents/the-relationship-between-mental-health-mental-illness-and-chronic-physical-conditions [https://perma.cc/28PC-QGVY] (last visited Jan. 15, 2024); *see generally Chronic Illness and Mental Health: Recognizing and Treating Depression*, https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health [https://perma.cc/3FXE-N5XZ] (last visited Jan. 15, 2024); Gregory A. Aarons et al., *The Association of Mental and Physical Health Problems in High-Risk Adolescents: A Longitudinal Study*, 43 THE J. OF ADOLESCENT HEALTH 260 (2008).
26. *See, e.g.*, Edmonds, *supra* note 7, at 294–300; *see also* Meg Anderson, *1 in 4 Inmate Deaths Happen in the Same Federal Prison. Why?* NPR (Sept. 23, 2023), https://www.npr.org/2023/09/23/1200626103/federal-prison-deaths-butner-medical-center-sick-inmates [https://perma.cc/KGJ5-F4RV].
27. Brinkley-Rubinstein, *supra* note 11; *see also* Susan J. Loeb & Azza Abudagga, *Health-Related Research on Older Inmates: An Integrative Review*, 29 RSCH. IN NURSING & HEALTH 556 (2006).
28. Bernadette Rabuy & Daniel Kopf, *Prisons of Poverty: Uncovering the*

and mental illness[29]—face the daunting task of navigating their complex health needs alone.[30] The initial reentry period is especially dangerous for individuals with substance use disorder or certain mental illnesses, as any disruption to their regular medical regimen may heighten their risk of death.[31] During the first two weeks after release, formerly incarcerated individuals face a 12.7 times greater risk of death than other individuals and a staggering 129 times greater risk of death from drug overdose.[32] Another leading cause of death upon release is suicide, which researchers attribute to the psychological stress of reentry and the difficulty of obtaining care and medications from community providers.[33]

People who survive the initial reentry window face other health-related challenges, such as the burdensome financial cost of acute care utilization.[34] A national study of over 150,000 people found that adults recently released from carceral settings had up to a 47.2 percent higher rate of emergency department utilization than the general population.[35] The study also found that "individuals with recent criminal justice involvement make up 4.2 percent of the U.S. adult population, yet account for an estimated 7.2 percent of hospital expenditures and 8.5 percent of e[mergency] d[epartment] expenditures."[36] Further, research suggests that lack of continuous health care upon release corresponds to heightened risks

Pre-Incarceration Incomes of the Imprisoned, Prison Pol'y Initiative (July 9, 2015), https://www.prisonpolicy.org/reports/income.html [https://perma.cc/UT5D-XD74]; Ctr. on Budget & Pol'y Priorities, Policy Basics: Introduction to Medicaid (April 14, 2020), https://www.cbpp.org/research/health/introduction-to-medicaid [https://perma.cc/V5G5–3TMS].

29. *See, e.g.*, Leah Wang, *Chronic Punishment: The Unmet Health Needs of People in State Prisons*, Prison Pol'y Initiative (June 2022), https://www.prisonpolicy.org/reports/chronicpunishment.html#mentalhealth [https://perma.cc/7V4Q-DM7J].
30. *See* Emily A. Wang et al., *A High Risk of Hospitalization Following Release from Correctional Facilities in Medicare Beneficiaries*, 173 JAMA Internal Med. 1621 (2013) ("Correctional health care systems are constitutionally responsible for health care while patients are incarcerated but not on release.") (citing Estelle v. Gamble, 249 U.S. 97 (1976)).
31. *See* MACPAC, *supra* note 4, at 70.
32. Binswanger et al., *supra* note 5.
33. *Id.*
34. This is, of course, in addition to the other numerous challenges and stressors people face upon reentry. *See, e.g.*, Carrie Pettus-Davis & Stephanie Kennedy, Inst. for Just. Rsch. & Dev., The Psychological Toll of Reentry: Early Findings from a Multi-State Trial 16–22 (Feb. 2019) (detailing the psychological stress upon reentry, including the challenge felony job restrictions, difficulties obtaining government identification, limited transportation options, and anxieties associated with post-release supervision).
35. Joseph W. Frank, Jeffrey A. Linder, William C. Becker, David A. Fiellin & Emily A. Wang, *Increased Hospital and Emergency Department Utilization by Individuals with Recent Criminal Justice Involvement: Results of a National Survey*, 29 J. Gen. Internal Med. 1226, 1226 (2014).
36. *Id.*

of rearrest and reincarceration—particularly among individuals with substance use disorders and mental illness.[37]

Despite these grim statistics, research also suggests that improved continuity of health care can decrease the risk of rearrest and reincarceration. According to one study, adequate mental health care upon reentry can decrease the likelihood of recidivism by forty-four percent.[38] Other studies indicate access to health care insurance—particularly Medicaid—decreases arrests by up to forty-one percent.[39] In short, although access to health insurance and Medicaid is by no means a silver bullet solution to the myriad of challenges people face upon reentry, it is at least one social support that has potential to alleviate some financial and health-related risks.

II. Background on Medicaid Coverage for Incarcerated People

A. *Origins and Scope of Medicaid*

Medicaid is a cooperative federal-state program that was created in 1965 to provide medical insurance for low-income people.[40] Although Medicaid is primarily federally funded,[41] each state administers its own program and establishes its own eligibility criteria and scope of services.[42] Initially, Medicaid was narrowly limited to the so-called "deserving poor."[43] The "deserving poor" concept traces back to England's Elizabethan Poor Laws, which limited assistance to "those made dependent through no fault of their own."[44] Correspondingly, when Medicaid was first enacted, it was limited to children, pregnant women, single caretakers

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37. *See* Kristen M. Zgoba, Rusty Reeves, Anthony Tamburello & Lisa Debilio, *Criminal Recidivism in Inmates with Mental Illness and Substance Use Disorders*, 48 J. Am. Acad. Psychiatry & L. 1, 1 (2020); Arthur J. Lurigio et al., *The Effects of Serious Mental Illness on Offender Reentry*, 68 Fed. Probation 1, 5 (2004).
38. Danielle Wallace & Xia Wang, *Does In-Prison and Mental Health Impact Recidivism?*, 11 SSM Pop. Health 1, 7 (2020).
39. Jessica T. Simes & Jaquelyn L. Jahn, *The Consequences of Medicaid Expansion Under the Affordable Care Act for Police Arrests*, 17 Plos One 1, 8 (2022); *see also* Erkmen G. Aslim, Murat C. Mungan, Carlos I. Navarro & Han Yu, *The Effect of Public Health Insurance on Criminal Recidivism*, 41 J. of Pol'y Analysis & Mgmt. 45, 48 (2022).
40. Ctr on Budget & Pol'y Priorities, Policy Basics: Introduction to Medicaid (April 14, 2020), https://www.cbpp.org/research/health/introduction-to-medicaid [https://perma.cc/KT47–4MHM].
41. "In operation, Medicaid benefits are technically provided to beneficiaries by states, but the federal government then pays states 50–83 percent of those costs (and 90 percent for the "expansion population" added by the ACA) . . . . States are responsible only for their costs remaining after this contribution." Matthew B. Lawrence, *Fiscal Waivers and State "Innovation" in Health Care*, 62 Wm. & Mary L. Rev. 1477, 1492–93 (2021).
42. Ctr on Budget & Pol'y Priorities, *supra* note 40.
43. David Orentlicher, *Medicaid at 50: No Longer Limited to the "Deserving" Poor?* 15 Yale Health Pol'y, L., & Ethics 185, 185–86 (2015).
44. *Id.*

of children, and people with disabilities.[45] These were groups that, in the 1960s, policymakers believed "could not fairly be held accountable for their inability to afford health care insurance, for they were not expected to be gainfully employed in the workplace."[46]

The notion that Medicaid was only available to those who "deserved" free or low-cost health care persisted in law for decades until the Affordable Care Act (ACA) was passed in 2010.[47] Relevant here, the ACA created the option for states to expand Medicaid eligibility to cover adults whose household income is below 138 percent of the poverty level, regardless of an individual's identity or health status—marking a dramatic expansion beyond Medicaid's original so-called "deserving poor" categories of eligibility.[48] As of January 2024, forty-one states, including Washington D.C., have adopted this Medicaid expansion.[49] The ten states that have not—which are mostly located in the South—instead continue to restrict Medicaid eligibility to an identity status, such as being a parent, and narrowly limit coverage to people with incomes below thirty-one percent of the federal poverty level.[50]

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45. *Id.* at 185.
46. *Id.*
47. *See generally* U.S. Dep't of Health and Human Services, About the Affordable Care Act, https://www.hhs.gov/healthcare/about-the-aca/index.html [https://perma.cc/EGZ5–6QWK] (last visited Feb. 19, 2024).
48. Orentlicher, *supra* note 43, at 186. The ACA also expanded other affordable health insurance options by providing tax credits for people with incomes between 100 percent and 400 percent of the federal poverty level. While this provides expanded options for many, in states that have not expanded Medicaid, a "gap" exists. In these states, people with incomes below 100 percent of the federal poverty level are neither eligible for the ACA tax credits, nor are they likely to be eligible for Medicaid. *See* HealthCare.Gov, Medicaid Expansion & What It Means for You, https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you [https://perma.cc/R2UQ-62QR] (last visited April 18, 2023).
49. KFF, Status of State Medicaid Expansion Decisions: Interactive Map (Mar. 20, 2024), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map [https://perma.cc/KT5G-VQPN].
50. *Id.* (showing that Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming have not expanded Medicaid); KFF, Medicaid Income Eligibility Limits for Adults as Percent of the Federal Poverty Level (Jan. 1, 2023), https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level [https://perma.cc/UMG8–296S]. Some states limit the income eligibility to sixteen percent of the federal poverty level. *Id.* The consequences for racial justice and the criminal legal system among the ten states that have not expanded Medicaid are numerous. *See e.g.*, Simes & Jahn, *supra* note 39; Jason Semprini, Abdinasir K. Ali & Gabriel A. Benavidez, *Medicaid Expansion Lowered Uninsurance Rates Among Nonelderly Adults in the Most Heavily Redlined Areas*, 42 Health Aff. 1439 (2023). However, the argument for expanding Medicaid and the potential political hurdles is beyond the scope of this Article.

B. *The Medicaid Inmate Exclusion Policy (MIEP)*

Despite the national shift toward providing Medicaid based on objective financial need, one bastion of the "deserving poor" limitation remains: the MIEP. The MIEP was enacted alongside Medicaid[51] to "prevent state and local governments from receiving matching federal funds to cover the healthcare costs of people in state prisons and local jails."[52] Consequently, state governments are responsible for covering the health care costs for all incarcerated people in state facilities, regardless of their Medicaid eligibility or enrollment status.[53] Importantly, the MIEP does not distinguish between people detained in jails and those in prisons.[54] Thus, the MIEP applies to people held in pretrial detention—i.e., people who are legally innocent and often unable to afford bail.[55] Prior to 2016, the MIEP also applied to individuals residing in halfway houses and individuals on parole in specialized nursing homes.[56]

Today, given the significant shifts in health care policy and mass incarceration, the MIEP stands out as an anomalous remnant of Medicaid's original "deserving poor" limitation. As noted, when Medicaid was enacted in 1965, it only provided coverage for certain demographics, such as children, pregnant people, and people with disabilities.[57] As a result, the MIEP's impact on the U.S. prison population—then totaling 210,895 people—was limited, as most incarcerated people did not fall into those "deserving poor" categories.[58] Fast forward to today, with Medicaid expansion and the surge in mass incarceration, the scale of people

51. Emily Widra, *Why States Should Change Medicaid Rules to Cover People Leaving Prison*, PRISON POL'Y INITIATIVE (Nov. 28, 2022), https://www.prisonpolicy.org/blog/2022/11/28/medicaid [https://perma.cc/X9WV-M3NG].
52. *Id.*
53. *Id.; See generally*, PEW CHARITABLE TRUSTS, PRISON HEALTH CARE: COSTS AND QUALITY 1 (Oct. 18, 2017). Many correctional facilities also require incarcerated individuals to contribute to the costs of their health care by requiring medical co-pays for physician visits, medications, and other health services. Wendy Sawyer, *The Steep Cost of Medical Co-Pays in Prison Puts Health at Risk*, PRISON POL'Y INITIATIVE (April 19, 2017), https://www.prisonpolicy.org/blog/2017/04/19/copays [https://perma.cc/U98G-QGME]. These co-pays typically range from $2 to $5, which can be prohibitive for incarcerated people who earn 14 to 62 cents per hour for non-industry jobs. *See id.*; *see also* Wendy Sawyer, *How Much do Incarcerated People Earn in Each State?*, PRISON POL'Y INITIATIVE (April 10, 2017), https://www.prisonpolicy.org/blog/2017/04/19/copays [https://perma.cc/2YLV-3D44].
54. Widra, *supra* note 51.
55. *See generally* Bernadette Rabuy & Daniel Kopf, *Detaining the Poor: How Money Bail Perpetuates an Endless Cycle of Poverty and Jail Time*, PRISON POL'Y INITIATIVE (May 10, 2016), https://www.prisonpolicy.org/reports/incomejails.html [https://perma.cc/LUK4-GZ4S].
56. Edmonds, *supra* note 7, at 308. Nonetheless, due to prohibitive costs, the development of Medicaid-funded specialized nursing homes has been limited. *See id.*
57. *Id.* at 280.
58. *Id.*; Littman, *supra* note 8, at 1407.

impacted by the MIEP looks entirely different.[59] As of December 2022, the U.S. prison population comprised over 1.2 million people.[60] And, due to ACA's income-based expansion of Medicaid, 18.8 million adults were covered by Medicaid who were previously ineligible.[61] Available data suggests a substantial overlap between current Medicaid-eligible and incarcerated populations. For example, from 2019 to 2020, ninety-two percent of adults released from state prisons and jails in Kentucky were enrolled in Medicaid at some point within five years prior to their release;[62] similarly, in Massachusetts, an estimated eighty-five percent of adults in prison were enrolled in Medicaid in 2020 prior to their release.[63] In short, the sheer number of people that the MIEP excludes from Medicaid benefits has increased drastically.[64]

C. *The MIEP's Impact on People During Incarceration*

Because the MIEP has existed since the enactment of Medicaid, its precise impact on health care financing and, relatedly, the quality of health care provided in prisons and jails is difficult to quantify.[65] How-

59. Edmonds, *supra* note 7, at 281.
60. E. Ann Carson, U.S. Dep't of just., Bureau of Just. Stat., Prisons Report Series: Preliminary Data Release (Sept. 2023), https://bjs.ojp.gov/library/publications/prisons-report-series-preliminary-data-release [https://perma.cc/Q2BS-S6FJ].
61. ASPE Office of Health Pol'y, Health Coverage Under the Affordable Care Act: Current Enrollment Trends and State Estimates (March 23, 2023), https://aspe.hhs.gov/sites/default/files/documents/8e81cf90c721dbbf58694c98e85804d3/health-coverage-under-aca.pdf [https://perma.cc/966L-F3ZH].
62. MACPAC, *supra* note 4, at 71. Data on pre-incarceration income levels among those who are incarcerated further indicate widespread Medicaid eligibility among incarcerated populations as well. For example, in 2014, the income threshold for Medicaid eligibility in ACA-expansion states was about $15,856. Kaiser Comm'n on Medicaid and the Uninsured, Medicaid Eligibility for Adults as of January 1, 2014, at 1 (Oct. 2013), https://www.kff.org/wp-content/uploads/sites/2/2013/12/8497-medicaid-eligibility-for-adults-as-of-january-1–2014.pdf [https://perma.cc/7ZNW-DV3P]. Two-thirds of people detained in jails report incomes below $12,000 prior to incarceration. Center for Community Change, The Relationship Between Poverty & Mass Incarceration 1, https://www.masslegalservices.org/system/files/library/The_Relationship_between_Poverty_and_Mass_Incarceration.pdf [https://perma.cc/XU25-AVCM] (last visited April 18, 2023). The numbers only slightly increase among those in prison: in 2014, men in prison had a median annual income of $19,650 prior to incarceration, and women had a median annual income of $13,890 prior to incarceration. Rabuy & Kopf, *supra* note 28.
63. Kinda Serafi & Mandy Ferguson, MassHealth's Role in Improving Health Outcomes and Recidivism Rates in Justice-Involved People 3 (June 2021), https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2021–06/MH_Impact_JIP_brief_FINAL.pdf [https://perma.cc/D9G5-FDXS].
64. Edmonds, *supra* note 7, at 281.
65. The academic literature is sparse on this topic, in part likely due to the highly technical and diverse ways each state finances and administers health care services in jails and prisons. For examples of four different state health care provision models, see Roger Antonio Tejada, *All Hope Is Not Lost: How the*

ever, three points are worth highlighting. First, some scholars argue that eliminating the MIEP would expand the scope of mental health and substance use disorder treatment offered in jails and prisons in alignment with ACA's Medicaid expansion, which increased coverage for behavioral health treatment in the general population.[66] Second, repealing the MIEP could have a "rapid and dramatic impact on the quality of health care received by incarcerated people across the country" based on the potential ability to shift state expenditures to the federal government and invest savings in improved correctional health care.[67]

Last, some commentary suggests that if the MIEP did not exist, aspects of correctional care could be incorporated into Medicaid-related community care structures, such as accountable care organizations (ACOs), to improve standards of care.[68] ACOs comprise networks of providers and hospitals that are incentivized to "improve care and reduce costs" for Medicaid (and Medicare) recipients through collective responsibility and monitoring.[69] This would be a notable shift from the status quo; unlike accredited hospitals, which are required to maintain a certain standard of care to receive federal Medicaid payments, correctional facilities presently have no "analogous incentive" to seek similar accreditations or accountability.[70]

"Alabama-Utah Model" Can Revolutionize Prison Healthcare Service Provision, 7 UCLA CRIM. JUST. L. REV. 27, 31–39 (2023).

66. Edmonds, *supra* note 7, at 311.
67. *See* Littman, *supra* note 8 at 1385 (noting the risks that "such reforms could undermine decarceral fiscal pressure" and "reduce the incentive to release elderly people through medical parole"); Kevin Fiscella, Leo Beletsky & Sarah E. Wakeman, *The Inmate Exception and Reform of Correctional Health Care*, 107 AM. J. PUB. HEALTH 384, 384–85 (2017).
68. Edmonds, *supra* note 7, at 311 (citing Rich et al., *supra* note 20, at 464) (discussing ACOs).
69. Rich et al., *supra* note 20, at 464.
70. Although organizations such as the National Commission on Correctional Health Care offer accreditation to jails and prisons for health care services, only seventeen percent of facilities have received such accreditations. DAVID CLOUD, ON LIFE SUPPORT: PUBLIC HEALTH IN THE AGE OF MASS INCARCERATION 14 (2014), https://www.vera.org/downloads/publications/on-life-support-public-health-mass-incarceration-report.pdf [https://perma.cc/63HR-6X2Q]. The principal quality control imposed upon correctional facilities is the low bar set by the U.S. Supreme Court in *Estelle v. Gamble*, which mandates that staff cannot be "deliberately indifferent" to an incarcerated person's serious medical needs. Estelle v. Gamble, 429 U.S. 97 (1976); *see also* Edmonds, *supra* note 7, at 296 ("In practice, the deliberate indifference standard has proven to be a powerful gatekeeper to all but the most egregious violations, and subsequent development in prison conditions jurisprudence has done little to expand prisoners' rights."). The minimal protection offered by *Estelle* is further limited by the formidable barriers incarcerated people face when seeking legal relief. *See generally* Alsan et al., *supra* note 12.

D. *The MIEP's Impact on People Upon Reentry*

While the impact of the MIEP during incarceration is somewhat speculative, the impact of the MIEP upon reentry is more concrete. As a preliminary matter, it is important to note that the MIEP does not make an incarcerated person *ineligible* for Medicaid; instead, it only prohibits the use of federal dollars to cover health expenses for an otherwise Medicaid-eligible person while they are incarcerated.[71] In other words, nothing in federal law requires states to terminate a person's Medicaid enrollment upon incarceration.[72] Yet, in practice, as of 2014, two-thirds of states automatically terminated a person's Medicaid enrollment upon incarceration in jails or prisons.[73] This led to dangerous gaps in coverage, forcing formerly incarcerated people to overcome bureaucratic hurdles and delays to re-enroll in Medicaid upon release.[74] When speaking on the issue, former director of the Obama White House Office of National Drug Control Policy, Michael Botticelli, stated that the failure to ensure immediate Medicaid coverage upon release from incarceration "can mean the difference between . . . life and death."[75]

Accordingly, HHS issued guidance in 2016 that states should *suspend* rather than terminate Medicaid eligibility.[76] As of the latest report in 2019, forty-two states suspend rather than terminate eligibility when people are incarcerated in jails.[77] However, even then, the administrative process of reinstating enrollment after suspension can cause delays in

71. *See* 42 U.S.C. § 1396d.
72. *See* Widra, *supra* note 51.
73. David L. Rosen et al., *Medicaid Policies and Practices in US State Prison Systems*, 104 Am. J. Pub. Health 418 (2014).
74. Jay Hancock, *HHS Acts to Help More Ex-Inmates Get Medicaid*, KFF Health News (April 29, 2016), https://kffhealthnews.org/news/hhs-acts-to-help-more-ex-inmates-get-medicaid [https://perma.cc/ZXE4-L8T5].
75. *Id.*
76. *See* Letter from Vikki Wachino, Director, U.S. Dep't of Health and Human Services, Letter to State Health Officials (April 28, 2016), https://www.medicaid.gov/federal-policyguidance/downloads/sho16007.pdf [https://perma.cc/HW99-AF6U].
77. KFF, State Reporting Corrections-Related Medicaid Enrollment Policies in Place for Prisons or Jails, https://www.kff.org/medicaid/state-indicator/states-reporting-corrections-related-medicaid-enrollment-policies-in-place-for-prisons-or-jails [https://perma.cc/6E5H-5HAV] (last visited April 18, 2023); Nat'l Conf. of State Legislatures, Connecting Recently Released Prisoners to Health Care – How to Leverage Medicaid (last updated Jan. 16, 2023), https://www.ncsl.org/civil-and-criminal-justice/connecting-recently-released-prisoners-to-health-carehow-to-leverage-medicaid [https://perma.cc/W3CQ-VS5G]. Pursuant to the Consolidated Appropriations Act of 2024, beginning in 2026, all states will be "required to suspend, rather than terminate, Medicaid coverage when people are incarcerated." John Sawyer, Vikki Wachino, Silicia Lomax, & Margo Cronin-Furman, *New Bipartisan Legislation Uses Changes to Medicaid Policy to Help Support Healthy Transitions Between Corrections and Community*, The Commonwealth Fund (March 14, 2024), https://www.commonwealthfund.org/blog/2024/new-bipartisan-legislation-uses-changes-medicaid-policy-help-support-healthy-transitions [https://perma.cc/7WJM-JJAD].

coverage. Only twenty-three of those forty-two states that suspend coverage have implemented automated electronic data exchange systems to expedite the process.[78]

The effects of the MIEP are also evident upon reentry when, in addition to potentially reenrolling in Medicaid, individuals face the challenge of establishing care with community providers that accept Medicaid.[79] Even when someone succeeds in establishing a patient-provider relationship with a Medicaid provider, providers report that inadequate medical record-sharing structures between correctional facilities and external health care providers are an obstacle to care continuity.[80] Patients often struggle to recount the specifics of their medical history with the precision necessary for effective continued care.[81] Consequently, community-based providers are often forced to make treatment decisions without a full understanding of a patient's medical history, leading to poorer health outcomes.[82] This issue is particularly salient for Medicaid-eligible individuals with mental illnesses or disabilities that impact their ability to self-report their medical needs.[83]

In sum, the MIEP's impact on individuals during reentry is palpable.[84] As one formerly incarcerated person described, "I've been out a week now and I still haven't been able to see a doctor because I don't have my [Medicaid] card."[85] People should be able to "get the health care they need,"[86] he summarized—it does not have to be this way. Part III discusses federal and state attempts to change the status quo.

78. KFF, *supra* note 77.
79. *See* Nathaniel P. Morris & Yaara Zisman-Ilani, *Communication Over Incarceration: Improving Care Coordination Between Correctional and Community Mental Health Services*, 73 Psychiatric Services 1409 (2022).
80. *See id.*; Kil Huh et al., Prison Health Care: Costs and Quality 50 (Oct. 2017).
81. *See* Huh et al., *supra* note 80.
82. *See* MACPAC, *supra* note 4, at 67.
83. *See, e.g.*, Daniel Teixeira da Silva, *Putting Medicaid Behind Bars*, The Hill (Nov. 28, 2021), https://thehill.com/opinion/healthcare/582772-putting-medicaid-behind-bars [https://perma.cc/87PA-CLUL] ("In my clinical training, I saw the consequences of the inmate exclusion policy firsthand. It was a medical mystery of a 57-year-old man with altered mental status and imbalance. He knew his name but couldn't tell us where he was or the date. He got brain and spine imaging, and dozens of lab tests. After two weeks in the hospital, we were not any closer to a diagnosis—that is, until the hospital social worker found out he was released from jail one month prior. He was having a psychotic break after being off his psychiatric medications."); *see also* Huh et al., *supra* note 80.
84. *See* Jay Hancock, *HHS Acts to Help More Ex-Inmates Get Medicaid*, KFF Health News (April 29, 2016), https://kffhealthnews.org/news/hhs-acts-to-help-more-ex-inmates-get-medicaid [https://perma.cc/ZN2F-L528].
85. *Id.* As discussed above, the two-week period upon release involves some of the highest risks of death. *See* Binswanger et al., *supra* note 5 and accompanying text.
86. Hancock, *supra* note 84.

III. Efforts to Limit the Scope of the MIEP

A. *Federal Attempts to Repeal the MIEP*

Attempts to repeal the MIEP through legislation introduced in the U.S. House of Representatives and Senate have been unsuccessful thus far. In 2019, sixteen Democrats and two Republicans in the House of Representatives co-sponsored the Human Correctional Health Care Act, which would have repealed the MIEP.[87] The bill was referred to several committees but eventually died.[88] In 2021, Congresswoman Ann Kuster re-introduced the Human Correctional Health Care Act.[89] It again received bipartisan co-sponsorship but did not make it out of committee.[90] Senator Cory Booker introduced a companion bill in the U.S. Senate that was similarly unsuccessful.[91] The press statements about these efforts focused on how the MIEP decreases access to care, strains state budgets, contributes to recidivism, and harms the "justice-involved population at a time when they are most in need of affordable, comprehensive health coverage, especially when a significant percentage live with serious health issues such as mental illness or substance use disorder."[92]

B. *Federal Attempts to Amend the MIEP*

Attempts to narrow the scope of the MIEP through proposed legislative amendments have also failed.[93] Notably, however, the Med-

87. H.R. 4141, 116th Cong. (1st Sess. 2019); *see also* S. 2305, 116th Cong. (1st Sess. 2019). For a brief discussion acknowledging the criticisms of bipartisan criminal legal system reform but highlighting some benefits derived from corresponding shifts in discourse, see Edmonds, *supra* note 7, at 305–06.
88. Actions: Humane Correctional Health Care Act, H.R. 4141, 116th Cong. (2019) https://www.congress.gov/bill/116th-congress/house-bill/4141/all-actions [https://perma.cc/M24Q-9KTM].
89. Humane Correctional Health Care Act, H.R. 3514, 117th Cong. (2022).
90. Actions: Humane Correctional Health Care Act, H.R. 3514, 117th Cong. (2022) https://www.congress.gov/bill/117th-congress/house-bill/3514/all-actions.
91. Joseph Choi, *Bipartisan Group of Lawmakers Reintroduces Bill to Give Inmate Medicaid Access*, The Hill (May 25, 2021), https://www.thehill.com/homenews/house/555375-bipartisan-group-of-lawmakers-reintroduces-bill-to-give-inmates-access-to [https://perma.cc/VYQ7-JPNG]; *see* S. 1821, 117th Cong. (1st Sess. 2021).
92. *Booker, Kuster, Fitzpatrick Introduce Bipartisan Legislation to End Outdated Policy that Prevents Incarcerated Individuals from Accessing Medicaid*, Cory Booker (May 25, 2021), https://www.booker.senate.gov/news/press/booker-kuster-fitzpatrick-introduce-bipartisan-legislation-to-end-outdated-policy-that-prevents-incarcerated-individuals-from-accessing-medicaid [https://perma.cc/J29A-7EVD].
93. *See* Lydia Kener, *Medicaid Section 1115 Demonstration Waivers for Reentry After Incarceration*, O'Neill Inst. for Nat'l & Global Health L. (Feb. 20, 2024), https://oneill.law.georgetown.edu/medicaid-section-1115-demonstration-waivers-for-reentry-after-incarceration [https://perma.cc/8B8A-DWVX]; *see, e.g.*, Colorado Counties, Inc., CALL TO ACTION: Assist Efforts to Repeal the Medicaid Inmate Exclusion Policy, https://www.ccionline.org/announcements/call-to-action-assist-efforts-to-repeal-the-medicaid-inmate-exclusion-policy [https://

icaid Reentry Act gained some traction. In 2021, fifty Democrats and seven Republicans in the House of Representatives co-sponsored H.R. 955, the Medicaid Reentry Act (MRA) of 2021.[94] The MRA would have permitted "Medicaid payment for medical services furnished to an incarcerated individual during the thirty-day period preceding the individual's release." The MRA garnered not only bipartisan Congressional support, but also endorsement from a coalition of 135 local and national organizations and leaders, ranging from the National Alliance on Mental Illness, Interfaith Action for Human Rights, the National Association of Criminal Defense Lawyers, the Prison Policy Initiative, Legal Action Center, the American Public Health Association, to the National Sheriffs' Association and American Jail Association.[95]

The coalition emphasized that "[a]llowing incarcerated individuals to receive services covered by Medicaid [thirty] days prior to their release from jail or prison will expand access to vital mental health and addiction services, thereby decreasing recidivism and improving health outcomes for individuals reentering the community."[96] The then-president of the American Psychiatric Association, Dr. Jeffrey Geller, urged Congress to pass the MRA because "[p]eople with substance use and other psychiatric disorders need continuity of treatment" and ensuring continuity of care "will save lives."[97] The coalition's support also partially derived from the bill's potential long-term economic impact.[98] The then-president of the National Sheriffs' Association, Sheriff Dave Mahoney, noted that "[i]n the long run this will reduce recidivism and

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perma.cc/LCT8–82EC] (last visited April 22, 2023) (describing the Medicaid Reentry Act, the Due Process Continuity of Care Act, and the Equity in Pretrial Health Coverage Act).

94. Medicaid Reentry Act of 2021, H.R. 955, 117th Cong. (2021), https://www.congress.gov/bill/117th-congress/house-bill/955 [https://perma.cc/K8P6-WVZM]. An equivalent bill was also introduced in the Senate. *See, e.g.*, COLORADO COUNTIES, INC., *supra* note 93.

95. *See* Medicaid Reentry Act Support Letter (June 30, 2021), https://www.apha.org/-/media/Files/PDF/advocacy/letters/2021/210630_Medicaid_Reentry_Act.ashx [https://perma.cc/W87E-HDLV]; *see also* Michelle Cottle, *This Bill Could Save the Lives of Formerly Incarcerated People*, N.Y. TIMES (Dec. 20, 2021), https://www.nytimes.com/2021/12/20/opinion/medicaid-reentry-act.html [https://perma.cc/FV49–9GZC]; *National Association of Counties Joins Over 135 Local and National Health, Mental Health and Justice Organizations in Calling on Senate Finance Committee to Consider Bipartisan Medicaid Reentry Act*, NAT'L ASS'N OF CNTYS. (July 1, 2021), https://www.naco.org/resources/press/naco-joins-over-135-local-and-national-health-mental-health-orgs [https://perma.cc/VDC9-YF8H].

96. *See* Medicaid Reentry Act Support Letter, *supra* note 95.

97. *Baldwin, Braun, Whitehouse and Brown Lead Senate Introduction of Bipartisan Medicaid Reentry Act*, TAMMY BALDWIN (Feb. 10, 2021), https://www.baldwin.senate.gov/news/press-releases/medicaid-reentry-act [https://perma.cc/8SFA-PQAL].

98. *See* Medicaid Reentry Act Support Letter, *supra* note 95. ("Furthermore, by investing in prevention, the Medicaid Reentry Act will provide savings on healthcare and criminal justice costs for jurisdictions across the country").

therefore ease budgetary burdens from the jail system. Our taxpayers deserve that."[99] Despite this diverse body of support, some commentators expressed concern about implementation concerns—such as the need to update correctional medical record systems, the bureaucratic burden of billing and reimbursement, and the challenges of implementation in jails, where "the timing of discharge is typically not known 30 days in advance."[100] The MRA was referred to several committees but eventually died.[101]

C. *State Regulatory Efforts to Limit the MIEP*

While attempts to repeal or limit the MIEP through federal legislation have failed, recent state-based agency efforts, on the other hand, have had promising success. Pursuant to Section 1115 of the Social Security Act, state agencies may submit proposals to the United States Department of Health and Human Services (HHS), through the Centers for Medicare and Medicaid Services (CMS), to "waive compliance" with certain Medicaid provisions as part of "experimental, pilot, or demonstration project[s]" that HHS deems are "likely to assist in promoting the objectives" of the Medicaid statute.[102] In January 2023, at California's request, HHS approved a "first-of-its-kind" Section 1115 demonstration project that waives aspects of the MIEP and thereby grants California the authority to use federal Medicaid funding to cover certain health care services to incarcerated individuals ninety days before their release.[103] In June 2023 and February 2024, HHS granted similar authority to Washington State and Montana, respectively.[104]

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99. Cottle, *supra* note 95.
100. Teixeira da Silva, *supra* note 83.
101. Medicaid Reentry Act of 2021, H.R. 955, 117th Cong. (2021), https://www.congress.gov/bill/117th-congress/house-bill/955 [https://perma.cc/K8P6-WVZM].
102. *See* Social Security Act § 1115, 42 U.S.C. § 1315, 113th Cong. (2nd Sess. 2014); Lawrence, *supra* note 41, at 1493.
103. CMS, *HHS Approves California's Medicaid and Children's Health Insurance Plan (CHIP) Demonstration Authority to Support Care for Justice-Involved People*, CMS.Gov (Jan. 26, 2023), https://www.cms.gov/newsroom/press-releases/hhs-approves-californias-medicaid-and-childrens-health-insurance-plan-chip-demonstration-authority [https://perma.cc/HX9E-4PHA]; *see also* Paul N. Samuels et al., *Novel 1115 Medicaid Waiver, First Conceived of by LAC Granted to California*, LAC (Jan. 27, 2023), https://www.lac.org/news/novel-1115-medicaid-waiver-first-conceived-of-by-lac-granted-to-california [https://perma.cc/AE26-ZYLU] (quoting a senior Medicaid official as describing the California Section 1115 demonstration project as "game-changing").
104. Patricia Boozang & Emily Polk, *CMS Approves WA's 1115 Waiver with Health-Related Social Needs & Justice-Involved Initiatives*, JD Supra (July 11, 2023), https://www.jdsupra.com/legalnews/cms-approves-wa-s-1115-waiver-with-3456532 [https://perma.cc/P4RE-BHSH]; Benjamin Ahmad, Virginia Morgan, & Kinda Serafi, *CMS Approves Montana's Reentry Services, Contingency Management, and Tenancy Supports 1115 Waiver*, JD Supra (March 7, 2024), https://www.jdsupra.com/legalnews/cms-approves-montana-s-reentry-services-8730775 [https://perma.cc/FBP9-EEQE].

The following sections provide background on Section 1115 demonstration projects and the approved and pending state-based Medicaid reentry Section 1115 demonstration projects.

1. Background on Section 1115 Demonstration Projects and the SUPPORT Act

Before discussing the mechanics of Section 1115 demonstration projects, some background on federal legislation and HHS directives is instructive. In 2018, the Trump Administration passed the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. Pertinently, Section 5032 required CMS to (1) "convene a stakeholder workgroup in order to develop best practices" for state efforts to improve health care transitions for formerly incarcerated people upon reentry "such as by ensuring continuity of health insurance or Medicaid coverage," and (2) "issue a letter to states outlining opportunities for Medicaid demonstration waivers based on identified best practices."[105] On April 17, 2023, CMS issued the required letter concerning Medicaid demonstration projects (CMS letter).[106]

The CMS letter encourages states to apply for Section 1115 waivers to "provide coverage for certain Medicaid services to incarcerated individuals who are soon to be released from incarceration."[107] The letter is clear that these projects are not intended to alter the status quo by shifting the financial burden of carceral health care costs from the state level to the federal level.[108] Instead, the letter instructs that all state savings from federal Medicaid dollars must be reinvested "into activities and/or initiatives that increase access to or improve the quality of health care services for individuals who are incarcerated."[109] Pursuant to the CMS letter, states may request federal funds for up to ninety percent of the cost of implementing systems for identifying and enrolling eligible incarcerated people in Medicaid.[110] HHS may also approve funding for wraparound services, such as IT support, outreach, and education.[111] Relevant here, the letter indicates that HHS hopes to approve projects that provide Medicaid coverage to people thirty days prior to their expected

105. SUPPORT for Patients and Communities Act, H.R. 6, 115th Cong. (2018).

106. CMS, *HHS Releases New Guidance to Encourage States to Apply for New Medicaid Reentry Section 1115 Demonstration Opportunity to Increase Health Care for People Leaving Carceral Facilities*, CMS.Gov. (April 17, 2023), https://www.cms.gov/newsroom/press-releases/hhs-releases-new-guidance-encourage-states-apply-new-medicaid-reentry-section-1115-demonstration [https://perma.cc/M4EQ-YWHE].

107. U.S. Dep't of Health & Human Services, Letter to State Medicaid Directors, at 10 (April 17, 2023), https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf [https://perma.cc/XGH9–27PB].

108. *Id.* at 10–11.

109. *Id.* at 11.

110. *Id.* at 14.

111. *Id.* at 30–31.

release date by partially waiving the MIEP.[112] Finally, the letter encourages states to incorporate other objectives into their proposed projects related to improving continuity of care, such as increasing the provision of pre-release medications for opioid use disorder (MOUD) and implementing presumptive Medicaid eligibility for those who might be unexpectedly released.[113]

2. Approved and Pending Section 1115 MIEP-Related Demonstration Projects

As of February 2023, fifteen states had applied for Section 1115 demonstration projects related to waiving the MIEP for some period prior to an incarcerated person's release.[114] All projects, if approved, would require robust data monitoring and evaluation as part of the Section 1115 requirement to determine whether the experimental "demonstration" project worked as intended. The scope of the proposals varied. At the time, Vermont and three other states had requested to waive the MIEP for *all* incarcerated people within a certain timeframe before their release.[115] California and ten other states, however, limited their proposals to waiving the MIEP only as to coverage of specified pre-release services, such as services for incarcerated people with mental illness, substance use disorder, HIV/AIDS, traumatic brain injuries, intellectual or developmental disabilities, or other chronic conditions, within a certain timeframe prior to their release.[116] Since the approval of California's waiver and issuance of the CMS letter, some states, such as Vermont, have withdrawn their waiver proposals to amend them in alignment with the guidance provided in the CMS letter.[117]

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112. *See id.* at 11, 42. The letter also indicates that HHS will consider approving projects that allow for Medicaid coverage up to ninety days prior to an individual's expected release date. *Id.* at 42.
113. *Id.* at 15, 22–24.
114. *See* Sweta Haldar & Madeline Guth, *Section 1115 Waiver Watch: How California Will Expand Medicaid Pre-Release Services for Incarcerated Populations*, KFF (Feb. 7, 2023), https://www.kff.org/policy-watch/section-1115-waiver-watch-how-california-will-expand-medicaid-pre-release-services-for-incarcerated-populations [https://perma.cc/J9YN-RJW3].
115. *Id.*
116. *Id.*; *see also* U.S. Dep't of Health & Human Services, Letter Approving Section 1115 Demonstration Project to Ms. Jacey Cooper, California State Medicaid Director, at 6–7 (Jan. 26, 2023), https://www.medicaid.gov/sites/default/files/2023–01/ca-calaim-ca1.pdf [hereinafter Letter to Cooper] [https://perma.cc/4PPS-EFVX].
117. *See, e.g.*, Ethan Weinstein, *Vermont Officials Seek Medicaid Benefits for Incarcerated People, but Federal Approval Could be a Long Time Coming*, VTDigger (Oct. 13, 2023), https://vtdigger.org/2023/10/13/vermont-officials-seek-medicaid-benefits-for-incarcerated-people-but-federal-approval-could-be-a-long-time-coming [https://perma.cc/UV3K-A3QK] (according to Ashley Berliner, who leads Vermont's Medicaid policy development, after the approval of California's waiver, Vermont determined "we would have to come back to the drawing board and really do some planning and design work before we went to have conversations with CMS," and hopes to receive waiver approval

As of April 2024, California, Washington, and Montana are the only three states that have received authorization from CMS to waive aspects of the MIEP through Section 1115 demonstration projects.[118] The scope of the California and Washington projects is similar—both states are now authorized to use Medicaid funding to cover a specified set of health services for incarcerated individuals who meet some of the aforementioned health criteria ninety days prior to their release.[119] The Washington project, for instance, permits the use of Medicaid funds to cover pre-release interventions, such as MOUD, behavioral health treatment, and "long-acting injectable anti-psychotics and medications for addiction treatment" for substance use disorders in an effort to reduce "decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release" and post-release acute care utilization.[120] The Montana project, on the other hand, more narrowly authorizes the use of Medicaid funds for certain pre-release services for people in state prisons with a "confirmed mental health diagnosis or a confirmed or suspected [substance use disorder] diagnosis" for thirty days prior to their release.[121]

As part of the approval package for each project, CMS set forth various technical "conditions of approval" that California, Washington, and Montana must satisfy to receive Medicaid funds at any given facility. For example, CMS has required Washington to make "pre-release outreach, along with eligibility and enrollment support, available to all individuals incarcerated in the facilities in which the demonstration is functioning."[122] CMS further mandated that approved Washington facilities provide MOUD "as clinically appropriate, with accompanying counseling," and "a 30-day supply of all prescription medications that

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in 2025); *see* U.S. Dep't of Health & Human Services, Letter Approving Section 1115 Demonstration Project to Charissa Fotinos, Washington State Medicaid Director, at 72 (June 30, 2023) https://www.medicaid.gov/sites/default/files/2023–06/wa-medicaid-transformation-ca-06302023.pdf [hereinafter Letter to Fotinos] [https://perma.cc/Y5BC-TYFP] (listing the extensive requirements Washington correctional facilities must satisfy prior to receiving Medicaid funds); *see also* David Raths, *More States Eye Expanding Medicaid Services to Justice-Involved Individuals*, Healthcare Innovation (Nov. 28, 2023), https://www.hcinnovationgroup.com/policy-value-based-care/medicare-medicaid/article/53079294/more-states-eye-expanding-medicaid-services-to-justice-involved-individuals [https://perma.cc/98YV-FGQ6] (discussing states that are developing waiver proposals).

118. *See* Letter to Cooper, *supra* note 116, at 1; Letter to Fotinos, *supra* note 117, at 1; U.S. Dep't of Health & Human Services, Letter Approving Section 1115 Demonstration Project to Mr. Michael Randol, Montana State Medicaid Director, at 1 (Feb. 26, 2024), https://dphhs.mt.gov/assets/heartinitiative/MTHEARTAmendmentApproval02262024.pdf [hereinafter Letter to Randol] [https://perma.cc/YZ99-QW4L].

119. *See* Letter to Cooper, *supra* note 116, at 6–8; Letter to Fotinos, *supra* note 117, at 6–7.

120. Letter to Fotinos, *supra* note 117, at 8.

121. Letter to Randol, *supra* note 118, at 2–3.

122. *Id.* at 9, 72–73.

have been prescribed for the beneficiary" immediately upon release.[123] Finally, among other things, Washington, California, and Montana each must develop and submit a "Reinvestment Plan" to CMS detailing how the federal funds received will be reinvested to "increase access to or improve the quality of health care services" and address health-related social needs of incarcerated and formerly incarcerated people.[124] Such reinvestments must go toward improving the quality of health care services and resources available to all incarcerated individuals, "and not supplant existing state or local spending on such services and resources."[125]

Ultimately, although the application process and "conditions of approval" associated with Section 1115 demonstration projects are intensive, states have regarded California, Washington, and Montana's progress with optimism.[126] For instance, in January 2024, Connecticut's Commissioner of the Department of Social Services Andrea Barton Reeves pitched a Section 1115 project in Connecticut similar to the California and Washington projects.[127] Although the proposed Connecticut project would take several years to implement, Commissioner Barton Reeves endorsed it as a "proactive" and cost-effective solution that would allow the state to innovate and improve the continuity of medical care and health-related services, such as housing assistance, for formerly incarcerated individuals.[128] Indeed, as Part IV will discuss in more detail, Section 1115 projects present a viable opportunity for states to limit the scope of the MIEP.

IV. Analysis and Recommendations

A. *A Feasible Path Forward: Section 1115 Demonstration Projects*

From a feasibility standpoint, as evidenced by the recent approvals of California, Washington, and Montana's Section 1115 demonstration projects, Section 1115 projects are an immediate, viable pathway to narrow the scope of the MIEP compared to federal legislation. Efforts to repeal or amend the MIEP at the federal level appear unlikely absent

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123. *Id.* at 9.

124. *See, e.g.*, *id.* at 11; Letter to Cooper, *supra* note 116, at 8–9; Letter to Randol, *supra* note 118, at 3–4.

125. *See, e.g.*, Letter to Fotinos, *supra* note 117, at 11; Letter to Cooper, *supra* note 116, at 9; Letter to Randol, *supra* note 118, at 4.

126. *See, e.g.*, Morgan Gonzales, *'Groundswell' of States Pursue Medicaid for Incarcerated People Pre-Release After California's Success*, Behav. Health Bus. (Feb. 9, 2024), https://bhbusiness.com/2024/02/09/groundswell-of-states-pursue-medicaid-for-incarcerated-people-pre-release-after-californias-success [https://perma.cc/MDX3-KD64].

127. Alex Putterman, *Incarcerated People in CT Could Get Health Insurance Under New Proposal*, CT Insider (Jan. 18, 2024), https://www.ctinsider.com/politics/article/incarcerated-people-prisons-healt-care-medicaid-ct-18611004.php [https://perma.cc/4CGA-BDZ9].

128. *Id.*

clearer empirical data and understanding of potential cost savings.[129] This is not uncommon for public health-related legislative proposals; indeed, even when data and long-term cost savings are clear, statutes and congressional rules make it difficult to pass legislation that the House and Senate budget committees' so-called "scorekeepers" predict will increase expenditures more than revenues.[130] As stated by Professor Matthew Lawrence, it is "difficult to overstate" the role "scorekeeping" plays in the federal legislative process.[131] Specifically, Professor Lawrence highlights that scorekeeping often "distort[s]" the budgetary effects of health care laws, discourages long-term investment in health care reform, and contributes to widespread "underinvestment" in public health measures.[132]

In contrast, Section 1115 demonstration projects present a unique opportunity to sidestep budget-based legislative gridlock while gathering data that may eventually tip the scorekeeping scales.[133] Although Section 1115 projects have some cost-related safeguards, such as an HHS-imposed requirement to maintain "budget neutrality," the negotiation of how those requirements are satisfied occurs between HHS and state agencies.[134] Put differently, Section 1115 projects delegate budgetary review to agencies with expertise and competence to "predict secondary effects on revenues and expenditures associated with changes in their programs," and more flexibly allow for cost offsetting by potential indirect benefits.[135] In fact, HHS's recent revision of its "budget neutrality" calculations facilitated, in part, its approval of the Washington, California, and Montana Section 1115 projects.[136]

Further, in addition to immediate pathways for change not otherwise available at the federal level, Section 1115 demonstration projects result in data collection and reporting that could potentially shift the discourse around correctional health care and inform budgetary considerations at the federal level. As noted, Section 1115 projects require

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129. *See supra* Part III.A–B; *see also* Max Blau, *In Reversal, Counties and States Help Inmates Keep Medicaid*, Stateline (Jan. 8, 2020), https://stateline.org/2020/01/08/in-reversal-counties-and-states-help-inmates-keep-medicaid [https://perma.cc/HV4C-TPM6] (discussing congress members' concerns about the cost of repealing the MIEP and a need for "more data" to understand "the issue's national scope").

130. Lawrence, *supra* note 41, at 1518; *see generally* Cong. Budget Off., CBO Explains Budgetary Scorekeeping Guidelines (Jan. 2021). The scorekeepers' general guidelines for measuring budgetary effects are known as "scorekeeping." *Id.*

131. Lawrence, *supra* note 41, at 1518.

132. *Id.* at 1518–20. This issue is further exacerbated by the fact that health programs are fiscally fragmented within the federal budget. *Id.* at 1520–22. Consequently, "state and federal investments that incur costs within one fiscal category but create benefits within another category" are effectively impeded. *Id.* at 1523.

133. *See id.* at 1523–24.

134. *Id.* at 1494–96.

135. *Id.* at 1524.

136. *See, e.g.*, Letter to Fotinos, *supra* note 117, at 11–15; Letter to Randol, *supra* note 118, at 5.

extensive data collection and reporting.[137] Such data will be forthcoming from the California, Washington, and Montana projects:[138] for instance, California is required to conduct a mid-point project assessment and report by early 2025,[139] and Washington will produce a similar report in fall 2026.[140] Accordingly, these demonstration projects will produce concrete data to better understand the precise impact of the MIEP and potentially pave the way for its eventual amendment or repeal.[141]

B. *Words of Caution*

As highlighted above, Section 1115 demonstration projects offer remarkable opportunities for innovation in correctional health care and change that might otherwise be precluded at the federal level. Nonetheless, it is worth mentioning three areas for caution or critique.

First, Section 1115 demonstration projects frequently raise concerns related to federalism and administrative law, in part due to how HHS uses its project-granting authority to steer or coerce states into adopting federal agency-preferred reforms.[142] In effect, guidance promulgated by HHS can result in "compliance" rather than "innovation."[143] Demonstration projects are already "cumbersome" to state officials,[144] so it makes good sense that state officials would be deferential to available HHS guidance, such as the CMS letter, in crafting Section 1115 project proposals. In fact, states would be prudent to follow this guidance to potentially "fast-track" proposals under a favorable administration.[145] However, by only focusing on the reforms that HHS has invited, state agencies miss reforms "never tried because of states' expectations that a fiscal waiver award would not be forthcoming"—such as projects seeking to waive the MIEP for all incarcerated people, regardless of specified health needs, or seeking to extend the waiver beyond the thirty-day pre-release window

137. *See supra* Part III.C.2.
138. California's approved project will not be fully rolled out until 2026. Ryan Levi & Dan Gorenstein, *Red and Blue States Look to Medicaid to Improve the Health of People Leaving Prison*, GPB (Feb. 23, 2023, 5:01 AM), https://www.gpb.org/news/shots-health-news/2023/02/23/red-and-blue-states-look-medicaid-improve-the-health-of-people [https://perma.cc/MRR4-J67V].
139. *See* Letter to Cooper, *supra* note 116, at 55–57.
140. Letter to Fotinos, *supra* note 117, at 139–41.
141. *See supra* Part III.A–B; Blau, *supra* note 129.
142. *See, e.g.*, Lawrence, *supra* note 41, at 1485, 1512; *see also* Nicole Johnson, *Section 1115 Waivers: Innovation Through Experimentation, or Stagnation Through Routine?*, 72 Emory L. J. 965, 969–70 (2023) (discussing abuse of Section 1115 demonstration projects). Section 1115 waivers drew significant scrutiny under the Trump Administration's steering and approval of so-called "work requirement" waivers, which cut Medicaid benefits. *Id.* at 980.
143. *See* Lawrence, *supra* note 41, at 1508.
144. *See* Stephen Eide & Carolyn D. Gorman, Manhattan Inst., Medicaid's IMD Exclusion: The Case for Repeal (2021).
145. *See* Lawrence, *supra* note 41, at 1510.

that the CMS letter recommended.[146] States should not shy away from innovative proposals to limit the scope of the MIEP.[147]

Second, the time-bound nature of Section 1115 demonstration projects may hamper the potential impact of long-term data collection opportunities associated with such projects. Section 1115 demonstration projects are statutorily prescribed to last three or five years, and they must be periodically reviewed to qualify for extensions from thereon.[148] However, the quantitative return of many public health investments, such as identifying state savings may require more than five years to fully accrue.[149] As a result, there is a risk that forthcoming economic data may not present the full picture of the impact of limiting the MIEP in order to move the political needle.[150]

Third and finally, any Section 1115-related reinvestment plans or future state savings related to any amendment or repeal of the MIEP should be carefully scrutinized to limit the risk of carceral entrenchment.[151] Professor Aaron Littman provides the following guidance: "The risk of carceral entrenchment is greatest when the remedial options pursued involve investment in physical structure that is difficult to repurpose, and less acute when human resources are at issue."[152] For example, "a prison with an expensive new heating, ventilation, and air conditioning system is harder to close than a prison with an expensive new psychiatric staff."[153] Accordingly, Section 1115 project reinvestment plans that designate funds for preventive medical and social services and personnel should be favored over plans that designate funds for developing physical infrastructure.

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146. *Id.* at 1511; *supra* Part III.

147. For example, as discussed in Part III, despite the CMS Letter's recommendation to waive the MIEP for thirty days prior to release, HHS has approved California and Washington's requests to waive the MIEP for ninety days prior to release.

148. *See* Johnson, *supra* note 142, at 968, 978.

149. Lawrence, *supra* note 41, at 1507.

150. *See id.; cf.* Marie Gottschalk, Caught: The Prison State and the Lockdown of American Politics 19 (2015) ("Framing the problem of mass imprisonment as largely a fiscal problem (i.e., we just cannot afford it anymore) will not sustain the political momentum needed over the long haul to slash the prison population and dismantle the carceral state").

151. *See* Littman, *supra* note 8, at 1471–72; *see also* Beth A. Colgan, *Beyond Graduation: Economic Sanctions and Structural Reform*, 69 Duke L.J. 1529, 1552 (2020) (cautioning against "monetary myopia" that distracts from important, competing concerns). For a nuanced discussion of how reform-based advocacy may comport with an abolitionist vision, see Littman, *supra* note 8, at 1466–69 ("The argument here is a modest one: so long as people remain incarcerated, advocacy for better—not acceptable but better—conditions will remain essential. In this effort, regulatory approaches may better serve abolitionists' long-term goals").

152. Littman, *supra* note 8, at 1472.

153. *Id.*

C. *Recommendations*

Given the recent executive-level support from HHS documented in the CMS letter, states should seize the opportunity to apply for Section 1115 demonstration projects to narrow the MIEP. Even if the presidential administration changes or priorities shift following the 2024 presidential election, approved multiyear projects will persist. When crafting Section 1115 demonstration applications, states should carefully heed the guidance provided by CMS in the CMS letter to increase their chances of approval and tailor their application to their state's specific population needs while simultaneously not shying away from opportunities to innovate beyond what is recommended in the letter. The more that states experiment and the more data that is collected, the more complete understanding policymakers will have when reconsidering possible federal legislation. In particular, given the high risk of overdose and suicide upon release from prisons and jails,[154] applications should focus on leveraging federal funds and opportunities to coordinate mental health and substance use disorder treatment leading up to and following release.

Additionally, per CMS guidance, states must develop detailed reinvestment plans for how state savings will be repurposed to "improve the quality of health care services" for incarcerated or recently incarcerated individuals "or for health-related social services that may help divert individuals from criminal justice involvement."[155] These reinvestment plans should prioritize, at minimum, medical personnel-based investments, expansion of mental health care offerings, and coordinated care and transition planning. When developing these plans, state officials should seek input from current and formerly incarcerated people.

Lastly, while awaiting project approvals and implementation and in compliance with the recently passed Consolidated Appropriations Act of 2024 (CAA), states should suspend, rather than terminate, Medicaid eligibility[156] and take steps to increase Medicaid enrollment while people are incarcerated. For example, some states, such as Illinois and New Mexico, have passed laws that explicitly permit people to enroll in Medicaid while incarcerated—whether previously enrolled or newly eligible—and prohibit the state from denying their application due to their incarceration status.[157] Other states, such as Arkansas, require that Medicaid reinstatement is automatic upon release.[158] Although some of these changes may require updated technology infrastructure to facilitate data exchange, states can leverage grants available under the CAA to address gaps in existing systems.[159]

154. *See supra* Introduction.
155. *See* Letter from the Department of Health & Human Services, *supra* note 107, at 11.
156. *See supra* Part II.B; Sawyer et al., *supra* note 77.
157. Gabrielle de la Guéronniere & Deborah A. Reid, Strengthening Access to Care 5 (2022).
158. *Id.* at 6.
159. *See* Sawyer et al., *supra* note 77.

Conclusion

Incarceration is a catalyst for worsening health. Prior to and upon release from jail and prison, people face numerous obstacles to obtaining life-saving care. By focusing on the MIEP, this Article has merely scratched the surface of policy considerations related to improving health care in carceral settings and continuity of care for the Medicaid-eligible reentry population. While the problems are daunting and vast, progress is possible. For instance, in 2014, over thirty states terminated Medicaid enrollment upon a person's incarceration—as of 2024, that number has dropped to eight—and by 2026, it will drop to zero.[160] Further, for the first time ever, people who are incarcerated in California, Washington, and Montana are now eligible to receive Medicaid benefits that they have been denied since Medicaid's enactment in 1965. The recommendations presented here, namely narrowing the MIEP through Section 1115 demonstration projects, are not end-all-be-all solutions. Medicaid itself is rife with limitations.[161] Nonetheless, such Section 1115 demonstration projects are a viable step toward change. As attempts to amend or repeal the MIEP through federal legislation remain unavailing, states should vigorously pursue Section 1115 demonstration projects to improve the quality and continuity of health care provided to incarcerated people and the reentry population.

160. *See supra* note 73 and accompanying text; Sawyer et al., *supra* note 77.

161. For instance, Medicaid's reimbursement rates are so low that some argue that they are a racial justice issue. *See* Tiffany N. Ford & Jamila Michener, *Medicaid Reimbursement Rates Are a Racial Justice Issue*, Commonwealth Fund (June 16, 2022), https://doi.org/10.26099/h5np-x425 [https://perma.cc/5RGM-Z3LJ].