COLORADO
Department of Health Care Policy & Financing

Federal Authority to Support Health-Related Reentry Services for Incarcerated Populations

Colorado Department of Health Care Policy and Financing

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EXECUTIVE SUMMARY

In 2023, the Colorado Department of Health Care Policy & Financing (HCPF) received funding appropriated through Senate Bill (SB) 22-196[1] with the intention to help improve the health care of the criminal justice population. The bill requires HCPF to evaluate and determine whether Colorado should seek additional federal authority to provide screening, brief intervention, and care coordination services through the Medicaid program to persons immediately prior to release from jails and prisons. Through legislative actions and policy guidance released by the Center for Medicaid and Medicare Services (CMS), the federal government has also demonstrated an interest in expanding Medicaid coverage in states that choose to do so for multiple populations, including those leaving jails and prisons. The below report and analysis reviews the impact of such policies.

In February 2023, HCPF engaged Health Management Associates (HMA), a national healthcare consulting firm, to fulfill the requirements of SB 22-196. HMA implemented a mixed methods assessment approach that included: a literature review, interviews and recommendations from Colorado justice system stakeholders, review of other state applications for a Medicaid reentry program, review of the federal requirements outlined in CMS' release of the April 17, 2023, State Medicaid Letter entitled, Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated (SMD #23-003) and a fiscal analysis that aims to provide the estimated overall healthcare costs and per-member costs associated with Colorado's Medicaid Reentry Section 1115 Demonstration proposal as well as the estimated overall State expenditure impact. The publication of this report was delayed from October 1, 2023 due to the release of this federal guidance, requiring significant change to the report assumptions and necessary contractual adjustments.

For Colorado to meet both state legislative and federal policy guidelines, the reentry benefit analyzed in this report included: physical and behavioral health clinical screenings and consultation services; case management & care coordination services; 30-day supply of prescription medications and medication administration; and medication-assisted treatment (MAT) and associated counseling for all FDA-approved medications including long acting injectables. The purpose of this program, as outlined in the federal guidance is to use the federal match and Medicaid benefit to increase access to care prior to release and after release, to improve quality and coordination of care, to provide opportunity for additional investments into health services, to better address physical/behavioral and health-related social needs of individuals who are at risk of incarceration, to reduce ED visits and hospitalizations and to reduce all causes of death post-release. Individuals with substance use disorders or substance-related criminal charges who are reentering the community are at greater risk of criminal re-involvement and recidivism, underscoring that addressing public health needs may help advance public safety outcomes.

In order to understand the impact of this benefit, HMA analyzed incarcerated populations, utilization of certain health services, and the current healthcare costs and the number of individuals released from custody annually. The analysis examines the potential for Colorado to seek and secure federal authority to have Medicaid cover a limited benefit for this population prior to their release, and if this policy changes could be used in an effective and fiscally responsible way to improve coverage and outcomes for individuals

[1] Senate Bill 22-196 Concerning Supporting the Health Needs of Persons Who May Be Involved with the Criminal Justice System, and, in connection therewith, making an appropriation.

transitioning out of jail, prison, or juvenile justice facilities. The report concludes with a high-level fiscal analysis of:

- The number of anticipated individuals and associated member months for the 90 days leading up to release from carceral facilities;
- Overall Medicaid expenditure and "Per Member Per Month" (PMPM) healthcare costs associated with meeting the requirements outlined in a Colorado Medicaid Reentry Section 1115 Demonstration and relevant comparisons to existing state expenditures;
- The estimated impact to overall state expenditures accounts for Federal Financial Participation (FFP) available under the Demonstration as well as offsetting reductions from State funded expenditures for these types of services that currently exist; and

If Colorado is able to prioritize administrative resources and adjust funding across relevant executive Departments, **HMA has identified public health and financial benefits to HCPF pursuing a Section 1115 Reentry Demonstration for its Medicaid eligible justice-involved population** impending release from a carceral setting within 90 days to improve outcomes for these individuals transitioning out of a carceral setting. **Based on the fiscal analysis, implementing transitional services for Medicaid-eligible members in prisons, jails and juvenile youth facilities is unlikely to increase state dollar expenditure**. However, the policy and fiscal analysis also shows significant differences between program cost estimates and implementation efforts for state-operated prisons and juvenile justice facilities compared to county- and city-operated local jails. The key findings below are separated into two sections; the first section is about the cost associated with implementing transitional services in prisons and juvenile facilities for youth and the second addresses the cost of implementing transitional services in jails. The Key Findings outline the current and potential total costs, federal Medicaid match, and opportunities for any funds remaining for reinvestment.

KEY FINDINGS

Population Characteristics

This analysis examines incarcerated individuals in three settings: state operated prisons, state operated juvenile justice facilities, and county- and city-operated jails. Individuals who have been incarcerated have higher rates of substance use disorders, mental health disorders, are more likely to have experienced abuse and trauma, have high rates of chronic physical health needs, and face significant health related social needs such as accessing employment, housing and social services. The policy parameters did not include individuals who are residing in federally-operated prisons, or individuals in state psychiatric hospitals that are receiving services before trial or after sentencing.

As of 2023, there were over 17,000 individuals incarcerated in 21 state prisons. The average stay in state prisons is 33 months, and over 94% of prisoners are male. There are approximately 5,883 releases per year, with 4,070 – 5,295 of those released are likely eligible for Medicaid.

There are 61 jails in Colorado which house over 10,000 inmates at any given time. The average length of stay in jails is 45 days for felonies and 17 days for misdemeanors. Average number of inmates, health care delivered, and programs available in Colorado jails varies by county. Most jails participate in the state-funded Jail-Based Behavioral Health Services program, which is administered by the Behavioral Health Administration, and provides screening and treatment services. There are approximately 136,629 releases per year, with 85,071 – 110,670 of those released eligible for Medicaid.

There are 15 Department of Youth Corrections facilities that provide onsite health care and contract with outside providers. There are approximately 242 individuals released from these facilities annually, with 126 - 163 individuals eligible for Medicaid.

All financial estimates are based on the upper bound estimates of the population.

Transitional Services in Prisons and Juvenile Youth Facilities

HMA estimates that providing transitional services to 5,500 individuals released from prisons and juvenile justice facilities would result in a total computable expense of $8 million annually. $6 million of the $8 million will be funded through federal funds as a part of the Section 1115 Demonstration, while $2 million of the $8 million will be funded through state funds only. The state is currently investing an estimated $5 million in reentry activities within prisons and juvenile youth facilities, **resulting in roughly $3 million in existing state funds that could be reinvested in new programs over time**. With the influx of new federal financial participation (FFP) for both services and administrative support, the State's overall expenditures for justice-involved persons reentering the community from prisons and juvenile youth facilities is anticipated to decrease over time. This is the result of expected streamlined cost-efficiencies across Medicaid and correctional health program expenditures such as the Department of Corrections (DOC) which is currently providing these benefits today. HCPF may realize future savings for enrollees impacted by this policy decision after their reentry into the community. Along with the increased focus on reentry services, individuals should benefit from increased preventive services that reduce future emergency department (ED) visits and inpatient hospital admissions that would have otherwise fallen to HCPF Medicaid expense.

Transitional Services in Jails

HMA estimates 110,500 releases from county jails occur annually and projects $76 million in Medicaid treatment costs, with $56 million of the costs funded through federal funds; this means the remaining $20 million would be funded through state funds. The Behavioral Health Administration (BHA) currently funds related transitional services in jails with $16 million in general fund through their Jail Based Behavioral Health Services (JBBS) program. **The existing general fund expenditure can be used to cover a portion of the state funds needed to cover transitional services in jails.**

Outreach to local jails regarding state and other funds (county, city, private, grant funds etc.) resulted in a low response rate which resulted in limited understanding of local jail costs and expenditures. HMA extrapolated from the information available and estimates that jails spend $33 million annually on transitional services, though this funding sources were unclear. With the $16 million from JBBS and the estimated $33 million in other jail expenses to cover the state portion of funds needed for Medicaid to cover transitional services in jails, there could be $29 million in existing state funds that could be reinvested in new programs. However, without comprehensive information from the jails on the state or local expenditures, the analysis lacks confidence.

Implementation

HCPF should consider a phased implementation approach to implementation, in which the state and local partners consider narrowing the eligibility criteria and/or specifying which facilities are included in the demonstration over time. As an example, HCPF could start with state prisons only, then expand to juvenile youth facilities and then to jails based on state and provider readiness. HMA recommends HCPF work with the jails to obtain the expense data needed to develop a comprehensive approach to implementing transitional

services in the jails in a manner that does not generate additional costs to the state; this approach can include scoping service eligibility to certain populations or limiting the benefit package available.

Based on the existing funding authority across executive state Departments, Colorado also will need to take additional budget and possibly legislative actions in order to adject the expenditure authority of each agency and reflect the new federally supported budget.

Finally, while this analysis focused on state actions, effective implementation in jail settings is contingent on state and local government and program partnerships, data sharing, and program development.

INTRODUCTION

In Colorado, approximately 120,000 individuals are involved in the criminal justice system which includes individuals who are incarcerated, on parole or in a work release.[2] HCPF estimates that 70% – 90% would be eligible for Health First Colorado based on a reentry coverage expansion. More than half of the formerly incarcerated are unable to find stable employment within their first year of return and three-fourths of them are rearrested within three years of release.[3] This research, along with the Center for Medicaid and Medicare Services State Medicaid Director letter describing this opportunity demonstrates the importance of health, housing, skill development, mentorship, social networks, and collaborations among public and private organizations to improve the reentry experience collectively.[4]

Individuals released from carceral settings like jails and prisons often have complex co-occurring health concerns, including substance use disorders (SUD), mental health needs, and ongoing chronic and infectious illness – all requiring linkages to community-based care upon reentry. **In the first two weeks following release from incarceration, individuals are 129 times more likely to die from an overdose** than their peers in the community and they often have higher rates of cardiac conditions, diabetes, Hepatitis C, mood, and anxiety disorders as well as severe and persistent mental illness.[5] Providing medication assisted treatment is an essential service for individuals who experience forced abstinence, such as those in jails and prisons. Individuals with substance use disorders or substance-related criminal charges who are reentering the community are at greater risk of criminal re-involvement and recidivism, underscoring that addressing public health needs may help advance public safety outcomes and reduce future incarceration.

Colorado has undertaken significant reform efforts designed to improve outcomes, services, and care for the justice-involved population. In 2022, the Legislature committed to exploring federal authorities to improve outcomes for the justice population through Senate Bill 22-196. Recommendations for developing a Colorado Section 1115 Reentry Demonstration align with CMS' overall objectives to increase equitable access to quality healthcare for returning citizens, improve care transitions from carceral settings, and reduce unnecessary emergency room usage and preventable deaths upon release.

There is growing recognition among federal and state policymakers, providers, and advocates that correctional settings across the country need additional tools, resources, and services to increase access to services and improve outcomes for the justice-involved population. The federal Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, allows states to apply for a Section 1115 Reentry Demonstration to provide services to incarcerated individuals. California was the first state to receive the Centers for Medicare & Medicaid Services (CMS) approval for a Section 1115 Reentry Demonstration in alignment with anticipated forthcoming guidance to be released by CMS. Accordingly, following California's approval, CMS issued a State Medicaid Director Letter (#SMD 23-003) entitled, Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated, as a framework to facilitate states' development of demonstration designs for a Section 1115 Reentry Demonstration. In the SMD, CMS stipulated that states must

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[2] About - Take Care - Health Matters.

[3] Ramakers, Anke A. T., et al., "Returning to a Former Employer: A Potentially Successful Pathway to Ex-prisoner Re-employment," The British Journal of Criminology, vol. 56, no. 4, 2016.

[4] Mallik-Kane, Kamala, and Christy A. Visher. Health and prisoner reentry: How physical, mental, and substance abuse conditions shape the process of reintegration, 2008. Washington, DC: Urban Institute & Justice Policy Center, p. 82, 2008.

[5] Binswanger IA, Stern MF, Deyo RA, Heagerty PJ, Cheadle A, Elmore JG, Koepsell TD. Release from prison--a high risk of death for former inmates. N Engl J Med. 2007 Jan 11;356(2):157-65. doi: 10.1056/NEJMsa064115. Erratum in: N Engl J Med. 2007 Feb 1;356(5):536. PMID: 17215533; PMCID: PMC2836121.

cover and ensure access to the minimum short-term, pre-release benefit package, including case management to assess and address physical and behavioral health needs and health-related social needs (HRSN), medication-assisted treatment (MAT) services for all types of substance use disorder (SUD) as clinically appropriate with accompanying counseling, and a 30-day supply of medication (as clinically appropriate based on the medication dispensed and the indication) provided to the beneficiary immediately upon release. This report was updated based on this SMD letter to recognize the federally required set of benefits are more expansive than the original benefits outlined in SB 22-196. The CMS guidance clarified that no 1115 demonstration waiver will be approved if it does not include the minimum set of benefits outlined in the SMD letter. Therefore, this analysis includes all services outlined in SB 22-196, plus the additional benefits included in the SMD.

HMA implemented a four-phased, mixed methods assessment approach that includes:

1. Findings from a literature review of Colorado's landscape and recommendations gleaned from Colorado justice system stakeholders.
2. Results from interviews with Colorado organizations, agencies, advocates, and stakeholders to inform the decision-making process related to the Section 1115 Reentry Demonstration opportunity.
3. Summary of applications from 13 states that submitted Section 1115 Reentry Demonstrations.
4. Summary of the federal requirements outlined in CMS' release of the April 17, 2023, State Medicaid Letter entitled, Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated (SMD #23-003).
5. A fiscal analysis that aims to provide the estimated overall healthcare costs and per-member costs associated with Colorado's Medicaid Reentry Section 1115 Demonstration proposal as well as the estimated overall State expenditure impact.

NATIONAL SUMMARY TAKEAWAYS

The national summary takeaways were prepared for HCPF to help inform the state on the current scope of reentry services for incarcerated individuals who meet Medicaid eligibility. The national summary takeaways provide a summary of research, evidence, and experiences in three key areas:

1. **Research** and an environmental scan of Colorado's landscape and **recommendations** gleaned from Colorado justice system stakeholders.
2. Description of **health needs** of incarcerated individuals and **best practices** for meeting the needs of incarcerated individuals after reentry.
3. Summary of applications from 13 states that submitted **Section 1115 Reentry Demonstrations** (as of September 7th, 2023) and information from surveys and interviews with six of these states.

RESEARCH AND RECOMMENDATIONS

Colorado is considering providing Medicaid-funded reentry services to incarcerated individuals across several settings, including state prisons, county jails, and youth in correctional facilities. HMA's research found that:

- As of 2023, there were over 17,000 individuals incarcerated in Colorado's 21 prisons.[6]
- The average length of stay in state prisons is 33 months, and over 94% of prisoners are male.[7]
- The Colorado prison health care delivery system provides physical health (PH), mental health (MH), dental, vision, and pharmaceutical services. A third-party contractor typically manages acute or emergency services delivered outside the prison.
- There are 61 county and municipal jails in Colorado which house over 10,000 inmates. The average length of stay is 45 days for felonies and 17 days for misdemeanors.[8]
- Health care delivered in Colorado jails varies by county, and sometimes jails within counties, but is primarily focused on physical and behavioral health (BH). Several jails participate in the state's Jail Based Behavioral Health Services program, funded through the Behavioral Health Administration (BHA).
- There are 15 Department of Youth Corrections facilities, managed by the Colorado Dept. of Human Services (CDHS) Office of Child and Youth Services (OCYF) that provide onsite health care and contract with outside providers.[9]

Six stakeholder groups were interviewed and all recommended that HCPF pursue a Section 1115 Medicaid Reentry Demonstration. The following recommendations emerged from stakeholder interviews:

- **Services**: should include durable medical equipment (DME), transportation, health related social needs (particularly housing), transition services, and medication-assisted treatment (MAT).
- **Eligibility**: should include juvenile population, jails, and prisons.
- **Data**: there should be investments to enhance health information exchange across agencies and facilities, with clear data standards, and outcomes that are continuously monitored.
- **Technical Assistance**: carceral facilities will need assistance with encounter-based care, billing, MAT, and change management.
- **Interagency Coordination**: planning and coordination should occur across agencies as the demonstration is developed.

HEALTH NEEDS AND BEST PRACTICE

The health needs of incarcerated individuals are significant and can be long lasting even after release. Incarcerated individuals tend to have higher rates of chronic disease, communicable disease, and behavioral health conditions as compared to the overall population.[10] As highlighted in the CMS SMD guidance, people of color and those who identify as LGBTQ are overrepresented in the incarcerated population and may have

[6] Statistics | Department of Corrections (colorado.gov).

[7] Prison Population Projection 2023 (January 2023) (state.co.us).

[8] Colorado Division of Criminal Justice Jail Data Dashboard.

[9] Division of Youth Services | Colorado Department of Human Services.

[10] Incarceration and Health: A Family Medicine Perspective (Position Paper).

specific health needs due to discrimination, structural racism, and unmet health-related social needs. These factors should be considered by HCPF when considering a Section 1115 Medicaid Reentry Demonstration.[11]

As individuals reenter society, they may be faced with many significant barriers. The Section 1115 Medicaid Reentry Demonstration should consider how individuals can confirm and maintain their Medicaid eligibility, connect to community healthcare resources, and connect to community organizations that address health-related social needs. Clear and effective care planning and care coordination will be critical to individuals with substance use disorders as they are at a higher risk for overdose immediately following release.

Best practices indicate that care coordination, case management, peer support, and services provided to address health-related social needs are critical to reentry.

SUMMARY OF 1115 DEMONSTRATION

As a result of the federal Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, states can apply for a Section 1115 demonstration to provide services to incarcerated individuals. A Section 1115 demonstration is currently the only Medicaid authority that allows states a narrow exception to receive federal expenditures for incarcerated persons who are otherwise eligible for Medicaid in light of the federal statutory Inmate Exclusion, which prevents Medicaid from paying for health care delivered to incarcerated individuals with one exception states can use Medicaid funds to pay for inpatient care for individuals outside of the carceral setting when a transfer is needed. For example, if a Medicaid-eligible individual pre-release timeframe could change at the discretion of a different White House Administration.

HMA reviewed and summarized pending and approved applications submitted by states to the CMS for a Section 1115 Reentry Demonstration. To date, only California and Washington have received approval. Although California's application was approved to provide reentry services 90 days before release, that exceeds the 30-day pre-release period specified in the SUPPORT Act. The key features of state Section 1115 reentry proposals pending with CMS are described in Appendix A. HMA notes that the pending applications were submitted prior to CMS' release of the April 17, 2023, State Medicaid Director Letter for reentry (SMD #23-003). These proposals are still under review. Medicaid-eligible individuals can have their eligibility suspended while incarcerated and reactivated upon release.

The Biden Administration uses discretionary Section 1115 authority to approve the additional 60 days of pre-release Medicaid services. The 90-day pre-release period has yet to be codified into law and the offering of this longer with CMS, and most do not align with the SMD guidance on the design parameters for approval. Based on HMA's experience with CMS, HMA believes these proposals may need to be formally amended to better align with the SMD guidance on design parameters to facilitate CMS approval. While HMA summarizes the pending state proposals in Appendix A, HMA recommends only using these proposed designs as informative material.

Persons on work release are not included in the CMS Section 1115 Reentry Demonstration initiative. The CMS guidance targets explicitly individuals who fall squarely under the federal statutory definition of an "inmate", i.e., individuals who are held involuntarily in a public institution, and that are otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP) but for incarceration. Accordingly, only those individuals

[11] LGBTQ People Behind Bars: A Guide To Understanding The Issues Facing

in carceral settings who will soon be released (and are otherwise Medicaid or CHIP eligible) are eligible for the Section 1115 Reentry Demonstration initiative. Should the state decide to pursue Section 1115 demonstration coverage for persons on work release, this would be considered a separate Section 1115 expenditure authority and subject to traditional budget neutrality principles requiring a showing of expected program savings. It would also be expected to lengthen CMS' consideration of the overall demonstration proposal for approval.

HCPF also sent surveys to 13 states with pending or approved applications and invited them to complete a survey and participate in an interview. Six of the 13 states participated in either the survey and/or interview. This information was used to inform the demonstration service design and eligible populations along with CMS guidance which is detailed below.

CMS GUIDANCE

As mentioned above, CMS released State Medicaid Director letter (SMD) #23-003 which describes the parameters for states to design state Section 1115 Reentry demonstrations in alignment with Section 5032 of the SUPPORT Act (Pub. L. No. 115-271). The SMD outlines the critical elements of the reentry demonstration design that should be outlined in a formal Section 1115 application to facilitate CMS' approval of state Section 1115 reentry programs. The reentry design parameters as described in the CMS SMD guidance, are outlined in Appendix B. While the CMS guidance indicates that interested states may propose a range of benefit designs in their Section 1115 applications, following the specific parameters outlined in the guidance is expected to expedite CMS' decision to approve a state Section 1115 Reentry Demonstration. Colorado can expect any variation from the parameters outlined in the SMD will lengthen CMS' review and decision on the state's Section 1115 proposal. For additional guidance on how Colorado can design its proposed Section 1115 Reentry Demonstration, HMA recommends focusing on the design parameters of the two Section 1115 Reentry Demonstrations approved by CMS to date in alignment with the SMD guidance – California and Washington.

States have flexibility to propose a broadly defined reentry demonstration population of otherwise eligible, soon-to-be former incarcerated individuals. **Within this broad flexibility, Colorado can determine if it wants to target all justice-involved Medicaid eligible individuals or only certain individuals with specific health conditions (e.g., SUD or behavioral health diagnosis)**. The state also has flexibility to establish separate eligibility criteria for different populations of justice-involved individuals. For example, the state could develop health condition specific criteria for one justice-involved population and not require health condition criteria for another justice-involved population. In the two states that CMS approved reentry demonstrations, Washington set its eligibility criteria to be open to all justice-involved adults and youth, as compared to California which established health condition specific eligibility criteria for justice-involved adults but not for justice-involved youth. Colorado can target their reentry demonstration in accordance with the priority needs of its justice-involved population(s) and the states' resources to support implementation.

Colorado has similar broad flexibility in determining the scale of implementation for uptake of a new reentry demonstration. **The state can determine whether it wants to proceed with a statewide implementation approach or a targeted (or phased-in) approach to offering reentry services.** The state can minimally target by carceral setting, geographic area, and population. It can decide to focus on a targeted implementation approach for the initial 5-year demonstration approval period or develop a phased-in approach that starts with a targeted implementation focus, then builds out to statewide implementation over the initial 5-year demonstration approval period. CMS is amenable to any proposed variation of implementation approaches

that aligns with the goals of the reentry initiative and the state's expectations for what can be successfully implemented. For example, based on the significant difference in funding mechanisms for jails and prisons, the state could initiate the program in state-funded prisons, and take more time to plan and build financial models for jails which vary greatly in their health operations and funding.

The table below outlines the design parameters for California and Washington as referenced above.

Table 1. Approved 1115 Demonstration Waiver for Reentry Services Components

Key Program Components	California's Approved Reentry Parameters	Washington's Approved Reentry Parameters
Pre-release period	90-day prerelease period	90-day prerelease period
Reentry Benefits	• Reentry case management services • MAT for all FDA-approved medications, including coverage for counseling • Physical and behavioral health clinical consultation services (telehealth or in-person) to diagnose health conditions, provide treatment, as appropriate, and support pre-release case managers' development of a post-release treatment plan and discharge planning • Medications and medication administration (including a minimum 30-day supply of outpatient prescribed medications and over-the-counter drugs as clinically appropriate) • Laboratory and radiology services • Services provided by community health workers with lived experience; and, • Outpatient prescribed medications and over-the-counter drugs	• Reentry case management to assess and address physical and behavioral health needs and HRSN • MAT for all types of SUD as clinically appropriate, with accompanying counseling • Physical and behavioral health clinical consultation services provided through telehealth or in-person, as needed, to diagnose health conditions, provide treatment, as appropriate, and support pre-release case managers' development of a post-release treatment plan and discharge planning • Medications and medication administration • Laboratory and radiology services; and, • Services provided by community health workers with lived experience • 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate) and durable medical equipment and supplies
Eligible Carceral Settings	State and/or local jails, prisons, and youth correctional facilities	State prison, county or city jail, and youth correctional facilities

Key Program Components	California's Approved Reentry Parameters	Washington's Approved Reentry Parameters
Beneficiary Eligibility	• Otherwise, Medicaid and CHIP eligible who are (incarcerated) justice-involved adults that have significant clinical and social needs; and, • Otherwise, Medicaid and CHIP eligible who are justice-involved individuals in youth correctional facilities	• Otherwise, Medicaid and CHIP eligible who are justice-involved adults or youth incarcerated in a state prison, county or city jail, or youth correctional facility
Expenditure Authority for Infrastructure Support / IT Implementation Planning	$1.85 billion over five years Total Computable – subject to state share	$304 million over five years Total Computable – subject to state share

HMA notes that the cost estimates provided herein account only for medical assistance (reentry) services that would become eligible for FFP under the CMS Section 1115 reentry demonstration initiative. **Administrative costs that the state may need to facilitate and support data interoperability between the Medicaid Agency and carceral facilities to support the Medicaid billing and reporting requirements associated with this initiative are not included in the estimated total computable cost of $84 million**. As provided under Appendix I, there are additional funding opportunities under this demonstration initiative to help the state establish information technology with participating carceral facilities. This administrative funding is separate from budget neutrality and is subject to state share in accordance with federal financial requirements. CMS is permitting broad flexibility in state identification of IT/infrastructure needs, at enhanced FFP rates (i.e., 90/10 or 75/25) for certain administrative activities. Colorado has to determine as part of its demonstration design, what specific administrative changes may be needed to support the provision of demonstration reentry services. There is no available information for which HMA could provide estimates of potential Colorado administrative needs and associated costs. However, as provided in table above, we report that CMS approved $1.85 billion in California and $300 million in Washington for administrative IT/infrastructure (separate from the costs authorized for the actual reentry benefit).

IMPACT ASSESSMENT

The impact assessment aims to examine the current state of accessible healthcare for individuals recently released from Colorado's carceral settings or on work release who would be eligible for Medicaid services. This includes an analysis of current healthcare costs and the number of individuals released from custody annually.

Data and Methodology

A combination of data sources, research, and clinical/subject matter expertise were used to develop the Impact Assessment. A Correctional Facility Reporting Tool was developed for the collection of medical costs, reentry service costs, and inmate demographic and health care needs information across all correctional facilities for the period covering January 2021 to December 2022.

The information requested within the Reporting Tool was intended to be used to approximate the number of individuals that the Section 1115 Demonstration may impact and to better understand the health care needs for the populations of focus. Minimal and incomplete responses were received, which limits the ability for robust analysis. However, HMA utilized data as available, and resulting analyses should be considered high-level estimates that rely on various assumptions. The following table summarizes the data received from each facility.

Table 2. Overview of Colorado Data and Responses used in Analysis

Facility	Data Received
State Prisons	Received one Correctional Facility Reporting Tool including all state prison annual Cost and Inmate Demographic experience from the DOC. This data is considered credible for high-level use.
County Jails	Received four out of 61 facility-specific reports (Arapahoe, Boulder, Larimer, and Mesa). Given the lack of responses, this data is not considered credible for use.
Juvenile Youth Facilities	Received committed (24–48-hour confinement) demographic and aggregate pharmacy expense data. Did not receive detained (long-term) demographic information or other medical expense data. Given the lack of complete information, this data is not considered credible for use.
Behavioral Health State Forensic Hospitals	Received two reports including demographic information only. Note, the current assumption is that behavioral health state forensic hospitals will be excluded from this Section 1115 Demonstration.

HMA also requested and received summarized claims, encounters, and eligibility information for all Health First Colorado members. This data included dates of service from January 1, 2021, through December 31, 2022, paid through July 31, 2023, and was provided by month of service. Please note, that SUD claims were excluded to adhere to federal requirements surrounding the confidentiality of SUD patient records (42 CFR Part 2).

HMA grouped normalized data longitudinally by both claim and encounter incurred months and enrollment months to check for missing data or data anomalies. There were no observed data outliers that warranted further investigation. The analysts relied on service definitions provided by HCPF's data team. The analysis discussed high-level data validation results with the department to ensure the volume of members and attributable dollars within the data extract were consistent with internal benchmarks. Although the analysts performed high-level data validation, the team did not independently audit HCPF's data. Inaccuracies in the data or interpretation of the data could significantly impact the observations in this report.

The claims data was limited to services included in the Section 1115 Demonstration benefit package only and included the month the member was released from incarceration (Month of Release). The analysis relied on the Month of Release field to identify the average number of individuals who joined Medicaid immediately

upon release from state prison and to summarize healthcare costs in the month preceding incarceration. Please note the detailed Medicaid data only contained incarceration information for members released from state prison. This information had to be extrapolated for county jails and juvenile youth facilities. The extrapolation process is discussed more within the Fiscal Analysis section.

Additionally, the analysis relied on publicly available research and detailed Medicaid enrollment information to approximate the percentage of soon-to-be former inmates eligible for medical assistance under Title XIX upon release.

Results

HMA summarized the number of releases from incarceration historically. **HMA estimates 89,267-116,128 releases will be eligible to receive 1-3 months of pre-release services if there are no limitations placed on the eligibility beyond standard Medicaid.** This estimate does not represent a unique count of individuals, as there are individuals with multiple releases within a one-year time period, but these individuals would qualify for services during each stay. In this circumstance, these individuals have been counted more than once within this analysis. Appendix C and Appendix D outline historical releases assumed number of releases that may be eligible for Medicaid, and additional details surrounding the specific data source and period used at the lower bound and upper bound assumptions. The number of releases eligible for Medicaid is a high-level assumption that was developed using research and counts provided within the detailed Medicaid data. As mentioned within CMS' April 17, 2023, letter to State Medicaid Directors, "most incarcerated individuals are eligible for Medicaid."[12] Furthermore, officials from Colorado estimate that "90 percent of state prison inmates" are likely eligible for Medicaid.[13]

As previously mentioned, HMA requested calendar year (CY) 2021 and CY 2022 medical and reentry cost information from carceral settings and received minimal responses from jails. The Reporting Tool request was intended to help examine the current system cost of healthcare for individuals within carceral settings. The information included within the Reporting Tool reflects data for all incarcerated individuals regardless of release date or anticipated Medicaid eligibility. Results for the individual facilities are not provided within this report to protect confidentiality; however, a summary of the information provided is included in Appendix E. Responses were minimal and incomplete depending on the carceral setting. Appendix E shows only the information included within the received responses and does not represent a full picture of current healthcare expenditures for jails across the state. The incomplete response rate should be considered a limitation of this analysis and suggests that implementation of this program in a jail setting will require significant state and local partnership efforts around engagement, program design, fiscal analysis, and budgeting.

REENTRY SERVICES CURRENTLY PROVIDED BY CORRECTIONAL FACILITIES

HMA requested additional details surrounding reentry services currently provided by the correctional facilities. The Correctional Facility Reporting Tool included the following questions with minor phrasing differences depending on the specific facility type:

1. Please provide details on the reentry services provided at your facility. Details could include reentry services offered (Medicaid enrollment, pharmaceuticals, drug treatment,

[12] Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated

[13] Medicaid and the Criminal Justice System

housing and/or job assistance, etc.), inmate qualification requirements, and inmate reentry service utilization.

2. Please provide details on any third-party organizations your facility contracts with to provide community-based support to inmates before release. Details could include specific services these community-based providers provide, and the cost associated with these services.
3. Please provide additional detail regarding the medical and reentry service cost information provided on the Correctional Reporting tab.
4. Additional comments

Due to the sensitive nature of responses, HMA has omitted the responses from this report and can provide the responses upon request.

FISCAL ANALYSIS

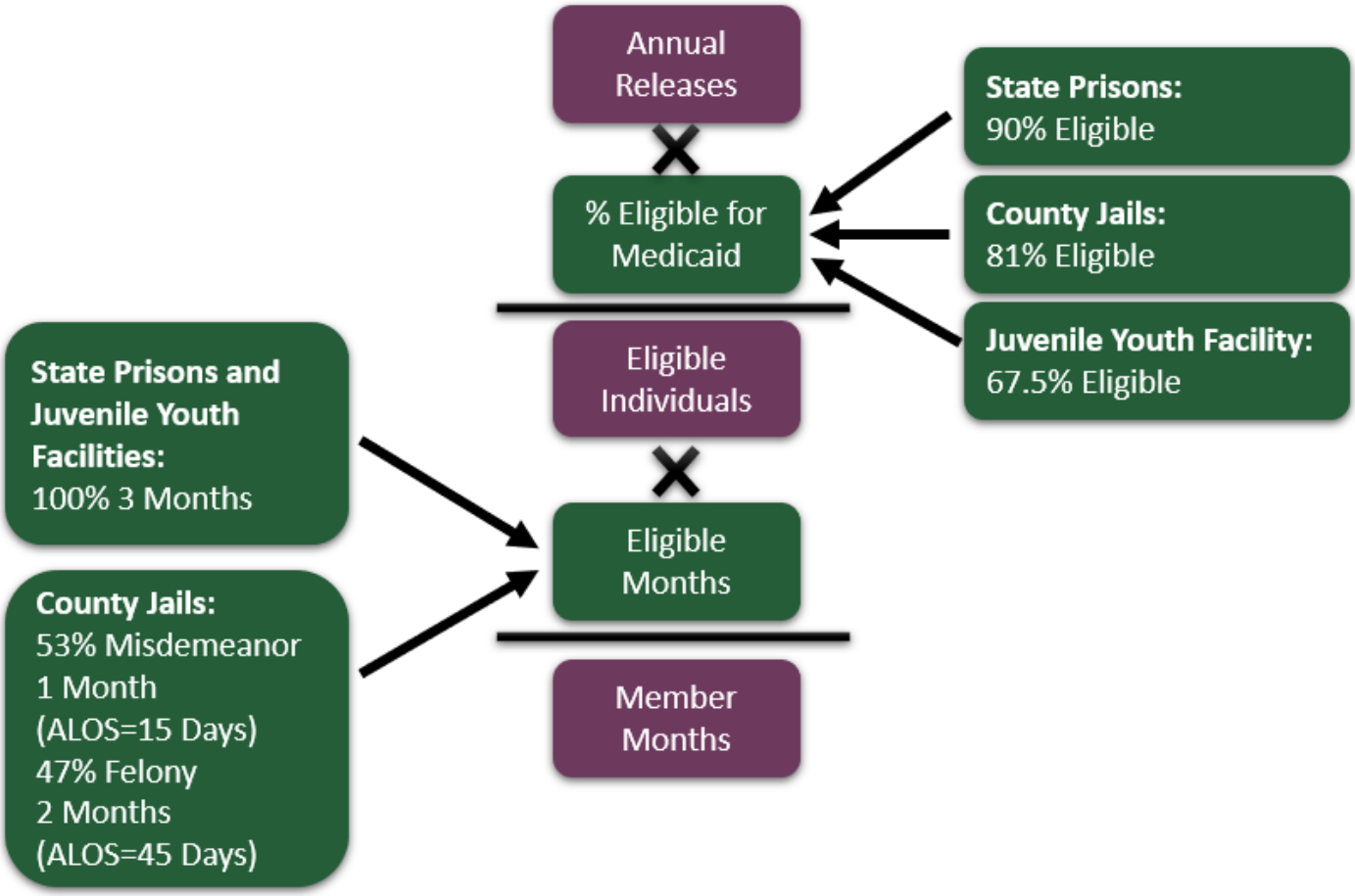
The fiscal analysis aims to project the state dollar expenditure impact as well as provide the estimated overall healthcare costs and per-member costs associated with Colorado's Medicaid Reentry Section 1115 Demonstration opportunity. The costs of these services reflect the current Medicaid reimbursable rates and are based on high-level utilization assumptions by service type. There are two critical components of the Fiscal Analysis: estimated member months and the assumed cost of reentry services.

Member Month Assumptions:

HMA estimated member months by multiplying the resulting "Releases Eligible for Medicaid" from the Impact Assessment by an assumed average duration of reentry services. HMA assumed a duration of three months for state prisons and juvenile youth facilities, reflecting the assumption that each member is eligible to receive 90-days of reentry services. HMA assumed a duration of 1.5 months for county jails, reflecting a shorter length of stay for members in these facilities. Based on the Colorado Division of Criminal Justice Jail Dashboard[14], 53% of CY 2022 releases were for Misdemeanor Offenses and 47% for Felony Offenses. The Jail Dashboard shows an average length of stay of ~15 days for misdemeanor offenses, equating to one member month for this analysis. **A member enrolled in Medicaid for one day and a member enrolled in Medicaid for 30 days are both assigned one member month, as there are no partial member months in the Health First Colorado program.** The Jail Dashboard additionally shows an average length of stay of ~45 days for felony offenses, equating to two member months for this analysis. Like the concept already discussed, a member enrolled in Medicaid for 32 days and a member enrolled in Medicaid for 60 days are both assigned two member months, as there are no partial member months in the Health First Colorado program. Combining these data points, the average member months for county jail experience is projected to be 1.5 months. The graphic below further illustrates the methodology used to calculate member months.

[14] Colorado Division of Criminal Justice Jail Data Dashboard.

Figure 1. Total Member Month Calculation Inputs Used in Fiscal Analysis



The narrative below includes additional detail on the assumptions used to estimate member months for each correctional facility:

- **State Prison:** Based on the Colorado Department of Corrections Monthly Population and Capacity Report[15] as of June 2023, there are roughly 6,000 releases annually from state prisons. At the upper bound, HMA assumed 90% of these members are Medicaid eligible. Since these members typically have a longer length of stay, HMA assumed each of these members would be eligible to receive a full three months of pre-release services. 5,883 Releases * 90% Eligible for Medicaid * 3 Eligible Months = **15,884 Member Months**.
- **County Jails:** Based on the Prior Reporting Quarter tab in the Colorado Division of Criminal Justice Jail Data Dashboard[16], there are roughly 34,000-38,000 releases from Colorado county jails quarterly. This equates to approximately 136,000-152,000 releases annually. At the upper bound, HMA assumed 81% of these releases would be eligible for Medicaid.
    - The Jail Data Dashboard includes data on the percentage of releases within county jails: 53% for Misdemeanor Offenses and 47% for Felony Offenses. The Jail Data Dashboard also includes data on the average length of stay within county jails: ~15 days (1 member month for this analysis) for Misdemeanor Offenses and ~45 days (2 member months for this analysis) for Felony Offenses. Deriving the average member month span from this data, HMA multiplied the estimated annual

[15] Colorado Department of Corrections Monthly Population and Capacity Report

[16] Colorado Division of Criminal Justice Jail Data Dashboard

releases by 1.5, reflecting that most members will likely only be eligible to receive one month of pre-release services. 136,629 Releases * 81% Eligible for Medicaid * 1.5 Eligible Months = **166,005 Member Months**.

- **Juvenile Youth Facilities:** Based on the SFY22 DYS Statistical Report[17], there are roughly 250 releases annually. At the upper bound, HMA assumed 67.5% of these releases will be eligible for Medicaid and that each of these members would be eligible to receive a full three months of pre-release services. 242 Releases * 67.5% Eligible for Medicaid * 3 Eligible Months = **490 Member Months**.

HMA is estimating a total of 116,128 releases will be eligible to receive 1-3 months of pre-release services, equating to an estimated 182,379 member months at the upper bound. The same methodology was applied to the lower bound estimates, resulting in 140,193 member months at the lower bound.

Cost Assumptions:

HMA worked with HCPF to estimate the following services that will be included in the proposed Section 1115 Demonstration Benefit package:

- Pharmacy
- Behavioral Health (BH) and Physical Health (PH) Screening
- Brief Intervention (Structured conversations and counseling designed to address alcohol and/or drug use once a person screens positive for substance use)
- Medication Assisted Treatment (MAT)
- Care Coordination; and,
- Case Management

Appendix F provides definitions of each of the proposed services at the HCPCS/CPT Procedure Code level of detail as provided by HCPF.

To estimate the costs of proposed services included under the Section 1115 Demonstration, HMA varied the utilization and unit cost assumptions for each service to reflect the variation and unknowns surrounding population utilization, acuity, and uptake. The resulting range surrounding the fiscal analysis reflects the variability in potential healthcare costs; however, it is strongly recommended that HCPF use the assumptions that yield the upper bound in the range of projected expense within budget neutrality discussions with CMS.

To the extent it was available, the analysts relied on HCPF's summarized historical claims data to help estimate the cost of the proposed reentry services. As mentioned previously, HMA requested summarized claims and encounter data for the six target services for all HealthFirst Colorado members, including those recently released from a state prison. Since SUD claims were excluded to adhere to federal requirements, only claims data for BH and PH Screening and Pharmacy services were robust enough to directly rely on within the cost analysis. The other proposed benefit package services rely on utilization and unit cost assumptions from higher level research, HCPF-specific fee schedules, and clinical expertise.

The following narrative outlines HMA's methodology for each of the six services included in the Section 1115 demonstration:

[17] SFY22 DYS Statistical Report

Pharmacy

- **Lower Bound:** HMA limited the summarized claims and eligibility data to members released from State Prisons. HMA then calculated the average number of scripts and cost per script in the month following release. The average scripts per member was then multiplied by the assumed "Releases Eligible for Medicaid" upon release. This resulted in a baseline estimate for the number of 30-day scripts members will receive upon release. Finally, the estimated number of scripts was multiplied by the average cost per script to arrive at an initial cost estimate for pharmacy expenditure included under the Section 1115 demonstration.

Notably, incarceration information was only available in the fee-for-service data for State Prisons. However, the same baseline utilization per 1000 and unit cost assumptions were applied to County jails and juvenile youth facilities.

Now that this service will be offered as part of the Section 1115 reentry effort and individuals will have active assistance getting necessary scripts, HMA expects an increase in utilization relative to what is inherent in the dampened fee-for-service data for individuals released from State Prisons. HMA increased the number of scripts by 25% to reflect the suppressed utilization inherent in the data.

- **Upper Bound:** HMA calculated the average number of scripts and cost per script for all HealthFirst Colorado members, regardless of incarceration status. The average prescriptions per member was then multiplied by the assumed "Releases Eligible for Medicaid" upon release, resulting in a baseline estimate for the number of 30-day scripts members will receive upon release. This approach assumes members released from incarceration will use a similar level of scripts per month as the average Medicaid enrollee. Finally, the estimated number of scripts was multiplied by the average cost per script to arrive at an initial cost estimate for the Pharmacy included under the Section 1115 demonstration.

These assumptions were applied specific to the three age bands (Adolescent 0-17, Adolescent 18-21, and Adult 21+); however, the same baseline assumptions were applied to County jails and Juvenile youth facilities.

BH and PH Screening

- **Lower Bound:** HMA limited the summarized claims and eligibility data to members released from State Prisons. The detailed claims data does not contain data for months in which an individual is incarcerated, so HMA relied on the average number of screenings and cost per screening in the three months immediately following release as a baseline estimate for the acuity and utilization-levels that may occur prior to release. Please note, that HMA received comprehensive utilization and unit cost information for PH screenings; however, data for BH (MH and SUD combined) screenings was limited. MH screenings are provided under a capitated arrangement with the Regional Accountable Entities (RAE) and thus the paid amount inherent on the encounters is not an accurate representation of the actual cost of the service. As such, only utilization information was available for MH screenings. Additionally, SUD screenings were not provided as part of the extract to comply with federal requirements. Due to these limitations, HMA used the following logic to help approximate the cost of BH and PH Screenings:

- BH Screenings: HMA doubled the MH screening utilization inherent in the encounter data to estimate the utilization for MH and SUD combined. Although fee-for-service rates are available for screenings, there were roughly 350 procedure codes comprising the BH and PH Screening category of service. Rather than estimating a precise mix of services for the individual procedure codes, HMA took a higher-level approach to estimating the unit cost. HMA relied on the aggregate unit cost information for PH screenings in the data as an estimate for the average unit cost of BH screenings. HMA used a dynamic approach to model this service and can test the sensitivity of this assumption with HCPF as appropriate.
- PH Screenings: HMA relied on the utilization and unit cost information for PH screenings in the fee-for-service data.

The average screenings per member per month (PMPM) was then multiplied by the assumed member months for each population, resulting in a baseline estimate for the number of screenings members will receive before release. Finally, the estimated number of screenings was multiplied by the average cost per screening to arrive at an initial cost estimate for BH and PH Screenings included under the Section 1115 demonstration.

Incarceration information was only available in the fee-for-service data for State Prisons. However, the same baseline utilization per 1000 and unit cost assumptions were applied to county jails and juvenile youth facilities.

If this service will be offered as part of the Section 1115 Demonstration reentry effort and individuals will have active assistance getting necessary services, HMA expects an increase in utilization relative to what is inherent in the dampened fee-for-service data for individuals released from State Prisons. HMA increased the screenings by 50% to reflect the suppressed utilization inherent in the data.

- **Upper Bound:** The average number of screenings and cost per screening for all Health First Colorado members was calculated regardless of incarceration status. Like the methodology discussed in the Lower Bound section above, HMA used the utilization and unit cost for PH screenings and the utilization for MH screenings to estimate the aggregate cost of BH and PH Screenings.
    - The average screenings PMPM was then multiplied by the assumed member months for each population, resulting in a baseline estimate for the number of screenings members will receive before release. Finally, the estimated number of screenings was multiplied by the average cost per screening to arrive at an initial cost estimate for BH and PH Screenings included under the Section 1115 Demonstration.
    - These assumptions were applied specific to the three age bands (Adolescent 0-17, Adolescent 18-21, and Adult 21+); however, the same baseline assumptions were applied to county jails and Juvenile youth facilities.

If this service is offered as part of the Section 1115 Demonstration Reentry effort and individuals will have active assistance getting necessary services, HMA expects an increase in utilization

relative to what is inherent in the data for individuals released from State Prisons. HMA increased the screenings by 25% to reflect the suppressed utilization inherent in the data.

Brief Intervention

- **Lower Bound:** HMA did not receive claims data for Brief Intervention services as these services are largely SUD-related and could not be provided per federal requirements. In the absence of historical data, HMA relied upon high-level assumptions using research and clinical expertise. At the lower bound, HMA assumed 5% of the Adolescent 0-17 population, 40% of the Adolescent 18-21 population, and 70% of the adult population will receive Brief Intervention services. HMA assumed members in State Prisons will receive an average of two Brief Intervention services and assumed members in County Jails and Juvenile Youth Facilities will receive an average of 1.5 Brief Intervention services due to their shorter length of stay. Brief Intervention services were defined by HCPF as procedure codes 99408 (Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes) and 99409 (Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes). HMA assumed the average cost per service is $68.39 using HCPF's fee schedule. The estimated number of utilizers was multiplied by the assumed number of services and the average cost per service to arrive at an initial cost estimate for Brief Intervention included under the Section 1115 Demonstration.
- **Upper Bound:** At the upper bound, HMA assumed 10% of the Adolescent 0-17 population will receive Brief Intervention services, 50% of the Adolescent 18-21 population, and 75% of the adult population. HMA assumed state prison members receive three Brief Intervention services, while individuals in county jails and juvenile youth facilities will receive an average of two Brief Intervention services due to their shorter length of stay. HMA assumed the average cost per service is $68.39 using HCPF's fee schedule. The estimated number of utilizers was multiplied by the assumed number of services and the average cost per service to arrive at an initial cost estimate for Brief Intervention included under the Section 1115 Demonstration.

Medication Assisted Treatment

- **Lower Bound:** HMA did not receive claims data for MAT as these services are SUD-related and could not be provided per federal requirements. In the absence of historical data, HMA relied upon high-level assumptions using research and clinical expertise. Per SAMHSA, regular use of opioids was reported in 17-19% of individuals sentenced to jail and state prisons[18]. CMS expects states to increase the availability of MAT within prisons and jails under this demonstration opportunity[19]. Given this expectation, we have assumed more individuals will be screened and identified as having opioid use disorder (OUD) treatment needs. At the lower bound, HMA assumed 23% of the population will receive MAT services. HMA assumed members in state prisons receive an average of 90 units of MAT services during the 90-day reentry period. HMA assumed members in county jails receive an average of 20 units and members in juvenile youth facilities receive an average of 60 units due to their shorter length

[18] Medication-Assisted Treatment (MAT) in the Criminal Justice System: Brief Guidance to the States

[19] Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated

of stay. HMA assumed the cost per MAT service per day is $37.75, a blend of the $15.50 per Methadone unit on HCPF's fee schedule and the roughly $1,800 cost per month of MAT injectables. The estimated number of utilizers was multiplied by the assumed number of services and the average cost per service to arrive at an initial cost estimate for MAT included under the Section 1115 demonstration.

- **Upper Bound:** At the upper bound, HMA assumed 25% of the population will receive MAT services. HMA assumed members in state prisons and juvenile youth facilities receive an average of 90 units of MAT services during the 90-day reentry period. HMA assumed members in county jails receive an average of 25 units due to their shorter length of stay. HMA assumed the cost per MAT service per day is $37.75, a blend of the $15.50 per Methadone unit on HCPF's fee schedule and the roughly $1,800 cost per month of MAT injectables. The estimated number of utilizers was multiplied by the assumed number of services and the average cost per service to arrive at an initial cost estimate for MAT included under the Section 1115 demonstration.

Care Coordination

- **Lower Bound:** Although DOC currently provides care coordination activities for incarcerated individuals, DOC did not separately report Case Management or Care Coordination expenses within the Reporting Tool. In the absence of historical data, HMA relied upon high-level assumptions using research and clinical expertise. HMA assumed all members that are part of the Section 1115 demonstration receive care coordination, estimated at $3.00 PMPM at the lower bound.
- **Upper Bound:** At the upper bound, HMA assumed care coordination activities cost $5.00 PMPM.

Case Management

- **Lower Bound:** In the absence of historical data, HMA relied upon high-level assumptions using research and clinical expertise. HMA assumed all members that are part of the Section 1115 demonstration receive case management services; however, HMA varied the average number of case management services members receive. At the lower bound, HMA assumed members in state prisons and juvenile youth facilities receive an average 2.5 case management services, while members in county jails receive an average of 1.75 due to their shorter length of stay. HMA assumed the average cost per case management visit is $102.65 (procedure code T2024 on HCPF's fee schedule[20]). The estimated number of utilizers was multiplied by the assumed number of services and the average cost per service to arrive at an initial cost estimate for Case Management included under the Section 1115 demonstration.
- **Upper Bound:** At the upper bound, HMA assumed members in state prisons and juvenile youth facilities receive an average of three case management services while members in County Jails receive an average of two due to their shorter length of stay. HMA assumed the average cost per case management visit is $102.65 (procedure code T2024 on HCPF's fee schedule). The estimated number of utilizers was multiplied by the assumed number of

[20] Targeted Case Management Fee Schedule

services and the average cost per service to arrive at an initial cost estimate for Case Management included under the Section 1115 demonstration.

RESULTS

HMA is estimating the total computable cost under this demonstration to be $48,490,306 at the lower bound and $84,324,294 at the upper bound. This includes $12,737,931 state dollars at the lower bound and $22,137,454 at the upper bound, which is partially covered by existing state general fund only investment in correctional facilities. The table below outlines the total computable cost by facility type.

Table 3. Total Cost Estimates for Reentry Services by Facility Type and Benefit

		Total Computable Cost	
Facility	**Service**	**Lower Bound**	**Upper Bound**
State Prisons	BH and PH Screening	$75,511	$117,402
State Prisons	Brief Intervention	$387,676	$811,466
State Prisons	Care Coordination	$36,630	$79,421
State Prisons	Case Management	$1,044,464	$1,630,503
State Prisons	Medication-Assisted Treatment	$3,172,076	$4,486,357
State Prisons	Pharmacy	$293,229	$679,960
State Prisons	**Total**	**$5,009,585**	**$7,805,108**
County Jails	BH and PH Screening	$789,164	$1,226,964
County Jails	Brief Intervention	$6,077,392	$11,307,496
County Jails	Care Coordination	$382,820	$830,023
County Jails	Case Management	$15,281,958	$22,720,501
County Jails	Medication-Assisted Treatment	$14,733,931	$26,048,273
County Jails	Pharmacy	$6,129,063	$14,212,521
County Jails	**Total**	**$43,394,329**	**$76,345,779**
Juvenile Youth Facilities	BH and PH Screening	$3,079	$4,109
Juvenile Youth Facilities	Brief Intervention	$4,109	$9,103
Juvenile Youth Facilities	Care Coordination	$1,130	$2,450
Juvenile Youth Facilities	Case Management	$24,767	$50,304
Juvenile Youth Facilities	Medication-Assisted Treatment	$44,612	$98,154
Juvenile Youth Facilities	Pharmacy	$8,696	$9,287
Juvenile Youth Facilities	**Total**	**$86,393**	**$173,408**
Total		**$48,490,306**	**$84,324,294**

HMA's estimates translate to $345.88 PMPM at the lower bound and $462.36 PMPM at the upper bound. Appendix G outlines the results of the Fiscal Analysis by population and service on a PMPM-basis. Appendix H includes a breakout by facility and age band of the total computable cost, with federal and state match combined. It is worth noting that HMA varied both dollar and member month assumptions to create the lower bound and upper bound estimates.

This projection would result in new Medicaid service expenditure funded through a mix of Federal Financial Participation (FFP) and State dollars. HMA anticipates that State funds currently being utilized to fund these types of services would decrease as a result of these benefits being covered by federal Medicaid. Additional information and high-level estimation of these offsetting costs is discussed in the State Budget Implications section below. The analysis was not designed to include local (city and county jail) funds, however further analysis and review is necessary to understand the total state general fund cost.

Section 1115 Budget Neutrality Implications HCPF worked with HMA to define the services to be included in the Section 1115 Demonstration covered benefit package that are considered Treatment versus Transition. Of the proposed Section 1115 Demonstration services included, BH and PH Screening, Care Coordination, and Case Management are considered Transition Services. Of the proposed Section 1115 Demonstration Services included, Brief Intervention, MAT, and Pharmacy are considered Treatment Services. The table below summarizes the estimated Section 1115 Demonstration covered expenditures by population and Treatment versus Transition benefit type.

Table 4. Total Reentry Benefit Costs based on Transition and Treatment, Upper Bound

	State Prisons, County Jails, and Juvenile Youth Facilities: Upper Bound Expenditure Estimates		
Population	**Transition**	**Treatment**	**Total Computable Costs**
Adolescent 0-17	$13,533	$15,453	$28,986
Adolescent 18-21	$363,634	$573,552	$937,186
Adult 21+	$26,284,510	$57,073,613	$83,358,122
Total Computable Costs	**$26,661,676**	**$57,662,618**	**$84,324,294**

HMA estimates 116,128 releases will be eligible to receive 1-3 months of pre-release services, equating to an estimated 182,379 member months.

Individuals released from county jails represent 92% of the total computable cost, as there is a significant amount of individuals released from county jails annually that would be eligible to receive pre-release services under this demonstration. Although most of these individuals will be eligible, the average length of stay in county jails is only 15-45 days, resulting in significant churn. HMA assumed most of the members released from county jails will only be eligible to receive one month of pre-release services in the member month calculation. Please see the Data and Methodology section for more detail. HCPF will be able to adjust the total allowable benefit in order to better manage program costs after further analysis for costs associated with jail populations.

The projected eligibility and corresponding expense discussed above will be direct increases to the Colorado HCPF Medicaid program. These figures would be included as hypothetical cost in budget neutrality estimates included within a Section 1115 Demonstration application to CMS. Although the assumptions underlying both the lower and upper bound are defensible, HMA recommends using the upper bound estimate to establish the proposed budget neutrality model for the Section 1115 Demonstration.

HMA has identified that if HCPF were to propose a PMPM methodology for its Section 1115 Reentry Demonstration proposal, this methodology would meet CMS's budget standards for an 1115 waiver. CMS's approach to developing budget neutrality expenditures in Section 1115 demonstrations utilizes an average

PMPM cost established from the state's projected historical baseline. This is then trended forward at an agreed-upon trend rate. **The PMPM methodology is the most flexible budget neutrality approach as it places the state at risk for only the average cost of services provided to eligible individuals.** The state is not at risk for the number of eligible individuals served. CMS's approach to budget neutrality is the "aggregate cap" methodology, in which CMS sets a finite total expenditure cap, and the state is held at risk for both the number of eligible individuals served and the cost of services. The "aggregate cap" approach is a stricter financial test for the state, particularly when there is insufficient Medicaid experience serving the reentry population, which limits establishing a firm baseline for projecting cost and number of eligible members going forward. Thereby, HMA strongly recommends the state develop a PMPM methodology for the Section 1115 proposal, irrespective of whether the delivery system will be FFS or managed care. The figures above assume that these benefits will be provided on an FFS basis.

Separate from the budget neutrality-specific increases to eligibility and expense, **HCPF may realize future savings for enrollees impacted by the demonstration**. Along with the increased focus on reentry services, individuals should benefit from increased preventive services that reduce future emergency department (ED) visits and Inpatient Hospital admissions that would have otherwise fallen to HCPF Medicaid expense. The estimate for these types of potential savings was not a part of the scope of this fiscal analysis but could be considered through additional analysis. Additional fiscal considerations associated with the approval of a Section 1115 Reentry Demonstration are the additional opportunities for new federal funding to support the state's overall Medicaid program in the uptake of a reentry initiative. These expenditures are separate from budget neutrality and are subject to state Medicaid match requirements but offer additional (one-time) funding to facilitate the state's overall success in demonstration implementation. Those associated new expenditures are listed in Appendix I. HMA is available to provide additional technical assistance on this point as requested.

State Budget Implications

All fiscal estimates discussed above are projections of total annual expenditures. The table below splits the total expenditure estimates into projected State and Federal share. The assumed Federal share is 50% for non-Expansion enrollees and 90% for Expansion enrollees. Historical HCPF data specific to individuals released from carceral settings were used to estimate the mix of non-Expansion and Expansion enrollment.

Table 5. Total Reentry Benefit Cost by Age, State Share and Federal Share, Upper Bound

	State Prisons, County Jails, and Juvenile Youth Facilities: Upper Bound Expenditure Estimates		
Population	**Federal Share**	**State Share**	**Total Computable Cost**
Adolescent 0-17	$14,493	$14,493	$28,986
Adolescent 18-21	$487,337	$449,849	$937,186
Adult 21+	$61,685,010	$21,673,112	$83,358,122
Total	**$62,186,840**	**$22,137,454**	**$84,324,294**

The estimates above introduce new annual Medicaid expenditure of $84 million. HMA projects that $62 million of this $84 million expenditure will be funded through FFP as a part of an 1115 Demonstration approval. This leaves $22 million expenditures that are State Medicaid funded through general fund expenditures. The state is currently investing an estimated approximately $21 - $54 million in general fund expenditures for reentry activities within correctional facilities, resulting in roughly up to $32 million in existing state funds that could be reinvested in new programs over time.

While this $22 million State Medicaid expense is new to the Medicaid system, the State of Colorado will likely realize decreased expenditure in other non-Medicaid areas. State Prison, County Jail, and Juvenile Youth Facility systems currently provide some level of care that overlaps with the services and individuals described above that will be considered Medicaid benefits under a Section 1115 Demonstration. These current program costs will decrease with the implementation of the Section 1115 Demonstration over time as they become Medicaid services. The table below provides a high-level estimate of overall state funding impacts by incorporating current costs that will likely be impacted by the new Medicaid eligible benefits.

Table 6. Section 1115 Demonstration Benefit Medicaid Expense Projection: Comparison to Current Other State Program Expenditures

	State Prisons	County Jails	Juvenile Youth Facilities	Total
Total Computable Medicaid Cost (a)	**$7,805,108**	**$76,345,779**	**$173,408**	**$84,324,294**
Federal Share (a1)	*$5,759,169*	*$56,338,079*	*$89,592*	*$62,186,840*
State Share (a2)	*$2,045,939*	*$20,007,699*	*$83,815*	*$22,137,454*
Current Reentry Expense Estimate (b)	**$5,037,488**	**$49,274,266**	**$111,919**	**$54,423,673**
Current DOC Expense Estimate (b1)	*$5,037,488*	*$0*	*$0*	*$5,037,488*
Current JBBS Expense (b2)	*$0*	*$16,000,000*	*$0*	*$16,000,000*
Current Other Expense Estimate (b3)	*$0*	*$33,274,266*	*$111,919*	*$33,386,185*
Overall State Funding Change: (a2) - (b)	**$(2,991,549)**	**$(29,266,566)**	**$(28,104)**	**$(32,286,219)**

The current reentry expense estimates were developed using the sources and assumptions described below.

- **Current DOC Expense Estimate (b1):** As discussed in the Impact Assessment, the DOC Reporting Tool provides robust annual expenditure information for the Prison facilities. As seen in Appendix E, the overall cost for CY 2022 in State Prisons was $189 million. HMA estimates **$5 million** of the $189 million was spent on reentry services, overlapping with the proposed Section 1115 Demonstration benefit package. HMA used the following methodology to estimate the expenditure overlap:
    - HMA excluded Physical Health expense of $127 million as these benefits do not overlap with the six proposed demonstration services. This results in $62 million of expenses that have some level of assumed overlap with the proposed Section 1115 Demonstration benefit package.
    - Solve for PMPM utilizing DOC reported inmate counts. The resulting PMPM that corresponds to the proposed Section 1115 Demonstration benefit package is $317.14.

    - Apply that PMPM to the assumed member months for individuals being released from prison discussed in the Member Months Assumptions section above resulting in $5 million of overlapping expense.
- **Current JBBS Expense (b2):** HMA estimates the portion of this current expense that overlaps with the proposed Section 1115 Demonstration benefit package to be **$16 million** within the jail facilities that are currently JBBS funded. This figure was provided by the Colorado Behavioral Health Administration.
- **Current Other Expense Estimate (b3):** The DOC and JBBS expenditures described above likely do not represent the full magnitude of services being rendered today that would overlap with the proposed Section 1115 Demonstration benefit package. Given the data limitations with respect to the jail and juvenile youth facilities, HMA has developed high level estimates for these expenditures leveraging the DOC data source as a guide.
    - The overall DOC prison expense for the proposed Section 1115 Demonstration benefit package services is estimated to increase by roughly 55% (heavily driven by the substantial increase in the MAT benefit) based on the figures referenced in the table above ($7.8 million estimated under the demonstration increased from $5.0 million covered today). This assumed increase is extrapolated to the jail and juvenile youth facilities to back into the assumed implied expense in those settings today for the comparable services. This yields the following results.
        - **Jails: $49 million** total historical State funded expense. Note, $16 million of this is accounted for in the JBBS expense above. This leaves **$33 million**, extrapolated from minimal jail expenditure data obtained, in the "Other Expense" category. *This figure needs further analysis to determine how much state and county funding is currently supporting transition services in jails.*
        - **Juvenile Youth Facilities: $0.1 million** total historical State funded expense.
- **Overall State Funding Change (a2) -(b):** This row estimates the overall change in state funding under the 1115 demonstration opportunity. This calculation assumes a significant portion of the reentry expenditures will be covered by FFP ($62 million), resulting in roughly $22 million needed in state funds. Given the assumption that the state is already spending $54 million on these efforts, HMA is projecting that there will be up to **$32** million in existing state funds that could be reinvested in new programs over time ($22 million minus $$54 million). Please note, this is a high-level estimate that is highly sensitive to the "Current Other Expense Estimate" described in the bullet above. To the extent this amount varies significantly from what was assumed, the overall state funding change would also vary significantly.
    - **State Funding Change for Prisons and Juvenile Youth Facilities:** HMA projects $6 million of the $8 million Medicaid costs will be funded through FFP, while $2 million of the $8 million will be funded through state funds only. The state is currently investing an estimated $5 million in reentry activities within prisons and juvenile youth facilities, resulting in roughly $3 million in existing state funds that could be reinvested in new programs over time. With the influx of new federal financial participation (FFP) for both services and administrative support, the State's overall expenditures for justice-involved persons reentering the community from prisons and juvenile youth facilities is anticipated to decrease over time via streamlined cost-efficiencies across Medicaid and correctional health program expenditures such as the Department of Corrections (DOC) a portion of these benefits today. HCPF may realize future savings for enrollees impacted by this policy decision. Along with the increased focus on reentry services, individuals should benefit from

increased preventive services that reduce future emergency department (ED) visits and inpatient hospital admissions that would have otherwise fallen to HCPF Medicaid expense.

- **State Funding Change for Jails:** HMA estimates 110,500 releases from county jails occur annually and projects $76 million in Medicaid treatment costs, with $56 million of the costs funded through FFP; this means the remaining $20 million must be funded through state funds. The Behavioral Health Administration (BHA) currently funds related transitional services in jails with $16 million in general fund through their Jail Based Behavioral Health Services (JBBS) program; the funds can be used to cover a portion of the state funds need to cover transitional services in jails. HMA attempt to ascertain expense information for transitional services from the 61 county and municipal jails in Colorado but only 4 jails responded. With such a low response rate HMA extrapolated from the information available and estimates that jails spend $33 million annually on transitional services. With the $16 million from JBBS and the estimated $33 million in jail expenses to cover the state portion of funds needed for Medicaid to cover transitional services in jails, with an additional $29 million in existing state funds that could be reinvested in new programs. While the jail analysis is informational, without comprehensive information from the jail on their actual spend, the analysis lacks confidence.

HMA also notes that based on their experience with CMS, state budget neutrality estimates serve as a baseline for CMS' consideration of the level of total outlays expected to incur under the proposed demonstration to ensure that projected demonstration costs do not exceed expected outlays for Medicaid in accordance with the President's Budget. The state's specific budget neutrality expenditure ceiling will be subject to negotiation with CMS in alignment with the specific approval parameters of a Colorado Section 1115 Reentry Demonstration. HCPF should expect to deliberate with CMS on a different budget neutrality expenditure ceiling than what is proposed in the state's application.

Reinvestment Opportunities

HMA believes the overall State expenditure for the proposed Section 1115 Demonstration benefits will be lower with CMS approval to provide these services as Medicaid-eligible benefits. This is driven by the significant opportunity for FFP matching expenditure created through the Demonstration. As a condition of receiving new FFP, as discussed in the CMS SMD guidance, CMS does not expect to approve federal matching funds through the Reentry Section 1115 Demonstration Opportunity for any existing carceral health care services that are currently funded with state and/or local dollars **unless** the state agrees to reinvest the total amount of federal matching funds received for such services under the demonstration into activities and/or initiatives that:

- increase access to or improve the quality of health care services for individuals who are incarcerated (including individuals who are soon-to-be released) or were recently released from incarceration, or
- for health-related social services that may help divert individuals from criminal justice involvement.
- Add to and/or improve the quality of health care services and resources for individuals who are incarcerated and those who are soon to be released from carceral settings, and
- not supplant existing state or local spending on such services and resources.

CMS will consider the state's share of expenditures for new, enhanced or expanded pre-release services approved under the demonstration can be considered an allowable reinvestment. In other words, states will receive FFP on the "reinvested" Medicaid funds; thereby obtaining 100% federal match on every reinvested dollar. Based on previous the SMD letter, stakeholder engagement, organized planning efforts like the Behavioral Health Task Force, and state policy analysis, optimal reinvestment opportunities include

addressing health related social needs like food and housing, expanded community behavioral health services, supports for those with serious mental illness including inpatient care, and technology supports to support care coordination and social service supports.

CLOSING

CMS' current priority focus on addressing key healthcare challenges for the justice-involved population and the resulting momentum of states pursuing Section 1115 reentry demonstrations, combined with strong support among Colorado agencies and stakeholders, signal that it may be an optimal time for the state to design and develop a new 5-year Section 1115 Demonstration application to improve access to health care services for the justice-involved population. Successful states have used robust interagency approaches to ensure the design of the demonstration reflects the priorities and fiscal needs of agencies, while aiming to improve outcomes for this vulnerable population. HCPF would need to ensure development of a scalable implementation approach that accounts for the necessary infrastructure, workforce and operational resources across agencies and correctional settings to achieve a successful statewide implementation approach inclusive of all targeted justice-involved populations. HCPF could consider a phased implementation approach by narrowing the eligibility criteria or specifying which facilities are included in the demonstration. As an example, HCPF could start with state prisons only, then expand to juvenile youth facilities and then to jail based on state and provider readiness. HMA recommends HCPF work with the jails to obtain the expense data needed to develop a comprehensive approach to implementing transitional services in the jails in a manner that does not generate additional costs to the state; this approach can include scoping service eligibility to certain populations or limiting the benefit package available. Upon further analysis the state could further cost savings allowing other programs and services to be implemented while remaining budget neutral. Refer to Appendix H for the breakout of expenditures for a DOC approach only. The state has flexibility to design its proposed Section 1115 Reentry Demonstration to CMS in this way – obtaining initial approval for statewide implementation but scaling up to statewide implementation over the 5-year approval period.

In alignment with California and Washington approved demonstrations, we recommend the general parameters for the design of the Section 1115 reentry design benefit

Table 7. Recommended Parameters for Colorado Reentry Program

Key Reentry Components	Recommended Reentry Design Parameters
Pre-release period	90-day prerelease period
Reentry Benefits	• Case management (care coordination) services that include physical and behavioral health clinical screenings and consultation services • 30-day supply of prescription medications and medication administration • Medication-assisted treatment (MAT) for all FDA-approved medications (including counseling)

Key Reentry Components	Recommended Reentry Design Parameters
Eligible Carceral Settings	County jails, state prisons, and youth correctional facilities.
Beneficiary Eligibility	Otherwise, Medicaid eligible adults and youth who are soon to be released from jail, prison, or juvenile youth facilities.
Budget Neutrality	Utilize fiscal estimates that are closer to the "Upper Bound" estimates (i.e., $84,324,294 total computable) provided under the "Section 1115 Budget Neutrality Implications" section of this report to account for the lack of experience serving the justice-involved in Medicaid. These expenditures become the "without waiver" hypothetical ceiling – and a broader ceiling provides more "cushion" to account for initial implementation costs that may be challenging to estimate.
Offsetting State Expenditure	The estimated $84,324,294 total computable new Medicaid expenditure would be funded through FFP and State funds. With the influx of new FFP (for both services and administrative support), the State's overall expenditures for justice-involved persons reentering the community is anticipated to decrease over time via streamlined cost-efficiencies across Medicaid and correctional health programs.

Based on the previous analysis, and the recognition that an 1115 Demonstration Waiver would require state budget actions and potentially legislative actions, and that HCPF has the necessary resources to apply for an implement this program, HMA has identified the following recommendations and next steps:

- HMA recommends that HCPF begin stakeholder engagement and application development before the end of the 2023 calendar year to allow for the required state public notice process before a February-April 2024 submission to CMS (average 2-3 months to account for tribal notice).
- HMA recommends that HCPF consider marrying the reentry proposal with other health related social needs (HRSN) 1115 benefits (e.g., nutrition or housing supports) to help facilitate the achievement of health outcomes and program goals, but also to take advantage of additional federal funding opportunities associated with the initial approval of a new HRSN approval. HMA can provide additional advice and recommendations as requested by HCPF.
- HMA does not recommend HCPF include transportation as a related HRSN, despite this being a recommendation from the interviewed stakeholder group discussed above. Non-medical transportation is excluded from the hypothetical budget neutrality approach CMS utilizes for the Section 1115 Reentry and HRSN demonstration initiatives – and would be considered a "cost not otherwise matchable" for which HCPF would need to show "savings" to cover under the demonstration. This is a more challenging financial test for a new Section 1115 demonstration approval.
- By starting with a benefit package with prison population first the state could conduct further analysis for a more complete picture of cost prior to implementation with no additional costs to the state to implement.

APPENDICES

Appendix A: States with CMS-Pending Section 1115 Reentry Proposals

States with CMS-Pending Section 1115 Reentry Proposals (As of August 21, 2023)				
State	**Proposed Population**	**Proposed Services**	**Proposed Reentry Period**	**Proposed Total Enrollment and Costs over 5-Year Period**
Arizona	Medicaid-eligible individuals with serious behavioral and physical health conditions who are at elevated risk of experiencing homelessness upon release from incarceration	One-on-one case management and education services, coordination for housing supports, care planning to link to PH (physical health) and BH needs, and peer supports	30 days prior to release	The state did not separate enrollment or costs for the justice- involved population in its application submission but provided total enrollment and costs by state plan eligibility group across all demonstration services.
Kentucky	Medicaid eligibles (up to 133% of federal poverty level (FPL) who are 18 or older and meet additional SUD eligibility criteria	SUD treatment services, member therapy, group therapy, family therapy, peer support services, case management, and medication management	• Department of Corrections (DOC) Division of Addiction Services would cover up to 10 hours of clinical treatment services a week for up to 6 months • SSI/SSDI Outreach, Access, and Recover (SOAR) would provide coverage for up to 7 hours a week for 30 months	31,200 persons at a total cost of $177,476,000

			• No limited period of time for medication mgmt. as prescribed until release	
Massachusetts	• Medicaid-eligible adult individuals with a chronic condition mental health condition • Youth in juvenile justice facilities	• Adults - certain medical, behavioral health, and pharmacy services to individuals with a chronic condition, mental health condition, or SUD • Juveniles - certain medical, behavioral health, and pharmacy services	• 30 days prior to release for Medicaid-eligible adult individuals • The full duration of their commitment for youth in juvenile justice facilities. • *PLUS*, provide continuous eligibility for one year after an individual leaves a carceral setting	The state did not separate enrollment for the justice-involved population in its budget neutrality submission but provided total enrollment by state plan eligibility group across all demonstration services. Total estimated costs: $116,052,259
Montana	Medicaid-eligible adults with SUD, Serious Mental Illness (SMI), or Serious Emotional Disturbance (SED)	• Limited community-based clinical consultation services, in-reach care management services, and a 30-day supply of medication for reentry into the community. • Individuals will also receive coverage of certain medications, including long acting or depot preparations for	30 days prior to release	112 persons at a total cost of $406,250

		chronic conditions and preventive or curative medications which will facilitate maintenance of medical and psychiatric stability upon release		
New Hampshire	Medicaid-eligible adults with BH disorders (i.e., SUD, Opioid Use Disorder (OUD), SMI, or SED)	Care coordination for: (i) MCO enrollment, (ii) peer recovery supports or counseling, and, (iii) new prescribing provider appointments with identified community behavioral health providers (i.e., one telehealth or in-person intake appointment and one or two peer support or counseling sessions)	45 days prior to release	3,058 persons at a total cost of $1,222,312
New Jersey	Medicaid-eligible adults with behavioral health diagnoses	Up to four behavioral health care management visits	60 days prior to release	10,000 persons at a total cost of $3,000,000
New Mexico	Medicaid-eligible adults and youth with high needs, including but not limited to those with SMI, SED, or SUD	Enhanced care management and coordination, medication assisted treatment (MAT), and 30-day supplies of medications and durable medical	30 days prior to release	48,970 persons at a total cost of $5,916,000

		equipment (DME) (as needed)		
New York	Medicaid eligible adults who have two or more qualifying chronic diseases (such as Chronic Obstructive Pulmonary Disease/COPD and diabetes), or one single qualifying condition of either Hepatitis C, HIV/AIDS, SMI, intellectual and developmental disabilities (I/DD), sickle cell disease, or a SUD	Targeted set of in-reach Medicaid services including care management and discharge planning, clinical consultant services, peer services, sexual and reproductive health information and connectivity, and medication management plan, including development and delivery of certain high priority medications	30 days prior to release	378,224 persons at a total cost of $748,000,000
Oregon	Medicaid-eligible adults Medicaid-eligible youth under 21	Transitional services for adult justice-involved prison populations • Full Medicaid services for all youth under 21 in juvenile detention facilities • Limited benefits for beneficiaries in jail or local correctional facilities	Up to 90 days pre-release for adults in prison Adults in jail or tribal correctional facilities or Youth in juvenile detention facilities - the duration of incarceration	50,024 persons The state did not separate costs for the justice-involved population in its budget neutrality submission but provided total cost by state plan eligibility group across all demonstration services.

Rhode Island	Medicaid-eligible adults and youth	Medicaid State Plan, including "in-reach" services provided by the managed care organizations (MCO)	30 days prior to release	The state did not separate enrollment or costs for the justice-involved population in its application submission but provided total enrollment and costs by state plan eligibility group across all demonstration services.
Utah	Medicaid-eligible adults with a chronic physical or behavioral health condition or a mental illness	• Individuals will receive benefits based on their specific Medicaid category eligibility. • Adults with dependent children and medically frail will receive a targeted benefit package of case management, prescribed drugs, and behavioral health services	30 days prior to release	6,456 persons at a total cost of $40,894,963
Vermont	Medicaid-eligible adults	Full state plan benefits	90 days prior to release	27,500 persons The state did not separate costs for the justice involved population in its budget neutrality submission but provided total cost

				by state plan eligibility group across all demonstration services.
West Virginia	Medicaid-eligible adults with a known or suspected SUD	Community-based clinical consultation services are provided in person or via telehealth, in-reach care management services, HIV/Hepatitis C screening and treatment, and a supply of medication sufficient to facilitate maintenance of medical and psychiatric stability for 30 days upon release	30 days prior to release	5,110 persons at a total cost of $48,612,261

Appendix B: Federal Requirements for Section 1115 Reentry Demonstrations (per SMS #23-003)

Reentry Program Element	Federal Requirements
Demonstration Goals and Objectives	• Increase coverage, continuity of coverage, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release • 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 • Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful reentry post-release • Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs (HRSN) • Reduce all-cause deaths in the near-term post-release; and • Reduce the number of emergency department (ED) visits and inpatient hospitalizations among recently incarcerated Medicaid beneficiaries through increased receipt of preventive and routine physical and behavioral health care
Pre-release period	Up to a 90-day prerelease period. If the state requests a pre-release coverage period longer than 30 days, the state should include one or more additional goals to be evaluated in addition to improving care transitions. If CMS approves a coverage period longer than 30 days, relevant hypotheses that the longer timeframe is needed to assess will be required to be incorporated into the state's evaluation design.
Eligible Carceral Settings	State and/or local jails, prisons, and/or youth correctional facilities. **NO federal prisons.**
Beneficiary Eligibility*	Individuals currently incarcerated who are otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP), and soon-to-be formerly incarcerated individuals. States have the flexibility to target the population by with specific health conditions (e.g., mental illness, SUD, chronic

Reentry Program Element	Federal Requirements
	condition, intellectual or developmental disability, traumatic brain injury, HIV/AIDS, and pregnancy or postpartum). * The Section 1115 application must describe how the state has or will have a system in place to suspend (instead of terminating) Medicaid or the Children's Health Insurance Program (CHIP) eligibility for inmates in carceral settings.
Minimum Benefits	• Case management to assess and address physical and behavioral health needs and HRSN • MAT services for all types of SUD as clinically appropriate with accompanying counseling; and, • 30-day supply of all prescription medications prescribed for the beneficiary at the time of release and provided to the beneficiary immediately upon release from the correctional facility
Optional Benefits	Because individuals who are incarcerated have a higher incidence of chronic physical and behavioral health conditions and disease burden, states are encouraged to request authority to cover additional physical and behavioral health pre-release services, such as family planning services and supplies for both men and women or screenings for blood pressure, diabetes, Hepatitis C, or HIV.
Provider Requirements	• Licensed, registered, certified, or credentialed in the state and providing services within their individual scope of practice • Participating providers and provider staff, including carceral providers, must have experience and receive appropriate training prior to furnishing demonstration-covered pre-release services • Participating providers of reentry case management services may be community-based or carceral providers who have expertise working with justice-involved individuals
Waiver and Expenditure Authorities	• Waivers of Section 1902 of the Social Security Act as necessary to implement the state's reentry design • Expenditure authority under Section 1903 of the Social Security Act for pre-release services to justice involved individuals in state prisons, county jails, and/or in youth correctional facilities for up to 90 days prior to release
Budget Neutrality Model	Hypothetical treatment for projected reentry expenditures. States do not have to show "savings" but just project estimated medical assistance and administrative expenditures

Reentry Program Element	Federal Requirements
Related New Program Authorities	• Expenditure authority for "Designated State Health Programs" (DSHP) to use the "freed up" State dollars toward new Section 1115 initiatives • One time "transitional non-service expenditures" for IT Modernization (electronic referral systems, new or updated EHRs, data warehouses, accounting, and billing systems, etc.) • Up to a 2-year implementation ramp-up can be authorized to fully implement infrastructure to support coverage of reentry services
Potential Condition of Approval	Increase in Medicaid fee-for-service and managed care provider rates should the state's Medicaid to Medicare provider rate ratio be below 80 percent in certain care categories
Post-approval Operational Requirements	
Implementation Plan	CMS authorization of federal financial participation (FFP) (i.e., federal Medicaid funding) is contingent upon their approval of this plan that is required to be submitted by no later than 120 days post approval. Describes the activities and associated timelines for achieving the five demonstration milestones specified in the SMD: • Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated • Covering and ensuring access to the minimum set of pre-release services for individuals who are incarcerated to improve care transitions upon return to the community • Promoting continuity of care • Connecting to services available post-release to meet the needs of the reentering population • Ensuring cross-system collaboration
Reinvestment Plan	This must be part of the **Implementation Plan** that is required as a condition to receive FFP. The reinvestment plan should align with the goals articulated for the reentry Section 1115 Demonstration opportunity in the SMD. The reinvestment plan should minimally address: • The state's plans to increase access to or improve the quality of health care services, as well as address the HRSN of individuals who are incarcerated, those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions • How the reinvestment funds will be used to support the successful transition of beneficiaries to the community, e.g., investments to

Reentry Program Element	Federal Requirements
	facilitate pre-release services, such as case management, or expansion of community-based capacity, e.g., increasing or improving mental health and SUD services ● The reinvestment plan should describe the activities and/or initiatives the state has selected to invest in and a timeline for implementation
Monitoring Protocol	The state will have to submit a Monitoring Protocol no later than 150 calendar days after the approval of the demonstration. The minimum content must address: ● The quantitative and qualitative methods of data collection for which the state will report key indicators of progress toward meeting milestones and performance/monitoring metrics (as determined by CMS) for the demonstration through Quarterly and Annual Monitoring Reports ● The state's plans and timeline for reporting metrics data stratified by key demographic subpopulations of interest ● Specification of the selection of quality of care and health outcomes metrics and population stratifications based on CMS' upcoming guidance on the Health Equity Measure Slate ● Describe the methods and timeline to collect and analyze non-Medicaid administrative data to help calculate applicable monitoring metrics
Evaluation Design	The state will have to submit an Evaluation Design no later than 180 calendar days after approval. States are encouraged to secure an independent entity to conduct the evaluation. The minimum content must include: ● Evaluation hypotheses must focus on, but not be limited to: ○ Cross-system communication and coordination ○ Connections between carceral and community services ○ Access to and quality of care in carceral and community settings ○ Preventive and routine physical and behavioral health care utilization; and, ○ Non-emergent emergency department visits and inpatient hospitalizations. performance targets ● A comprehensive analysis of services rendered by type of service over the duration of the 90-day pre-release coverage period

Reentry Program Element	Federal Requirements
	• Evaluation of any relationship identified between the provision and timing of services with post-release outcomes • Assessment of the extent to which the coverage timeline facilitated providing more coordinated, efficient, and effective reentry planning, enabled pre-release management and stabilization of physical and behavioral health conditions • An examination of carceral provider qualifications and standards as well as the experiences of carceral and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community • A comprehensive cost analysis to support developing estimates of implementing the reentry demonstration initiative, including covering associated services
Mid-Point Assessment	Due by the end of the third demonstration year covering the first 2.5 years of implementation and must be conducted by an independent entity. The minimum content must address: • Progress toward meeting each milestone and period approved in the Implementation Plan • Progress toward meeting performance metrics as approved in the Monitoring Protocol • A determination of factors that affected achievement on the milestones and progress • A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of missing those milestones and performance targets; and, • For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the Implementation Plan or to pertinent factors that the state can influence that will support improvement

Appendix C: Lower Bound Estimate of Individuals Eligible for Medicaid Upon Release

Current Releases for Individuals within Carceral Settings and Estimated Medicaid Eligibility Upon Release				
Population	**Facility Type**	**Historical Releases***	**Releases Eligible for Medicaid**	**% Eligible for Medicaid**,***
Adolescent 0-17	State Prisons	-	-	N/A
Adolescent 0-17	County Jails	-	-	N/A
Adolescent 0-17	Juvenile Youth Facilities	56	29	51.9%
Adolescent 0-17	**Total**	**56**	**29**	**51.9%**
Adolescent 18-21	State Prisons	71	49	69.2%
Adolescent 18-21	County Jails	1,645	1,024	52.3%
Adolescent 18-21	Juvenile Youth Facilities	186	97	51.9%
Adolescent 18-21	**Total**	**1,902**	**1,170**	**61.5%**
Adult 21+	State Prisons	5,812	4,021	69.2%
Adult 21+	County Jails	134,984	84,047	62.3%
Adult 21+	Juvenile Youth Facilities	-	-	N/A
Adult 21+	**Total**	**140,797**	**88,068**	**62.5%**
Total	State Prisons	5,883	4,070	69.2%
Total	County Jails	136,629	85,071	62.3%
Total	Juvenile Youth Facilities	242	126	51.9%
Total		**142,754**	**89,267**	**62.5%**

*State Prisons: Colorado Department of Corrections - July 2022 through June 2023

County Jails: CDPS Jail Dashboard - July 2021 through June 2022

Juvenile Youth Facilities: Colorado Division of Youth Services DYS Statistical Report - July 2022 through June 2023

**HMA assumed 69% uptake for State Prisons based on the detailed data provided by HCPF.

***The 69% assumption for State Prisons was dampened by 90% for County Jails and 75% for Juvenile Youth Facilities, reflecting a smaller portion of the population eligible for Medicaid upon release.

Appendix D: Upper Bound Estimate of Individuals Eligible for Medicaid Upon Release

Current Releases for Individuals within Carceral Settings and Estimated Medicaid Eligibility Upon Release				
Population	**Facility Type**	**Historical Releases***	**Releases Eligible for Medicaid**	**% Eligible for Medicaid**,***
Adolescent 0-17	State Prisons	-	-	N/A
Adolescent 0-17	County Jails	-	-	N/A
Adolescent 0-17	Juvenile Youth Facilities	56	38	67.5%
Adolescent 0-17	**Total**	**56**	**38**	**67.5%**
Adolescent 18-21	State Prisons	71	64	90.0%
Adolescent 18-21	County Jails	1,645	1,332	81.0%
Adolescent 18-21	Juvenile Youth Facilities	186	126	67.5%
Adolescent 18-21	**Total**	**1,902**	**1,522**	**80.0%**
Adult 21+	State Prisons	5,812	5,231	90.0%
Adult 21+	County Jails	134,984	109,337	81.0%
Adult 21+	Juvenile Youth Facilities	-	-	N/A
Adult 21+	**Total**	**140,797**	**114,568**	**81.4%**
Total	State Prisons	5,883	5,295	90.0%
Total	County Jails	136,629	110,670	81.0%
Total	Juvenile Youth Facilities	242	163	67.5%
Total		**142,754**	**116,128**	**81.3%**

*State Prisons: Colorado Department of Corrections - July 2022 through June 2023

County Jails: CDPS Jail Dashboard - July 2021 through June 2022

Juvenile Youth Facilities: Colorado Division of Youth Services DYS Statistical Report - July 2022 through June 2023

**HMA assumed 90% uptake for State Prisons based on supplemental research and HMA experience.

***The 90% assumption for State Prisons was dampened by 90% for County Jails and 75% for Juvenile Youth Facilities, reflecting a smaller portion of the population eligible for Medicaid upon release.

Appendix E: Current Cost of Healthcare for Individuals within Carceral Settings

Current Cost of Healthcare for Individuals within Carceral Settings Note: Data Reported as Available and is Not Complete				
Facility	**Category**	**Service**	**CY 2021**	**CY 2022**
State Prisons	Medical	Medication Assisted Treatment	$155,743	$319,806
State Prisons	Medical	Reentry Pharmacy	$608,201	$571,865
State Prisons	Medical	Other Pharmacy	$17,428,877	$18,060,273
State Prisons	Medical	Physical Health	$116,056,294	$127,002,509
State Prisons	Medical	Behavioral Health	$29,346,073	$31,089,262
State Prisons	Medical	Other Medical	$0	$0
State Prisons	Reentry	Case Management	$0	$0
State Prisons	Reentry	Screening and Brief Intervention	$0	$0
State Prisons	Reentry	Community Transition Support	$9,146,815	$12,223,585
State Prisons	Reentry	Community Health Workers & Peer Support Specialists	$0	$0
State Prisons	Reentry	Care Coordination	$0	$0
County Jails*	Medical	Medication Assisted Treatment	$593,458	$738,043
County Jails	Medical	Reentry Pharmacy	$10,573	$4,548
County Jails	Medical	Other Pharmacy	$316,398	$335,241
County Jails	Medical	Physical Health	$2,951,455	$3,699,119
County Jails	Medical	Behavioral Health	$772,564	$1,028,814
County Jails	Medical	Other Medical	$1,200,141	$1,535,474
County Jails	Reentry	Case Management	$884,589	$1,175,067
County Jails	Reentry	Screening and Brief Intervention	$297,514	$378,742
County Jails	Reentry	Community Transition Support	$112,449	$520,699
County Jails	Reentry	Community Health Workers & Peer Support Specialists	$217,739	$210,289
County Jails	Reentry	Care Coordination	$9,944	$15,734
Juvenile Youth Facilities**	Medical	Medication Assisted Treatment		
Juvenile Youth Facilities	Medical	Reentry Pharmacy		
Juvenile Youth Facilities	Medical	Other Pharmacy	$277,845	$283,816
Juvenile Youth Facilities	Medical	Physical Health		
Juvenile Youth Facilities	Medical	Behavioral Health		
Juvenile Youth Facilities	Medical	Other Medical		
Juvenile Youth Facilities	Reentry	Case Management		

Current Cost of Healthcare for Individuals within Carceral Settings Note: Data Reported as Available and is Not Complete				
Facility	**Category**	**Service**	**CY 2021**	**CY 2022**
Juvenile Youth Facilities	Reentry	Screening and Brief Intervention		
Juvenile Youth Facilities	Reentry	Community Transition Support		
Juvenile Youth Facilities	Reentry	Community Health Workers & Peer Support Specialists		
Juvenile Youth Facilities	Reentry	Care Coordination		

*HMA received information from four county jails. The figures included in this table reflect actual data reported by the four entities. As such, there may be reporting inconsistencies and/or inaccuracies within the aggregated information.

**The Division of Youth Services did not provide medical cost information. Pharmacy expenditures were reported by Psych and Non-Psych. Pharmacy expenses related to reentry activities were not separately identified. Pharmacy expenditures were reported on a Fiscal Year basis.

Appendix F: Proposed Demonstration Benefits Definition

- **Pharmacy:** Claim Type 'P' or 'Q'
- **Behavioral Health (BH) and Physical Health (PH) Screening:** Procedure Codes 90791, 90792, 90887, 96116,96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, 98966, 98967, 98968, H0001, H0031, H0032, H2000, H0002, G8431, G8510, 0065T, 0066T, 0091U, 0163U, 0333T, 0400U, 0469T, 1100F, 1101F, 1220F, 20090, 3014F, 3015F, 3016F, 3017F, 3294F, 3351F, 3353F, 3354F, 3450F, 3451F, 3452F, 3455F, 3510F, 3511F, 3512F, 3513F, 3514F, 3725F, 3754F, 3755F, 3759F, 3775F, 3776F, 4004F, 4290F, 4293F, 6010F, 71271, 74263, 76083, 76092, 77052, 77057, 77063, 77067, 80081, 80100, 80101, 80104, 80300, 80301, 80302, 80303, 80304, 82270, 82441, 82776, 82960, 83015, 83068, 83866, 84203, 85291, 85390, 85635, 85670, 85675, 86005, 86036, 86038, 86063, 86156, 86255, 86308, 86403, 86408, 86850, 86902, 86903, 86904, 86940, 87081, 87084, 88142, 88143, 88144, 88145, 88148, 88150, 88152, 88153, 88160, 88161, 88162, 88164, 88165, 88166, 88167, 88175, 92551, 92558, 92560, 92650, 94160, 96110, 99172, 99173, 99174, 99177, C9007, D0190, D9912, G0028, G0029, G0030, G0037, G0101, G0102, G0103, G0104, G0105, G0106, G0107, G0117, G0118, G0120, G0121, G0122, G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, G0202, G0203, G0296, G0297, G0314, G0315, G0327, G0328, G0389, G0403, G0404, G0405, G0430, G0431, G0432, G0433, G0434, G0435, G0442, G0444, G0449, G0450, G0464, G0472, G0475, G0476, G0499, G2196, G2197, G2198, G2199, G2204, G8232, G8234, G8236, G8270, G8271, G8272, G8273, G8401, G8423, G8424, G8425, G8426, G8431, G8432, G8433, G8434, G8435, G8436, G8510, G8511, G8516, G8517, G8534, G8535, G8536, G8537, G8538, G8733, G8734, G8735, G8777, G8778, G8779, G8940, G8941, G9228, G9229, G9230, G9252, G9253, G9279, G9281, G9357, G9358, G9359, G9360, G9383, G9384, G9385, G9386, G9451, G9452, G9453, G9454, G9456, G9522, G9618, G9619, G9620, G9621, G9622, G9623, G9624, G9659, G9745, G9820, G9821, G9899, G9900, G9902, G9903, G9904, G9905, G9919, G9920, G9921, G9922, G9923, G9924, G9925, G9926, G9932, G9933, G9935, G9966, G9967, H0002, H0003, H0049, M1000, M1003, M1004, M1005, M1018, M1069, M1070, M1207, M1208, P3000, P3001, Q0061, Q0091, S0285, S0302, S0601, S0625, S3620, S3625, S3626, S3890, S8032, T1023, T2010, T2011, V5008, V5362, V5363, V5364, W7000, W7013, W7015, W7016, Z0090, Z6000, Z9000, 80345, 80348, 80353, 80354, 80358, 80365, 80366, 80367, 80372, 80373
- **Brief Intervention (Structured conversations and counseling designed to address alcohol and/or drug use once a person screens positive for substance use):** Procedure Codes 99408, 99409
- **MAT:** Procedure Codes H0020 (Modifier HF), S9445 (Modifier HF)
- **Care Coordination:** Procedure Codes H0006, H0045, T1017, H1002, H1004, T1016 as defined by HCPF; HMA assumes a broad $5 PMPM for coverage of Care Coordination within modeling.
- **Case Management:** Procedure Codes T1017, H0006 as defined by HCPF; HMA utilizing T2024 as well within modeling.

Appendix G: Total Computable PMPM Estimates

Population	Service	Upper Bound PMPM Estimates
Adolescent 0-17	BH and PH Screening	$11.69
Adolescent 0-17	Brief Intervention	$4.56
Adolescent 0-17	Care Coordination	$5.00
Adolescent 0-17	Case Management	$102.65
Adolescent 0-17	Medication-Assisted Treatment	$113.25
Adolescent 0-17	Pharmacy	$18.46
Adolescent 0-17	**Total**	**$255.61**
Adolescent 18-21	BH and PH Screening	$7.39
Adolescent 18-21	Brief Intervention	$41.40
Adolescent 18-21	Care Coordination	$5.00
Adolescent 18-21	Case Management	$129.30
Adolescent 18-21	Medication-Assisted Treatment	$148.11
Adolescent 18-21	Pharmacy	$33.97
Adolescent 18-21	**Total**	**$365.17**
Adult 21+	BH and PH Screening	$7.39
Adult 21+	Brief Intervention	$66.90
Adult 21+	Care Coordination	$5.00
Adult 21+	Case Management	$133.88
Adult 21+	Medication-Assisted Treatment	$168.28
Adult 21+	Pharmacy	$82.43
Adult 21+	**Total**	**$463.88**
Total		**$462.36**

Appendix H: Fiscal Analysis by Correctional Facility Type

		State Prisons	
Population	**Service**	**Lower Bound**	**Upper Bound**
Adolescent 0-17	**Total**	**N/A**	**N/A**
Adolescent 18-21	BH and PH Screening	$1,138	$1,413
Adolescent 18-21	Brief Intervention	$2,681	$6,539
Adolescent 18-21	Care Coordination	$441	$956
Adolescent 18-21	Case Management	$12,575	$19,630
Adolescent 18-21	Medication-Assisted Treatment	$29,966	$43,314
Adolescent 18-21	Pharmacy	$3,530	$3,652
Adolescent 18-21	**Total**	**$50,330**	**$75,506**
Adult 21+	BH and PH Screening	$74,373	$115,988
Adult 21+	Brief Intervention	$384,995	$804,926
Adult 21+	Care Coordination	$36,189	$78,464
Adult 21+	Case Management	$1,031,889	$1,610,873
Adult 21+	Medication-Assisted Treatment	$3,142,110	$4,443,043
Adult 21+	Pharmacy	$289,698	$676,308
Adult 21+	**Total**	**$4,959,254**	**$7,729,602**
Total		**$5,009,585**	**$7,805,108**

		County Jails	
Population	Service	Lower Bound	Upper Bound
Adolescent 0-17	**Total**	**N/A**	**N/A**
Adolescent 18-21	BH and PH Screening	$11,889	$14,772
Adolescent 18-21	Brief Intervention	$42,027	$91,122
Adolescent 18-21	Care Coordination	$4,609	$9,993
Adolescent 18-21	Case Management	$183,984	$273,539
Adolescent 18-21	Medication-Assisted Treatment	$139,188	$251,488
Adolescent 18-21	Pharmacy	$73,790	$76,344
Adolescent 18-21	**Total**	**$455,487**	**$717,259**
Adult 21+	BH and PH Screening	$777,275	$1,212,192
Adult 21+	Brief Intervention	$6,035,365	$11,216,374
Adult 21+	Care Coordination	$378,211	$820,030
Adult 21+	Case Management	$15,097,974	$22,446,961
Adult 21+	Medication-Assisted Treatment	$14,594,743	$25,796,785
Adult 21+	Pharmacy	$6,055,273	$14,136,177
Adult 21+	**Total**	**$42,938,841**	**$75,628,520**
Total		**$43,394,329**	**$76,345,779**

		Juvenile Youth Facilities	
Population	Service	Lower Bound	Upper Bound
Adolescent 0-17	BH and PH Screening	$838	$1,326
Adolescent 0-17	Brief Intervention	$149	$517
Adolescent 0-17	Care Coordination	$262	$567
Adolescent 0-17	Case Management	$0	$11,641
Adolescent 0-17	Medication-Assisted Treatment	$5,265	$12,843
Adolescent 0-17	Pharmacy	$1,743	$2,093
Adolescent 0-17	**Total**	**$8,257**	**$28,986**
Adolescent 18-21	BH and PH Screening	$2,241	$2,784
Adolescent 18-21	Brief Intervention	$3,960	$8,586
Adolescent 18-21	Care Coordination	$869	$1,883
Adolescent 18-21	Case Management	$24,767	$38,663
Adolescent 18-21	Medication-Assisted Treatment	$39,347	$85,311
Adolescent 18-21	Pharmacy	$6,953	$7,194
Adolescent 18-21	**Total**	**$78,136**	**$144,422**
Adult 21+	BH and PH Screening	$0	$0
Adult 21+	Brief Intervention	$0	$0
Adult 21+	Care Coordination	$0	$0
Adult 21+	Case Management	$0	$0
Adult 21+	Medication-Assisted Treatment	$0	$0
Adult 21+	Pharmacy	$0	$0
Adult 21+	**Total**	**$0**	**$0**
Total		**$86,393**	**$173,408**

Appendix I: Potential New Federal Matching Dollars Associated with New Reentry Demonstrations

Potential New Federal Matching Dollars Associated with New Reentry Demonstrations	
New Expenditures for Technology/ Infrastructure Support	● Advance Planning Document (APD) process available to support implementation at 90/10 enhanced federal match for new MMIS build or at 75/25 enhanced federal match for refinements of current MMIS. *Not subject to budget neutrality.* ● One time "transitional non-service expenditures" for IT Modernization (electronic referral systems, new or updated EHRs, data warehouses, accounting and billing systems, etc.)
New Expenditures for Expanding Workforce	● New provider flexibilities for collaboration with non-traditional providers (e.g., lived experience workers, community-based organizations) ● Development of new business and operational practices and related health IT to support the coordination of pre- and post-release services ● Hiring and training of staff to assist with the justice-involved individuals receiving services
New Expenditures for Outreach and Engagement	● Outreach, education, and stakeholder convening to advance collaboration between correctional facilities, Medicaid agencies, and other organizations.
New Expenditures for Medicaid Reinvestment	Federal match on state-required "reinvestment plan" to increase access to or improve the quality of health care services to justice-involved individuals. States have the flexibility to identify particular activities and/or initiatives in their reinvestment plan based on the focus of the state's proposal and the needs of individuals in their state. Such as, for example: ● Improved access to behavioral and physical health care services. ● Improved access to and/or quality of carceral health care services. ● Improved health information technology and data sharing.