REENTRY HEALTH WORKING GROUP

October 19, 2026

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

Submitted by email to 1115WaiverComments@mass.gov

Re: Comments on MassHealth 1115 Demonstration Extension Request

Dear Assistant Secretary Schwarz,

On behalf of the Massachusetts Reentry Health Working Group (RHWG), we appreciate the opportunity to comment on MassHealth's proposed Section 1115 Demonstration Extension for 2028–2032. Our comments focus on continuing and strengthening the Reentry Demonstration to improve access to health care and continuity of care for people returning to their communities after incarceration. The RHWG is a statewide coalition of health care providers, reentry and community-based organizations, legal advocates, people with lived experience of incarceration, and other stakeholders working to improve access to health care and coverage before, during, and after reentry.

We strongly support MassHealth's request to continue the Reentry Demonstration and its commitment to providing meaningful pre-release Medicaid services and high-quality care for eligible beneficiaries. We recognize that recent changes in federal law may limit the scope of federal authority available to Massachusetts during the next Demonstration period. Those constraints make it all the more important that MassHealth preserve the strongest federal authority available and use the Commonwealth's remaining implementation flexibility to build the best possible Reentry Demonstration. As MassHealth advances this renewal, we urge it to prioritize robust pre-release services, strong partnerships with community-based providers, and clear statewide standards for implementation and accountability.

The stakes of these implementation choices are particularly high during the transition from incarceration to the community, when disruptions in treatment and care can have serious, even fatal, consequences. Massachusetts data have long documented the extraordinary risk of overdose following incarceration: the opioid-related overdose death rate among formerly incarcerated people has been estimated at 50 to 120 times that of the general population, with the greatest risk in the first month after release.[1] More recent research found that approximately one in twenty releases from Massachusetts state prisons between 2015 and 2020 was followed by an opioid overdose within 90

[1] Laura McElherne et al., *Implementation evaluation of a Massachusetts pilot program designed to reduce overdose deaths among Black and Latino men returning from incarceration*, 14 Frontiers in Public Health 1950283 (2026).

days.[2] Massachusetts Department of Public Health findings also show the importance of treatment before release: among people with opioid use disorder in participating county correctional facilities, receipt of medication for opioid use disorder while incarcerated was associated with 45% lower odds of experiencing an opioid-related overdose within 30 days after release.[3] These findings underscore that decisions about when pre-release services begin, what care they include, and how effectively they connect people to treatment after release can have life-or-death consequences for people returning to the community.

The Reentry Demonstration offers Massachusetts a critical opportunity to bridge the gap between correctional and community-based health care. Its success should be measured not simply by whether Medicaid-covered services are available before release, but by whether people leave incarceration with active coverage, necessary medications, established provider connections, and the support needed to continue their care in the community. We urge MassHealth to build on the Demonstration's existing foundation by strengthening the services, community partnerships, and statewide standards necessary to achieve meaningful continuity of care. To that end, we offer the following recommendations.

1. **We strongly support MassHealth's request for the maximum allowable pre-release period and urge MassHealth to preserve a comprehensive scope of pre-release services.**

We strongly support MassHealth's request to continue providing Reentry Demonstration services for up to 90 days before release. As MassHealth recognizes in its extension request, "providing services up to 90 days prior to release is critical to the success of the Reentry Demonstration."[4] A meaningful pre-release period allows providers to assess health needs, build relationships, coordinate treatment and community-based care, and develop individualized transition plans. We urge MassHealth to preserve the full 90-day period wherever federally permissible.

California's experience illustrates why sufficient pre-release time matters. Since beginning phased implementation of its Reentry Initiative in October 2024, California has allowed Enhanced Care Management (ECM) care managers to engage individuals before release and continue supporting them afterward. California's 2026 Reentry Initiative impact report emphasizes how early engagement allows care teams to build trust, assess needs, and develop concrete transition plans. As one implementation partner observed, "The more time that the pre-release care managers have to do their work, the more concrete the plans are."[5] California's early implementation experience therefore supports MassHealth's continued effort to preserve as much pre-release time as federal policy permits.

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[2] Kristina Yamkovoy et al., *Using Decision Tree Models and Comprehensive Statewide Data to Predict Opioid Overdoses Following Prison Release*, 94 Annals of Epidemiology 81 (2024).

[3] Massachusetts Department of Public Health, *An Examination of Opioid-Related Overdose Deaths Among Massachusetts Residents: 2025 Report* 14 (July 2025).

[4] Massachusetts Executive Office of Health and Human Services, *MassHealth Section 1115 Demonstration Extension Request*, 51 (Sept. 14, 2026).

[5] California Department of Health Care Services, *From Incarceration to Care: California's Medi-Cal Reentry Initiative—Impact Report* 13 (Mar. 2026).

Although CMS has indicated that future approvals of pre-release services for adults generally will be limited to 60 days, while up to 90 days remain available for youth,[6] we support MassHealth's continued efforts to secure the maximum allowable period. If Massachusetts is limited to a shorter federally reimbursable period for adults, that restriction should not delay broader reentry planning. To the extent permissible, MassHealth should ensure that eligibility and enrollment assistance, identification of anticipated release dates and health needs, consent and information-sharing, provider matching, and other preparatory work begin early enough to maximize the authorized period for care and coordination. **The beginning of the Medicaid reimbursement window should not become the default starting point for every aspect of reentry planning.**

We also urge MassHealth to preserve the broadest federally permissible scope of pre-release services. Its approved Reentry Demonstration Implementation Plan contemplates services including case management, medications for addiction treatment, medication administration, physical and behavioral health consultations, and laboratory and radiology services.[7] The renewal request, however, commits to the three federally required minimum services while identifying several components of that broader package—including physical and behavioral health consultations, medications and medication administration, laboratory and radiology services, and durable medical equipment and supplies—as "potential additional services."[8] CMS's September 2026 guidance expressly permits states to cover services beyond the required minimum package.[9] **The federal minimum should therefore serve as a floor, not a ceiling, for the Massachusetts Reentry Demonstration.** We urge MassHealth to preserve authority for the fuller service package envisioned under the current Demonstration rather than allowing the three-service minimum to become the renewal's permanent benefit design.

2. **We urge MassHealth to ensure meaningful pre-release participation by community-based providers and reentry organizations, with sustainable funding for their work.**

MassHealth's renewal request recognizes the importance of connecting correctional and community health care, while its approved Implementation Plan emphasizes pre-release engagement with community-based providers through in-reach, information-sharing, and care coordination.[10] However, the Implementation Plan identifies a significant barrier: community providers have often lacked reimbursement for pre-release services.[11]

The renewed Demonstration should address both sides of that problem. Community-based providers and reentry organizations should be able to engage members before release, not simply receive

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[6] Centers for Medicare & Medicaid Services, *Frequently Asked Questions (FAQs) for Reentry Section 1115 Demonstrations* 1–2 (Sept. 2026).

[7] Massachusetts Executive Office of Health and Human Services, *Attachment X: Reentry Demonstration Initiative Implementation Plan*, 19-20 (approved May 29, 2025).

[8] *MassHealth Section 1115 Demonstration Extension Request*, at 51.

[9] *Frequently Asked Questions (FAQs) for Reentry Section 1115 Demonstrations*, at 2.

[10] *MassHealth Section 1115 Demonstration Extension Request*, at 50; *MassHealth Reentry Implementation Plan*, at 31–34.

[11] *MassHealth Reentry Implementation Plan*, at 31.

referrals afterward. Providers expected to support members after release should have opportunities to establish relationships beforehand, participate in individualized transition planning, exchange information with appropriate consent, and coordinate with correctional and pre-release care management staff. MassHealth should establish statewide procedures for community-provider access, information-sharing, and coordination across facilities rather than leaving engagement dependent on individual facility practices.

Community health workers (CHWs) and peer support specialists play an important role in connecting individuals to care before and after release. Their shared cultural backgrounds, languages, or lived experiences can help build trust and bridge gaps between health care systems and justice-impacted members.[12] California allows embedded or community-based in-reach care management models, with CHWs and peer specialists among those who may provide community-based in-reach services.[13] Illinois has also proposed expanding Medicaid coverage for certified CHW services, including health system navigation and resource coordination.[14] Building on these state approaches, we urge MassHealth to establish clear pathways for CHWs, peer support specialists, and other qualified community-based workers—particularly those with lived experience of incarceration—to participate in pre-release in-reach, care coordination, and transition planning, with appropriate compensation for their services.

MassHealth should also establish a sustainable payment mechanism for community-provider participation. In January 2026, MassHealth proposed expanding CSP-JI "to allow for services to be provided during the pre-release period by community providers."[15] That proposal is not clearly carried forward in the September extension request. **We urge MassHealth to clarify in its final extension request whether it continues to seek authority for pre-release CSP-JI services.** If CSP-JI is not the mechanism MassHealth ultimately pursues, the Commonwealth should establish an alternative reimbursement or funding pathway for qualified community providers and reentry organizations to conduct pre-release in-reach, care coordination, and transition planning. Meaningful community partnership should not depend on providers absorbing the costs of the very work the Demonstration relies on them to perform.

3. **We urge MassHealth to establish clear statewide warm-handoff and day-of-release standards and measure whether members successfully connect to care after release.**

MassHealth's approved Implementation Plan sets a strong standard for continuity of care, expressly recognizing that "a simple referral is not sufficient" and emphasizing the importance of warm handoffs and follow-up.[16] The Plan also calls for pre-release case managers to arrange appointments with community providers, connect members with post-release case management, and coordinate

[12] Johns Hopkins Center for Health Equity, *Community Health Workers*.

[13] California Department of Health Care Services, *Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative* 133-134 (Oct. 20, 2023).

[14] Illinois Department of Healthcare and Family Services, *Proposed Changes in Methods and Standards for Establishing Medical Assistance Payment Rates* (Apr. 10, 2026).

[15] Massachusetts Executive Office of Health and Human Services, *MassHealth 2028–2032 1115 Waiver Demonstration - January 2026 Update* 9 (Jan. 2026).

[16] *MassHealth Reentry Implementation Plan*, at 34.

information necessary for continued care. We urge MassHealth to preserve these commitments and establish clear, enforceable statewide expectations for participating facilities.

A successful transition should be measured by what is actually in place for the member at release—not simply whether a facility made a referral or completed an internal process. At a minimum, MassHealth should require participating facilities and care managers to ensure, as applicable to each member's needs, that coverage is active and usable at release; prescribed medications and necessary supplies are in hand; the member has received their person-centered care plan; a community provider or post-release case manager has been identified and contacted before release; necessary appointments have been scheduled; relevant records and treatment information have been shared with appropriate consent; transportation or other immediate access barriers have been addressed; and the member knows whom to contact if a problem arises after release. These standards should apply consistently across participating facilities.

MassHealth should also establish an expedited transition protocol for people released with little or no advance notice. Unexpected release should not mean losing the Demonstration's continuity-of-care protections. When standard discharge planning cannot be completed before release, MassHealth should establish procedures and responsibilities for promptly activating or restoring coverage, ensuring access to necessary medications, transferring essential health information with appropriate consent, connecting members with community providers or care managers, and arranging timely follow-up.

MassHealth's Implementation Plan contemplates contact between members and care managers within one to two days after release and a second appointment within one week, with more rapid contact when individual needs or risks warrant it.[17] MassHealth should preserve these expectations and ensure that post-release follow-up remains an integral part of the transition.

Other states are similarly designing reentry care around continuity across the point of release. Vermont's community-based in-reach model provides continuity through a care coordinator who begins working with an individual before release and remains involved afterward. The coordinator works with correctional staff to develop a reentry care plan, connect the member with community providers and peer supports, and coordinate services in the community.[18] This model illustrates how responsibility for care coordination can follow the member across the point of release.

Finally, MassHealth should measure whether warm handoffs result in successful transitions to community care. The renewed Demonstration should establish statewide measures of transition outcomes, including whether coverage is active at release, necessary medications are in hand, members have established contact with a community provider or post-release case manager before release, follow-up appointments are scheduled, timely post-release case-management contact occurs, and members attend their initial post-release health care appointments. MassHealth should use these measures to identify gaps, assess differences across participating facilities, and require corrective action where transition processes are not achieving their intended results. **Ultimately, the Demonstration's success should be measured not merely by whether facilities have procedures**

[17] *Id*. at 34.

[18] Vermont Agency of Human Services, *Vermont's Reentry Initiative: CMS Site Visit* 6 (Aug. 2024); see also Vermont Chronic Care Initiative, *Vermont's Medicaid Reentry Initiative*, 10 (Jan. 2026).

in place, but by whether people successfully connect to and remain engaged in care after incarceration and experience meaningful improvements in health outcomes.

4. **We urge MassHealth to establish clear statewide timelines and accountability standards for full implementation, strengthen facility-readiness requirements, and provide greater transparency throughout the rollout.**

We recognize the operational challenges of implementing a new Medicaid benefit across correctional facilities with differing staffing, infrastructure, and levels of readiness. Nevertheless, the Reentry Demonstration can achieve its statewide purpose only if eligible members can access services regardless of where they are incarcerated. MassHealth's renewal request states that the Commonwealth intends to fully implement the Demonstration during the next waiver period, including enrolling all county and state correctional facilities as Medicaid providers and conducting a readiness assessment for each facility.[19] We strongly support this commitment and urge MassHealth to establish clear, publicly available milestones and timelines for achieving it. The final extension request and subsequent implementation guidance should identify when additional facilities are expected to begin providing services, when participating facilities are expected to move beyond the initial minimum-service phase, and what steps MassHealth will take to address facilities that do not meet readiness requirements.

Facility readiness should reflect the full purpose of the Reentry Demonstration, not simply a facility's ability to enroll members, deliver covered services, and bill Medicaid. Readiness should also include established partnerships with community providers and reentry organizations, procedures for pre-release in-reach and information-sharing, and the capacity to deliver effective warm handoffs. MassHealth's approved Implementation Plan already recognizes the need for coordination and data-sharing between correctional and community providers, continued assessments, and corrective action when deficiencies are identified.[20] **We urge MassHealth to make community transition capacity an express component of readiness and to require facilities to demonstrate how members will actually connect with providers and supports outside the facility before MassHealth certifies full readiness.**

Facility-readiness requirements should be accompanied by technical assistance and resources to address implementation barriers. As California's Reentry Initiative expanded, smaller community-based organizations encountered challenges with Medicaid provider enrollment, billing, and administrative capacity. California developed a technical assistance marketplace, while at least one county explored a shared administrative hub to help smaller organizations manage these requirements. California has also incorporated telehealth to address workforce limitations and facilitate pre-release engagement when in-person services are not feasible.[21] We urge MassHealth to identify common implementation barriers across correctional facilities and community partners and provide targeted technical assistance, shared administrative infrastructure, and telehealth options where appropriate to support successful statewide implementation.

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[19] *MassHealth Section 1115 Demonstration Extension Request*, at 51.

[20] *MassHealth Reentry Implementation Plan*, at 34, 50.

[21] Justice System Partners (JSP) & Health and Reentry Project (HARP), *Implementing the Medicaid Reentry Waiver in California: Key Policy and Operational Insights from 11 Counties* 33, 35 (Oct. 2, 2024).

As implementation expands, MassHealth should provide regular public updates identifying which correctional facilities have launched the Demonstration, which remain in the readiness process, what services are available at each facility, and anticipated timelines for broader implementation. Where implementation is delayed, MassHealth should identify the principal barriers and steps being taken to address them. This transparency would help community providers, advocates, and people directly affected by the Demonstration understand service availability, prepare for implementation, identify recurring barriers, and provide informed feedback.

MassHealth should use the Community Feedback Forum and other stakeholder processes to meaningfully inform implementation decisions. Community providers, reentry organizations, and people with lived experience should have opportunities to review and respond to issues involving facility readiness, rollout, member-facing materials, community-provider relationships, monitoring, and implementation barriers before key decisions are finalized whenever practicable. MassHealth should report back on significant concerns and explain how feedback has informed its decisions or corrective actions.

Full implementation must also include a clear strategy for serving pretrial members and individuals with short or unpredictable periods of incarceration. MassHealth's approved Implementation Plan contemplated serving both sentenced and pretrial populations, including initiating pre-release services for eligible pretrial members upon notification of incarceration.[22] However, the initial implementation phase is limited to sentenced adults, and CMS's September 2026 guidance introduces additional challenges for individuals whose release dates are difficult to predict.[23] **We urge MassHealth to clarify how it intends to serve pretrial members, individuals with short or unpredictable stays, and people released unexpectedly from court under the new federal framework.** Where standard pre-release processes are not feasible, MassHealth should establish expedited procedures for eligibility screening, coverage coordination, care planning, and connections to community-based services so that uncertain release dates do not unnecessarily prevent these populations from receiving meaningful reentry support.

5. **We urge MassHealth to dedicate reinvestment and other available funding to community reentry capacity and establish a sustainable financing plan for statewide implementation.**

The current Reentry Demonstration terms require Massachusetts to reinvest new federal funding for services previously funded by correctional authorities. Those terms expressly permit reinvestment in increased community-based provider capacity, expanded community services and supports, health information technology and data-sharing, and other investments that support reentry and smoother transitions before and after release.[24] These priorities align with the implementation needs identified in these comments.

We urge MassHealth to dedicate reinvestment funding to strengthening community-based reentry

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[22] *MassHealth Reentry Implementation Plan*, at 7-8.

[23] *Frequently Asked Questions (FAQs) for Reentry Section 1115 Demonstrations*, at 2.

[24] *MassHealth Medicaid and CHIP Section 1115 Demonstration Special Terms and Conditions*, STC 22.10, at 224-225 (updated Aug. 4, 2025).

services and infrastructure. Community providers and reentry organizations need resources to conduct pre-release in-reach, recruit and retain community health workers and peer support specialists, coordinate behavioral health and substance use disorder treatment, provide benefits navigation, facilitate information-sharing with correctional providers, address transportation and other immediate barriers to care, and support individuals returning to the community with urgent or complex needs. **Reinvestment should address these gaps rather than be concentrated primarily on infrastructure and services within correctional facilities.** The Demonstration cannot achieve lasting continuity of care if the community-based providers and organizations receiving members after release lack the capacity to meet their needs.

MassHealth should also use reinvestment strategically to address barriers identified during implementation. Facility-readiness assessments, monitoring data, unsuccessful warm handoffs, gaps in provider capacity, and feedback from people with lived experience of incarceration and community-based organizations should inform reinvestment priorities. Where recurring barriers emerge—including insufficient behavioral health capacity, limited community-provider in-reach, data-sharing challenges, or regional gaps in reentry services—MassHealth should direct reinvestment or other available funding toward practical solutions. **Reinvestment should serve as a tool for strengthening implementation and addressing demonstrated needs, not merely as a financial requirement of the Demonstration.**

The reinvestment process should be transparent and accountable to the communities it is intended to serve. We urge MassHealth to publicly release the Reentry Demonstration Initiative Reinvestment Plan and subsequent updates; report the categories and amounts of reinvestment expenditures; explain how investments respond to identified reentry needs; and provide meaningful opportunities for community-based providers, reentry organizations, and people with lived experience of incarceration to inform funding priorities. The current Special Terms and Conditions already require the Reinvestment Plan to identify expected investments and report actual reinvestment expenditures to CMS.[25] MassHealth should make this information accessible to the communities and stakeholders whose health care systems and reentry services these investments are intended to strengthen.

Finally, the renewal should establish a sustainable financing strategy for statewide implementation. The current Demonstration authorizes planning and implementation investments in technology, data exchange, staffing and training, billing systems, telehealth infrastructure, and coordination among correctional facilities and community partners.[26] MassHealth's extension request also acknowledges that the Commonwealth will need to operate under CMS's new budget-neutrality framework during the next Demonstration period.[27] To the extent federal policy limits or changes the availability of existing implementation funding, MassHealth should identify how the Commonwealth will sustain the infrastructure necessary for statewide reentry implementation through reinvestment, Medicaid administrative funding where available, state resources, managed care arrangements, or other appropriate funding mechanisms. **Changes in federal financing should not undermine the infrastructure and community partnerships necessary to implement the Reentry Demonstration successfully statewide.**

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[25] *Id*. at 225 (STC 22.10(b)).

[26] *Id.* at 225–28 (STCs 22.11–22.12).

[27] *MassHealth Section 1115 Demonstration Extension Request*, at 64.

We strongly support MassHealth's request to continue the Reentry Demonstration and appreciate its efforts to preserve meaningful pre-release Medicaid services in a changing federal environment. As MassHealth advances this renewal, we urge the Commonwealth to preserve the broadest permissible scope of pre-release services, strengthen partnerships with community-based providers and reentry organizations, establish clear standards for successful transitions to community care, ensure transparent and accountable statewide implementation, and invest in the community capacity necessary to sustain these efforts.

Ultimately, the promise of the Reentry Demonstration will be realized not simply by expanding access to services before release, but by ensuring that people return to their communities with active health coverage, necessary treatment and medications, and meaningful connections to the providers and supports they need to remain engaged in care. We appreciate MassHealth's continued commitment to this work and look forward to collaborating to strengthen the Demonstration throughout its implementation.

Thank you for the opportunity to provide these comments. If you have any questions, please contact Isabel Wanner (iwanner@mlri.org) and Johnathon Card (jcard@law.harvard.edu).

Respectfully submitted,

The Massachusetts Reentry Health Working Group