



Justice and Medicaid Roadmap for the New England Regional Judicial Opioid Initiative



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Regional Judicial Opioid Initiative

In April 2019, six Northeastern states — Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont — established the New England Regional Judicial Opioid Initiative (NE RJOI), a multistate collaborative aimed at developing regional solutions to the overdose epidemic from a court perspective, while strengthening collaboration among stakeholders. This initiative includes chief justices, state courts, state criminal justice agencies, supervision agencies, state public health agencies, legislators, treatment providers, medical experts, and child welfare representatives.

With funding from the Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP), the National Center for State Courts provides project management for the collaborative initiative. To address data and research needs of the NE RJOI, an action research partner (Dr. Brad Ray with RTI International) is tasked with informing potential public health strategies. Given ongoing efforts to expand public healthcare to those involved with criminal-legal systems, the NE RJOI hosted a “Justice and Medicaid” workshop aimed at increasing knowledge of these systems among the stakeholders. This report, produced by the action research partners, presents justice and Medicaid approaches across the region by providing a state-by-state snapshot of current policies impacting incarcerated Medicaid beneficiaries and Medicaid-eligible individuals.

Medicaid Policy for Justice-Involved Individuals

Before detailing the results of the environmental scan, the following is a brief outline of the history of Medicaid as it pertains to justice-involved populations. While the incarceration rates in New England are generally lower than the national average, the United States (U.S.) has the highest incarceration rate in the world (Miller, 2021). On any given day there are over 2.2 million adults involuntarily detained in carceral settings, with approximately 600,000 people entering prison and 11 million people booked into jail yearly (Zeng & Minton, 2021). Overall, persons in carceral settings are significantly less healthy than the general population; they are more likely to have a chronic physical condition (e.g., diabetes, heart disease) and have higher rates of infectious diseases. Mental health and substance use disorders also are prevalent among the justice-involved population, with approximately half or more with these conditions (Bui et al., 2019).

Signed into law in 1965, Medicaid is a combined federal and state program that provides healthcare coverage for low-income individuals including children, mothers, pregnant women, elderly individuals, and people with disabilities. Although the federal government sets requirements for the program, states have flexibility in how they administer their Medicaid program, and as a result, Medicaid eligibility, coverage, and policies vary across states (*Medicaid Program History*, 2022). In 2014, the enactment of the Affordable Care Act (ACA) brought about the option for states to expand Medicaid coverage to childless low-income adults up to 133% of the poverty level and others, and it provided enhanced federal Medicaid funding for this population. Since the expansion became available, most states, but not all, have opted to expand Medicaid coverage to low-income adults.

While access to healthcare during incarceration is mandated by the U.S. Constitution (Eber, 2009), Medicaid has not been a primary payer of healthcare services for detained citizens due to a federal Medicaid statute that prohibits coverage for persons in public institutions (referred to as the Medicaid inmate exclusion policy or inmate payment exclusion) with an exception for off-site inpatient care that lasts more than 24 hours (Acoca et al., 2014; Gates et al., 2014)(U.S. Congress 1965; see [IF11830 \(congress.gov\)](#)). Thus, carceral facilities are responsible for funding healthcare for incarcerated persons, with services provided by either a public county health agency or contracted out to a private provider, and for seeking Medicaid reimbursement for eligible inpatient services. It is important to note the Medicaid inmate exclusion policy only

refers to payment of services; the policy does not preclude an inmate from being eligible for and enrolled in Medicaid per se, but historically, many states terminated a person's Medicaid coverage during incarceration (see [IF11830 \(congress.gov\)](#)). Most states now suspend eligibility for at least some time during incarceration or retain eligibility but suspend coverage to services other than inpatient care (KFF, 2019). Such suspensions are intended to not only facilitate Medicaid reimbursement for covered inpatient services during incarceration but also reinstatement of Medicaid coverage for returning citizens upon release.

In recent years, states have placed more focus on expediting the reactivation of Medicaid coverage for returning citizens whose coverage was suspended and new Medicaid eligibility determinations for others prior to release. In fact, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act, enacted in 2018, now prohibits states from terminating Medicaid eligibility for juveniles under age 21 or former foster care youth up to age 26 during incarceration and requires states to redetermine Medicaid eligibility for these individuals prior to release without a new application.

States are using a variety of approaches to facilitate Medicaid enrollment at release and improve continuity of care for justice-involved individuals at reentry through Medicaid (Haldar and Guth, 2021). Beyond the ACA coverage expansion to low-income adults, these approaches efforts to partially waive the inmate exclusion policy near release, facilitation of Medicaid eligibility determinations and enrollment prior to release, and additional care coordination and supports to returning citizens. Two key mechanisms states have used to execute these efforts are: 1) Amendments to Medicaid state plans and 2) Section 1115 demonstration applications, which, if approved by the federal government, allow states to waive certain provisions of Medicaid law in order to carry out pilot or demonstration projects (e.g., related to waiving the inmate inclusion policy or providing targeted services to justice-involved individuals in the community). In addition, states have leveraged their contracts with managed care organizations (MCOs) for targeted outreach and coordination efforts to Medicaid beneficiaries post release.

Report Methodology and Data Collection

From August 11, 2022, to September 30, 2022, researchers at RTI International (D. Spencer and A. Van Dall) conducted an environmental scan of policies and services across the NE RJOI states aimed at expanding coverage and improving continuity of care for incarcerated Medicaid beneficiaries and Medicaid-eligible individuals who are returning citizens. Given the focus of the NE RJOI on substance use disorders (SUD), opioid use disorder (OUD), and overdose prevention efforts within criminal-legal systems, the environmental scan focused on policies and services impacting incarcerated Medicaid-eligible individuals and Medicaid beneficiaries across these areas.

The environmental scan relied on publicly available documentation including state and federal government reports and briefs from research and policy organizations. Whenever possible, information about policies and services was abstracted directly from public state documents in the form of agency bulletins, legislation, or white papers. Specifically, each state's Medicaid and Department of Corrections websites were searched for relevant policies and initiatives for each area of inquiry. This approach allowed for tailored reporting for each state, but there are a few limitations to note.

The implementation of legislature is not published as freely as the legislation itself, meaning these data sources cannot definitively indicate to what extent a policy has been actualized. Considering the challenges posed by the COVID-19 pandemic, as well as the complex logistics required to execute and document correctional programming in general, it is not certain if the legislature referenced herein has materialized into practice or the quality of the states' implementations. Legislation can also be amended or repealed quickly and with little notice. Finally, some of the government and policy reports and briefs leveraged are dated and the policies and services described in this work have not yet been vetted with key NE RJOI stakeholders with knowledge of these policies and are subject to change.

Environmental Scan Results

Results of the environmental scan are shown across several tables providing a state-by-state snapshot of available information for the NE RJOI states on specific areas of focus along with the steward responsible for enacting that policy or service (Medicaid, local jail, or prison). In discussing these tables, themes emerged with justice-involved populations that include the importance of maintaining Medicaid eligibility through the carceral process (including post-release), the shared responsibilities of Medicaid and corrections agencies during reentry planning, and the availability of medications for opioid use disorder (MOUD)ⁱ across correctional systems.

MEDICAID ELIGIBILITY LANDSCAPE FOR THE JUSTICE INVOLVED

As illustrated in Table 1, all the NE RJOI states are Medicaid expansion states. Due to the Medicaid inmate exclusion policy described above, most states now suspend Medicaid eligibility for at least some time during incarceration or retain eligibility but suspend coverage to services other than inpatient care. Such suspensions are intended to not only facilitate Medicaid reimbursement for covered inpatient services during incarceration but also to facilitate reinstatement of Medicaid coverage for returning citizens upon release. Reapplying and receiving approval for Medicaid coverage unnecessarily delays returning individuals from accessing healthcare and may also complicate reentry planning for individuals with pressing healthcare needs.

TABLE 1. MEDICAID COVERAGE OF LOW-INCOME ADULTS

State	Medicaid Expansion Status (KFF, 2022) ¹ Steward: Medicaid
CT	Yes
ME	Yes
MA	Yes
NH	Yes
RI	Yes
VT	Yes

¹[Status of State Medicaid Expansion Decisions: Interactive Map | KFF](#)

ⁱ Please note that MOUD (medications for opioid use disorder) and MAT (medication assisted therapy) are considered interchangeable; however, there is a growing movement to use MOUD that is backed by research suggesting it results in less explicit bias; see Ashford, R. D., Brown, A. M., & Curtis, B. (2018). Substance use, recovery, and linguistics: The impact of word choice on explicit and implicit bias. *Drug and alcohol dependence*, 189, 131-138.

Table 2 shows that all NE RJOI states suspend benefits. Connecticut’s policy specifies that suspensions may only last three years before termination, meaning Medicaid members serving longer sentences would require reapplication before or after discharge.

At present, the Massachusetts and Vermont state Medicaid programs have submitted proposals to federal Centers for Medicare & Medicaid Services (CMS) to expand coverage for incarcerated persons, while the state legislature in Rhode Island has approved it, but the waiver had not yet been sent at the time of developing this report (see Table 2). The pending proposals from Massachusetts and Rhode Island would allow state offices to provide coverage in the 30 days prior to release from incarceration, with the latter state also requesting to continue eligibility for the first 30 days of incarceration. Vermont has requested to offer coverage for 90 days prior to release. None of these proposals have received approval from CMS at the time of reporting.

TABLE 2. ELIGIBILITY UPON AND DURING INCARCERATION

State	Suspension vs. Termination of Medicaid Enrollment at Incarceration (KFF, 2019; MACPAC, 2018) ^{1,2} Steward: Medicaid	Waiver of Inmate Exclusion Policy Steward: Medicaid
CT	Suspension Up to 3 years, then terminated (Conn. Office of Legislative Research, 2016) ³	NA
ME	Suspension	NA
MA	Suspension	Pending 1115 waiver including state plan benefits for incarcerated adults with 30 days prior to release and youth in juvenile facilities (KFF, 2022a; MassHealth, 2022) ^{4,5}
NH	Suspension	NA
RI	Suspension	RI Medicaid Reentry Act Benefits for adult inmates during 1st 30 days and last 30 days (R.I. Legislature, 2022) ⁶ Senate approved waiver application for last 30 days.
VT	Suspension	Pending 1115 waiver including Full Medicaid State Plan benefits for all eligible inmates 90 days prior to release (KFF, 2022a; KFF, 2021) ^{4,7}

¹ States Reporting Corrections-Related Medicaid Enrollment Policies In Place for Prisons or Jails | KFF

² Medicaid-and-the-Criminal-Justice-System.pdf (macpac.gov)

³ <https://www.cga.ct.gov/2016/rpt/pdf/2016-R-0261.pdf>

⁴ State Waivers List | Medicaid

⁵ <https://www.mass.gov/service-details/1115-masshealth-demonstration-waiver>

⁶ SB2694 | Rhode Island 2022 | AN ACT RELATING TO STATE AFFAIRS AND GOVERNMENT -- THE MEDICAID REENTRY ACT (Requires that Medicaid enrollment be maintained or provided to all inmates in the first 30 days of incarceration at the adult correctional institutions within the department of corrections and the last 30 days of incarceration.) | TrackBill

⁷ State Policies Connecting Justice-Involved Populations to Medicaid Coverage and Care | KFF

REENTRY PLANNING VIA INTERAGENCY COLLABORATION

Collaboration between Medicaid and corrections agencies is critical during the immediate pre- and post-reentry phases to facilitate linkages to Medicaid enrollment and healthcare. Table 3 identifies the approaches states take to facilitate returning citizens' enrollment in Medicaid in anticipation of release for individuals whose Medicaid coverage or benefits were suspended during incarceration. The DOCs in Connecticut and New Hampshire contact Medicaid directly to restore benefits while Maine stipulates that incarcerated individuals must receive assistance from DOC staff to renew and Massachusetts operates a program through which corrections staff are trained by Medicaid to provide application counseling to incarcerated applicants.

TABLE 3. MEDICAID ENROLLMENT APPROACHES IN ANTICIPATION OF RELEASE

State	Eligibility Renewal for Individuals for Whom Medicaid Enrollment was Suspended Stewards: State Medicaid, Prisons and Jails	Automated Data Exchange to Facilitate Reinstatement of Enrollment (KFF, 2019) ¹ Stewards: State Medicaid, Prisons and Jails	Application Assistance/ Enrollment Process for Uninsured Individuals Stewards: State Medicaid, Prisons and Jails
CT	DOC contacts Medicaid agency as individuals are released; benefits are restored (KFF, 2016) ²	Yes	Pre-release enrollment program with streamlined application/determination involving DOC (Urban, 2016) ⁶
ME	Statute requirement that incarcerated beneficiaries receive assistance to renew (ME Legislature, 2021) ³	No	State requirement that eligible individuals receive assistance to apply; DOC memo of understanding to provide assistance in applying for benefits (ME Legislature, 2021) ³

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State	Eligibility Renewal for Individuals for Whom Medicaid Enrollment was Suspended Stewards: State Medicaid, Prisons and Jails	Automated Data Exchange to Facilitate Reinstatement of Enrollment (KFF, 2019) ¹ Stewards: State Medicaid, Prisons and Jails	Application Assistance/ Enrollment Process for Uninsured Individuals Stewards: State Medicaid, Prisons and Jails
MA	Reintegration program involving both Medicaid and DOC to enroll individuals; eligibility is based on prior application within last year or new application; DOC staff trained as application counselors (KFF, 2016) ⁴	No	Reintegration program involving both Medicaid and DOC to enroll individuals; eligibility is based on prior application within last year or new application; DOC staff trained as application counselors (KFF, 2016) ⁴
NH	DOC contacts Medicaid to lift suspension (N.H. HHS, 2019) ⁵	Yes	DOC or county jail staff initiate the application process (N.H. HHS, 2019) ⁵
RI	Unable to locate	Yes	Medicaid application and assistance integrated into DOC discharge planning (NASHP, 2015) ⁷
VT	Unable to locate	No	Unable to locate

¹ States Reporting Corrections-Related Medicaid Enrollment Policies In Place for Prisons or Jails | KFF

² Connecting the Justice-Involved Population to Medicaid Coverage and Care – Issue Brief – 8876 | KFF

³ Title 22, §3174-CC: Medicaid eligibility during incarceration (maine.gov)

⁴ Connecting the Justice-Involved Population to Medicaid Coverage and Care – Issue Brief – 8876 | KFF

⁵ Medical Assistance Manual (nh.gov)

⁶ Using Jail to Enroll Low-Income Men in Medicaid (urban.org)

⁷ Rhode Island: State Strategies to Enroll Justice-Involved Individuals in Health Coverage - The National Academy for State Health Policy (nashp.org)

Interagency data sharing and automated data exchange has the potential to expedite benefit activation post release and reduce much of the labor associated with establishing Medicaid for re-entering members. Data sharing pathways between state agencies can be leveraged to submit required documentation for incarcerated members' Medicaid renewals and first-time applications. Connecticut, New Hampshire, and Rhode Island have implemented automatic file exchanges between the state Department of Corrections (DOC) and State Medicaid for the purposes of Medicaid benefits activation. It should be noted this does not guarantee all incarcerated Medicaid members are accounted for given that Medicaid members in jail are not likely to have DOC records, apart from those in unified systems.

Corrections and Medicaid can also form workflows to assist individuals preparing to re-enter with first-time Medicaid applications. Connecticut and Massachusetts both operate programs that streamline the Medicaid application and eligibility determination process for individuals preparing for release. Rhode Island incorporates Medicaid applications as part of the discharge planning process, but eligibility decisions are not made until the day of release. Maine and New Hampshire have policies in place requiring corrections staff to assist incarcerated individuals in applying for Medicaid.

MEDICAID SERVICES DURING AND BEYOND REENTRY

Several of the RJOI states' Medicaid programs provide targeted services to re-entering individuals that can facilitate access to and continuity of care during the transition back to the community and after (see Table 4). In September 2022, Massachusetts received approval for its Section 1115 demonstration extension which includes providing 12 continuous months of Medicaid enrollment to adults and juveniles after release from incarceration (Health and Human Services, 2022). Vermont's pending 1115 Waiver includes permanent supportive housing benefits for eligible justice-involved individuals along with a Community Support Program for individuals released from prison or jail in the previous year and individuals on parole. Program beneficiaries receive case management for housing and healthcare, coaching to achieve employment, education, and other daily living skills, and crisis stabilization services.

TABLE 4. MEDICAID SERVICES DURING AND BEYOND REENTRY

State	Continuous Medicaid Eligibility Post-Release Steward: Medicaid	Care Coordination Steward: Medicaid	Other Services for Justice-Involved Individuals Living in Community Steward: Medicaid
CT		Medicaid voucher for a 30-day supply of medically necessary prescription medications (KFF, 2021; MACPAC, 2018) ^{3,4}	
ME		FFS care coordination services prior to release (KFF, 2021) ³	
MA	Approved 1115 waiver providing 12 months of continuous enrollment to qualified adults and youth		Approved 1115 Waiver Diversionary behavioral health services: Community Support Program for people who have been incarcerated

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State	Continuous Medicaid Eligibility Post-Release Steward: Medicaid	Care Coordination Steward: Medicaid	Other Services for Justice-Involved Individuals Living in Community Steward: Medicaid
	following release (KFF 2022a; MassHealth, 2022) ^{1,2}		(KFF 2022a; MassHealth, 2022) ^{1,2}
NH		MCO/FFS care coordination services prior to release (KFF, 2021) ³	
RI		MCO outreach, assessment, and care coordination (NASHP, 2015) ⁵ Health home focused on opioid treatment for Medicaid beneficiaries with chronic health conditions on re-entry (Commonwealth Fund, 2020) ⁶	
VT			Pending 1115 Waiver permanent supportive housing benefits for individuals with justice system involvement in past 12 months (KFF, 2022a) ¹

¹ Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State | KFF

² <https://www.mass.gov/service-details/1115-masshealth-demonstration-waiver>

³ State Policies Connecting Justice-Involved Populations to Medicaid Coverage and Care | KFF

⁴ Medicaid-and-the-Criminal-Justice-System.pdf (macpac.gov)

⁵ Rhode Island: State Strategies to Enroll Justice-Involved Individuals in Health Coverage - The National Academy for State Health Policy (nashp.org)

⁶ Medicaid's Role Advancing Health People Involved Justice System | Commonwealth Fund

Medicaid programs may also lend support to returning individuals via case management services. Maine, New Hampshire, and Rhode Island's Medicaid programs provide care coordination services to releasing Medicaid members. Maine offers fee-for-service (FFS) care coordination and New Hampshire offers both managed care and FFS care coordination pre-release. In Rhode Island, outreach, risk assessment, and care-coordination services are provided by managed care organizations while Connecticut offers returning citizens a voucher to be used for a 30-day supply of necessary medications upon release.

MOUD ACROSS THE CORRECTIONS SPECTRUM

Given NE RJOI’s focus on addressing SUD and OUD among the justice-involved population, supports were examined for MOUD and adjunctive behavioral health services for the general Medicaid population in correctional settings and during reentry across the NE RJOI states. As documented in Table 5, all of the NE RJOI states are currently participating in the Section 1115 Substance Use Disorder Demonstration for enhanced substance use disorder treatment, and in all states, Medicaid provides coverage for all three FDA approved MOUD: buprenorphine, naltrexone, and methadone.

Unlike the prior policies reviewed from this environmental scan, the agencies at the helm of justice system OUD programs are the jails and prisons who are responsible for the healthcare of detainees. To avoid OUD treatment disruption due to incarceration, jails and prisons should continue treatment upon admission and screen for individuals with unmet needs (US Department of Health and Human Services, 2019).

TABLE 5. MEDICAID SUBSTANCE USE DISORDER AND OPIOID USE DISORDER TREATMENT

State	Section 1115 SUD Waiver Status (KFF, 2022a; KFF, 2022d) ^{1,2} Steward: Medicaid	Coverage of MAT for Opioid Use Disorder (KFF, 2019; KFF, 2022b) ^{3,4}			
		Buprenorphine Steward: Medicaid	Naltrexone Steward: Medicaid	Methadone Steward: Medicaid	Suboxone Steward: Medicaid
CT	Approved 4/14/22	Yes	Yes	Yes	Yes
ME	Approved 12/22/20	Yes	Yes	Yes	Yes
MA	Extension Approved 9/28/2022	Yes	Yes	Yes	Yes
NH	Approved 7/10/18	Yes	Yes	Yes	Yes
RI	Approved 12/20/18	Yes	Yes	Yes	Yes
VT	Approved 6/6/18	Yes	Yes	Yes	Yes

¹ Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State | KFF

² State Waivers List | Medicaid

³ States Reporting Corrections-Related Medicaid Enrollment Policies In Place for Prisons or Jails | KFF

⁴ State Category | Medicaid Behavioral Health Services | KFF

Table 6 documents current OUD treatment offerings in jails and prisons. A diversion program operating in Connecticut, the Treatment Pathways Program, has shown promise as a model to limit the pretrial SUD population. Program participants displayed improved failure-to-appear, rearrest, and incarceration sentencing outcomes. However, there are only four participating courts and eligibility for participation requires screening and approval from bail staff, clinicians, and the presiding judge, with approximately 51% of individuals screened being admitted.

The Maine Sheriff's Association introduced a model in all county facilities to standardize the process for enrolling pretrial detainees into OUD treatment, although jails are given discretion in whether they enroll individuals who were not being treated prior to arrest. In 2021, Maine DOC expanded to offer buprenorphine and naltrexone to all individuals housed by the department.

In 2019, Massachusetts Sheriff's Association implemented a similar jail pilot program in seven counties to continue MOUD therapy for individuals entering with an existing treatment regimen, but they did not deem the funding they received in the 2022 state budget adjustment adequate to expand the program to other facilities. The Massachusetts DOC aimed to provide MOUD in all state prisons by June 1, 2022.

New Hampshire folded provisions into the 2020 House Bill 1639 that requires all county jails to perform SUD screening and provide MOUD for individuals meeting clinical criteria for SUD, regardless of treatment status at intake.

Rhode Island and Vermont have provided MOUD since 2016 and 2018, respectively. The proportion of incarcerated individuals in Vermont with a prescription for MOUD increased from 0.8% to 33.9% between 2017 and 2020, and post-release overdose deaths decreased from 1.1% to 0.03% during the same period. In June 2021, the Connecticut DOC also aimed to provide MOUD in nine state facilities, including the women's prison.

Each state's DOC screening protocols are also summarized in Table 6. Connecticut screens during jail intake, as does New Hampshire. Massachusetts screens at intake and intermittently thereafter. Rhode Island and Vermont's screening protocols were not enumerated. Maine's SUD screening protocols were not available but may have been altered recently given the new MOUD program implementation.

TABLE 6. SUBSTANCE USE DISORDER AND OPIOID USE DISORDER TREATMENT DURING INCARCERATION

State	Corrections-Based MOUD Offerings Stewards: Jails and Prisons	Substance Use Disorder Screening in Corrections Stewards: Jails and Prisons
CT	“Treatment Pathways Program” operating in four courts. (Conn. DMHAS, 2022) ¹ DOC offering MOUD (all 3 classes) in 9 state facilities.(Conn. DOC, 2021a) ²	SUD screening completed at jail intake; not duplicated during prison intake (Conn. DOC, 2021b). ¹⁰
ME	All jails authorized to enroll detainees in MOUD, though access may depend on disposition prior to arrest. Specific MOUDs available may vary (NASHP, 2015). ³ Buprenorphine/Naltrexone offered in all DOC facilities (Maine DOC, 2021). ⁴	Recent MOUD program overhaul. Screening protocol not clear.
MA	MOUD program operating in 7 county facilities (MassLive, 2022). ⁵ DOC working to expand all MOUDs in all prisons (Mass. DPH, 2022). ⁶	SUD screening required at intake and intermittently thereafter (Mass. DPH, 2022; Mass DOC, 2022). ^{6,11}
NH	2020 HB 1639 requires MOUD for individuals in county facilities regardless of disposition before incarceration. (N.H. Legislature, 2020). ⁷	2020 HB 1639 requires screening in jails for SUD (N.H. Legislature, 2020). ⁷
RI	All 3 classes of MOUDs offered in all facilities (CODAC, 2022). ⁸	Revised screening protocol in 2016 associated with MOUD program rollout (Pew Trusts, 2020). ¹²
VT	All 3 classes of MOUDs offered in all facilities (NASHP, 2021). ⁹	“Tailored extensive” screening protocol designed by addiction physician (Pew Trusts, 2020). ¹²

¹ <https://ctvideo.ct.gov/dmhas/Criminal%20Justice%20Effort%20Recording.mp4>

² <https://portal.ct.gov/-/media/DOC/Pdf/PressRelease/Press-Releases-2021/DOC-PRESS-RELEASE-re-DOC-Expands-MOUD-programs-061721.pdf>

³ Rhode Island: State Strategies to Enroll Justice-Involved Individuals in Health Coverage - The National Academy for State Health Policy (nashp.org)

⁴ <https://www.maine.gov/corrections/sites/maine.gov.corrections/files/inline-files/MDOC%20MAT%20Expansion%20Statement.pdf>

⁵ <https://www.masslive.com/springfield/2022/03/sheriffs-massachusetts-county-jails-filling-gap-in-substance-use-mental-health-care.html>

⁶ <https://www.mass.gov/doc/bsas-moud-in-correctional-settings-presentation-1522-0/download>

⁷ <https://legiscan.com/NH/text/HB1639/id/2198330>

⁸ <https://codacinc.org/programs-services/ri-aci/>

⁹ <https://www.nashp.org/wp-content/uploads/2021/05/VT-DOC-report-4-29-2021.pdf>

¹⁰ https://portal.ct.gov/-/media/DOC/Pdf/Coronavirus-3-20/IMS-Assessment-Report-to-CT-DOC-022821_051021.pdf

¹¹ download (mass.gov)

¹² <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2020/04/opioid-use-disorder-treatment-in-jails-and-prisons>

Conclusions

Given the health vulnerabilities among the incarcerated population, access to healthcare during reentry is critical for continuing treatment received while incarcerated, managing chronic conditions, and averting health crises especially while facing additional reentry barriers such as housing, employment, and possible court requirements (Altschuler & Brash, 2004; Freudenberg et al., 2005; Golzari & Kuo, 2013). Indeed, research suggests that health deteriorates in the year following release, with rates of hospitalizations, emergency room visits, and mortality that far exceed those for individuals without recent incarceration histories (Binswanger et al., 2007; Frank et al., 2014; Visher & Mallik-Kane, 2007). Recent research has shown that efforts to facilitate Medicaid enrollment at release are associated with increased Medicaid coverage (Blackburn et al., 2020), and Medicaid coverage at reentry is associated with increased access to outpatient care and substance use treatment (Burns et al., 2022).

Results from this environmental scan show that NE RJOI states have several mechanisms in place that help to connect the justice-involved population to Medicaid coverage. This includes Medicaid coverage of low-income adults and suspension rather than termination of enrollment upon incarceration. Additionally, three of the NE RJOI states have pursued or are seeking a waiver of the inmate exclusion policy and have enacted efforts for parity in services and screening. Most NE RJOI states also have at least some targeted services aimed at connecting Medicaid enrollees to healthcare or treatment at reentry, and two states are taking steps to extend assistance to other community services for justice-involved individuals living within the community.

This environmental scan also focused on SUD and OUD as a policy area of importance for the NE RJOI and found that corrections-based programs that include MOUD as initiatives have expanded considerably in recent years across many of the NE RJOI states, but access is not yet consistent within systems and not all medications are provided. Moreover, the screening methodology varies between facilities and systems resulting in potential disruption of treatment, particularly for individuals whose MOUD protocol requires prior authorization from Medicaid. Correctional healthcare vendors and corrections systems are generally not registered Medicaid providers, so individuals who initiate MOUD treatment in a correctional setting may need to be seen and evaluated by a new provider before they can continue treatment post-release using their Medicaid benefits.

It is important to remember that getting persons signed up with Medicaid is just the first step; getting people connected to and engaged in the care that they need is crucial, and with SUD treatment there are gaps in the availability of care, particularly in rural jurisdictions and those with a high percentage of uninsured residents (Cummings et al., 2014). While it is beyond the scope of this environmental scan to assess the availability of these services across the NE RJOI states, the results from this scan suggest need for additional research.

Investigating more fully whether these policies — especially where there is variation in how they are implemented — are associated with improvements in Medicaid coverage and SUD service utilization, as well as reductions in recidivism or use of criminal-legal systems, could reveal best practices.



References

- Acoca, L., Stephens, J., & Vleet, A. V. (2014). *Health Coverage and Care for Youth in the Juvenile Justice System: The Role of Medicaid and CHIP* (p. 15).
- Altschuler, D. M., & Brash, R. (2004). Adolescent and Teenage Offenders Confronting the Challenges and Opportunities of Reentry. *Youth Violence and Juvenile Justice, 2*(1), 72–87. <https://doi.org/10.1177/1541204003260048>
- Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from Prison — A High Risk of Death for Former Inmates. *The New England Journal of Medicine, 356*(2), 157–165. <https://doi.org/10.1056/NEJMsa064115>
- Blackburn, J., Norwood, C., Rusyniak, D., Gilbert, A. L., Sullivan, J., & Menachemi, N. (2020). Indiana’s Section 1115 Medicaid Waiver And Interagency Coordination Improve Enrollment For Justice-Involved Adults. *Health Affairs, 39*(11), 1891–1899. <https://doi.org/10.1377/hlthaff.2019.01823>
- Bui, J., Wendt, M., & Bakos, A. (2019). Understanding and Addressing Health Disparities and Health Needs of Justice-Involved Populations. *Public Health Reports, 134*(1_suppl), 3S-7S. <https://doi.org/10.1177/0033354918813089>
- Burns, M. E., Cook, S., Brown, L. M., Dague, L., Tyska, S., Hernandez Romero, K., McNamara, C., & Westergaard, R. P. (2022). Association Between Assistance With Medicaid Enrollment and Use of Health Care After Incarceration Among Adults With a History of Substance Use. *JAMA Network Open, 5*(1), e2142688. <https://doi.org/10.1001/jamanetworkopen.2021.42688>
- Cummings, J. R., Wen, H., Ko, M., & Druss, B. G. (2014). Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States. *JAMA Psychiatry, 71*(2), 190–196. <https://doi.org/10.1001/jamapsychiatry.2013.3575>
- Eber, G. B. (2009). Using the constitution to improve prisoner health. *American Journal of Public Health, 99*(9), 1541–1542. <https://doi.org/10.2105/AJPH.2009.168112>
- Frank, J. W., Linder, J. A., Becker, W. C., Fiellin, D. A., & Wang, E. A. (2014). Increased Hospital and Emergency Department Utilization by Individuals with Recent Criminal Justice Involvement: Results of a National Survey. *Journal of General Internal Medicine, 29*(9), 1226–1233. <https://doi.org/10.1007/s11606-014-2877-y>

- Freudenberg, N., Daniels, J., Crum, M., Perkins, T., & Richie, B. E. (2005). Coming Home From Jail: The Social and Health Consequences of Community Reentry for Women, Male Adolescents, and Their Families and Communities. *American Journal of Public Health, 95*(10), 1725–1736. <https://doi.org/10.2105/AJPH.2004.056325>
- Gates, A., Artiga, Samantha, & Rudowitz, R. (2014). *Health Coverage and Care for the Adult Criminal Justice-Involved Population*. <https://www.kff.org/uninsured/issue-brief/health-coverage-and-care-for-the-adult-criminal-justice-involved-population/>
- Golzari, M., & Kuo, A. (2013). Healthcare utilization and barriers for youth post-detention. *International Journal of Adolescent Medicine and Health, 25*(1), 65–67. <https://doi.org/10.1515/ijamh-2013-0008>
- Haldar, S. & Guth, M. (2021, December 17). State Policies Connecting Justice-Involved Populations to Medicaid Coverage and Care. *KFF*. <https://www.kff.org/medicaid/issue-brief/state-policies-connecting-justice-involved-populations-to-medicaid-coverage-and-care/>
- Health and Human Services. (2022, September 28). *HHS Approves Groundbreaking Medicaid Initiatives in Massachusetts and Oregon* | *HHS.gov*. <https://www.hhs.gov/about/news/2022/09/28/hhs-approves-groundbreaking-medicaid-initiatives-in-massachusetts-and-oregon.html>
- KFF. (2019, October 17). *States Reporting Corrections-Related Medicaid Enrollment Policies In Place for Prisons or Jails*. KFF. <https://www.kff.org/medicaid/state-indicator/states-reporting-corrections-related-medicaid-enrollment-policies-in-place-for-prisons-or-jails/>
- Medicaid Program History*. (2022, October 2). <https://www.medicaid.gov/about-us/program-history/index.html>
- Miller, S. (2021). Higher Education behind Bars: Expanding Post-Secondary Educational Programs in New England Prisons and Jails. New England Board of Higher Education.
- US Department of Health and Human Services. (2019). *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings ((Evidence-based Resource Guide Series)*. Lulu.com.
- Visher, C. A., & Mallik-Kane, K. (2007). Reentry Experiences of Men with Health Problems. In R. B. Greifinger (Ed.), *Public Health Behind Bars: From Prisons to Communities* (pp. 434–460). Springer. https://doi.org/10.1007/978-0-387-71695-4_25
- Zeng, Z., & Minton, T. D. (2021). *Jail Inmates in 2019*. US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, NCJ 255608. <https://bjs.ojp.gov/content/pub/pdf/ji19.pdf>