MLRI MASSACHUSETTS LAW REFORM INSTITUTE

CHLPI CENTER for HEALTH LAW and POLICY INNOVATION HARVARD LAW SCHOOL

September 9, 2023 (as revised with 30 co-signers)

Michael Levine, Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Submitted by email to 1115WaiverComments@mass.gov

Re: Comments on MassHealth 1115 Demonstration Amendment Request

Dear Assistant Secretary Levine,

On behalf of the undersigned organizations, thank you for the opportunity to submit comments on MassHealth's Section 1115 Demonstration waiver amendment released for public comment on August 2, 2023. These comments address just one of the eight proposed amendments: No. 8 "Provide Pre-Release MassHealth Services to Individuals in Certain Public Institutions." Several of the undersigned organizations have submitted or endorsed comments that also address one or more of the other proposed amendments.

We strongly support MassHealth's amended proposal to provide pre-release services to MassHealth eligible individuals in carceral settings. We appreciate that the agency is committed to extending services as broadly as possible in light of the April guidance from CMS and the waivers CMS has already approved for California and Washington. We make the following comments and recommendations in furtherance of that shared goal.

1. We urge the agency to include a provision for an advisory council composed of a broader group of stakeholders, particularly prioritizing people with lived experience.

There are many important decisions to come in developing, implementing, and monitoring the demonstration. In depth discussions about the current MassHealth initiative have been limited to MassHealth and its interagency Coordinating Council, largely made up of state correctional agencies.

We strongly urge MassHealth to expand the interagency Coordinating Council with which it has been working since 2021 to encompass a broader group of stakeholders, including individuals with personal experience of justice involvement and the community providers that are often directly responsible for their care. While correctional partners play an integral part of providing care during and after incarceration, these other stakeholders have invaluable perspectives that are not currently being considered.

Current Stakeholders Involved in Massachusetts' 1115 Proposal

Since January 2021, MassHealth has convened an interagency Coordinating Council to inform the development of its 1115 proposal on providing pre-release services in Massachusetts's carceral settings.[1] The Coordinating Council includes representatives from the Department of Corrections (DOC), the Massachusetts Sheriffs' Association, the fourteen Massachusetts Sheriffs' Offices (of which thirteen have correctional facilities), Department of Youth Services (DYS), Parole and Probation Units, and the state Executive Office of Public Safety and Security (EOPSS).[2] These members are exclusively from Massachusetts's correctional agencies and do not reflect any representation of individuals currently or formerly incarcerated in the system, nor does it include other advocates and community health partners that would inevitably play a role in designing care transition plans.

Federal Guidance To Include Stakeholders with Lived Experience

In 2021, the Medicaid Reentry Stakeholder Group, established under Section 5032 of the SUPPORT Act, met to identify strategies for improving care transitions for individuals being released from incarceration.[3] In January 2023, the group's recommendations were published in a Report to Congress. Of its recommendations, the significance of stakeholder representation and their continued engagement in the decision-making process was apparent. The report specifically noted the value of bringing in individuals with personal experience of justice involvement as well as the individuals from communities historically overrepresented in carceral facilities. The value of doing so "from the onset of demonstration design and engaging them throughout the process, to ensure that the opportunity is person-centered and well-tailored to the needs of [the justice-involved population]" is stressed repeatedly by the Stakeholder Group.[4]

Influenced by the findings of this Stakeholder Group, CMS concluded that it "strongly encourages states contemplating submitting a demonstration application to engage individuals with lived experience who were formerly incarcerated in both the design and implementation of a state's Section 1115 Reentry Demonstration proposal."[5] By engaging individuals with lived experience within this system, in addition to soliciting input from care providers with specialized experience working with the justice-involved population, CMS highlights the importance of this group's inclusion to identify the specific and unique challenges encountered by an individual in their transition from incarceration to the community. Attempting to make such decisions without the participation of the people who will be most directly impacted by its implementation would negate the federal guidance directed by the Medicaid Reentry Stakeholder Group and CMS.

---

[1] Commonwealth of Massachusetts, Executive Office of Health and Human Services, 2023. *MassHealth Section 1115 Demonstration Amendment Request.*

[2] Ibid.

[3] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Medicaid Reentry Stakeholder Group, 2023. *Health Care Transitions for Individuals Returning to the Community from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group*.

[4] Medicaid Reentry Stakeholder Group, 33.

[5] Centers for Medicare & Medicaid Services, 2023. *Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated*.

Lessons from California and Washington

California and Washington are currently the only states with 1115 waivers approved for financing pre-release services with Medicaid funds. Both states' waivers specify the inclusion of justice-involved stakeholders and would serve as excellent models for MassHealth in its efforts to expand its stakeholder reach to justice-impacted individuals and the advocates and organizations working with them directly.

California, the first state to receive CMS approval for its 1115 request, has included justice-involved individuals since the initial phases of designing its proposal. To supplement its efforts in expanding Medicaid services to the states' incarcerated population, CalAIM has regularly convened the CalAIM Justice-Involved Advisory Group since October 2021.[6] This advisory group reports to CalAIM on all policy matters related to the state's Justice-Involved Initiative, including its 1115 amendment request. The Advisory Group is made up of a diverse range of stakeholders involved in the California criminal justice system, including the state's correctional partners as well as community health providers, health plans and MCOs, other community-based organizations involved in reentry, and CalAIM members with lived experience in the justice system.[7] Their meetings are scheduled in advance, held regularly, and open to the public.

Similarly, Washington's approved 1115 waiver detailed an advisory process that emphasized diverse stakeholder engagement, including consulting with groups outside of the solely correctional scope. In the state's approved waiver request, Washington stated its commitment to convene key stakeholders in planning the waiver's implementation, including "state agencies responsible for Medicaid managed care, benefits and eligibility, corrections, juvenile justice, and behavioral health; correctional facilities; behavioral health providers; MCOs; counties; tribal health programs; community-based organizations; people with lived experience; and Tribal representatives."[8]

Both California and Washigton's approved 1115 amendments provide for more stakeholder engagement of people with lived experience and their advocates than MassHealth's current interagency Coordinating Council. We strongly encourage MassHealth to use both states as a model for stakeholder participation in the Massachusetts demonstration.

Importance of Including Stakeholders with Lived Experience

As MassHealth acknowledged in their proposal:

> Individuals leaving carceral settings tend to experience difficulties accessing the care they need, largely due to challenges in establishing or reestablishing Medicaid coverage, making appointments before coverage is established, and planning around uncertain

[6] California Department of Health Care Services, 2023. *California Advancing and Innovating Medi-Cal (CalAIM) Justice-Impacted Advisory Group: Update on CalAIM Justice-Impacted Waiver Approval.* https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Adivsory-Group-Feb-2023.pdf.
[7] Ibid.
[8] Washington State Health Care Authority, 2022. *Medicaid Transformation Project (MTP) Waiver Renewal Application*. https://www.hca.wa.gov/assets/program/wa-mtp-renewal-application.pdf, 43.

release dates. They are also more likely to lack health insurance. Other barriers include trouble navigating the health care system, lack of transportation, interruption in medication, and unmet health-related social needs (HRSN) such as food insecurity or homelessness.[9]

The people described above, who stand to benefit the most from this demonstration— and to suffer the resulting harm if policy or administrative decisions do not meet their needs— are being left out of the conversation. The inclusion of MassHealth members with lived experience must be a priority for this 1115 demonstration if MassHealth seeks to provide equitable access to care.

Since the health and health-related social needs faced by incarcerated populations are unique and often traumatic, it is essential that the perspectives of individuals with lived experience are taken into consideration at all steps of decision-making in the 1115 waiver process. In this way, their participation should not only be valued but considered as a requirement for working with this population. In addition, the stakeholder group should include the community-based organizations that will be providing services to returning citizens after their release.

One example of an area where community engagement will be useful is in determining what additional services are needed to serve young people in carceral settings. The facilities under the Department of Youth Services (DYS) differ from the adult carceral setting in many key ways, including its modalities of health care and treatment for detained juveniles. It will be important to maintain and support the protections that have already been put in place for detained juveniles within DYS systems and extend those protections to juveniles in other carceral settings. Feedback will be particularly helpful for determining what gaps currently exist that can be addressed through enhanced pre-release or transitional services.

To date, meaningful stakeholder engagement has not included community-based providers, managed care plans, or people with lived experience despite the fact that a key purpose of these waivers is to improve access to care and services in the community and smooth the transition from the carceral setting to the community. The goals of the 1115 waiver for pre-release coverage generally and MassHealth specifically cannot be achieved without the agency engaging a broader group of stakeholders from the community to advise on the development of the proposal, including people with lived experience. It is crucial to engage a broader group early and in all remaining stages of the process: now, before submission, during negotiations with CMS, in the 120 days after approval when MassHealth will be finalizing the implementation plan and reinvestment plan, and on an ongoing basis as the program is being implemented over time. We urge the agency to make this commitment and include it in its proposal to CMS.

2. **We urge the agency to include more incentives to involve managed care plans, community-based health care providers, and other community-based organizations in providing case management, health care and reentry services prior to release.**

[9] Commonwealth of Massachusetts, Executive Office of Health and Human Services, 2023. *MassHealth Section 1115 Demonstration Amendment Request.*

The success of MassHealth's proposal, which seeks to improve care transitions and health outcomes after reentry, requires the participation of community-based providers as early in the pre-release process as possible. We urge MassHealth to do more to involve the individuals and organizations who will be providing services in the community in providing services during the pre-release period as well. Of course, the mix will vary among facilities—for example, DYS facilities already contract with community-based providers such as Boston Children's Hospitals. However, the current proposal leaves the mix of facility-based service providers and community-based providers entirely to the discretion of the facility. We urge MassHealth to build in incentives to affirmatively encourage the involvement of community-based providers in providing health care and case management services to patients prior to release.

Many of the same community-based stakeholders who should be involved in developing the demonstration should also be involved in the delivery of pre-release services under the demonstration. This includes the MassHealth managed care plans. For most MassHealth members who are returning citizens, their health care services in the community will be delivered by managed care plans. Yet the proposal indicates that pre-release services will be provided exclusively on a fee-for-service basis. This raises a variety of administrative concerns, including that providers who participate in MassHealth managed care plans but not fee-for-service *will not* be able to provide services prior to a patient's release. Further, there are already successful models of how to engage managed care plans in pre-release services, and we urge the agency to consider them as it develops its proposal.

In MLRI's discussions of barriers to arranging services at reentry with community-based organizations, CPCS social workers, and people with lived experience, the two most common problems identified were: (1) problems scheduling appointments on release when providers cannot confirm an individual's eligibility for anything but inpatient-only services, and (2), that on release, when full coverage is activated, "it's the wrong kind of MassHealth." When we inquired further in one-on-one interviews,[10] we learned what makes it the "wrong kind of MassHealth" is that it is fee-for-service. In Massachusetts, the fee-for-service system has not kept pace with managed care, particularly in terms of participating behavioral health providers. Thanks to the Behavioral Health Roadmap, MassHealth recently expanded the types of licensed behavioral health providers it will allow to participate in the fee-for-service system. However, the managed care plans still offer greater access to participating providers other than hospitals and community health centers than the MassHealth fee-for-service system.

The Report to Congress describes successful models other states have developed for Medicaid managed care organizations to be involved in pre-release discharge planning, even without an MIE waiver and federal reimbursement. This includes New Mexico, where care coordinators provide education about Medicaid benefits and help develop a care plan for returning community members, and Ohio, where all Medicaid MCOs are required to deliver pre-release care coordination services including social worker and nurse-led care management as well as Peer-to-Peer Medicaid Guides.[11]

[10] Massachusetts Law Reform Institute interviews with MassHealth members who self-identify as justice-involved or a returning citizen, 2022.

[11] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Medicaid Reentry Stakeholder Group, 2023. *Health Care Transitions for Individuals Returning to the Community*

More importantly, CMS expectations for the Reentry Section 1115 Demonstration Opportunity highlight the importance of involving the community organizations that will be providing services after release *during the pre-release period*. The goals CMS identifies for the demonstration notably include to:

- Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry,
- Improve coordination and communication between correctional systems, Medicaid systems, managed care plans, and community-based providers,
- Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs (HRSN); and
- Develop a plan for organizational level engagement, coordination, and communica,ion between the corrections systems, community supervision entities, health care providers and provider organizations, state Medicaid agencies, and supported employment and supported housing agencies or organizations.[12]

The Report to Congress also emphasizes the importance of community-based in-reach services. "In-reach occurs when community-based professionals--such as case managers, social workers, or other supportive personnel--come into correctional facilities and provide in-person assistance such as care coordination, discharge planning, and/or cross-sector coordination. Cross-sector coordination integrates support across multiple sectors including health, housing, and employment. In this collaborative effort, in-reach staff inform community-based staff of the needs of soon-to-be-released individuals. In-reach care coordinators undergo necessary training to be awarded the security clearance to work in jails and prisons. In some states, including New York and Rhode Island, peer navigators with histories of justice system involvement participate in the in-reach process and assist with pre-release discharge planning. Compared to remote care coordination and cross-sector coordination, in-reach is associated with greater engagement in care following release."[13]

Greater involvement of community-based providers is also evident, not only in the planning of California's 1115 waiver demonstration but in its implementation. For example, California's definition of "case management" in its 1115 waiver includes:[14]

- "Providing warm linkages with designated managed care plan care managers (including potentially a care management provider, for which all individuals eligible for pre-release services will be eligible) which includes sharing discharge/reentry care plans with managed care plans upon reentry"

---

from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group, p. 18. Also, see the discussion of data sharing at pages 20-21 and the MIE waiver proposals of some states to initially provide services on a fee for service basis and transition to managed care 30 days prior to release at page 30.

[12] Centers for Medicare & Medicaid Services, 2023. *Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated*, p. 11, 33.

[13] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Medicaid Reentry Stakeholder Group, 2023. *Health Care Transitions for Individuals Returning to the Community from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group*, 17.

[14] California Department of Health Care Services, 2023. *Reentry Demonstration Initiative Amendment Approval*. https://www.medicaid.gov/sites/default/files/2023-01/ca-calaim-ca1.pdf, 48-50.

- "Ensuring that, as allowed under federal and state laws and through consent with the member, data are shared with managed care plans, and, as relevant to physical and behavioral health/SMI/SUD providers to enable timely and seamless hand-offs"
- "Making warm linkages to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, transportation, childcare, child development, and mutual aid support groups."

Also specifically included in its definition of "pre-release services" are services provided by community health workers with lived experience.[15]

We urge MassHealth, in consultation with the relevant stakeholders, to build in a greater role for community-based health care providers, managed care plans, and other community-based organizations pre-release, which will facilitate successful reentry into the community.

3. We urge MassHealth to more explicitly leverage the pre-release coverage proposal to combat Hepatitis C among the justice-involved population.

We strongly support MassHealth's commitment to remedying health disparities for people who are incarcerated, and we encourage MassHealth to make a clear, explicit commitment to screening for and treating the hepatitis C virus (HCV) in furtherance of this goal. Hepatitis C is disproportionately concentrated among people who experience incarceration. Experts believe that at least 2.4 million people in the United States are living with hepatitis C,[16] and up to 30% of these individuals spend time in a carceral facility in any given year.[17] The main mode of transmission of HCV is the use of contaminated needles for injection drug use, and high incidences of housing instability along with stigma against people who use drugs further complicate the facilitation of access to HCV treatment. Periods of incarceration present a crucial opportunity to address these issues and reduce rates of HCV transmission. Thus, we urge MassHealth to prioritize HCV treatment in the design and implementation of the new pre-release coverage program.

CMS has also made clear that waivers for pre-release Medicaid coverage should be used to promote access to treatment of HCV. The CMS guidance specifically states, "we recognize that there may be other important physical and behavioral health services that states request to cover on a pre-release basis, such as… treatment for Hepatitis C." Moreover, in considering activities related to coordinated care, the CMS guidance again points to HCV as a condition for which

[15] Ibid, 11.

[16] *See* State of Medicaid Access, Center for Health Law and Policy Innovation, Harvard Law School & National Viral Hepatitis Roundtable (June 2023), https://stateofhepc.org/; *See also* Brian R. Edlin, et al., *Toward a more accurate estimate of the prevalence of hepatitis C in the United States*, 62 HEPATOLOGY 1353 (2015), https://pubmed.ncbi.nlm.nih.gov/26171595/ (indicating that estimates of Hepatitis C prevalence are likely even higher than reports suggest).

[17] Tessa Bialek & Matthew J. Akiyama, 2023. *Policies for Expanding Hepatitis C Testing and Treatment in United States Prisons and Jails*. https://www.globalhep.org/sites/default/files/content/resource/files/2023-04/Clearinghouse WhitePaper2_Hepatitis_C_Testing_and_Treatment_in_US_Jails_and_Prisons.pdf.

states will want to ensure the "ability to bi-directionally share data with public health entities and community providers."[18]

We applaud the work that MassHealth has done thus far to enable facilities to use the pre-release coverage waiver to combat HCV and write here to highlight further opportunities that MassHealth should incorporate. Foremost, MassHealth should identify HCV treatment as a priority for pre-release services, make clear that testing and treatment will be covered benefits under the demonstration, and encourage facilities to regularly offer opt-out screening for HCV.[19] Doing so will encourage stakeholders to develop and implement best practices that reduce the incidence and spread of HCV. Additionally, we support MassHealth's decision to request the authority to provide 90 days of medication post-release as clinically appropriate. Since HCV regimens can be completed in as little as 56 days,[20] specifically including HCV treatment among those for which up to 90 days of medication can be provided would enable people leaving incarceration with a recent HCV diagnosis to be discharged with a full course of medications. Inclusion of HCV treatment in both pre- and post-release services that may be covered under the proposed waiver would drastically increase the ability of incarcerated people to receive and adhere to HCV treatment, especially those that are in facilities for only short stays.

We also recommend that MassHealth utilize this demonstration to support and encourage better data sharing for purposes of inter-agency coordination and more effective collaboration with community-based providers and organizations. As noted above, CMS has recognized and emphasized to states that data sharing is important for effective HCV care, especially given the significant role that the Department of Public Health plays in controlling and responding to infectious disease. MassHealth should ensure that carceral facilities are prepared to gather and monitor the appropriate data, and that the necessary infrastructure exists to support readily sharing health information with relevant providers.

Lastly, we encourage MassHealth to provide resources to all demonstration stakeholders that will directly participate in the care of patients. Stigma and bias play a significant role in the ability of people with HCV who are incarcerated to access and adhere to treatment.[21] All stakeholders should be provided support to understand how to provide non-stigmatizing and culturally responsive services. Moreover, providers and other relevant stakeholders should receive ongoing

[18] Centers for Medicare & Medicaid Services, 2023. *Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated*.
[19] The Infectious Diseases Society of America and the American Association for the Study of Liver Diseases promote universal screening as a crucial piece of HCV treatment strategies. *See* Debika Bhattacharya, et. al., *Hepatitis C Guidance 2023 Update*, https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciad319/7179952.
[20] Ibid.
[21] *See e.g.*, Alysse G. Wurcel, et al., *"I'm not gonna be able to do anything about it, then what's the point?": A broad group of stakeholders identify barriers and facilitators to HCV testing in a Massachusetts jail*, https://pubmed.ncbi.nlm.nih.gov/34038430/.

support to understand whether and to what extent HCV treatment is covered under the demonstration, including any future policy changes.

4. We urge MassHealth to include in the reinvestment plan services that prevent incarceration and to adopt program accountability and oversight measures.

We appreciate MassHealth's thoughtful framing of the future reinvestment plan into four core pillars. However, we encourage MassHealth to expand beyond these four core pillars and include the opportunity for reinvestment in services that are likely to prevent incarceration altogether. While the four listed categories are broad and potentially inclusive of such services, stakeholders should be made aware of the opportunity to use reinvestment funds for new or innovative approaches to reducing incarceration. In the proposed amendment, MassHealth itself states, "funds will be reinvested into critical activities and initiatives... for health-related social services that help divert people from criminal justice involvement."[22] The creation of a fifth pillar would simply solidify this priority as in-line with the others and make clear the opportunity for investment in pre-incarceration services.

Utilizing reinvestment funds to reduce incarceration rates and related health inequities closely aligns with the goals of the Massachusetts demonstration. The U.S. Department of Health and Human Services, as part of their Healthy People 2030 campaign, identified incarceration as a social determinant of health, articulating that incarceration itself has negative impacts on the wellbeing of people who are incarcerated as well as their families and communities.[23] As MassHealth states in the amendment, incarceration also disproportionately affects some racial and ethnic groups. In particular, Black and Latino people are incarcerated at significantly higher rates than white counterparts as well as other racial groups and suffer disparities in health outcomes that further compound the detriments of incarceration. This is also true for many other systemically marginalized identities, including, but not limited to, LGBTQ+ individuals and people with disabilities. These disparities suggest that interventions and programming that prevent or reduce the risk of incarceration would further MassHealth's goals of addressing health inequities for justice-involved populations.

The CMS guidance encourages a broader approach to reinvestment than MassHealth has taken, and specifically allows for investment in services for people who "may be at higher risk of criminal justice involvement."[24] For example, CMS suggests that Medicaid programs could invest in "the addition or expansion of mobile crisis services," or other health services that can help people with complex conditions avoid incarceration. It is therefore clear that CMS is willing

[22] Commonwealth of Massachusetts, Executive Office of Health and Human Services, 2023. *MassHealth Section 1115 Demonstration Amendment Request.*
[23] U.S. Department of Health and Human Services, 2020. *Incarceration*. Healthy People 2030. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/incarceration/
[24] Centers for Medicare & Medicaid Services, 2023. *Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated*.

to approve the use of reinvestment funds for services that not only support reentry but instead disrupt criminalization, which negatively impacts health. We strongly encourage MassHealth to build upon their current framework and include an additional pillar that specifically supports investment in upstream interventions for those at higher risk of incarceration.

We also strongly encourage MassHealth to consider the importance of developing mechanisms for accountability and oversight as these programs are implemented. Pre-release coverage offers a multitude of opportunities to address the health needs of justice-involved populations. However, CMS has made overwhelmingly clear that demonstrations are not to be used to shift financial responsibility for carceral health care to state Medicaid programs.[25] Therefore, MassHealth should be intentional in working with carceral and community stakeholders to ensure that the reinvestment plan prioritizes currently unmet needs of the justice-involved population first and foremost, and that the availability of pre-release coverage does not create an unintended incentive to delay care until an inmate is within the 90-day pre-release timeframe.

5. We encourage MassHealth to add provisions for improving the suspension process and include any necessary funding.

In its April 2023 letter to State Medicaid Directors, CMS makes clear that suspension, rather than termination, and pre-release eligibility and enrollment support will be a requirement for 1115 approval for all individuals incarcerated in facilities in which the demonstration is operating.[26] This was one of the special terms and conditions in California's approved 1115 demonstration and applied to all incarcerated individuals, not just those who had been screened and found eligible for pre-release service under California's approach.[27]

In its proposal, MassHealth notes that it was one of the first states to suspend coverage, rather than terminate it,[28] and says it will continue its practice of suspending enrollment upon incarceration—implying that there will be no improvements in the current suspension process. However, in Massachusetts, suspension still relies on manual processing by a designated MassHealth office, "workarounds," use of faxes (at some facilities), and little or no public-facing information describing the process.[29] We strongly recommend that MassHealth acknowledge the limitations of its current suspension system and allocate the resources to design and implement a better and more transparent system.

---

[25] "…the Reentry Section 1115 Demonstration opportunity is not intended to shift current carceral health care costs to the Medicaid program." *Ibid*.
[26] Ibid, 14.
[27] California Department of Health Care Services, 2023. *Reentry Demonstration Initiative Amendment Approval*. https://www.medicaid.gov/sites/default/files/2023-01/ca-calaim-ca1.pdf.
[28] Commonwealth of Massachusetts, Executive Office of Health and Human Services, 2023. *MassHealth Section 1115 Demonstration Amendment Request.*
[29] See, unpublished July 2023 subregulatory guidance entitled, "MassHealth Policy Updates for Justice-Involved MassHealth Members."

Pursuant to state legislation enacted in 2014, MassHealth first implemented a suspension process in 2015.[30] Since 2015, the MassHealth process has suspended all but an inpatient-only benefit during incarceration.[31] However, the implementation of the suspension process is problematic. For one thing, it has never been reflected in state regulations. The eligibility regulations on residence requirements provide that incarcerated individuals will not receive MassHealth unless they are inpatients in a medical facility.[32] The integrated application form for MassHealth and the Health Connector has a question for the Contact Person completing the application asking if anyone on the application is in prison or jail. If the answer is Yes, the HIX system will issue a denial or termination notice for the incarcerated person. The manual process used for applications from carceral facilities employs a "workaround" by the designated MEC to address this limitation of the HIX system, but no such workaround applies to individuals applying through an authorized representative in the community or on their own.

For example, in at least one county, the Sheriff only allowed applications to be submitted by facility staff for sentenced individuals with a release date. When a CPCS social worker attempted to submit a pre-release application for a client who required an appropriate medical placement as a condition of release, the local MEC told her they accepted such applications only from prisons and jails. This is just one example of both the value of hearing from people in the community and of the need to improve the system.

Another issue not addressed in the current suspension system is how the incarceration of one member of a household affects other household members in the community, such as a family in a MAGI household that will be filing taxes jointly with an incarcerated spouse. This is information both the family who may be completing an application, renewal or update needs to know, as well as information that facility personnel who complete an application or redetermination for an incarcerated person need to know. In MLRI's interviews with returning citizens, most reported meeting with a reentry officer who did not ask questions corresponding to questions on the application and did not supply a copy of either the application or the Member Book, but simply asked the client to sign papers needed for MassHealth after release.

Another factor for consideration that will have a significant effect on returning citizens is implementation of continuous eligibility for 12 months from release. It has been in place since April 1, 2023 for applications or redeterminations submitted by correctional facilities, but there has been no guidance for people applying in the community. When 24-month continuous eligibility for the homeless is implemented later this year and 12-month continuous eligibility for all adults is implemented pursuant to another of the proposed amendments, it will be important

[30] Sec. 227, c. 165, Acts of 2014; Eligibility Operations Memo 15-09 (Dec. 2015).
[31] See, EOM 19-17.
[32] 130 CMR 502.003(H).

to assure that an individual eligible for more than one of the three provisions has the benefit of the longest available period of continuous eligibility.

Relying exclusively on the facilities to identify people released from incarceration and eligible for 12-months continuous eligibility also leaves out people returning to the community after stays too short to trigger suspension. The pre-trial population makes up the largest share of the population cycling in and out of incarceration, and their stays average fewer than 30 days. Under the proposed 1115 amendment they are eligible for pre-release services, however, unlike sentenced individuals, they may have no pre-determined release date. However, they should be identified not only for purposes of obtaining continuous eligibility for 12-months after release but also for purposes of enhanced case management. California, like Massachusetts, continues Medicaid enrollment for short stays, and has also identified a set of services to be offered within 48 or 72 hours of incarceration for these individuals, including reentry planning and coordination.[33]

MassHealth's proposal requests authority to use presumptive eligibility for individuals with short-term stays. CMS in its April 2023 letter recommends that states consider permitting prisons and jails to serve as "qualified entities" able to make presumptive eligibility determinations.[34] There are clear advantages to enabling prisons and jails to immediately authorize an individual to qualify for MassHealth. On the other hand, a presumptive determination is only temporary and coverage will end if an eligible individual does not complete a full application within 45 days. An individual released with only temporary coverage is at risk of losing coverage for this procedural reason alone. In light of this risk, CMS cautions states that it is preferable for a full application to be submitted prior to release if time permits. While MassHealth has implemented Hospital Presumptive Eligibility since it was required by the ACA in 2014, prisons and jails are very different settings, and we are concerned that MassHealth allocate the resources needed to be sure that presumptive eligibility operates as intended within correctional settings.

The proposal should include the suspension process when it identifies funding needs and in its design of accountability systems. In the current proposal, there is no mention of the suspension process in the request for expenditure authority to support capacity building and information technology.[35] Similarly, the accountability systems which will be necessary to monitor delivery of Medicaid-paid services within carceral settings should also include monitoring and support for the suspension and reapplication process. In interviews with returning citizens about their reentry experience, MLRI found that the process operated very differently within different facilities and even among reentry officers within the same facility. The suspension and enrollment process is

[33] See, Table 10, Short Term Model: Key Activities and Timeline Requirements, p. 80 California Draft Policy and Operations Guide (June 2023).
[34] Centers for Medicare & Medicaid Services, 2023. *Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated*.
[35] Commonwealth of Massachusetts, Executive Office of Health and Human Services, 2023. *MassHealth Section 1115 Demonstration Amendment Request,* 23-24.

one of many areas where the contributions of stakeholders will be important to inform and improve the demonstration.

* * *

In closing, we want to express our appreciation for MassHealth's efforts to address the needs of its justice-involved members. We urge you to consider our recommendations to better serve this population through the 1115 demonstration waiver opportunity. We look forward to continuing to work with you on MassHealth's justice-involved initiatives and are eager to see any pending changes to the current 1115 amendment. If you have any questions, please contact Isabel Wanner (iwanner@mlri.org), Victoria Pulos (vpulos@mlri.org), or Johnathon Card (jcard@law.harvard.edu).

Respectfully submitted by the following organizations:

AccessHealth MA (formerly Community Research Initiative)
Actual Justice Task Team of the Southern New England United Church of Christ
Boston Health Care for the Homeless
Center for Health Law and Policy Innovation, Harvard Law School
Central West Justice Center
Citizens for Juvenile Justice
Committee for Public Counsel Services
Community Reentry Program Inc.
Disability Law Center
Gavin Foundation
Greater Boston Legal Services, CORI & Reentry Project
Harvard Law School Safety Net Project
Healing Our Land, Inc.
Health Care For All
Health Law Advocates
Lynn Health Task Force
JRI Health Law Institute
Massachusetts Association for Mental Health
Massachusetts Law Reform Institute
Massachusetts Organization for Addiction Recovery
Metrowest Legal Services
MLPB
New Beginnings Reentry Services, Inc.
Prisoners' Legal Services of Massachusetts
Recovery Homes Collaborative of Massachusetts
Ruth's Way
Temple Sinai

The F8 Foundation
Women and Incarceration Project, Suffolk University

Individuals (affiliations included for identification purposes only)
Gatewood West, LICSW, Greater Boston Reentry Task Force