

February 3, 2022

The Honorable Xavier Becerra, Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

RE: MassHealth 1115 Demonstration Extension Request: Letter in Support of Proposals for Justice-Involved Populations

Dear Secretary Becerra:

The undersigned organizations and individuals are submitting these comments in strong support of MassHealth’s proposals for justice-involved populations and to urge you to approve them.

Many of the undersigned organizations are separately commenting on other aspects of the demonstration extension, regarding our support of the bold innovations to reduce health disparities, address health-related social needs, and improve access to coverage and care for vulnerable populations—initiatives that, together with the proposals for justice-involved individuals, wholly advance CMS’ stated policy priorities around coverage and access, equity, and innovation and whole person care.¹

We write here to comment specifically on MassHealth’s proposals to provide Medicaid coverage to individuals in state Departments of Correction (DOC) or County Correctional Facilities (CCF) 30 days prior to release and to provide 12 months of continuous eligibility after a person’s release from DOC, CCF, or the Department of Youth Services (DYS). These comments draw on the overwhelming body of evidence highlighting the necessity of these levers to improve outcomes for justice-involved Medicaid beneficiaries and on the experiences of Massachusetts advocates working with incarcerated individuals and people leaving carceral settings, including in areas of social services, health care, and public health, as well as advocates working in criminal justice and Medicaid law and policy.

1. Support for Medicaid Coverage 30 Days Prior to Release

A. Background

Health insurance coverage is a critical resource for justice-involved individuals. In its proposal, MassHealth cites some of the tremendous health disparities, including that 36% of male and 81% of female individuals incarcerated in Massachusetts DOC facilities have a mental health condition and over half of incarcerated adults have a substance use disorder.² The agency flags the disproportionate burden of some chronic diseases such as hypertension (e.g., incarcerated adults are approximately 1.2 times more likely to have hypertension)—a mere glimpse into the

¹ “A Strategic Vision for Medicaid and the Children’s Health Insurance Program (CHIP),” Health Affairs Blog, November 16, 2021.

² MassHealth Section 1115 Demonstration Extension Request, 63.

reality that half of people incarcerated in jail and prison report having a chronic condition such as cancer, high blood pressure, stroke-related problems, diabetes, heart-related problems, kidney-related problems, arthritis, asthma, HIV, and cirrhosis of the liver.³ Importantly, we also know that these health challenges disproportionately impact Black and Latinx people, and other people of color, considering that these communities are vastly overrepresented in carceral settings. Black individuals in the United States are incarcerated at 5 times the rate of white individuals, and Latinx individuals are incarcerated at 1.3 times the rate of white individuals (but in Massachusetts, Latinx people are incarcerated at 4.1 times the rate of white people, representing the widest such ethnic disparity in the country).⁴

Access to care and care continuity during the initial weeks and months following release from incarceration is especially critical. People are in a period of significant transition and the likelihood of disruption(s) is high. Mortality risk is higher;⁵ in an assessment of fatal and nonfatal overdoses in Massachusetts, one quarter of MassHealth members who had a fatal overdose had been recently released from incarceration.⁶ Health risks are exacerbated by difficulties meeting basic health-related social needs, such as housing.⁷

Despite Medicaid being, as explained by the Department's Assistant Secretary for Planning and Evaluation (ASPE) "a key source of coverage for this high needs, high risk population, facilitating access to much needed physical and behavioral health services," individuals face complex barriers to coverage upon release.⁸ Enrollment and coverage reinstatement delays, competing priorities, difficulties establishing care, and challenges relaying medical histories are common. More than a decade's worth of published studies examining post-release emergency department utilization have consistently found that newly-released individuals present to emergency rooms in higher numbers and for concerns more appropriately addressed in outpatient settings. Several of these studies attribute the high utilization to lack of insurance upon release.⁹ These challenges also drive up health care costs through higher utilization.

To date, a number of states have been tinkering around the edges of reform. They may have instituted prison-based Medicaid enrollment assistance, shifted from terminating coverage during incarceration to suspending coverage, and/or they may provide people leaving prison with a supply of medications. These strategies are helpful. Wisconsin's pre-release enrollment effort

³ U.S. DEP'T OF JUST., BUREAU OF JUST. STATS., MEDICAL PROBLEMS OF STATE AND FEDERAL PRISONERS AND JAIL INMATES 4 (2016), <https://www.bjs.gov/content/pub/pdf/mpsfjji1112.pdf>.

⁴ Ashley Nellis, "The Color of Justice: Racial and Ethnic Disparity in State Prisons," The Sentencing Project, October 13, 2021, <https://www.sentencingproject.org/publications/color-of-justice-racial-and-ethnic-disparity-in-state-prisons/>.

⁵ Binswanger I., Stern M., Deyo R., Heagerty P., Cheadle A., Elmore J., Koepsell T. (2007) "Release from Prison – A High Risk of Death for Former Inmates." *New England Journal of Medicine* 356(2): 157-165.

⁶ MassHealth Section 1115 Demonstration Extension Request, 63.

⁷ "Prison And Jail Reentry And Health," Health Affairs Health Policy Brief, Oct. 28, 2021. DOI: 10.1377/hpb20210928.34531.

⁸ ASPE Issue Brief: The Importance of Medicaid Coverage for Criminal Justice Involved Individuals Reentering Their Communities, Apr. 2016, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/146076/MedicaidJustice.pdf.

⁹ See, e.g., Joseph W Frank, et al., Emergency department utilization among recently released prisoners: a retrospective cohort study, *BMC Emerg. Med.* 2013; 13: 16. Published online 2013 Nov. 5. doi 10.1186/1471-227X-13-16.

has had a positive impact on the number of people who have a visit with a doctor within 30 days of release from incarceration.¹⁰ Based on our experience in Massachusetts and elsewhere, however, they have also proven insufficient.

We commend MassHealth's proposal for going further to ensure that individuals who are eligible for Medicaid and who need Medicaid are enrolled, connected to care, and have necessary support in place as they navigate the transition back into their community. The agency's approach to pre-release coverage is necessary to ensure that MassHealth is able to meet the core goal of Medicaid: providing medical assistance.¹¹

B. Improving Access to Coverage and Care for Medicaid Members

We can not overemphasize the importance of resolving barriers to coverage and care. The following are only some of the ways in which we see this proposal positively impacting individuals, a number of which are explored in further detail below:

- Access to pre-release coverage provides the opportunity to resolve administrative issues that come up during the enrollment or reinstatement process, to approve prior authorizations, to arrange necessary behavioral health services amid the Commonwealth's severe workforce shortage,¹² and to otherwise minimize harmful disruptions.
- Transitions of care will be streamlined and immediate. For example, an individual will be able to transfer into a skilled nursing facility immediately post-release. Right now, they may be unable to do so because facilities will not accept applications without proof of insurance.
- There will be a stronger likelihood of engagement in care post-release, because community providers and care coordinators will have the opportunity to establish a relationship with members and have access to the information they need.
- Providers will be better able to practice whole person care upon release, including through prior screening for health-related social needs and arrangements for Flexible Services Program (i.e., housing, nutrition) and other supports.
- Improved access to care is ultimately likely to have a positive impact on health care costs.¹³ Individuals who have full access to care upon reentry are more likely to be able to effectively manage health conditions and are less likely to require expensive emergency services.

¹⁰ Burns ME, Cook S, Brown LM, et al. Association Between Assistance With Medicaid Enrollment and Use of Health Care After Incarceration Among Adults With a History of Substance Use. *JAMA Netw Open*. 2022;5(1):e2142688. doi:10.1001/jamanetworkopen.2021.42688.

¹¹ *Stewart v. Azar*, 366 F. Supp. 3d 125, 138 (D.D.C. 2019).

¹² Katie Lannan, State House News Service, "Industry Leader Sounds Alarm on 'Mental Health Crisis' In Mass., Pitches Legislation To Increase Access, Sept. 15, 2021, <https://www.wbur.org/news/2021/09/15/inpatient-behavioral-health-issues-massachusetts-proposed-bills>.

¹³ ASPE Issue Brief: The Importance of Medicaid Coverage for Criminal Justice Involved Individuals Reentering Their Communities, Apr. 2016, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/146076/MedicaidJustice.pdf ("Uninterrupted access to health coverage [post-release] helps individuals maintain continuous health care. Continuity of care has been associated with lower health care costs, fewer hospitalizations, and decreased mortality. Continuity of care is also linked to reduced emergency department use and reductions in unnecessary procedures.").

Enrollment

Focusing on the aspect of pre-release enrollment, MassHealth has in place a process for paper applications to be completed and submitted up to 30 days prior to the release date with a specific cover letter for that purpose available to correctional facilities. However, the actual determination is not made until the date of release. Thus, it is only after the individual is released that the applicant, and those who assisted with the application, learn of problems that may have prevented a favorable determination. If the determination were made during incarceration, barriers like this could be addressed prior to release.

For example, prior to COVID, an organization certified as a navigator by our state-based Marketplace helped people to apply by arrangement with two CCFs. They found that some individuals they helped to apply were denied based on an outstanding renewal or request for information from a past MassHealth application, or because the applicant was still shown as the member of another household. However, the navigators would learn this only after the release date. At that point, the navigators often had no way to reach the individual. They reported that at the time they completed the application, very few individuals could supply a telephone number, and many could not supply an address in the community. The navigators identified these applicants as homeless, supplied their office as the mailing address, and encouraged applicants to contact them on release. However, they heard back from very few. Similarly, some individuals were found provisionally eligible but on the condition of supplying verification within 90 days. Again, the navigators received these notices only after the release date. Had the determination been made during incarceration, they could have worked with the individual to resolve such problems prior to release.

In another example, case managers for a MassHealth participating behavioral health organization providing “in-reach” services during incarceration reported some individuals who came to them after release had been denied MassHealth for a variety of reasons—some of them complex problems that were time-consuming to resolve. In one case, an individual who was over 65 and subject to an asset test was denied because he still had a legal interest in the one-time marital home which he was restrained from entering. Had they known of this problem earlier, they could have obtained assistance for the individual prior to his release.

In yet another example, social workers at the Committee for Public Council Services (CPCS) (the public defender program in Massachusetts) reported that while some CCFs would check the eligibility status of pre-trial detainees and assist them in applying, other CCFs would only assist with an application before a scheduled release date for a sentenced individual. If determinations could be made during incarceration, such individuals would not be so dependent on the good will of CCF personnel using the process currently in place.

Access to Care and Care Continuity

Currently, MassHealth eligibility and enrollment for individuals in CCFs and the state prison system are at best “suspended” during incarceration, queued up for a determination on release, or limited to an inpatient hospital benefit. This makes it almost impossible for CPCS social workers, correctional personnel, or health care providers offering in-reach services in

cooperation with one or more of the facilities or family members to arrange services on the day of release or shortly thereafter. And, as MassHealth has outlined in its request, it is the first two weeks after release that pose the greatest risk of overdose deaths.

Case managers from community organizations working with individuals prior to release, as well as CPCS social workers, all report difficulties scheduling appointments or securing beds in treatment facilities in advance of release. One reason for this is that when MassHealth providers consult the eligibility verification system to confirm enrollment, individuals in carceral settings are not shown as eligible and providers will not schedule an appointment for someone who is not a current MassHealth member or otherwise insured. Further, all report that even before COVID, there could be long delays in obtaining even primary care services for newly-released individuals. Similarly, managed care enrollment can now only be arranged after release.

For individuals with complex chronic conditions, especially people depending on care continuity in specialty services or long term services and supports, the problem is particularly acute. Substance use and behavioral health services are in great demand. During the COVID-19 pandemic, the demand has increased at the same time that the health sector is experiencing a shortage of workers.¹⁴ Further, certain supports and medications are not obtainable without prior authorization from a participating MassHealth provider with whom the individual currently has no connection until release.

Concerning whole person care, individuals reenter the community with a host of practical problems such as lack of stable housing and transportation as well as the need for health services.¹⁵ The enhanced benefits that MassHealth offers through the Section 1115 demonstration—including housing and nutrition supports, community partners, and community support programs—are all tied to enrollment in managed care. Accordingly, the 30-day period of eligibility prior to release also improves the ability of individuals to transition from incarceration into these programs.¹⁶

Shifting from Lost-to-Care to Engaged-in-Care

Medicaid enrollment 30 days prior to release will enable the individual and their community providers to have a therapeutic relationship prior to release which will increase the likelihood of the individual's engagement with health care services in the community.

¹⁴ The continuous coverage protections in place during the COVID-19 PHE have temporarily improved the situation for some individuals whose community MassHealth coverage has not been terminated or suspended during the PHE.

¹⁵ For example, formerly incarcerated people are 10 times more likely than the general population to be homeless, and the risk is highest among those recently released. Lucius Couloute, "Nowhere to Go: Homelessness among formerly incarcerated people," Prison Policy Initiative, Aug. 2018, <https://www.prisonpolicy.org/reports/housing.html/>.

¹⁶ Social determinants of health can have a significant impact on both health outcomes and utilization. Elham Hatem, et al., Assessing the Impact of Social Needs and Social Determinants of Health on Health Care Utilization: Using Patient- and Community-Level Data, 24 Population Health Management 222 (2021), <https://doi.org/10.1089/pop.2020.0043>. Considering the detrimental health effects associated with, for example, homelessness, programs that link individuals to housing also may also have a positive impact on spending. Immediate access to these kinds of supports post-release also promotes stability and more effective reentry, which in turn may allow individuals to prioritize management of their health for improved outcomes over time.

If individuals are enrolled in MassHealth 30 days prior to release, they will have an opportunity to engage with the provider and managed care plan that will deliver their health care services in the community. Advocates and providers for the justice-involved population report many benefits of having such a relationship in place prior to release.

The Boston Health Care for the Homeless program has a program of “in-reach” services focusing on individuals with substance use disorders. Because the program is an FQHC that offers these services itself, it has been able to engage individuals on release. For example, they report many difficulties their patients face filling prescriptions on release. Sometimes, the individual has not been able to fill a prescription because the pharmacy reported that the individual’s MassHealth was not active. When paper scripts were in use, sometimes the individual left the script inside or the CCF provider failed to supply the “wet” signature required by the pharmacy. With electronic prescriptions, some individuals did not know to which pharmacy the prescription had been sent. To fill a prescription for certain Medication Assisted Treatment, pharmacies require a photo ID, which few recently-released people possess. Because Health Care for the Homeless case managers were there to meet the individual on release and could connect them with the medical staff of the program, the individuals were able to obtain their medication and were more likely to remain engaged with the program.

Having a connection with MassHealth community providers also offsets the variability among the CCFs in such policies as to whether or not individuals received at least a 30-day supply of medications on release. Organizations working with newly released prisoners report that CCF policies differ with some providing a 30-day supply, some only a 7-day supply, and some not reliably providing the medication blisterpack at all.

Pre-release care from a community provider may also empower individuals to address emerging or exacerbated health risks that they may face upon reentry (and as Medicaid members) proactively and with support. Health care in correctional facilities is not necessarily provided with an eye on a member’s needs upon release. Certain treatments are not now readily available in carceral settings but provide tremendous benefits. By way of examples:

- As of 2019, HIV prevention medication (PrEP) had not been integrated into any correctional setting.¹⁷ Research suggests, however, that people leaving prison may be especially vulnerable to HIV infection.¹⁸ Moreover, the recent market approval of a long-acting injectable HIV prevention medication improves our ability to reduce risk of HIV acquisition in preparation for reentry.
- Opioid agonist therapies offer another example. Drug overdose is one of if not the leading causes of death among recently released individuals.¹⁹ Among the root causes of

¹⁷ Lauren Brinkley-Rubinstein, et al., The Path to Implementation of HIV Pre-exposure Prophylaxis for People Involved in Criminal Justice Systems, *Curr. HIV/AIDS Rep.*, 2018 Apr; 15(2): 93-95. doi: 10.1007/s11904-018-0389-9.

¹⁸ Jack Stone, et al., Incarceration history and risk of HIV and hepatitis C virus acquisition among people who inject drugs: a systematic review and meta-analysis, *Lancet Infect. Dis.* 2018 Dec; 18(12):1397-1409. doi: 10.1016/S1473-3099(18)30469-9.

¹⁹ Shabbar I. Ranapurwala, Meghan E. Shanahan, Apostolos A. Alexandridis, Scott K. Proescholdbell, Rebecca B. Naumann, Daniel Edwards Jr, and Stephen W. Marshall, 2018: Opioid Overdose Mortality Among Former North Carolina Inmates: 2000–2015, *American Journal of Public Health* 108, 1207_1213, <https://doi.org/10.2105/AJPH.2018.304514>.

heightened vulnerability is that individuals do not receive treatment while incarcerated. People for whom opioid agonist therapies are appropriate may not have access while incarcerated or may be discouraged from engaging during incarceration.²⁰

- Many behavioral health conditions go untreated or undertreated during incarceration. According to ASPE, about two thirds of people in prison and less than half of people in jail who had previously been treated with a psychiatric medication had taken medication for a mental condition since incarceration.²¹ Reentry is then a particularly vulnerable period for people. It is associated with significant stress and, therefore, a high risk of crisis, especially for people with behavioral health conditions.
- Some CCF health vendors are reportedly reluctant to initiate hepatitis C treatment because of concerns over harmful disruptions in the regimen if the course of treatment is not completed during incarceration. If services were offered or coordinated with the individual's community providers, this barrier could be overcome.

MassHealth managed care organizations, care coordinators, and providers, by contrast, would be charged with initiating these kinds of services as appropriate. (Of additional note, MassHealth coverage during incarceration will ideally give the agency some leverage with the facilities to standardize and improve quality of care. However, at the same time it will be important to have policies and processes in place to ensure that facilities do not further defer treatment until the costs of coverage are borne by MassHealth.)

In addition to these important benefits of improved care transitions, improved health outcomes and decreased health care utilization resulting from these policies may lead to programmatic savings as a result of more effective disease management²² and a decrease in emergency department utilization.²³

²⁰ ASPE Issue Brief: The Importance of Medicaid Coverage for Criminal Justice Involved Individuals Reentering Their Communities, Apr. 2016, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//146076/MedicaidJustice.pdf.

²¹ *Id.*

²² Lack of effective access to care for formerly-incarcerated people can lead to higher health care utilization because of improper disease management, more rapid and severe disease progression, and subsequent late-stage and emergency interventions. Effective disease management has proven to have an impact on cost savings, including among Medicaid enrollees, and continuity of care is linked to fewer complications and fewer emergency department visits. See Ning Jackie Zhang, Thomas T.H. Wan, Louis F. Rossiter, Matthew M. Murawski & Urvashi B. Patel, Evaluation of chronic disease management on outcomes and cost of care for Medicaid beneficiaries, 86 Health Policy 345, 352 (2008), <https://doi.org/10.1016/j.healthpol.2007.11.011>; Peter S. Hussey, Eric C. Schneider & Robert S. Rudin, Continuity and the Costs of Care for Chronic Disease, 174 JAMA Internal Medicine 742, 747 (2014), <https://doi.org/10.1001/jamainternmed.2014.245>. However, these savings can only be realized if individuals have meaningful access to primary care physicians and specialists, as well as the kinds of care management services offered by MassHealth ACOs and MCOs, and continuity of care during and after reentry. MassHealth's proposals to more effectively link people leaving carceral settings to coverage offer the opportunity for effective management of chronic health conditions and associated cost savings.

²³ Individuals leaving carceral settings visit the emergency department at astonishing rates. Numerous published studies examining post-release emergency department utilization have consistently found that newly-released inmates present to emergency departments in higher numbers than the general population, and as a result accrue higher costs. Joseph W. Frank, Jeffrey A. Linder & Emily A. Wang, Increased Hospital and Emergency Department Utilization by Individuals with Recent Criminal Justice Involvement: Results of a National Survey, 29 J Gen Intern Med 1226, 1229 (2014), <https://doi.org/10.1007/s11606-014-2877-y>. Continuity of care and meaningful access to treatment at the time of release is critical to address avoidable health crises and their associated costs. For example, the risk of overdose among those released from prison or jail is highest in the two weeks immediately following

Reentry and Recidivism

Finally, we want to highlight some of the ways in which Medicaid—the ability to effectively and timely transition people into Medicaid coverage and care—has a downstream impact on people leaving prison or jail. Behavioral health evaluation and/or compliance with a treatment regimen may be a condition of someone’s parole or probation. But, in the midst of serious behavioral health care provider shortages in Massachusetts, disruptions in care are often outside of an individual’s control. People are set up to fail when they face such requirements without sufficient time and support to establish a patient-provider relationship. Individuals enrolled in MassHealth prior to release, will have the benefit of primary care providers and care coordinators who can arrange care on reentry. Research also more broadly suggests that Medicaid coverage decreases risks for recidivism, owing to factors such as increased utilization of mental health and substance use treatment.²⁴

C. Consistency with Section 1115 Demonstration Authority

The proposal satisfies the threshold requirements for Section 1115 demonstration approval. It is an “experimental, pilot, or demonstration” project likely to promote the objects of the Medicaid Act. The “central objective” of the Medicaid program is to “provide medical assistance”²⁵ and, as set forth above, pre-release coverage is critical to MassHealth’s effective provision of medical assistance to members upon release.

The Medicaid Inmate Exclusion Policy (MIEP), 42 C.F.R. § 1396d, which generally limits Medicaid funding for an “inmate of a public institution” does not bar approval. First, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018 clearly establishes that there is Section 1115 demonstration authority to provide Medicaid services to people in carceral settings for the 30-day period preceding release.²⁶ This is a logical reading of the statute’s explicit direction that the Secretary of Health and Human Services issue guidance on best practices for not only “providing assistance and education for enrollment” but on establishing “systems. . .providing health care services for such individuals during such period” via Section 1115 demonstration projects.²⁷

This reading is also consistent with the Secretary’s historical approval of Section 1115 proposals to modify provisions similarly-situated as the MIEP, particularly demonstrations regarding services for people in “institutions of mental disease” (IMDs).²⁸ CMS has even issued guidance

release. Timely access to treatment for opioid use disorder, facilitated by per-release coverage and appropriate linkage to care, is paramount to address this risk as it arises. Similarly, a high number of emergency department visits for recently-released people are attributable to mental health issues. Continuity of care through pre-release coverage allows individuals to develop relationships with mental health professionals, avoiding crises and the costs associated with crisis services, emergency department use, and inpatient psychiatric care.

²⁴ Elaine Michelle Albertson, Christopher Scannell, Neda Ashtari, and Elizabeth Barnert, 2020: Eliminating Gaps in Medicaid Coverage During Reentry After Incarceration, *American Journal of Public Health* 110, 317_321, <https://doi.org/10.2105/AJPH.2019.305400>.

²⁵ *Stewart v. Azar*, 366 F. Supp. 3d 125, 138 (D.D.C. 2019).

²⁶ Pub. Law No. 115–271, S. 5032.

²⁷ *Id.*

²⁸ The Department first approved Section 1115 demonstrations allowing Medicaid funds to be used for people in IMDs in the 1990s (Tennessee). United States Government Accountability Office, “MEDICAID: States Fund

inviting Section 1115 demonstrations “extending coverage for services in inpatient and/or residential settings that are within the definition of IMD.”²⁹

We are aware that the Secretary has declined to approve certain proposals to initiate Medicaid coverage for individuals who are incarcerated in preparation for reentry and that several others are pending. In the event the Department continues to decline these 1115 demonstrations, we urge the Department to swiftly issue guidance to states on opportunities pursuant to the SUPPORT Act and to work with states to quickly approve subsequent proposals.

2. Support for Continuous Coverage

MassHealth eligibility 30 days prior to release must also be coupled with 12-months continuous eligibility to enable justice-involved individuals to not only re-enter the community with coverage but to maintain that coverage. As MassHealth acknowledges in its request, “churning” of eligible individuals in and out of coverage is a long-standing problem. The problem is not limited to Massachusetts but is inherent in a means-tested program where eligibility is based on current month’s circumstances.³⁰ The Secretary has previously granted authority for New York and Montana to provide continuous eligibility for adults.³¹ We urge the Secretary to do the same for justice-involved individuals (as well as people experiencing homelessness) in Massachusetts.

Income volatility is common in the MassHealth program. In 2017, 34% of those terminating their Health Connector coverage were individuals transitioning to MassHealth, and 31% of new Health Connector enrollees were transitioning from MassHealth.³² Medicaid recipients with chronic health conditions who undergo changes in coverage experience higher emergency department utilization, increased acute care costs, increased uncompensated care costs, and overall worse health outcomes.³³

Services for Adults in Institutions for Mental Disease Using a Variety of Strategies” (Aug. 2017), <https://www.gao.gov/assets/gao-17-652.pdf>.

²⁹ Centers for Medicare & Medicaid Services, State Medicaid Director Letter; Re: New Service Delivery Opportunities for Individuals with Substance Use Disorder (July 27, 2015; SMD#15-003), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd15003.pdf>.

³⁰ ASPE Issue Brief, Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic, Apr. 12, 2021, <https://aspe.hhs.gov/system/files/pdf/265366/medicaidchurning-ib.pdf>.

³¹ GIS 15 MA/022: Continuous Coverage for MAGI Individuals, New York State Department of Health, Dec. 2015. https://www.health.ny.gov/health_care/medicaid/publications/gis/15ma022.htm; Section 1115 Waiver for Additional Services and Populations (WASP). Montana State Department of Public Health and Human Services. <https://dphhs.mt.gov/montanahealthcareprograms/medicaid/medicaid1115waiver>.

³² D. Nelson and J. Rushakoff. Massachusetts’ remaining uninsured, Harvard Kennedy School, (2019), at 26. <https://www.hks.harvard.edu/sites/default/files/degree%20programs/MPP/files/PAE%20Final%20-%20Nelson%20Rushakoff%20NO%20LOGO%20NO%20NAME.pdf>.

³³ X. Ji et al. Discontinuity of Medicaid Coverage: Impact on Cost and Utilization among Adult Medicaid Beneficiaries with Major Depression, 55(8) Med. Care 735 (2017). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6684341/>; J.C. Rusley et al. Discontinuity of Medicaid Coverage Among Young Adults with HIV, 33(3) AIDS Patient Care and STDs 89 (2019). <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6442235/>.

Risks for the justice-involved population are exacerbated. As discussed above and as MassHealth documents in its request, chronic conditions are common among justice involved individuals particularly behavioral health conditions—coverage and continuity of care are critical. At the same time, individuals newly released from incarceration are even more at risk of losing coverage owing to factors including the nature of such transition and competing priorities. Moreover, for individuals released on parole, engaging in treatment may be a condition of parole. Losing coverage for them may mean a parole violation and return to incarceration.

The request for 12-months continuous coverage will also extend to children and young adults returning to the community from DYS care and custody. We commend MassHealth for providing state-funded MassHealth coverage to children and young adults while they are in DYS custody. Unfortunately, once returned to the community, these young people will once more be subject to the churning which causes so many families to experience loss of coverage.

We urge 12-months continuous coverage to extend to young adults 18-22 who have attained the age of mandatory discharge from DYS custody but elect to receive voluntary services through the DYS Youth Engagement in Services (YES) program throughout the course of that program and for 12 months after turning 22. MassHealth has already exercised its state plan and Section 1115 authority to extend MassHealth to former foster care children up to age 26. It seems likely that many of the young adults leaving DYS, like almost all former foster children, will not have access to employer-sponsored insurance based on their own employment or that of a parent.

* * *

In closing, we appreciate MassHealth’s thoughtful approach to addressing the needs of justice-involved members in its demonstration extension request. The proposed changes described above have tremendous potential and we are confident that these initiatives will promote access to coverage, care, and health and social supports, improve health outcomes, and advance health equity.

Thank you for your consideration of these comments. If you have any questions, please contact Rachel Landauer (rlandauer@law.harvard.edu), Julia Harvey (jharvey@law.harvard.edu), or Vicky Pulos (vpulos@mlri.org).

Respectfully,

Organizations

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Committee for Public Counsel Services
Community Research Initiative
Disability Law Center
Greater Boston Legal Center
Health Law Advocates
Massachusetts Association for Mental Health
Massachusetts Law Reform Institute
Northeast Justice Center
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