

A Roadmap to Evaluating 1115 Reentry Waiver Outcomes:

*Ensuring a safe and healthy reentry from
incarceration to communities*



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Executive Summary

In a recent letter to state Medicaid Directors, the Centers for Medicare and Medicaid Services (CMS) encouraged states to apply for the 1115 Reentry Waiver, which would for the first time expand Medicaid coverage to individuals during incarceration. This expansion presents an opportunity to develop consistent standards of healthcare quality in correctional health services, pre-release services, post-release services, and community reentry. CMS highlighted that states must include a plan for evaluating the success of their waiver.

The goal of this brief is to define a set of prioritized program evaluation components and a starter set of core quality measure domains and measures for policymakers and states implementing the 1115 Reentry Waiver that are aligned with the CMS National Quality Strategy.

These 1115 Reentry Waivers should promote the delivery of high-quality care for all beneficiaries across settings, including carceral settings. Waivers should be implemented to help Medicaid enrollees who are incarcerated establish connections to community providers to better ensure their health care needs are met during the reentry process.¹

Standardized quality measurement will allow Medicaid, carceral and community health systems, providers, and most importantly, patients who have been historically disadvantaged and underserved, to gauge the quality of this unprecedented expansion of healthcare coverage and service delivery.

The Transitions Clinic Network (TCN), the SEICHE Center for Health and Justice at Yale, and the Health, Homelessness, and Criminal Justice Lab at the Hennepin Healthcare Research Institute developed a comprehensive roadmap for program evaluation and quality measurement, informed by existing evidence, to assess the quality of care delivered to justice-involved populations and the effectiveness of Reentry Waivers. The team consisted of healthcare providers who have worked in carceral health systems and in the community, researchers, and community health workers (CHWs) with lived experience of incarceration.

The historic expansion of Medicaid into carceral systems necessitates that CMS and states systematically collect, analyze, and use data to examine the effectiveness of the 1115 Reentry Waiver so that the benefits of this expansion translate into direct improvements in

¹ 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

patient care, the delivery of health care services, and transition back to the community.

The recommended program evaluation considerations are consistent both with CMS guidance and expert opinion and also that of practitioners caring for people during incarceration and people with lived experience of incarceration. Given the variability in Medicaid programs, 1115 Reentry Waiver applications, statutory authority, financing models, and delivery mechanisms across and within states and carceral systems, these program evaluation considerations should be contextualized within each state, but these areas are the core domains that ought to be considered across locales:

- Access (e.g., provision and availability of services; structural barriers to care)
- Utilization (e.g., systematic screening to determine eligibility)
- Seamless care coordination (e.g., plan for updating data systems to facilitate activation and continuation of coverage)
- Equity (e.g., racial, ethnic, and gender disparities)

In addition, the team identified a starter set of high-priority healthcare quality measurement domains and fully specified measures endorsed by a consensus-based entity and in use in CMS Quality Reporting Programs. The domains and measures are intended to assess the success of implementation and reflect the disproportionate burden of disease and risk factors affecting justice-involved individuals,² while taking into consideration the availability of administrative data. The following principles were prioritized when developing domains:

- Success and equity of implementation
- Healthcare quality for carceral populations related to behavioral health (e.g., screening for depression and follow-up care, and initiation and engagement in substance use disorder treatment)
- Chronic disease management
- Disparities-sensitive wellness and prevention (e.g., screenings for various cancers, immunization status, and infectious and chronic diseases)

The roadmap is both comprehensive, to enable CMS and states to initiate program evaluation and quality measurement as soon as possible, and aspirational, to prepare for increased capacity and resources in the future. We intend this report to be useful to states in planning the evaluation of their 1115 Reentry Waivers. This report also highlights important gaps in available validated quality measures for future investment in measure development from CMS.

2. Incarceration and Health: A Family Medicine Perspective

Background and Introduction

CMS provides health insurance coverage for one in three Americans and is able to influence quality of care at a population level by tying payment to quality metrics. Due to the Medicaid Inmate Exclusion Policy (MIEP), Medicaid beneficiaries are denied coverage during periods of incarceration, and CMS oversight of health care delivery, subsequently, does not pertain to carceral settings. This policy, then, necessitates that county and state correctional systems cover the cost of care of incarcerated people. There is significant variability in how states and counties finance and oversee carceral health and also in the quality of care delivered across local, state, and federal carceral facilities. Standardized program evaluation and quality measures that assess performance in carceral health systems are scarce and not mandated, and the results are rarely public, which limits accountability.³ Reentry Waivers, then, will allow states and counties to share the costs of care with the federal government, both inside carceral facilities and post-release, and in so doing, CMS will implement a quality measurement strategy that spans multiple care settings, allowing for cross-comparisons across programs and helping identify measurement gaps.

A standardized approach to evaluating the implementation of 1115 Reentry Waivers,

as well as associated quality measures, would enable stakeholders to gauge the quality of available services and compare it to the quality Medicaid requires in other community healthcare settings. Furthermore, program evaluation and quality measures must reflect the disproportionate rates of disease, morbidity, and mortality in this population and the current evidence about how best to engage individuals in healthcare in the carceral system and following release.

We thus provide these program evaluation components and quality domains and measures to inform current and future program development, evaluation, and quality measurement and to ensure that Medicaid funding improves the care of people leaving incarceration and does not just shift how carceral healthcare is financed. Future investments in infrastructure and human resources will be necessary to advance data collection and reporting, management, and quality improvement activities to maximize the full impact of this waiver.

Methodology and approach

Our team, which includes members of Transitions Clinic Network (TCN) and affiliated clinicians and researchers at the SEICHE Center for Health and Justice at Yale, and the Health, Homelessness, and Criminal Justice Lab, has over fifteen years

3. [Aligning Correctional Health Standards With Medicaid-Covered Benefits](#)

of experience in providing clinical care and conducting research on the health impacts of incarceration in partnership with people with histories of incarceration. TCN is a national network of community-based primary care programs that provides healthcare and social support to people who are reentering their communities after incarceration by employing community health workers (CHWs) with histories of incarceration, which has been cited by the Agency for Healthcare Research and Quality and National Reentry Council as a best practice and was mentioned by CMS as a model program for locales to adopt in order to transition care from carceral systems to the community as part of the 1115 Waiver.

In proposing this starter set of program evaluation components and quality measures, we have drawn on our collective experience and research and centered our recommendations on the priorities of TCN CHWs who have lived experiences of incarceration and expertise with managing transitions of care.

Our process to define a set of program evaluation components and core quality domains involved multiple phases. At the 2023 annual meeting of the TCN, various stakeholders, including CHWs with lived experience of incarceration, correctional and community health care providers, and researchers, brainstormed an initial set of quality measures based on our network's data and experience providing care. Next,

we reviewed the CMS National Quality Strategy and the CMS Universal Foundation for quality measurement to identify important measurement areas for quality reporting programs across all sites of care that receive Medicaid or Medicare reimbursement, and we aligned measures identified at the TCN meeting with these CMS-approved measures. We then reviewed the literature, focusing on the burden of disease and illness affecting carceral populations, evidence-based practices for providing healthcare to justice-involved populations, and analyses of Medicaid policy and national quality metrics. Taken together, we formulated a set of program evaluation components and proposed measure domains and quality measures.

We then conducted four structured key informant interviews with stakeholders with varying perspectives and experiences in Medicaid policy, correctional healthcare, and private healthcare insurance to ensure that our proposed measures were achievable and appropriate. Specifically, the key informants focused on three key areas: their individual and/or organization's readiness and preparedness related to implementation of the 1115 Waiver, their perceptions of the program evaluation attributes, and their perceptions of the domains and measures. Last, we brought the identified domains and measures back to the TCN community to ensure that the domains were consistent with their priorities.

Results

Perceptions related to readiness and preparedness

Generally, the 1115 Reentry Waiver has been received with optimism and great anticipation and is viewed as a first step to integrating carceral care into community healthcare systems and moving carceral populations from episodic care to continuity of care and services (e.g., from pre- to post-release). Key informants expressed that the program could potentially decrease recidivism and substance use-related deaths by strengthening continuity of care for individuals with physical and behavioral health needs during reentry.

The degree of preparedness for the 1115 Reentry Waiver varies across locales and is often dictated by internal (e.g., organizational) and external (e.g., state or federal) capacity; data systems, including the inability to activate and deactivate Medicaid services; the existence of local partnerships; state, county, or facility policy; the capacity of community health systems; community providers' and health systems' preparedness; and increased demand impacting CMS' processing times. Of particular concern were the infrastructure updates that will be needed to appropriately share and integrate carceral healthcare and community healthcare electronic health record and payment systems. Lastly, the critical need for

healthcare providers to facilitate transitional services in carceral settings, particularly in jails, is a resource gap that has the potential to impact the effectiveness of appropriate transitions and continuity of care pre- and post-release.

Program evaluation considerations

Implementation of the 1115 Reentry Waiver should include monitoring whether policy approval results in the subsequent key service changes. If the following services changes do not occur, it is unlikely states would see improvements in health outcomes in this population.

- **Medications for behavioral health and other chronic conditions during incarceration and after release:** Given that an individual is at the highest risk for opioid overdose in the period immediately following release from a carceral setting, and a large percentage of overdose deaths in the US occur in individuals recently released from jails and prisons,⁴ perhaps the single most important intervention for reducing the health risks following release is the provision of medication for opioid use disorder prior to release and ensuring continuity of care.⁵ Starting individuals on medication prior to release, ensuring they leave incarceration with a sufficient supply, and facilitating their continuity of care are essential for reducing overdose deaths.⁶

4. [Criminal justice system as a point of intervention to prevent opioid-related deaths](#)

5. [A conceptual model for understanding post-release opioid-related overdose risk](#)

6. [Opioid Use Disorder Treatment for People Involved in the US Criminal Justice System—Promising Advances and Critical Implementation Challenges](#)

- Provision of medication for substance use disorders, including opioid and alcohol use disorders, and medication for mental health disorders during incarceration and 90 days post-release or maximum allowable quantity (e.g., 30 days for buprenorphine).
- Changes in carceral facility to allow for the provision of MOUD pre-release
- **Infrastructure:** Effectively engaging people in care post-release will require both the data and personnel infrastructure to support reentry. A plan to integrate carceral and Medicaid data systems to activate post-release coverage immediately upon release is essential, as is the ability to track and report healthcare quality measure performance. Evidence from the TCN and the recent expansion of Medicaid through the Affordable Care Act⁷ suggest that Medicaid coverage alone does not lead to engagement in care following release. Realizing the full potential of the waiver will require a workforce of people with histories of incarceration to engage people returning from incarceration into community care. Data from TCN demonstrates that patients who engage with CHWs upon release have

decreased utilization of emergency departments,⁸ shorter hospital stays, and are less likely to have probation violations and be reincarcerated.⁹ Additionally, data from Los Angeles found that patients with HIV who interact with peer navigators prior to release from incarceration have better outcomes than standard of care.¹⁰

- Availability of services (e.g., trained peer and CHW supports, community-based reentry services and supports, and community-based provider capacity) that is attuned to the specific needs of and able to serve justice-involved individuals.
- Any individual with a behavioral health condition should be offered coordination services.
- Due to the markedly limited opportunity for individuals to earn any reasonable income, there should be no co-payments or costs¹¹ associated with pre-release services.

- **Equity**

- Monitor the receipt of prerelease and post-release services by race and ethnicity and gender.

- **Utilization**

- Assess systemic administration of screenings to identify individuals eligible for pre-release services.

7. [Health Insurance and Mental Health Treatment Use Among Adults With Criminal Legal Involvement After Medicaid Expansion](#)

8. [Transitions clinic: creating a community-based model of health care for recently released California prisoners](#)

9. [Propensity-matched study of enhanced primary care on contact with the criminal justice system among individuals recently released from prison to New Haven](#)

10. [Effectiveness of a Peer Navigation Intervention to Sustain Viral Suppression Among HIV-Positive Men and Transgender Women Released From Jail](#)

11. [“Prison Ain’t Free Like Everyone Thinks”: Financial Stressors Faced by Incarcerated Women](#)

- (e.g., Medicaid enrollment, primary care, substance use care, and mental health care).
- Post-release emergency department and hospital utilization.
- Utilization of applicable pre- and post-release services (e.g., primary, substance use, mental health, care coordination, CHWs/peer support specialist) and receipt of community support services where available.

Illustrative priority domains and measures

Incarceration is associated with an elevated risk of morbidity and mortality from infectious disease, cancer, cardiovascular disease, mental health disorders, and opioid and other substance use disorders when compared to the general population.¹² At a high level, this illustrative list of domains and measures reflects the healthcare priorities of justice-involved populations and is a starting point with which to assess the quality of care that they receive (pre- and post-release). Specifically, the six measures in the starter set are associated with three healthcare quality domains including behavioral health, disparities-sensitive wellness and prevention, and chronic illness. Each measure is fully specified and currently used in CMS Quality Reporting Programs,¹³ and all but two measures (CMIT ID 672 and CMIT ID 26) are endorsed by a consensus-based entity.

Measurement gaps and other challenges

The starter set is not intended to be an exhaustive list of quality metrics for this new area of measurement but rather a starting point for states that are preparing to implement the 1115 Reentry Waiver by providing them with an opportunity to adapt and validate existing, ready-to-use measures. Some of the identified elements may require several years to implement, given the current infrastructure in carceral settings, including the lack of data interoperability; variability in program implementation and health financing across states; limited ways of paying for CHWs through Medicaid; and insufficient data on race, ethnicity, and other social determinants of health recorded in carceral and community health system electronic health records.

One particular implementation challenge noted by stakeholders is the difficulty in linking carceral system data to other data systems (e.g., healthcare records, social services), including the inability to link those data due to legislative and judicial constraints. Connecting data to social needs, particularly housing and employment, and safeguarding confidential and sensitive data related to incarceration status and history are critically important priorities as well. Data integration also presents an opportunity to improve information shared between relevant systems, states, the criminal justice system,

12. [Linkages Between Incarceration and Health](#)

13. [CMS Quality Reporting and Value-Based Programs & Initiatives](#)

Illustrative priority domains and measures¹⁴

Domain	Measure
Behavioral health	CMIT ID 672: Screening for depression and follow-up plan and measure
	CMIT ID 394: Initiation and engagement of substance use disorder treatment (including the provision of medications)
Disparities-sensitive wellness and prevention	CMIT ID 139: Colorectal cancer screening
	CMIT ID 118: Cervical cancer screening
	CMIT ID 26: Adult immunization status (for influenza, tetanus, diphtheria or tetanus, diphtheria (Td) and acellular pertussis (Tdap), zoster and pneumococcal immunizations)
Chronic illness	CMIT ID 167: Controlling high blood pressure

14. [Centers for Medicare & Medicaid Services Measures Inventory Tool](#). The details of each measure can be found by entering the measure ID into the search bar.

and Medicaid organizations. For this reason, CMS is actively encouraging eligible states to apply for funding to update their data systems to be able to determine eligibility and enrollment and to improve case management and connections to social services.¹⁵

In addition, in discussions about how to best assess healthcare quality pre- and post-release, several measurement gaps emerged, especially within the area of disparities-sensitive wellness and prevention: HIV, HPV, hepatitis B and C, dementia, psychosis, and sleep deprivation and related stressors. The need to assess overdose deaths, provider cultural competency and stigma, peer and CHW engagement (including access to patients pre-release), integration of CHWs as part of the post-release healthcare team, appropriate handoffs (e.g., care coordination), and availability of discharge planning were also emphasized.

For these priorities, we encourage state Medicaid programs to work with CMS and others to develop and validate quality measures relevant to the Reentry population.

Recommendations & Next Steps

The implementation of 1115 Reentry Waivers presents an opportunity for CMS, states, managed care organizations, correctional facilities, healthcare providers, community organizations, and the individuals and communities impacted by the criminal justice system to identify and develop national, consensus priorities with which to assess the success of 1115 Reentry Waivers in helping individuals transition from incarceration to the community. In turn, these efforts may help address the absence of transparent, mandated, standardized, and publicly available quality measures across the US carceral system.

Efforts to monitor and improve care for individuals returning from incarceration should be evidence-driven and include assessments of management of opioid use disorder, continuity of care, engagement with CHWs, and connections to social needs. Finally, there is an opportunity to establish national or regional quality improvement programs and learning collaboratives that promote cross-sectoral relationships within and between states preparing to implement the waiver and those that are further along the process.

15. [Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated](#)

Appendix A:

The authors acknowledge the invaluable insights of the following key informants:

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