PUBLIC SECTOR SERVICES

Medicaid Opportunities: Implementing Community Reentry

The intersection of criminal justice and safety-net healthcare programs has generated substantial interest in community reentry (CRE) as an opportunity for state Medicaid programs. As states develop new 1115 demonstrations and consider changes to existing programs, they can learn from emerging practices within the states with fully approved demonstrations. At the same time, states will also need to weigh their program design and goals against new budget neutrality guidance from the Centers for Medicare & Medicaid Services (CMS).

As of July 2026, this analysis includes 17 states with CMS-approved Special Terms and Conditions (STCs) for CRE demonstrations,[1] but STC approval is only the first step toward full implementation. Federal financial participation depends on CMS approving an implementation plan that covers milestone timelines, anticipated implementation challenges and mitigations, a strategy to reduce health disparities, and a reinvestment plan, among other topics.[2] CMS has developed a template for such implementation plans, and as of July 2026, eight states have had their CRE implementation plans approved.[3]

Aside from an approved implementation plan, states must also demonstrate budget neutrality, and CMS's recent budget neutrality guidance creates a narrower pathway to obtaining CRE planning and implementation expenditures. The services covered under most CRE demonstrations remain viable under the framework in SMD #26-003, but states likely need to pursue alternatives to fund implementation costs for infrastructure and capacity building. Beginning January 1, 2027, states seeking approval of a new demonstration, amendment, or renewal under the standard may need to identify alternative funding approaches.[4]

CMS-approved caps on implementation expenditures totaled ~$1.5 billion. States that cannot demonstrate budget neutrality for this component will need to explore alternative funding sources.

This may make future approval of CRE planning and implementation expenditures more difficult. The scale is substantial: as of July 2026, CMS-approved caps on planning and implementation expenditures across the 17 states included in this analysis totaled approximately $1.5 billion.[5] States that cannot demonstrate budget neutrality for this component will need to explore alternative funding sources such as Department of Justice or Substance Abuse and Mental Health Services Administration grants, Medicaid Advanced Planning Documents (APDs), and state general funds.[6]

A&M reviewed the CRE implementation plans approved to date to identify common themes and assess what CMS has approved in practice. One of CMS's objectives in creating CRE waivers was to improve care transitions[7] for individuals being released from carceral systems into Medicaid-funded community care, and most of the challenges we identified traced back to that goal. One of the major takeaways is that Medicaid eligibility determination and provider billing are often new or unfamiliar processes for many carceral facilities, which have historically operated in isolation from Medicaid. The implementation curve for these capabilities can be steep.

The challenges and mitigation strategies are set out in the table below.

Common Implementation Challenges, Mitigation Strategies, and Examples in Approved State Plans

Common Implementation Challenge	Mitigation Strategies	Examples in Approved State Plans
Short-term stays and unpredictable release dates: These can make it difficult to identify the exact start of the reentry window and to open coverage with enough time to deliver all services.	■ Issue guidance on priority services for shorter stays ■ Maximize duration of coverage to provide a larger time window for service delivery ■ Presume the service window opens upon incarceration for facilities with short-duration stays ■ Conduct eligibility screening at intake to maximize the runway to complete this process ■ For states using clinical criteria for eligibility: Standardize substance use disorder (SUD) and serious mental illness (SMI) screening processes, and perform clinical assessments early in the stay	■ **Illinois** *(proposed in approved plan; process described as draft):* presume that individuals in facilities with average stays of less than 90 days, such as Cook County Jail, are within the 90-day pre-release period. ■ **Massachusetts** *(proposed in approved plan):* use a statewide average approach to meet its approved 90-day duration of coverage.
Eligibility processing challenges: Carceral facilities may be unfamiliar with Medicaid processes and have varying abilities to support this process. This challenge may contribute to difficulties opening the reentry window with enough time for service delivery, particularly during short stays.	■ Provide Medicaid eligibility training, including refreshers, to facilities ■ Determine the most efficient eligibility process for carceral facilities to use, such as an online application, and identify whether funding is needed to support it, for example, devices and connectivity for online portals ■ Employ peer educators or navigators to support this process, which may even be a coverable service under the demonstration ■ Develop specialized teams, points of contact, email inboxes, or other communications channels with dedicated eligibility staff to assist with this process	■ **Massachusetts** *(existing at plan approval):* dedicated team of eligibility workers specializing in incarcerated individuals. ■ **New Hampshire** *(existing at plan approval):* designated Department of Health and Human Services subject matter expert and eligibility inbox for incarcerated eligibility cases. ■ **New Mexico** *(existing program to be expanded):* JUST Health liaison serves as a single point of contact for managed care organizations on administrative and coverage-related transition tasks.

Common Implementation Challenges, Mitigation Strategies, and Examples in Approved State Plans

Common Implementation Challenge	Mitigation Strategies	Examples in Approved State Plans
Delays in activating full Medicaid coverage upon release: It can be challenging to ensure seamless access to Medicaid following reentry, which may create unintended access barriers, such as providers being unable to deliver and bill for services during a perceived lapse in coverage.	■ Require carceral facilities to contact local eligibility offices within 24 hours following an unplanned release ■ Offer dedicated communications channels for eligibility, such as specialized shared email inboxes ■ Communicate in advance with managed care organizations (MCOs) to streamline post-release enrollment ■ Enroll individuals in MCOs prior to release so that MCOs manage the entire reentry benefit package	■ **New Hampshire** *(planned in approved plan):* enroll eligible individuals in MCOs during the pre-release window, with MCOs beginning care management at that point. ■ **Illinois** *(existing procedure at plan approval):* use a dedicated email for Medicaid members and providers experiencing service-access problems caused by delayed coverage-status updates.
Difficulty sharing data: Facilities face challenges sharing data with community providers. These challenges include technology capabilities and privacy concerns. Data sharing is important to facilitate timely and efficient case-management handoffs, appointment scheduling, federal reporting, and state quality monitoring.	■ Update data-sharing agreements between facilities, providers, and state agencies ■ Standardize the timing and frequency of release-data exchanges across correctional facilities ■ Define key data terms for collection and analysis, for example, a standardized definition of recidivism or a method for calculating expected release dates ■ Streamline release-of-information (ROI) workflows and standardize ROI forms with providers and MCOs ■ Develop an informed-consent form encompassing the entire package of covered reentry services ■ Integrate data and tracking into one system of record wherever possible so that data can be shared more easily among partners ■ Provide technical assistance to carceral facilities to identify processes and technology necessary for data sharing	■ **Massachusetts** *(planned in approved plan; plan target Q1 2025):* standardize the timing and frequency of file sharing with the Department of Correction and county correctional facilities.

Common Implementation Challenges, Mitigation Strategies, and Examples in Approved State Plans

Common Implementation Challenge	Mitigation Strategies	Examples in Approved State Plans
Unfamiliarity with the Medicaid billing process: Carceral facilities have a learning curve to understand Medicaid billing. This can make it challenging for facilities to collect reimbursement for covered services and may affect long-term sustainability.	■ Arrange funding for training and technical assistance, electronic health record (EHR) systems such as medical records and pharmacy management, billing software, and technology equipment ■ Offer state Medicaid agency support for Medicaid provider enrollment and billing activities	■ **Washington** *(in procurement at plan approval):* procure a third-party administrator to serve as a claims clearinghouse and give facilities a single point of contact for submitting claims.
Access to prescription medications: It can be difficult to coordinate a 30-day supply of prescription medications in hand at release, especially in cases of unplanned releases or in facilities with limited onsite pharmacy resources.	■ Facilitate contracting with local pharmacies if they are not already used as a backup to onsite or mail-order pharmacies ■ Explore enhancing the onsite pharmacy presence within carceral facilities, funded through the reimbursement model ■ Consider covering the full Medicaid formulary of prescription drugs pre-release, which would allow the state Medicaid agency to take full advantage of rebates for the entire reentry benefit ■ Streamline prior authorization (PA) requirements for post-release prescription medications, and facilitate sharing of medical records so that PAs can be put in place prior to release	■ **Washington** *(planned in approved plan):* work with participating facilities, where needed, to enroll their pharmacies as Medicaid providers and align facility formularies with the Medicaid formulary. ■ **Massachusetts** *(planned in approved plan; plan target Q2 2025; current status unverified):* work with facilities that rely on the State Office for Pharmacy Services or vendors rather than onsite pharmacies to establish processes for providing at least a 30-day supply of covered medications at release.
ID cards at release: Participants who leave without a valid Medicaid ID may have trouble accessing services in the community, so states need robust processes to help ensure participants have their ID in hand before leaving the facility.	■ Ensure that electronic versions of the Medicaid ID are available to individuals and carceral facilities, and encourage facilities to print a copy for individuals prior to release ■ Mail Medicaid ID cards to the facility, with duplicates mailed to the post-release address of record ■ Expand the definition of "address of record" to include a district office or other safe storage location for those at risk of or experiencing homelessness ■ Require storage of Medicaid ID and health plan ID in an individual's medical record to facilitate billing before and at release, as well as continuity of care after release	■ **New Mexico** *(planned in approved plan):* help members access and print their member card through the YesNM portal or an MCO member services website. ■ **Massachusetts** *(planned in approved plan; plan target Q3 2025; current status unverified):* request that a replacement ID card be sent to the facility in addition to the member's community address.

Common Implementation Challenges, Mitigation Strategies, and Examples in Approved State Plans

Common Implementation Challenge	Mitigation Strategies	Examples in Approved State Plans
Provider availability for pre- and post-release services: Some community providers have limited availability to schedule appointments. Facilities may also not be aware of the various provider options.	■ Use or expand telehealth wherever possible, which may require investment to install access points with adequate privacy ■ Provide a curated list of potential community-based organization partners by region ■ Deputize in-reach care managers to lead appointment scheduling ■ Engage proactively with community provider organizations about program design and goals, and articulate the opportunity for them ■ Explore incentive structures to align interests on pre- and post-release reimbursement and prioritization of this population ■ Ensure that billing codes are available and tested prior to launch, and that providers understand and are comfortable using the codes	■ **New Hampshire** *(planned in approved plan):* identify service needs early and schedule post-release appointments within MCO networks while individuals remain incarcerated.

Source: A&M analysis of CMS-approved Section 1115 reentry implementation plans available as of July 2026. Status descriptions reflect each state's position at the date its plan was approved. Examples are illustrative, not exhaustive. The review was not designed to assess subsequent implementation or the effectiveness of the approaches described.

These implementation challenges share a common thread: they often require new funding, staffing, or technology investment, and CMS's recent budget neutrality guidance changes how states can finance them. For states still developing their CRE waiver programs, funding strategy is one of several design considerations that will shape implementation timelines and ultimately the program's chances for success.

A&M has supported states on CRE planning and implementation since 2022, before CMS issued the reentry demonstration guidance, and can help address these and other challenges.

In future pieces, we will examine key differences across the eight states with approved implementation plans, including variations in funding and mitigation strategies.

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Endnotes

1 Alvarez & Marsal analysis of "Reentry Section 1115 Demonstrations," Centers for Medicare & Medicaid Services, accessed July 2026. Excludes Oregon, which decided not to implement the reentry demonstration under its current waiver, and Michigan, which withdrew prior to formal implementation. Oregon Health Authority, "Oregon's 1115 Medicaid Waiver: All Come Webinar," November 12, 2025, slide 15; Michigan Department of Health and Human Services to Centers for Medicare & Medicaid Services, "Michigan Section 1115 Reentry Services Demonstration Withdrawal Request," December 4, 2025.

2 Daniel Tsai, "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated," SMD #23-003 (Centers for Medicare & Medicaid Services, April 17, 2023), 1–2.

3 A&M tally of CMS reentry implementation plan approvals posted to Medicaid.gov as of July 2026. Approved plans: California (March 6, 2024), New Hampshire (January 2, 2025), Washington (January 8, 2025), New Mexico (January 17, 2025), Massachusetts (May 29, 2025), Montana (October 10, 2025), Illinois (December 12, 2025), and Maryland (December 16, 2025). California's plan was approved before CMS published the current template for comment and is structured differently. The template was published for comment in Centers for Medicare & Medicaid Services, "Medicaid and Children's Health Insurance Program (CHIP) Generic Information Collection Activities: Proposed Collection; Comment Request," Federal Register 89, no. 212 (November 1, 2024): 87375–76, which describes the reentry implementation plan template as one of three templates that are strongly encouraged but optional. Table example locators: Illinois (Attachment K: short-term-stay presumption, p. 12; coverage-status email, p. 5); Massachusetts (statewide average and specialized eligibility team, p. 6; standardized file sharing, p. 4; medication supply, p. 28; replacement ID card, p. 14); New Hampshire (eligibility inbox and subject matter expert, pp. 5–6; MCO enrollment and pre-release care management, p. 10; appointment scheduling, p. 12); New Mexico (JUST Health liaison, p. 11; member-card access, p. 5); and Washington (pharmacy enrollment and formulary alignment, p. 6; third-party administrator and claims clearinghouse, p. 7).

4 "Budget Neutrality and Certification by the Chief Actuary of CMS for Section 1115 Medicaid Demonstration Projects," SMD #26-003 (Centers for Medicare & Medicaid Services, June 11, 2026), 1–2, 24–25, "Transitional Impacts: Assessment of Current Demonstration Projects."

5 A&M analysis of CMS-approved Section 1115 special terms and conditions and related approval attachments. As of July 2026, annual limits on total computable expenditures for the Reentry Demonstration Initiative Planning and Implementation Program across the 17 states included in this analysis totaled $1,544,388,610, or approximately $1.5 billion. Oregon and Michigan are excluded. These amounts represent approved expenditure ceilings, not actual expenditures, and include both federal and non-federal shares.

6 Implementation funding may come from several sources. For new, amended, or renewed section 1115 authority beginning January 1, 2027, SMD 26-003 may constrain approval of planning, capacity-building, and infrastructure expenditures. States may still explore Medicaid Advanced Planning Documents for qualifying technology investments; Department of Justice, Substance Abuse and Mental Health Services Administration, or other federal grants; private foundation grants; and state general funds. See Centers for Medicare & Medicaid Services, "Advanced Planning Documents (APD) for System Development Associated with 1115 Demonstrations," June 13, 2019.

7 "SMD #23-003"; see note 2.