PayerTrends
Insights For Behavioral Health

Innovations For Managing Justice-Involved Consumers With Behavioral Health Disorders

A Health Plan Guidebook

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Advancing Continuity Of Care For Justice-Involved Populations

Justice-involved individuals are among some of the most medically and socially complex members in any population—disproportionately affected by co-occurring behavioral health, substance use, and chronic physical conditions.[1]

As states implement Medicaid 1115 demonstration waivers and adopt 90-day pre-release coverage models, health plans have a unique opportunity to close care gaps like ensuring continuity of psychiatric medications, strengthening primary care linkages, and ultimately improving reentry outcomes while lowering costs.

Emerging best practices point to a shared blueprint: early engagement, integrated navigation, and real-time coordination between correctional, community, and Medicaid systems.

This guide is designed to take decision makers from *insight to impact*, connecting data, policy, and real-world care models that are moving the needle on outcomes and engagement.

Health Plans Can Use These Insights To:

1. **Strengthen** seamless prerelease and post-release transitions by aligning with state 1115 demonstration flexibilities and initiating enrollment before release.
2. **Build** closed-loop partnerships with correctional health, community-based organizations, and peer or Community Health Worker (CHW) programs to ensure a smooth intake and continuity of care.
3. **Track** outcomes that drive sustainability—recidivism reduction, continuity of care, medication adherence, and emergency department utilization.
4. **Leverage** Medicaid momentum and value-based payment pilots to fund cross-system care coordination and demonstrate ROI through improved health and justice outcomes.

Sources in the Reference List

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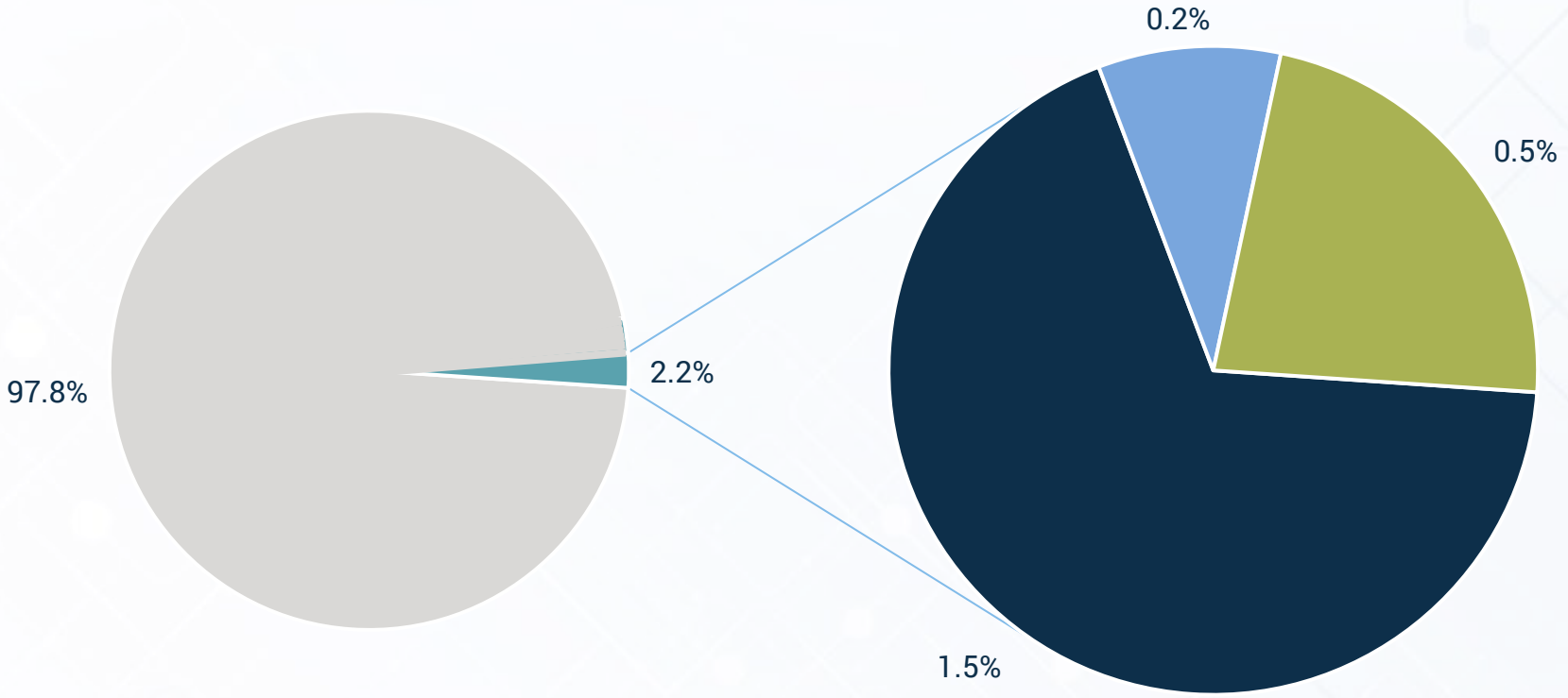
1. Justice-Involved Health Plan Consumers: The Metrics

Definition Of Justice-Involved Consumer

Anyone under custody, supervision, diversion, or community reentry.
Includes jail, prison, probation, parole, court-supervised programs, and diversion.[2]

Percentage of Population Who Are Justice-Involved Consumers[3-5]



*Estimated
Sources in the Reference List

Around 2% of U.S. adults are incarcerated or under supervision. For health plans this means 1 in 50 adults are under correctional control. This population is generally low income and either on a public plan or uninsured indicating a likely unmet need for those seeking behavioral health intervention.

Justice-Involved Consumers Behavioral Healthcare Coverage[4,6,7]

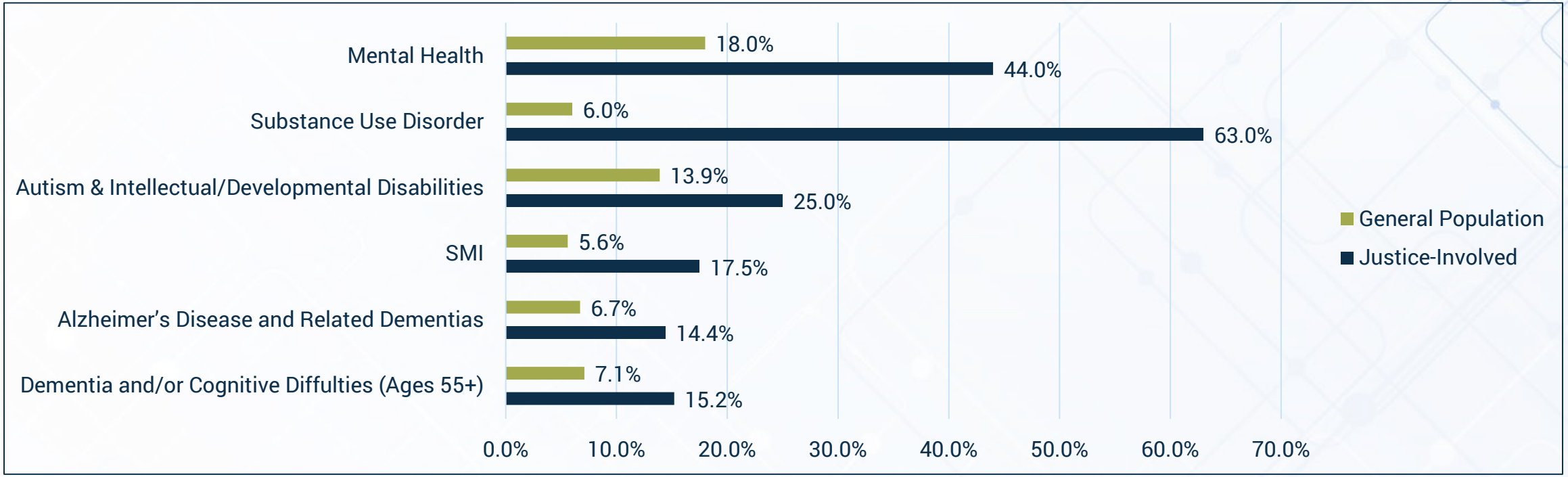
Phase	Funding Source	Coverage Components (May Include)
Jail or Prison	Correctional budgets, Departments of Corrections, Federal Bureau of Prisons (federal)	Behavioral Health treatment dependent on correctional staff or contracted providers, SUD treatment, crisis, and suicide prevention
Pre-Release (~30-90 days)	Correctional budgets, federal grants, and Medicaid 1115 Reentry Demonstrations (19 states in 2025)	Care management, transition planning, assessment, SUD treatment, medication supply for reentry
Post-Release	Mostly Medicaid or uninsured. Kentucky, for example, reports up to 93% Medicaid enrollment prior to incarceration. Nationally, many were uninsured before entering the justice system, with a small percentage covered by Medicare (1%–4%) or commercial plans.	If insured, full coverage with an emphasis on SUD

As of 2025, behavioral health treatment for incarcerated individuals is typically funded outside of health plan budgets. With limited correctional funding and a historical focus on crisis stabilization or Substance Use Disorder (SUD) treatment, many individuals leave incarceration without having received adequate care for co-occurring behavioral health conditions. Upon release, as they reenter the workforce and becoming eligible for health plan coverage, untreated needs often resurface, driving increased utilization and higher costs for plans tasked with managing their care.

Sources in the Reference List

Justice-Involved Consumers By Behavioral Health/Cognitive Disorder

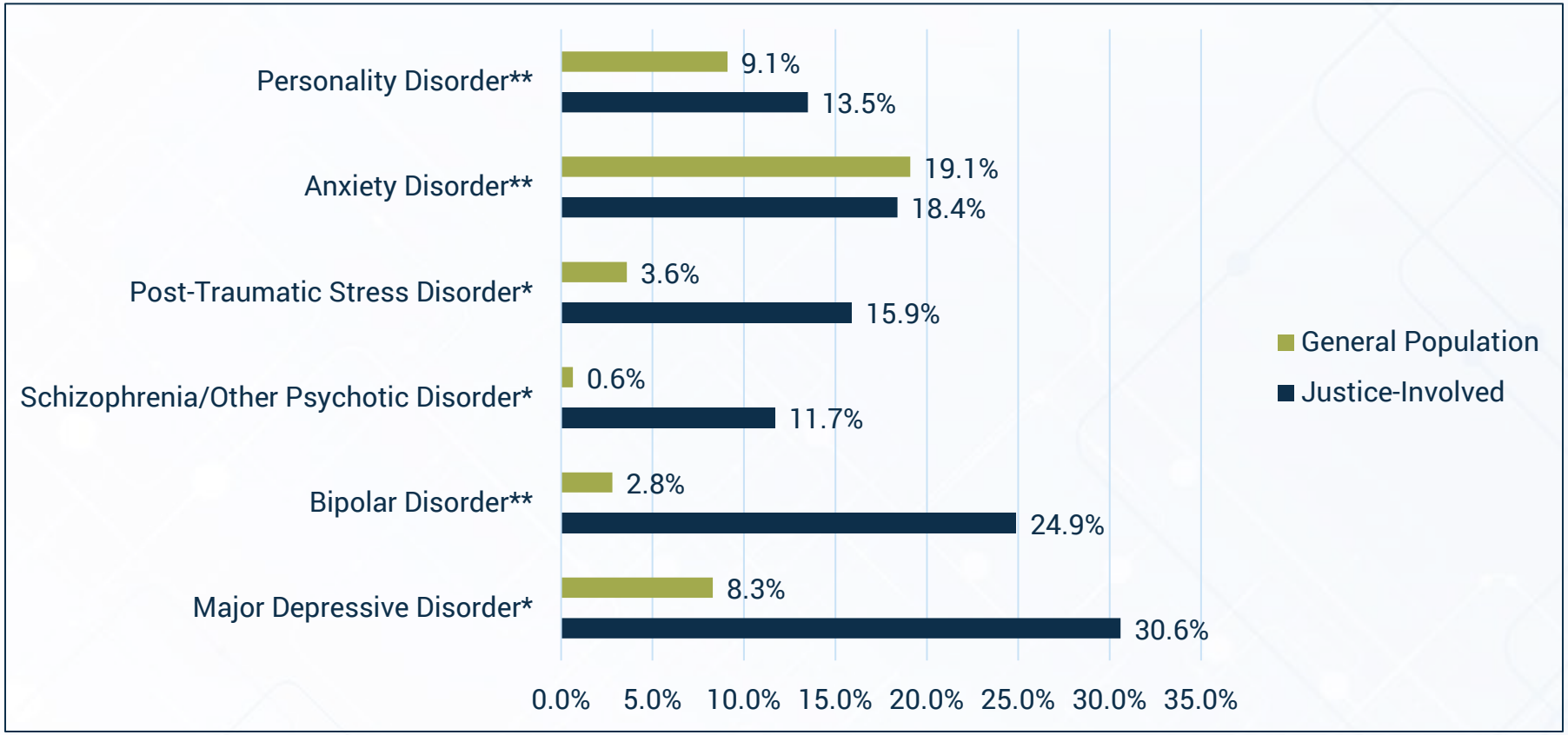
Overview: Justice-Involved Consumers By Behavioral Health/Cognitive Disorder[8-14]



Justice-Involved consumers have a higher prevalence of every noted condition, most notably, substance use disorders and serious mental illness. As a result, reentry programs have increasingly focused on these areas, recognizing that untreated SUD or mental health needs are closely linked to higher rates of recidivism.

Numbers may not add up to 100%. Data is estimated.
Sources in the Reference List

Mental Health & Serious Mental Illness (SMI)[15,16]

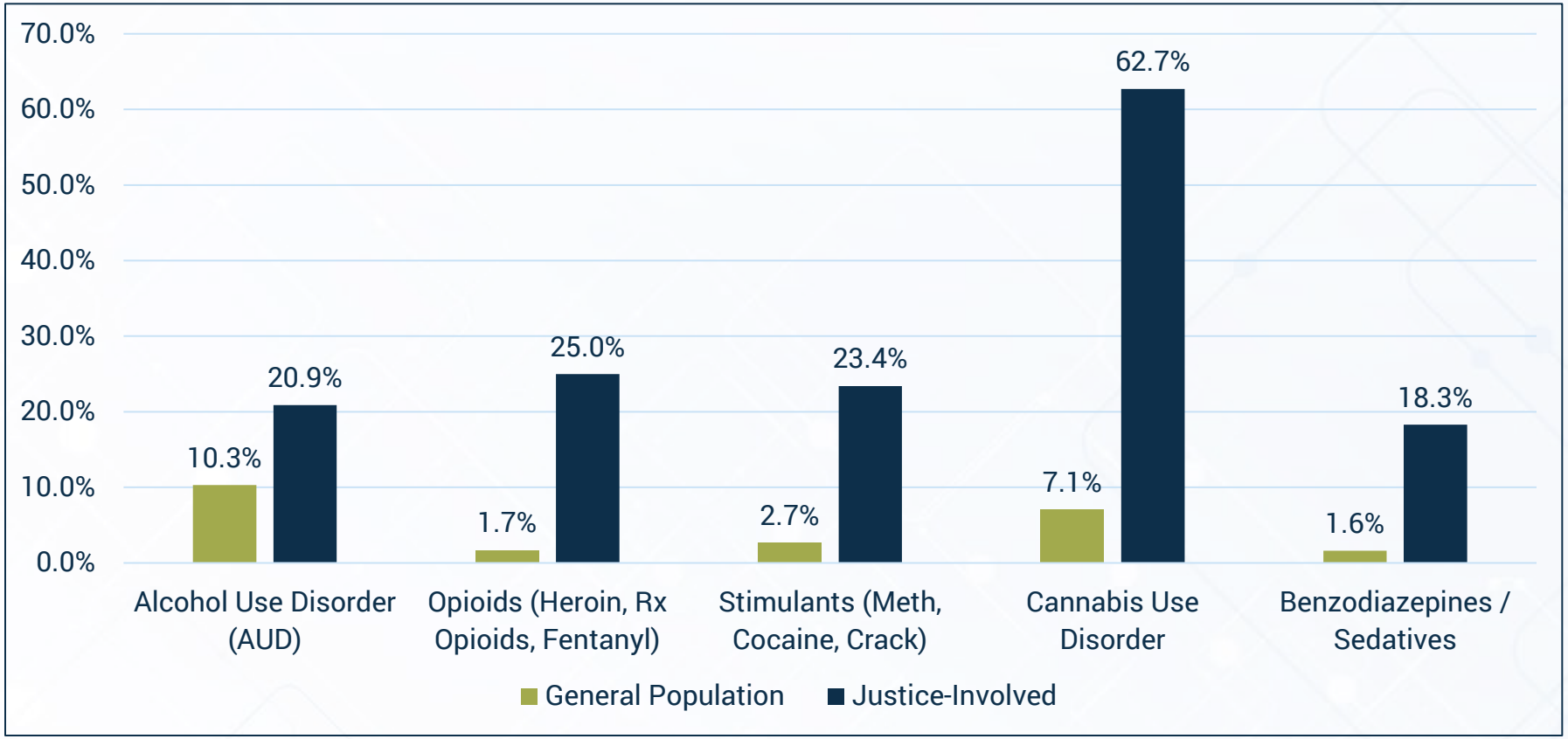


Several conditions show disparities between justice-involved individuals and the general population. To drive impact, health plans should be prepared to focus their attention in the areas with the largest gaps.

It should be noted that many formerly incarcerated individuals may have experienced trauma while in the corrections system that can influence health outcomes and recidivism risk. Integrating trauma-informed approaches into care planning is essential for long-term stability and engagement.

* Considered as a SMI
**Multiple types that may constitute as Mental Health or SMI.
Sources in the Reference List

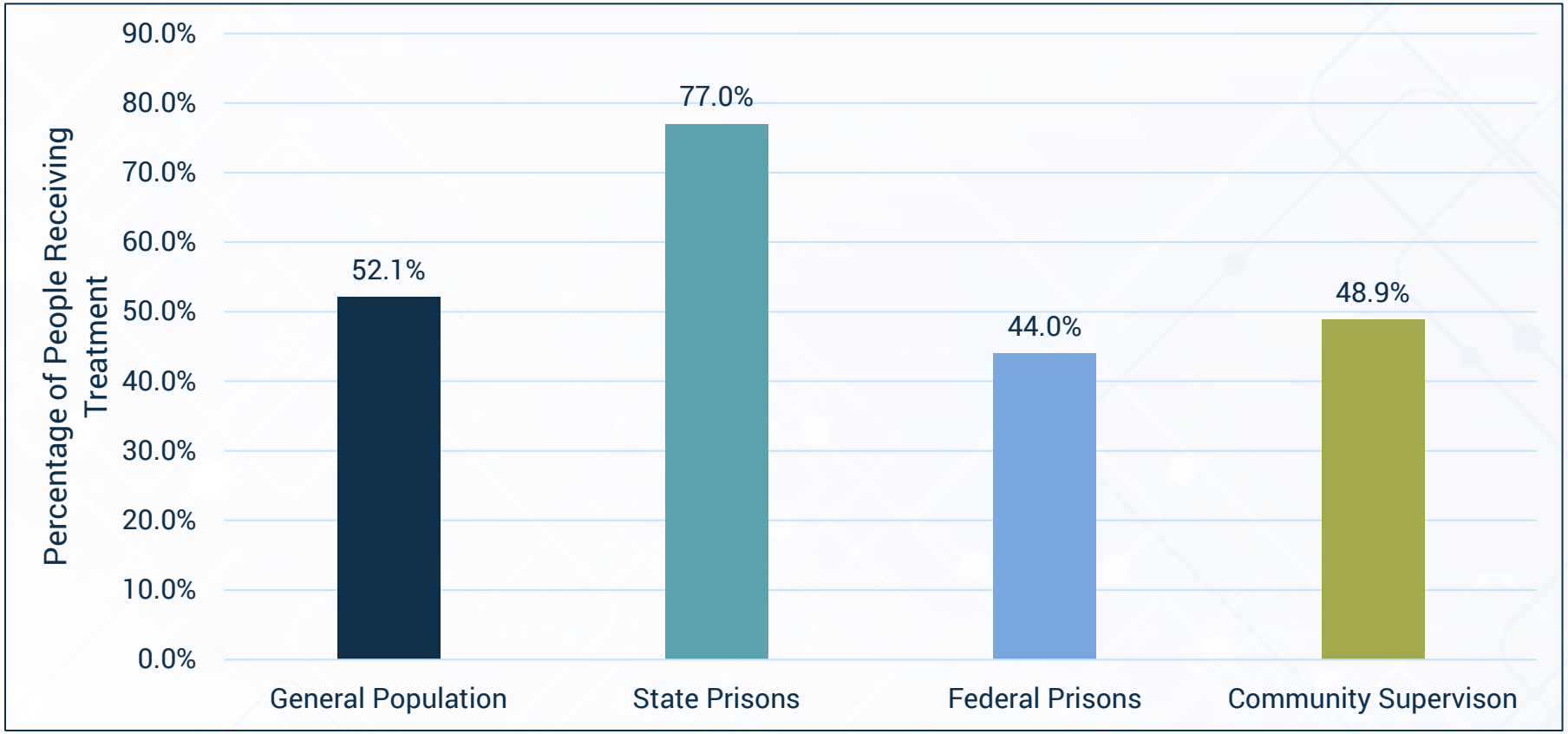
Substance Use Disorders (SUD)[17-23]



Justice-involved people who participate in prison-based treatment for SUD and continue to receive treatment after release are 7 times more likely to be drug free and 3 times more likely to not be arrested for criminal behavior. These outcomes have not gone unnoticed. Many states are now prioritizing reentry programs as a key factor upon release.

Sources in the Reference List

Treatment Rates: Justice-Involved Consumers By Behavioral Health/SUD/Cognitive Disorder[9,24,25]



Although treatment for incarcerated individuals is funded through state and federal budgets, many people with mental illness, most often those with SUD, do receive care while in jail or prison. Because treatment engagement frequently declines after release, health plans should prioritize smooth transitions to maintain continuity of care.

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2. Medicaid Policy Landscape

Reentry Waivers Related To Justice-Involved Populations[6]

Medicaid's 1115 Reentry Demonstrations allow states to test and scale new approaches for individuals who are incarcerated—providing Medicaid coverage prior to release and ensuring continuity of care for SMI, SUD, and complex medical needs.

The states highlighted on the following page represent a rapidly growing movement to:

1. Reconnect Medicaid coverage 30–90 days pre-release
2. Increase access to evidence-based SUD and behavioral health treatment,
3. Reduce emergency department use, overdose risk, and psychiatric crises
4. Lower recidivism and downstream criminal justice costs
5. Test new models of cross-system collaboration

These waivers demonstrate a shift from a fragmented reentry system to one in which behavioral health and medical care are part of the core infrastructure supporting successful community reintegration.

Current Reentry Waivers[6]

These demonstrations test innovate approaches to try and ensure the justice-involved population is covered as they re-enter into society thus, they are more likely to receive treatment for SUD and behavioral health.

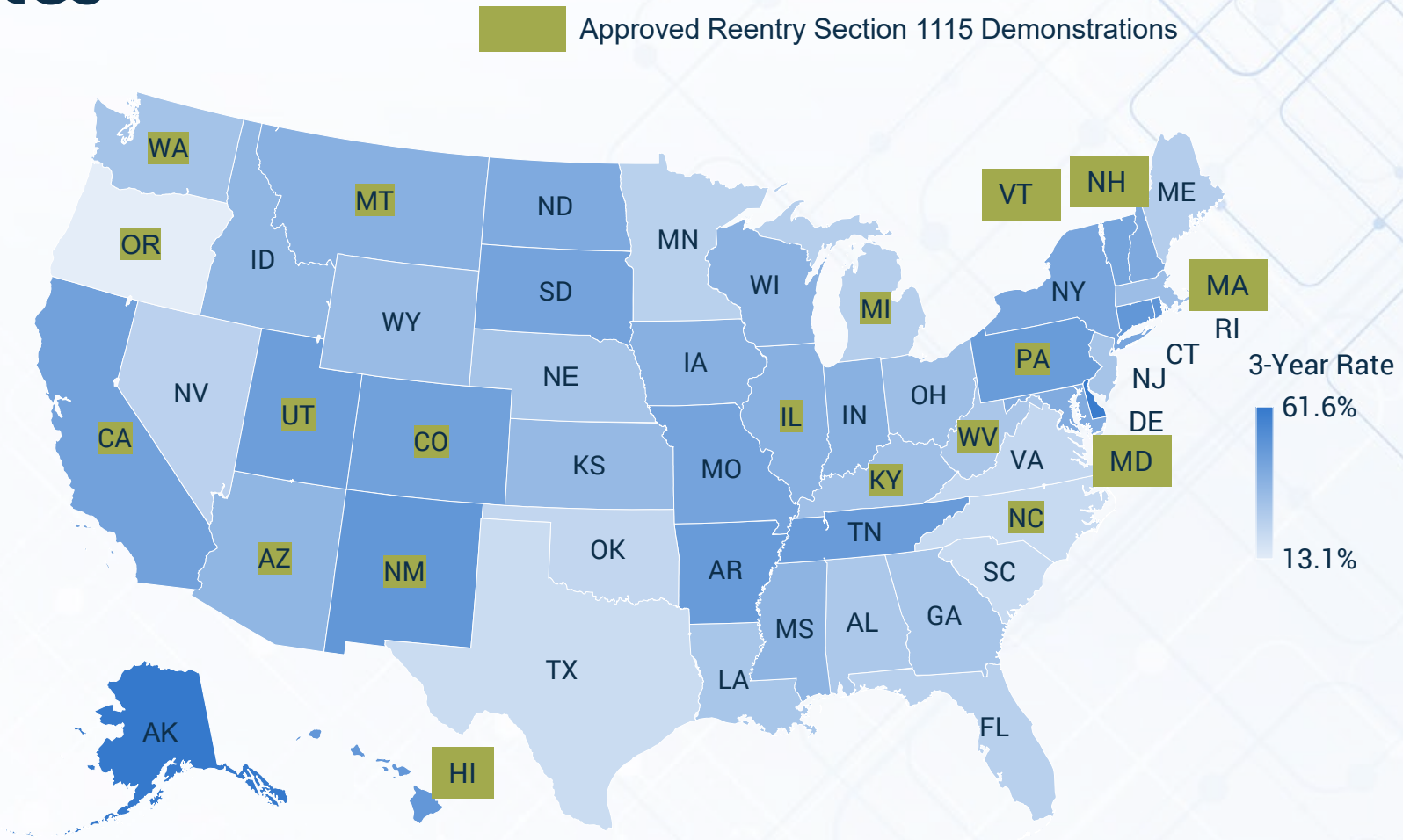
See map on next page for waiver status and reincarceration trends.

Sources in the Reference List

Approved State	Demonstration
Arizona	Arizona Health Care Cost Containment System
California	California Advancing and Innovating Medi-Cal (CalAIM)
Colorado	Colorado Expanding the Substance Use Disorder Continuum of Care
Hawaii	Hawaii QUEST Integration
Illinois	Illinois Behavioral Health Transformation
Kentucky	TEAMKY
Maryland	Maryland Health Choice
Massachusetts	MassHealth Medicaid and Children's Health Insurance Plan (CHIP) Section 1115 Demonstration
Michigan	Michigan Reentry Services Demonstration
Montana	Montana Healing and Ending Addiction through Recovery and Treatment (HEART)
North Carolina	North Carolina Medicaid Reform Demonstration
New Hampshire	Substance Use Disorder, Serious Mental Illness, and Serious Emotional Disturbance, Treatment Recovery and Access
New Mexico	New Mexico Turquoise Care
Oregon	Oregon Health Plan
Pennsylvania	Pennsylvania Keystones of Health
Utah	Medicaid Reform 1115 Demonstration
Vermont	Vermont Global Commitment to Health
Washington	Washington Medicaid Transformation Project
West Virginia	Evolving West Virginia Medicaid's Behavioral Health Continuum of Care

Reentry Section 1115 Demonstrations & Reincarceration Rates[26]

AK	61.6%	AZ	36.3%
DE	60.2%	ID	36.3%
RI	50.0%	KS	34.7%
NM	49.1%	WY	33.8%
CT	49.0%	MA	33.0%
HI	48.9%	OH	32.7%
AR	47.5%	KY	32.2%
TN	47.2%	WA	30.7%
PA	47.1%	NJ	30.4%
UT	46.0%	NE	30.2%
CO	44.9%	GA	30.0%
CA	44.7%	LA	29.6%
SD	44.0%	WV	29.3%
MO	43.9%	AL	28.7%
VT	43.8%	ME	26.3%
NY	43.0%	MI	26.0%
NH	41.5%	FL	25.4%
ND	41.2%	MN	25.0%
MD	40.5%	NV	24.6%
IA	38.7%	OK	22.6%
MT	38.6%	VA	22.3%
IL	38.5%	NC	21.0%
IN	38.2%	SC	21.0%
WI	38.1%	TX	20.3%
MS	36.8%	OR	13.1%



Data is between 2018 and 2025.
Sources in the Reference List

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Benefit Continuation During Incarceration[27-32]

The federal inmate exclusion policy prohibits health insurance companies from continuing to provide coverage for the justice-involved population that is incarcerated. The funding for this mostly comes from correctional, state, and federal budgets.

Sources in the Reference List

Service Type	During Incarceration	Pre-Release	Notes
SUD – MOUD	May continue or be initiated clinically; insurance cannot pay	Medicaid can cover initiation, assessment, planning, and medication transition	Federal "inmate exclusion" prohibits Medicaid/Medicare/commercial coverage during incarceration; care funded by jails/prisons
SUD – Counseling, Therapy, Groups	Provided by correctional health or vendors	Medicaid can cover care coordination & clinical handoff, but not treatment itself	In-custody programming varies widely; often limited intensity
SUD – Withdrawal Management / Detox	Provided onsite	Planning only	Insurance only covers detox when individual is admitted as inpatient outside facility
SUD – Residential or Therapeutic Communities (TC) Inside Prisons	Exists in some facilities	Pre-release planning	Not insurance-funded during incarceration
Mental Health – Medication Management	Provided in-facility; prescriptions often continued	Medicaid can cover transition planning & medication handoff	Not insurance-billable during incarceration except inpatient events
Mental Health – Therapy / Counseling / Psychiatry	Provided by correctional clinicians	Limited to planning, screening, assessment	Access varies dramatically across states and jails
Mental Health – Crisis Stabilization / Suicide Prevention	Provided onsite	Medicaid may cover discharge planning from crisis units	Acute psychiatric inpatient hospitalizations outside facility can be Medicaid/Medicare covered

Benefit Continuation During Incarceration[8,33-37]

(Continued)

Service Type	During Incarceration	Pre-Release	Notes
SMI Care	High need; care delivered but may be sparse	Medicaid reentry supports transition to community SMI care	SMI is severely undertreated in many facilities due to staffing shortages
I/DD – Behavioral Supports	Some supports exist, but very limited in most facilities	Medicaid reentry can coordinate Home and Community-Based Services (HCBS)/I/DD services for release	I/DD screening rare; supports often inadequate
I/DD – Personal Assistance / HCBS Services	Typically, not provided in custody (beyond basic American Disability Act (ADA) accommodations)	Planning for HCBS or I/DD placement	Full I/DD benefits restart only after release
I/DD – Specialized Therapy	Very limited; not standard in correctional systems	Medicaid can help establish services & providers pre-release	Correctional environments generally lack I/DD treatment infrastructure
Cognitive Disorders	Basic care, but rarely specialized dementia care	Medicaid reentry supports referral & care planning	Prison population is aging; cognitive care often insufficient
Cognitive Care – Long-Term Services & Supports (LTSS)	Not available in correctional settings	Pre-release assessment/transition support	Facilities rely instead on general custody care
Inpatient Hospitalization (Medical or Psychiatric)	If transported to outside hospital	Same	This is the major exception to the inmate exclusion

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3. Case Studies

Los Angeles County Department Of Health Services - Office of Diversion & Reentry (ODR)[38-40]

Target Population

- Adults with Serious Mental Illness /Substance Use Disorder at risk of or in custody in LA County jails

Model Overview:

- Large-scale diversion from jail to community-based treatment, housing, and wraparound supports; multiple subprograms (Office of Diversion and Reentry (ODR) Housing, Misdemeanor Incompetent to Stand Trial Diversion (MIST) restoration, Let Everyone Advance with Dignity / Law Enforcement Assisted Diversion (LEAD), maternal health, Felony Incompetent to Stand Trial Program (FIST))

Key Features & Innovations:

- 14,000+ individuals diverted from jail into community placements
- Integrated medical/BH, legal navigation, and long-term housing pathways
- County-health–led model with justice partnerships

Health Services
LOS ANGELES COUNTY

Source Links: https://dhs.lacounty.gov/office-of-diversion-and-reentry/our-services/office-of-diversion-and-reentry; bscc.ca.gov; https://www.rand.org/content/dam/rand/pubs/research_reports/RR3200/RR3232/RAND_RR3232.pdf

Outcomes & Impacts

- Documented large-scale decarceration (the reduction of individuals held in jail or prison) paired with improved behavioral health stability and long-term engagement
- 91% housing stability at 6 months; 74% at 12 months (Supportive Housing cohort)
- 63% reduction in psychiatric hospitalizations among participants
- $38,000 per person per year net savings (county-level cost analysis combining jail, inpatient, and crisis service reductions)

Takeaways & Implementation Tips For Health Plans:

- Pair diversion with permanent supportive housing/step-down.
- Health plan role: fund intensive Care Management (CM)/ECM, SUD treatment, step-down housing supports aligned with CalAIM justice-involved benefits

Washington State Law Enforcement Assisted Diversion (LEAD)[41-43]

Target Population

- Adults with behavioral health needs engaged in low-level drug or prostitution offenses

Model Overview:

- LEAD is a pre-booking diversion model that prioritizes care, not custody. Instead of booking individuals for low-level, non-violent offenses tied to unmet behavioral health needs, LEAD diverts them at the point of police contact into a coordinated, community-based support system.

Key Features & Innovations:

- Pre- and post-arrest diversion
- Intensive community health worker (CHW)/case management collaboration linking the, to services such as treatment and housing.
- Community-based approach with coordinated efforts among police, case managers, and service providers

Source Links: https://www.leadbureau.org; https://static1.squarespace.com/static/5df26b2fdf5e4e7c1df1d45a/t/5e1f0f78f3f8c75939d32d84/1579136510188/LEAD_Evaluation2015.pdf; http://static1.squarespace.com/static/58afdb2f5016e19fdbfce1a9/t/5914fcdbe58c629f459b64d8/1494532940215/LEAD_Evaluation2017.pdf

Outcomes & Impacts

- 58% fewer arrests post-enrollment vs. controls
- 89% retention in case management at 12 months
- 39% reduction in jail bookings

Takeaways & Implementation Tips For Health Plans:

- Ideal model for Enhanced Care Management (ECM)+ In Lieu of Services (ILOS)-aligned funding

Rhode Island Department of Corrections Statewide Medications For Opioid Use Disorder (MOUD) Program[44-46]

Target Population

- Adults with Opioid Use Disorder (OUD) currently incarcerated in prisons and jails.

Model Overview:

- Police diversion into case management, treatment, and housing instead of arrest.

Key Features & Innovations:

- Universal screening at intake and access to all FDA-approved MOUD during incarceration
- Statewide coordination to link individuals to community MAT providers for continued care
- Ensured day-of-release MOUD continuity to reduce overdose risk during reentry

Source Links: https://www.addiction-programs.net/news/prison-medication-assisted-treatment-program-leads-to-60-decrease-in-ods/; https://www.sciencedirect.com/science/article/abs/pii/S0091743519302427; http://www.doc.ri.gov

Outcomes & Impacts

- 60% reduction in post-release overdose deaths
- Highest national post-release treatment retention with 82% MAT continuation at reentry

Takeaways & Implementation Tips For Health Plans:

- Providing MOUD during incarceration and ensuring day-of-release continuity significantly reduces post-release overdose death
- Strong linkage to community MAT providers improves long-term treatment engagement, stabilizing individuals during the highest-risk period after release
- Support this model by facilitating smooth prerelease coordination and rapid post-release MAT access, reinforcing continuity during the transition back to the community

Camden Coalition Jail-To-Community Medication Assisted Treatment (MAT) Transition Program[47,48]

Target Population

- Adults with OUD transitioning from jail to the community who need continuation of MOUD and other supports

Model Overview:

- A transition program that pairs in-jail engagement with CHW navigation to guarantee seamless, immediate continuation of MAT after release

Key Features & Innovations:

- CHWs with lived experience provide prerelease engagement and trusted support, helping individuals navigate reentry challenges
- High-touch release planning coordinates appointments, transportation, and immediate needs, ensuring continuity from custody to community
- Rapid linkage to community MAT providers guarantees continuation of MOUD and minimizes the high-risk treatment gap after release

Camden Coalition

Source Links: https://camdenhealth.org/; https://camdenhealth.org/resources/evaluating-the-camden-county-correctional-facilitys-medications-for-opioid-use-disorder-program/

Outcomes & Impacts

- 41% less likely to overdose in the next 180 after jail release
- 39% less likely to overdose within 365 days after jail release
- Likely less hospitalizations with less overdoses

Takeaways & Implementation Tips For Health Plans:

- MAT continuity during reentry, supported by CHW navigators with lived experience, reduces ED visits, overdose risk, and early activation barriers
- Warm handoffs and rapid clinic access reduce fragmentation and support immediate post-release engagement
- Use ECM/ILOS to fund day-of-release MAT, transportation, and transitions-of-care supports
- Boost engagement by reserving post-release MAT appointments and embedding CHW/peer navigators prerelease

Allegheny County Forensic Assertive Community Treatment (FACT) Program[49,50]

Target Population

- Adults with SMI who repeatedly cycle through the crisis system, courts, jail, and emergency departments
- SMI individuals repeatedly cycling through crisis and justice systems

Model Overview:

- High-intensity assertive community treatment (ACT) modified for justice-involved individuals with SMI, combining behavioral health care, housing supports, and integrated probation/legal collaboration

Key Features & Innovations:

- Multidisciplinary ACT-style team with integrated probation/legal coordination to address criminogenic needs and reduce justice involvement
- High-intensity, community-based behavioral health care with time-unlimited support, medication management, and crisis response.
- Housing-focused wraparound model that stabilizes living situations and strengthens treatment continuity for individuals with SMI

ALLEGHENY COUNTY

Source Links: https://analytics.alleghenycounty.us/wp-content/uploads/2020/09/Cross-Systems-Evaluation-Intercepts-_final-report_9-24-20.pdf; https://www.urban.org/sites/default/files/publication/33641/413252-Evaluation-of-the-Allegheny-County-Jail-Collaborative-Reentry-Programs.PDF

Outcomes & Impacts

- 24% reductions in re-arrest when considering all re-entry programs
- Fewer hospitalizations and improved housing stability

Takeaways & Implementation Tips For Health Plans:

- FACT serves a small but extremely high-cost subset of justice-involved SMI members, consistently reducing arrests, hospitalizations, and crisis use through an intensive multidisciplinary model that aligns well with alternative payment structures
- Use PMPM rates, integrated probation/legal partnerships, and real-time data sharing to enhance FACT performance and reduce revocations
- Fund ILOS housing supports, given housing stability's central role in FACT success

Miami-Dade Criminal Mental Health Project (CMHP) Program & Evaluation Sources[51,52]

Target Population

- Adults with SMI facing non-violent charges

Model Overview:

- A court-based diversion model that identifies individuals with serious mental illness at intercept points and redirects them from jail into community treatment and supports through coordinated justice–behavioral health partnerships

Key Features & Innovations:

- Crisis intervention teams (CIT) trained law enforcement and specialized mental health courts that improve crisis response and support treatment-focused case processing
- Pre- and post-booking diversion pathways that shift individuals with SMI from arrest and jail into treatment
- Coordinated linkage to community behavioral health and social services, reducing system fragmentation and supporting long-term stability

Source Links: https://www.jud11.flcourts.org/Criminal-Mental-Health-Project; https://psychiatryonline.org/doi/10.1176/appi.ps.201900572

Outcomes & Impacts

- Estimated $12,000,000 reduction in costs each year
- 45% lower jail population
- Closure of a jail facility

Takeaways & Implementation Tips For Health Plans:

- Early diversion, housing and treatment supports, and CIT-trained crisis response reduce jail bookings and unnecessary arrests, while an integrated system minimizes fragmentation across courts, behavioral health, and medical services
- Implement CMHP-style diversion pilots and reimburse crisis stabilization, community treatment, and housing supports
- Use VBP models tied to jail reductions and treatment engagement and partner with counties on CIT training integrated with BH crisis systems

Washington Health Care Authority – Reentry Initiative (Medicaid Transformation Project)[53-55]

Target Population

- Adults up to 90 days pre-release from prisons/jails who are Medicaid-eligible on reentry.

Model Overview:

- Pre-release coverage/services: Reentry Targeted Case Management (rTCM), MOUD/medications for alcohol use disorder (MAUD), labs/radiology, pharmacy (30-day supply at release), CHWs with lived experience, clinical consultations

Key Features & Innovations:

- Structured eligibility, clinical assessment, treatment adherence requirements
- Countywide network of MH dockets and specialty paths

Washington State Health Care Authority

Source Link(s): https://www.hca.wa.gov/assets/program/reentry-overview-facilities.pdf ; https://www.hca.wa.gov/about-hca/news/news-release/washington-state-recognized-groundbreaking-reentry-program ; https://www.manatt.com/insights/newsletters/health-highlights/advancing-medicaid-reentry-initiatives-early-implementation-successes

Outcomes & Impacts

- County communications highlight network expansion
- Increased prerelease care coordination contacts
- Improved continuity of MOUD with hopefully fewer lapses in treatment at 30 days (Impact report not available as of December 29, 2025)

Takeaways & Implementation Tips For Health Plans:

- Mirror Washington's benefit structure in plan contracts (MOUD access, rTCM, pharmacy fills)
- Invest in CHW hiring pipelines (lived experience)

San Diego County Sheriff – Reentry Services; Health & Human Services Agency (HHSA) Public Health Reentry Toolkit; Workforce Partnership "Reentry Works"[56,57]

Target Population

- Adults returning from county jail/prison to San Diego communities

Model Overview:

- County ecosystem providing evidence-based in-custody programming and reentry services, public health toolkits, and pre/post-release employment supports and navigation

Key Features & Innovations:

- Sheriff's Reentry Services with evidence-based classes and community linkages
- County HHSA Reentry Toolkit for coordinated resources
- Workforce "Reentry Works" pre-release training + post-release job links/supportive services

SAN DIEGO COUNTY Sheriff's Office

Source Link(s): https://www.sdsheriff.gov/bureaus/detention-services-bureau/reentry-services ; https://www.secondchanceprogram.org/annualimpact/

Outcomes & Impacts

- "Reentry Works" shows 70% employment placement rate among participants
- County-reported reductions in recidivism tied to evidence-based reentry and employment pathways (program materials)
- Strong community-based organizations (CBO) partnerships (e.g., Second Chance) sustain engagement

Takeaways & Implementation Tips For Health Plans:

- Contract with CBOs for ECM/CHW-delivered navigation
- Build closed-loop referrals (jail → plan Primary Care Provider (PCP)/BH; plan → workforce/housing partners)

Maricopa County Correctional Health Services[58,59]

Target Population

- Adults in Maricopa County jails (high Seriously Mentally Ill & Substance Use Disorder prevalence)

Source Link(s): https://www.maricopa.gov/5161/About-Correctional-Health-Services-CHS; https://azpha.org/2025/01/15/pioneering-reentry-care-arizonas-evidence-based-step-to-improve-health-for-incarcerated-people-just-prior-to-release

Model Overview:

- On-site medical, dental, and mental health care across six jail facilities with ~100,000 annual bookings; increasingly aligned to prerelease linkage

Outcomes & Impacts

- 100% enrollment
- MAT for SUD with the evidence-based goal of reducing the risk of overdose and recidivism after release
- 30-day prescription supply after release

Key Features & Innovations:

- Full-spectrum in-custody health care; expanding reentry linkage
- Arizona Health Care Cost Containment System (AHCCCS) state approach enabling evidence-based MOUD prerelease statewide

Takeaways & Implementation Tips For Health Plans:

- Formal “in-reach” handoffs to plan-network clinics 30–90 days pre-release.
- Bundle MOUD + Care Management (CM) + pharmacy fills at release to reduce Emergency Department (ED) use/overdose

New York City Health & Hospitals – Correctional Health Services; Point Of Reentry And Transition (PORT) Program[60,61]

Target Population

- Adults in custody on Rikers Island and those returning to the community

Source Link(s): https://www.nychealthandhospitals.org/correctionalhealthservices/our-services; https://www.chcs.org/empowering-transitions-from-jail-to-community-health-the-point-of-reentry-and-transition-program

Model Overview:

- Comprehensive jail health (medical, mental health, forensic psych) plus Post-Overdose Response Teams (PORT) program linking people leaving Rikers to trauma-informed primary care and social services using Community Health Workers (CHWs) with lived experience

Outcomes & Impacts

- High rates of successful warm handoffs to primary care, aided by community health workers (CHWs)
- Rates of attendance on first appointment is at almost the same rate as non-justice-involved individuals which the program remarks as exceptional

Key Features & Innovations:

- Full medical and behavioral services in custody, court-ordered forensic psych services
- Post-Overdose Response Teams (PORT): rapid linkage post-release to primary care and supports via CHWs

Takeaways & Implementation Tips For Health Plans:

- Contract for CHWs/peer reentry navigators as covered benefits
- Build same-day/next-day new-member appointment access at release

Features Of Programs Achieving Desired Outcomes

1. Intensive, Person-Centered Case Management
2. Strong Cross-System Collaboration
3. Housing & SUD/MH Integration (Whole Person Care)
4. Diversion From Criminal Justice System Into Treatment
5. Prioritization Of Behavioral Health Treatment

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4. Conclusion

Key Takeaways & Implications For Health Plans[62,63]

Prevalence & Complexity

- Justice-involved populations show high concentrations of behavioral health disorders—often multiple comorbidities (SMI, SUD, IDD, dementia).
- High medical, behavioral, and social costs concentrate within a small number of individuals repeatedly cycling through correctional, emergency, and inpatient systems. States can spend up to $72 dollars per citizen on recidivism costs alone.
- Continuity of coverage and care is a strong predictor of successful reentry outcomes.

Best-Practice Models Converge On Common Design Elements

- Early engagement (in custody or pre-arraignment).
- Intensive case management and peer/CHW navigation.
- Integration of housing, employment, and benefits access.
- Real-time data exchange between correctional health, Medicaid, and community providers.
- Strong outcome tracking—recidivism reduction, continuity of care, ED utilization, medication adherence.

Medicaid Policy Momentum

- Centers for Medicare & Medicaid Services (CMS) 1115 demonstration waivers and new benefit-continuation flexibilities are transforming how states fund prerelease and post-release care.
- The emerging “90-day prerelease” coverage model (WA, NC, CA) is the national benchmark—plans will increasingly manage these transitions.
- States are requiring MCO participation in justice-involved pilots, meaning plans must be ready with network and data-sharing capacity.

Where Health Plans Typically Fall Short

- Data sharing barriers with sheriffs, jails, and probation officers
- Pharmacy continuity for both medications and MOUD
- Next-day appointments after release
- Benefit design confusion (i.e., ECM vs. CHW vs. ILOS housing vs. SUD benefit

Sources in the Reference List

Actionable Recommendations For Health Plans

A. Build Infrastructure for Pre-Release Coverage

- Establish MOUs with jails/prisons to begin enrollment and care planning before release.
- Assign reentry care coordinators or CHWs as part of Enhanced Care Management (ECM) or comparable benefit.

B. Design Cross-System Provider Networks

- Include correctional health partners in network development.
- Contract with CBOs and peer organizations specializing in reentry and housing support.

C. Strengthen Data Sharing & Analytics

- Implement data feeds from correctional systems to flag upcoming releases.
- Track post-release continuity metrics—30-day follow-up visits, MOUD adherence, recidivism reductions.

D. Align Incentives With Outcomes

- Incorporate performance-based payments for continuity of care and reduced recidivism.
- Use value-based purchasing pilots to reward integrated models like Allegheny JRS or LA ODR.

E. Address Social Drivers Directly

- Integrate housing, employment, and case management into benefit design (through ILOS/Community Support Services).
- Partner with local Workforce Development Boards and housing authorities to extend supports beyond clinical care.

Definitions

Name	Definition
Any Mental Illness (AMI)[19]	Defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (e.g., individuals with serious mental illness as defined below).– National Institute of Mental Health
Serious Mental Illness (SMI)[19]	Defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI. – National Institute of Mental Health
Children vs. Adults[19]	**Children/Adolescents (Youth)** are typically defined as individuals ages 12–17 in most national behavioral health surveys (e.g., NSDUH). **Adults** are defined as individuals **18 years and older**. Adult mental health prevalence and impairment estimates apply to this population in SAMHSA, CDC, and NIMH reporting.
Low-Risk vs. High-Risk Groups[64]	A small subset of high-acuity individuals account for a disproportionate share of cost, cycling repeatedly across ED, inpatient psych, jail, and homelessness

*Child and adolescent data was not included in this supplement as the data is lacking, and the juvenile system operates very differently than the adult system.

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