Center on Budget and Policy Priorities

Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

February 28, 2025

Robert F. Kennedy, Jr.
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Minnesota's Reentry Section 1115 Demonstration Waiver Proposal

Dear Secretary Kennedy,

The Center on Budget and Policy Priorities and Georgetown University Center for Children and Families appreciate the opportunity to comment on Minnesota's proposed section 1115 demonstration, "Minnesota Reentry Waiver."[1]

The Center on Budget and Policy Priorities (CBPP) is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, CBPP conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes. Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes.

Minnesota is seeking to increase coordination of and access to care for certain adults leaving carceral settings by providing services in the 90 days prior to transitioning into the community. We support this proposal, as it would help minimize negative health outcomes that may occur in the period immediately following reentry and promote better health for people leaving carceral settings. We also support Minnesota's request because it promotes coverage, consistent with the objectives of Medicaid as required for section 1115 demonstrations, and would improve access to care. We support CMS approval of the proposal, subject to the recommendations below.

[1] Office of Governor Tim Walz & Lt. Governor Peggy Flanagan, "Minnesota Reentry Waiver Application for Section 1115(a) Demonstration Waiver," January 15, 2025, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mn/Minnesota-Family-Planning-Project/mn-pndng-rntry-aplctn-01162025.pdf

**Targeted pre-release services during the last 90 days of incarceration would reduce gaps in coverage and care, supporting successful transitions back to the community.**

Minnesota is requesting approval to provide targeted pre-release services to justice-involved adults who would be eligible for Medicaid but for their incarceration in participating carceral settings. We support Minnesota's desire to provide pre-release supports for incarcerated individuals with substance use disorders, mental illness, chronic medical conditions, or pregnancy/postpartum status, and therefore we support approval of the state's request, consistent with CMS's letter to State Medicaid Directors, which outlined standards for approval of pre-release services.[2]

People in jail and prison have high rates of untreated, chronic conditions as well as a high incidence of substance use disorder and mental illness. However, they often return home without adequate access to medications or care coordination. Once home, health care often falls by the wayside as people face competing demands, including securing housing, finding work, filling prescriptions, connecting with family, and fulfilling court-ordered obligations. Gaps in coverage and care contribute to a litany of poor health outcomes and compound the harmful effects of mass incarceration and the over-policing of people of color.[3] As outlined in Minnesota's application, Black and American Indian individuals are incarcerated at significantly higher rates than White individuals (9.1 times and 18.75 times, respectively). This demonstration has the potential to address significant disparities in coverage and care, aligning with the priorities of improving health outcomes for American Indian and Alaska Native populations. The demonstration would help advance longstanding federal efforts to combat the opioid crisis, first declared a public health emergency in 2017 by President Trump.[4] By requesting approval to provide medication-assisted treatment services prior to release, along with substance use assessment, SUD treatment coordination, and peer recovery support services, Minnesota aims to reduce post-release overdoses and deaths. This approach aligns with federal priorities to expand access to proven treatments and ensure care continuity during the transition period from incarceration to the community.

As part of an approval, we encourage CMS to work with the state to fill in some details that will be necessary to promote effective implementation. In the application, Minnesota indicates that the "implementation plan will provide more details about the processes the state will use to expedite managed care enrollment." In particular, we note the potential for discontinuity if the state covers individuals in fee-for-service (FFS) during the pre-release period, but then quickly transitions to managed care post release. How would pre-release FFS case managers schedule post-release care

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[2] State Medicaid Directors Letter, "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated, SMD 23-003, CMS, April 17, 2023, https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf.

[3] Christopher Wildeman and Emily Wang, "Mass Incarceration, Public Health, and Widening Inequality in the USA," The Lancet 389, April 2017, https://doi.org/10.1016/S0140-6736(17)30259-3; Michael Massoglia and Brianna Remster, "Linkages Between Incarceration and Health," Public Health Reports, May 1, 2019, https://doi.org/10.1177/0033354919826563.

[4] *Ongoing emergencies* | *CMS*. (n.d.). Retrieved February 19, 2025, from https://www.cms.gov/about-cms/what-we-do/emergency-response/current-emergencies/ongoing-emergencies

appointments if they don't know what health plan an individual will enroll in after release, and thus which providers would be in-network? CMS should work with the state to clarify how this would work as well as ensure individuals have adequate education and support during the plan selection process to promote smooth transitions and minimize disruptions to the care plan developed during the pre-release period. The state's implementation plan should detail specific timelines and processes for managed care enrollment to minimize disruption of services during this critical transition period.

The state's phased implementation approach is a prudent strategy to ensure that facilities have the necessary capacity to deliver services prior to drawing down federal funds. This approach also mitigates the risk of eligible individuals being promised services that cannot be provided. If there is successful implementation in the selected facilities, the state and CMS should consider expanding the demonstration to facilities statewide to provide all eligible individuals in carceral settings the opportunity to receive pre-release services as is feasible.

The state plans to develop and submit a reinvestment plan within 120 days of the demonstration approval, and we urge CMS to monitor state compliance with reinvestment. As we have noted in other comment letters, the Reentry Initiative Reinvestment Plan to ensure that Medicaid funding does not simply replace other current funding sources is an important part of CMS's guidance on reentry demonstrations.

Finally, we encourage CMS to discuss with the state if there are additional steps that can be taken to bolster continuity of care upon reentry. For example, the state could also consider implementing continuous eligibility for the 12-month period after release to ensure continued access to care. Continuous eligibility can help individuals in transitional situations, like leaving carceral settings, maintain greater continuity of coverage and reduces their administrative burdens; we urge CMS to make this recommendation a standard part of reentry demonstration discussions.

**Conclusion**

Our comments include numerous citations to supporting research, including direct links to the research, for HHS's benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

Thank you for the consideration of our comments. If you would like any additional information, please contact Allison Orris (aorris@cbpp.org) or Joan Alker (joan.alker@georgetown.edu).