

January 29, 2024

The Honorable Xavier Becerra  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

Re: **Comment on Arkansas' December 31, 2023 Request for Approval of Section 1115 Demonstration Project**

Dear Secretary Becerra:

Thank you for the opportunity to comment on Arkansas' request for approval of its Section 1115 Demonstration Project, "Opportunities to Test Transition-Related Strategies to Support Community Reentry from Incarceration and Institutions for Mental Disease." In its request, Arkansas seeks waiver of two key Medicaid provisions: the exclusion of services provided in Institutions for Mental Disease (IMDs) from federal Medicaid reimbursement, and the exclusion from federal support through Medicaid for services provided to any adult who is an "inmate of a public institution." We have serious concerns about Arkansas' proposal, and urge CMS to deny the state's request for approval.

The Bazelon Center for Mental Health Law is a national nonprofit organization that works to advance the rights of people with mental disabilities. The Center was instrumental in the passage of the Americans with Disabilities Act (ADA) and played a key role in the historic case of *Olmstead v. L.C. (Lois Curtis)*,<sup>1</sup> in which the Supreme Court found that needless segregation of people with disabilities violates the ADA.

Arkansas' proposal combines its request for waivers of these two Medicaid exclusion rules into a single proposed Demonstration Project the state describes as a "Reentry Waiver." The state appears to seek federal financial support through Medicaid for all health services provided in both IMDs and carceral settings for up to 180 days—a time period and scope far exceeding any waiver of the exclusion rules that CMS has ever granted. For the following reasons, we urge you to reject Arkansas' proposal.

### **Arkansas' Request for Waiver of the IMD Exclusion**

Medicaid's "IMD exclusion" prohibits the federal government from subsidizing states for services rendered to Medicaid-eligible individuals residing in IMDs, defined as hospitals,

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<sup>1</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999).

nursing facilities, or other institutions of more than 16 beds primarily engaged in providing treatment and care to people with behavioral health disabilities, including people with substance use conditions, mental health disabilities, and co-occurring conditions.<sup>2</sup>

Arkansas seeks a waiver of the IMD exclusion for “all Medicaid covered services” provided to adults with these conditions “while being treated in an IMD for up to 90 days upon admission and up to 90 days prior to discharge.”<sup>3</sup> Its waiver proposal identifies 11 private IMDs and one public IMD, the Arkansas State Hospital (ASH),<sup>4</sup> which would presumably seek federal Medicaid reimbursement for services provided to patients with behavioral health disabilities that otherwise would not be available under the IMD exclusion.

Arkansas acknowledges that Section 1115 demonstration projects must test hypotheses that providing services in ways otherwise not allowed under Medicaid will assist the state in promoting the objectives of Medicaid.<sup>5</sup> Among the hypotheses that Arkansas proposes to test through its IMD waiver, should it be granted, are whether the waiver will result in reductions of utilization of stays in emergency departments among Medicaid beneficiaries while awaiting behavioral health treatment, and whether it will result in “reductions in preventable readmissions to acute care hospitals and residential settings.”<sup>6</sup>

### **Arkansas’ Hypotheses Have Already Been Disproven**

These hypotheses have already been tested and disproven. Between 2012 and 2015, the federally mandated Medicaid Emergency Psychiatric Demonstration (MEPD) provided for federal Medicaid reimbursement for services provided in IMDs in 11 states and the District of Columbia.<sup>7</sup> This study reimbursed each state for extended short-term IMD stays of the same nature (though not the same length) Arkansas now proposes, to test the same theories the state says it will test through its Reentry Waiver program. At the conclusion of the study, the MEPD program found no reduction in emergency department admissions or lengths of stay, and no reduction in general hospital admissions or lengths of stay.<sup>8</sup> In fact, in two states individuals were more likely to go to

<sup>2</sup> 42 U.S.C. §§ 1905(i), 1396d(a).

<sup>3</sup> State of Arkansas Dep’t of Human Servs., Section 1115 Demonstration Project: Opportunities to Test Transition-Related Strategies to Support Community Reentry from Incarceration and Institutions for Mental Disease 25 (Dec. 31, 2023) [hereinafter Arkansas Section 1115 Proposal].

<sup>4</sup> *Id.* at 16-17.

<sup>5</sup> *Id.* at 6, 42-47.

<sup>6</sup> *Id.* at 42-43.

<sup>7</sup> U.S. Dep’t of Health & Hum. Serv., Medicaid Emergency Psychiatric Demonstration: Response to 21st Century Cures Act Requirements, Report to Congress xi-xiv (2019)

<sup>8</sup> *Id.*; Crystal Blyler et al., *Medicaid Emergency Psychiatric Services Demonstration Evaluation: Final Report*, Mathematica Pol’y Rsch. 27, 54-55, 74 (Aug. 18, 2016).

the hospital for mental health crisis after the IMD reimbursement extension.<sup>9</sup> There was also no improvement in access to inpatient care and no improvement in follow-up care.<sup>10</sup> A later report to Congress regarding the MEPD noted that utilization rates for IMDs in the 11 states were, at an average of 93 percent, “very high” and “substantially above the national average of 66 percent across all hospital types.”<sup>11</sup>

The MEPD study answers the questions Arkansas proposes to test through its proposed Amendment. Granting Arkansas’ request for waiver of the IMD exclusion for services provided during IMD stays will fund expensive care that will not achieve the stated goals of reducing emergency room boarding and hospital admissions. Additional investment in Section 1115 waivers to test this already disproven theory would be an inappropriate use of federal Medicaid resources.<sup>12</sup>

### **Increased Services in IMDs Will Not Address the Root Issue**

The unmet need for mental health care in Arkansas is caused not by too few inpatient beds, but by a lack of community-based mental health services. The MEPD study found a lack of community-based services as a primary reason for continued psychiatric hospitalizations.<sup>13</sup> This deficit particularly harms continuity of care and discharge planning.<sup>14</sup> When individuals are unable to access voluntary, community-based services, they are often pushed into institution-based and involuntary settings.<sup>15</sup> This results in more costly care, and worse mental health outcomes for individuals with significant needs. For these reasons, the National Association of State Mental Health

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<sup>9</sup> Medicaid Emergency Psychiatric Demonstration, *supra* note 7, at xiii.

<sup>10</sup> Medicaid Emergency Psychiatric Services Demonstration Evaluation, *supra* note 8, at 70.

<sup>11</sup> Medicaid Emergency Psychiatric Demonstration, *supra* note 7, at 12-13 & Table II.4 (Sep. 30, 2019). The MEPD further found this did not decrease long-term state spending on mental health services, as the programs either increased or had no effect on spending. *Id.*

<sup>12</sup> Among other things, Arkansas states that, should its request for an IMD waiver be approved, it will require the state’s 11 private IMDs to open acute crisis units (ACUs), which the state also refers to as a “Crisis Stabilization Center,” as an alternative setting for crisis stabilization. Arkansas Section 1115 Request at 17-18. In our experience, IMDs are not appropriate settings for helping individuals experiencing a mental health crisis de-escalate and engage in planning for future supports. We urge Arkansas to invest in crisis homes or apartments led by people with lived experience working as peer specialists, which have been shown to help guests connect with services and avoid future hospitalization. See, e.g., Bazelon Center for Mental Health Law, *When There’s a Crisis, Call a Peer: How People with Lived Experience Make Mental Health Crisis Services More Effective* 21, 38-47 (Jan. 2004).

<sup>13</sup> Medicaid Emergency Psychiatric Demonstration, *supra* note 7, at xiv.

<sup>14</sup> Medicaid Emergency Psychiatric Services Demonstration Evaluation, *supra* note 8, at 77.

<sup>15</sup> Olukunle Fadipe, *Affordable Mental Health Care in the Post Healthcare Reform Era*, 57 WYNE L. REV. 575, 593-94 (2011).

Program Directors has emphasized that the pressure to increase psychiatric inpatient capacity “often actually stems from an underfunded community mental health system.”<sup>16</sup>

Arkansas’ Section 1115 request acknowledges the importance of community-based services, affirming that a goal of its demonstration project is to improve “access to community-based services to address . . . chronic mental health care needs.”<sup>17</sup> As Arkansas notes, the need for community-based services in the state is significant, and dire: in 2022, over 38 percent of Arkansans with mental health symptoms reported unmet needs in accessing community counseling or therapy.<sup>18</sup> Arkansas has significantly lower utilization rates than the national average for intensive community-based services that have been shown to be effective in helping people avoid hospitalization, such as Assertive Community Treatment (ACT), supported housing, and supported employment services.<sup>19</sup>

The state’s elected officials appear to understand the need for increased support for community-based mental health services. Last year, the Arkansas legislature passed bills requiring the state’s Medicaid program to reimburse behavioral health services provided in outpatient settings, and also passed a bill creating a legislative study on behavioral health that will make recommendations for future action.<sup>20</sup> But the state’s Reentry Waiver proposal does not seek additional federal support for critical community-based services delivered to individuals in their homes or elsewhere in the community. Community-based services are less costly to the state and have better outcomes for users.<sup>21</sup> Individuals receiving community-based services report greater satisfaction with the care they receive in the community than that provided in institutional settings.<sup>22</sup> These services also help ensure state compliance with *Olmstead* and the ADA’s community integration mandate.<sup>23</sup>

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<sup>16</sup> Sherry Lerch & Kevin Martone, The Role of Permanent Supportive Housing in Determining Psychiatric Inpatient Bed Capacity, Nat’l Ass’n of State Mental Health Program Dirs. 4 (Aug. 2017).

<sup>17</sup> Arkansas Section 1115 Proposal, *supra* note 3, at 45.

<sup>18</sup> Kaiser Family Foundation (KFF), Unmet Need for Counseling or Therapy Among Adults Reporting Symptoms of Anxiety and/or Depressive Disorder During the COVID-19 Pandemic (2022; KFF Analysis of U.S. Census Bureau, Household Pulse Survey, 2020-2022).

<sup>19</sup> U.S. Dep’t of Health & Hum. Serv., Substance Abuse & Mental Health Serv. Admin., 2022 Uniform Reporting Summary Output Tables 1-2 (2023).

<sup>20</sup> State of Arkansas House of Representatives, Mental Health Legislation 2023 (Apr. 27, 2023).

<sup>21</sup> Meghan K. Moore, *Piecing the Puzzle Together: Post-Olmstead Community-Based Alternatives for Homeless People with Severe Mental Illness*, 16 Geo. J. on Poverty L. & Pol’y 249, 264-65 (2009).

<sup>22</sup> John H. McGrew, et al., *An Exploratory Study of What Clients Like Least About Assertive Community Treatment*, 53 Psychiatric Services 761, 761 (2002).

<sup>23</sup> *Olmstead v. L.C.*, 527 U.S. 581, 599-00 (1999).

Other states have requested and received approval for increased federal support for an array of intensive community-based services—including Assertive Community Treatment (ACT), intensive case management, housing support services, supported employment, peer support services, and mobile crisis services—through Medicaid Section 1915(i) or 1915(c) authorities, or through Section 1115 demonstration projects. If Arkansas wants to increase access to community-based services, these options are available and would help the state avoid the overuse of emergency rooms, hospitals, and long-term care facilities.<sup>24</sup>

### **Unnecessary Care in IMDs Violates Disability Rights**

Although some proponents of waivers of the IMD exclusion argue that it discriminates against Medicaid-eligible individuals with behavioral health disabilities, because Medicare and private insurance programs may pay for services provided to individuals in IMDs, this argument—which Arkansas’ proposal adopts—misses the mark. Medicaid beneficiaries may receive inpatient behavioral health services if they are provided in general hospitals, where people without disabilities also receive care.

Congress’ choice to provide federal support for inpatient services in general hospital settings does not amount to discrimination, and the incentive created by the IMD exclusion for states to build capacity to provide effective community-based services to individuals with behavioral health disabilities also is not discriminatory. If anything, the opposite is true. Congress’ decision in 1965 to provide Medicaid coverage only for inpatient mental health services in non-segregated settings reflects a clear intent to help hasten the end of the era of unnecessary institutionalization.

Allowing federal reimbursement through Medicaid for services provided in IMDs—which are, by definition, institutional settings—will likely increase the state’s capacity to provide care in IMDs, but also increase the risk that people with disabilities will be unnecessarily segregated in those settings. Experience has shown that if new IMD beds come online they will be filled, at the expense of funding for community-based services that better meet the needs of people with behavioral health disabilities, including helping them avoid the need for costly inpatient care.

Any weakening of the IMD exclusion, including through waivers of this rule, is inconsistent with the “community integration mandate” of the Americans with Disabilities Act (ADA), our nation’s landmark civil rights law protecting the rights of people with disabilities. As announced by the U.S. Supreme Court in its seminal decision in *Olmstead v. L.C. (Lois Curtis)*, unnecessary segregation, including in psychiatric

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<sup>24</sup> Increased federal support through Medicaid for community-based services would help Arkansas address the “severe statewide shortages in mental health professionals” it describes in its proposal. Arkansas Section 1115 Request at 5, 25. This is more likely to increase access to community-based care that has been shown to help individuals with mental health disabilities avoid hospitalization than would increasing inpatient treatment capacity through waiver of the IMD exclusion.



institutions (like IMDs), is disability-based discrimination.<sup>25</sup> The ADA's community integration mandate requires state and local governments to provide services to people with disabilities in the most integrated setting appropriate to their needs.<sup>26</sup> As such, federal law prohibits unnecessary segregation and institutionalization of people with disabilities who could be served in community settings.

This is because, as the Supreme Court recognized, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life . . . and institutional confinement severely diminishes the everyday life activities of individuals."<sup>27</sup> Waiver of the IMD exclusion to allow federal support through Medicaid for services provided in institutions like IMDs is inconsistent with the ADA and *Olmstead*—and with the federal government's responsibility to enforce these legal requirements.

### **Arkansas' Request for Waiver of the Inmate Payment Exclusion Is Overbroad and Inconsistent with CMS Guidance**

Medicaid also prohibits the use of federal funds to pay for the health care of an "inmate of a public institution," generally defined as a jail, prison, detention facility, or other setting organized for the primary purpose of involuntary confinement, except when the individual is receiving inpatient care in a non-IMD medical institution.<sup>28</sup>

In addition to its request for waiver of the IMD exclusion, Arkansas' Section 1115 Demonstration Project request seeks waiver of this "Inmate Payment" exclusion rule. Specifically, Arkansas seeks Medicaid reimbursement for "all Medicaid services" provided to incarcerated individuals for two potentially separate 90-day periods, for a total of up to 180 days for some persons: 90 days at the beginning of incarceration and up to 90 days prior to release.<sup>29</sup>

We have opposed legislative efforts that would broadly repeal Medicaid's Inmate Payment exclusion. For example, we have opposed the Medicaid Reentry Act, which would lift the bar on Medicaid reimbursement for medical services provided to individuals during the last 30 days of incarceration, because the bill does not require that new Medicaid dollars be spent on activities designed to engage inmates and facilitate successful transition to the community. Instead, the bill would permit federal Medicaid resources to be used to reimburse state and local governments for basic services that are currently provided to incarcerated individuals by correctional staff,

<sup>25</sup> *Olmstead*, 527 U.S. at 597.

<sup>26</sup> *Id.* at 596 (citing 28 C.F.R. § 35.130(d) ("A public entity shall administer services . . . in the most integrated setting appropriate to the needs of qualified individuals with disabilities.")).

<sup>27</sup> *Id.* at 600–01 (1999).

<sup>28</sup> 42 U.S.C. § 1396d(a); see also U.S. Dep't of Health & Human Servs., Centers for Medicare & Medicaid Servs., State Health Official Letter Re To Facilitate Successful Re-Entry for Individuals Transitioning from Incarceration to Their Communities 11 (Apr. 28, 2016).

<sup>29</sup> Arkansas Section 1115 Proposal, *supra* note 3, at 4, 6.

making their incarceration less costly to states. We cannot support a change in Medicaid policy that may incentivize incarceration in this way.

We appreciate that CMS has announced a Section 1115 re-entry opportunity that waives the Inmate Payment exclusion for certain transition-related services provided to individuals immediately before discharge but places some guardrails around the waiver to reduce any potential incentives to incarcerate. Last year, at Congressional direction CMS provided guidance to states on what should be included in proposals for these “short-term” waivers, which should test “innovative approaches to coverage and quality to improve care transitions, starting pre-release, for individuals who are incarcerated, thereby facilitating continuity of care once the individual is released.”<sup>30</sup> The guidance notes that improving care transitions will likely help persons leaving carceral settings to access “high-quality, evidence-based, coordinated, and integrated care during reentry.”<sup>31</sup>

We look forward to learning more about CMS’ approval and monitoring of Section 1115 programs for which waivers have been granted under this re-entry opportunity. CMS monitoring of state implementation of these programs is key to ensuring that they achieve their objectives, including smooth transitions from carceral settings to the community and better health outcomes for formerly incarcerated individuals.

On its face, Arkansas’ Reentry Waiver proposal is inconsistent with important aspects of the CMS guidance, including many of the guardrails intended to ensure that federal Medicaid reimbursement for services provided in carceral settings does not simply replace the funds that state and local governments expend for medical care provided in these settings. We are concerned that the proposal will have harmful consequences, both for the state and for its Medicaid beneficiaries.

We have serious concerns about the following aspects of Arkansas’ request for waiver of the Inmate Payment exclusion:

**Time Period.** As the 2023 CMS guidance indicates, Congress has explained that the new Section 1115 re-entry opportunity is intended to help states “improve care transitions for certain soon-to-be released individuals.”<sup>32</sup> As such, states may not begin to cover services that would otherwise be excluded from Medicaid reimbursement

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<sup>30</sup> U.S. Dep’t of Health & Human Servs., Centers for Medicare & Medicaid Servs., State Medicaid Director Letter Re: Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated 1-2 (Apr. 17, 2023) (citing the SUPPORT Act, Pub. L. No. 115-271) [hereinafter CMS 2023 Transition Guidance].

<sup>31</sup> *Id.* at 2.

<sup>32</sup> *Id.* at 27.

“before the date that is 30 days immediately prior to the individual’s expected release date.”<sup>33</sup>

The guidance also states that CMS may approve Medicaid coverage for certain pre-release services for up to 90 days before the expected release date, but that “such demonstrations must have a demonstration purpose and related experience that go beyond improving care transitions for soon-to-be released individuals.”<sup>34</sup> That is, states must identify additional goals, hypotheses for how the 90-day waiver will help the state meet those goals, and how the hypotheses will be tested.

Arkansas’ proposal identifies the same goals as did California’s request for a 90-day waiver, which was approved by CMS in January 2023.<sup>35</sup> In addition to the explicit goals that CMS has identified, such as improving care transitions and continuity of care, Arkansas’ proposal states that it will test whether the waiver will result in increased outpatient and community-based behavioral health services, expansion of service delivery models already available through the state’s system, and reduction in “all cause deaths,” emergency department visits, and inpatient admissions after transition.<sup>36</sup> As it did for California’s request, we would expect that, should Arkansas’ proposal comport with its guidance in other respects, CMS would approve the state’s request for waiver of the Inmate Payment exclusion for up to 90 days before an inmate’s expected release date.

Arkansas goes much, much further, however, and seeks waiver of the exclusion for an additional period of up to 90 days in addition to what CMS has indicated it would approve, for a period of time that starts on what the state has described as “at the beginning of incarceration,” and “beginning on the first day of incarceration in which benefits have been restarted.”<sup>37</sup> As such, Arkansas seeks waiver of the Inmate Exclusion for a period as long as 180 days during an individual’s detention in carceral settings. This, along with other aspects of the state’s proposal, raises the specter that Arkansas is simply seeking to federalize the standard services it provides inmates in the state’s jails and prisons, without the limited focus intended by Congress and CMS: to help incarcerated persons transition smoothly to community-based services post-release.

Arkansas asserts that waiver of the Inmate Payment exclusion for the 90 days beginning at an individual’s entry to the carceral setting is needed because “[i]t can be difficult to determine an exact release date for many incarcerated individuals, especially

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<sup>33</sup> *Id.*

<sup>34</sup> *Id.* at 28.

<sup>35</sup> Letter from U.S. Dep’t of Health & Human Servs., Centers for Medicare & Medicaid Servs., to Ms. Jacey Cooper, State Medicaid Director, California Dep’t of Health Care Servs. 6 (Jan. 26, 2023).

<sup>36</sup> Arkansas Section 1115 Proposal at 35-41.

<sup>37</sup> *Id.* at 4, 6.



those who are in a county jail setting,” and because “jail stays are often shorter in duration than 90 days.”<sup>38</sup> But there is nothing in the CMS guidance that indicates the 90-day waiver for the period of time immediately preceding release cannot be applied to services provided to those individuals who are incarcerated for less than 90 days.

Further, as discussed below CMS has indicated that states have other options for ensuring smoother care transitions for individuals incarcerated for short periods of time or for whom the period of incarceration is uncertain, without running afoul of the 30-day waiver Congress intended to provide as part of the Section 1115 re-entry opportunity, or the 90-day waiver CMS has said it will consider if the state identifies other goals and hypotheses that CMS has the legal authority to approve.

**Covered Services.** The CMS guidance is clear: the Section 1115 re-entry opportunity is “not intended to shift current carceral health care costs to the Medicaid program.”<sup>39</sup> The purpose of this initiative is “to improve care transitions for certain [Medicaid-eligible] individuals who are soon-to-be former inmates of a public institution.”<sup>40</sup> Although CMS has indicated that states may propose to cover additional services through these waiver programs, there must be some limit to what services should be covered. The services should be limited to those that engage inmates, facilitate transition back to the community, and link them with community-based services and housing. To improve continuity of care, the services should be provided by community-based services providers, including “peer bridge” programs, which push into carceral settings to coordinate care and enable smoother transitions to the community.<sup>41</sup>

Unlike other states whose applications CMS has approved, Arkansas’ proposal appears to place no limits on the services for which it seeks federal Medicaid reimbursement during the as-many-as 180 days during which an eligible individual is incarcerated. Arkansas’ proposal requests authority “[t]o cover all Medicaid services” for Medicaid eligible individuals.<sup>42</sup> “All state plan services would be made available to the Demonstration populations.”<sup>43</sup> The proposal indicates no limit as to what services the state would expect federal financial assistance through Medicaid to pay for.<sup>44</sup>

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<sup>38</sup> *Id.* at 22.

<sup>39</sup> CMS 2023 Transition Guidance at 10.

<sup>40</sup> Pub. L. 115-271, § 5032(b).

<sup>41</sup> See, e.g., U.S. Dep’t of Health & Human Servs., Substance Abuse and Mental Health Servs. Admin. (SAMHSA), Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide 15 (2017) (describing peer bridge program in which peer mentors meet with incarcerated individuals pre-release, then follow them into the community to help them get to appointments and engage in treatment).

<sup>42</sup> Arkansas Section 1115 Proposal at 6; see also *id.* at 21 (“[A]ll medically necessary Medicaid covered services will be available to an individual during the pre-release periods . . .”).

<sup>43</sup> *Id.* at 31.

<sup>44</sup> In contrast, California proposed and CMS approved certain specified pre-release services, including “in-reach” case management services, physical and behavioral health clinical

The Arkansas proposal nods to CMS' direction that states receiving a waiver from the Inmate Payment exclusion include at least three services provided to incarcerated individuals pre-release: person-centered, trauma-informed case management, Medication-Assisted Treatment (MAT), and a 30-day supply of all needed prescription medication in-hand upon release.<sup>45</sup> But the Arkansas proposal does not explain in adequate detail what will be included in these services, and how they will be provided.

For example, the 2023 CMS guidance explains in detail that case management meeting expectations for waiver approval will include: (1) assessment of the individual's needs; (2) development of a person-centered care plan based on the assessment; (3) coordination of services identified in the plan; and (4) monitoring of the individual's program and revision, if necessary, of the care plan.<sup>46</sup> Care planning should be trauma-informed, and the care plan should not only address the person's physical and behavioral health needs, but also health-related social needs like employment, housing, food, transportation, and social integration.<sup>47</sup> Arkansas' proposal says only that individuals exiting a carceral setting will be enrolled in its Provider-led Arkansas Shared Entity (PASSE) managed care program and receive care coordination through the PASSE program for 12 months, and that "[t]he care coordination provided by PASSEs meets and exceeds the expanded definition of case management" that CMS identified in the guidance.<sup>48</sup> Without more detail, we are skeptical that care coordination provided through the PASSE managed care program will meet the needs of those individuals transitioning from carceral settings to the community. Arkansas' bald assertion that it will does not assuage our concerns.

**Reinvestment Plan.** As noted above, CMS has clearly indicated that the Section 1115 re-entry opportunity is not intended to "Medicaidize" all health care costs incurred by state and local correctional agencies.<sup>49</sup> The 2023 CMS guidance conditions grant of any waiver from the Inmate Payment exclusion on a state's agreement to reinvest the funds it saves through federal matching Medicaid funds into "activities and/or initiatives

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consultation services, laboratory and radiology services, medications and medication administration, MAT for all types of substance use conditions, community health worker and peer community navigator services, and a 30-day supply of needed prescription and over-the-counter drugs and durable medical equipment as the individual exits the facility. Letter to Cooper, *supra* note 35, at 7-8.

<sup>45</sup> CMS 2023 Transition Guidance at 17-24; *cf.* Arkansas Section 1115 Proposal at 19.

<sup>46</sup> CMS 2023 Transition Guidance at 18-22.

<sup>47</sup> *Id.* at 20-21.

<sup>48</sup> Arkansas Section 1115 Proposal at 21-22

<sup>49</sup> CMS 2023 Transition Guidance at 10; *see also id.* ("This demonstration opportunity does not absolve carceral authorities of their constitutional obligation to ensure needed health care is furnished to inmates in their custody and is not intended as a means to transfer the financial burden of that obligation from a federal, state, or local carceral authority to the Medicaid program.").

that increase access to or improve the quality of health care services for individuals who are incarcerated (included individuals who are soon-to-be released) or were recently released from incarceration, or for health-related services that may help divert individuals” from criminal system involvement.<sup>50</sup> The guidance states that states will need to commit at the time of the demonstration approval to a reinvestment plan, and then develop and submit the plan for CMS approval post-approval of the waiver request.<sup>51</sup>

Although Arkansas’ proposal mentions that it will submit a reinvestment plan post-approval, it provides inadequate detail as to what services and supports it will reinvest in. We cannot assess whether Arkansas’ reinvestment plan will amount to a meaningful investment in health services that are likely to divert individuals from incarceration without more detail about the state’s plans. We hope that, should its proposal be approved, the state will reinvest funds saved through federal Medicaid reimbursement for a finite set of re-entry focused services provided pre-release into community-based services offered post-release that have been shown to help individuals with behavioral health challenges avoid cycling through carceral settings. These services include housing support services (and safe and affordable housing), Assertive Community Treatment (ACT), mobile crisis services, supported employment, and peer support services.<sup>52</sup>

***Eligibility for Medicaid Benefits.*** The CMS guidance states that CMS “does not expect” to approve a Section 1115 re-entry waiver proposal unless the state suspends, rather than terminates, an individual’s Medicaid eligibility, when an individual becomes incarcerated “for the duration of their incarceration.”<sup>53</sup> The guidance explains in detail how states may implement a “suspension strategy” so that incarcerated individuals may more quickly access Medicaid-billable services upon release.<sup>54</sup>

Although Arkansas’ proposal states that it currently suspends, and does not terminate, the Medicaid eligibility of individuals who are incarcerated, it also says that the state suspends eligibility “for up to 12 months.”<sup>55</sup> The proposal does not indicate that this policy will be changed to meet the expectation described in the CMS guidance that the Medicaid eligibility of incarcerated individuals be suspended “for the duration of their incarceration.” Inmates in county jails or state prisons who may be incarcerated for

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<sup>50</sup> *Id.* at 11.

<sup>51</sup> *Id.*

<sup>52</sup> See generally Bazelon Center for Mental Health Law, *Diversion to What? Evidence-Based Mental Health Services That Prevent Needless Incarceration* (Sept. 2019).

<sup>53</sup> CMS 2023 Transition Guidance at 14 (emphasis added).

<sup>54</sup> *Id.* at 14-16.

<sup>55</sup> Arkansas Section 1115 Proposal at 11.

longer than 12 months must have their eligibility suspended for as long as (but not longer than) they are incarcerated.<sup>56</sup>

Congress has also directed states seeking federal Medicaid reimbursement through this Section 1115 re-entry opportunity to provide inmates who are Medicaid-eligible but not enrolled in Medicaid “assistance and education for enrollment.”<sup>57</sup> The CMS guidance urges states to work with “correctional facility partners”—correctional agencies but also vendor operating private prisons—to help incarcerated persons who are not enrolled in Medicaid to apply for it “upon the individual’s incarceration, throughout the period of incarceration and no later than 45 days before the individual’s expected date of release.”<sup>58</sup> States are also expected to conduct outreach well in advance of the 30-day pre-release period to be tested through the re-entry opportunity.<sup>59</sup> “Without outreach and support to assist all interested individuals to apply for Medicaid coverage or renewal, it is generally not possible to assess who ‘may be eligible’ for Medicaid.”<sup>60</sup>

Arkansas’ proposal states that under the Reentry Waiver jails, prisons, and other detention facilities will begin the Medicaid application process for individuals not enrolled in Medicaid 135 days prior to release in order to determine eligibility by 45 days before release.<sup>61</sup> But the proposal provides no detail about how those individuals who are Medicaid-eligible but not enrolled will be identified, and no detail about what, if any, outreach activities will be conducted to engage eligible individuals in the Medicaid application process. As such, the proposal leaves us concerned that many individuals who are Medicaid-eligible and could benefit from re-entry-focused services will fall through the cracks.

Also, the CMS guidance suggests that, should it prove difficult to enroll incarcerated persons who are Medicaid-eligible but who are only in jail for a brief period of time, or for whom there may be some uncertainty as to when they will be released, states should consider utilizing Medicaid’s presumptive eligibility mechanism to allow these individuals access to Medicaid services upon re-entry while they complete the Medicaid application or are waiting for an eligibility determination.<sup>62</sup> Presumptive eligibility has been used in other Medicaid contexts, including for children, pregnant adults, and for hospitalized persons who appear to be Medicaid-eligible.<sup>63</sup> Although Arkansas’

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<sup>56</sup> Arkansas Div. of Corr., Ark. Sentencing Comm’n, & Ark. Cmty. Corr., Ten-Year Adult Secure Population Projection 2020-2030 (Jun. 2020) (noting that average length of stay in Arkansas prisons was 18.8 months in 2019).

<sup>57</sup> Pub. L. 115-271, § 5032(b)(1).

<sup>58</sup> CMS 2023 Transition Guidance at 13-14

<sup>59</sup> *Id.* at 14.

<sup>60</sup> *Id.* (emphasis in original).

<sup>61</sup> Arkansas Section 1115 Proposal at 19.

<sup>62</sup> CMS 2023 Transition Guidance at 15.

<sup>63</sup> See, e.g., Medicaid.gov, Presumptive Eligibility (Aug. 23, 2021) (describing how certain “qualified entities” can screen children for Medicaid eligibility and immediately enroll children

proposal expresses concern about the transitions of individuals with short or uncertain lengths of stay in jails,<sup>64</sup> nowhere does it indicate that the state is considering or will consider addressing these concerns by making use of presumptive eligibility to ensure that these individuals access Medicaid services immediately upon release.

\* \* \*

The past fifty years have seen a clear and deliberate public policy shift away from the historic overreliance on psychiatric institutions and toward increased investment in the cost-effective community mental health services that reduce the need for hospitalization. This has occurred for two reasons: (1) a recognition that many individuals receive better care and achieve recovery in home and community-based settings, and (2) the need to comply with the ADA's integration mandate and the Supreme Court's decision in *Olmstead v. L.C. (Lois Curtis)*,<sup>65</sup> which requires states to offer individuals with disabilities the opportunity to be served in the most integrated setting appropriate. The IMD exclusion has been an important driver of this positive shift. Granting Arkansas' request for waiver of the IMD exclusion would undermine progress made towards these crucial goals.

Although we generally appreciate Congress' and CMS' goals in making the Section 1115 re-entry opportunity available to states in order to help them facilitate successful care transitions and care continuity as individuals are discharged from carceral settings to the community, CMS must carefully determine whether state Section 1115 proposals for waiver of the Inmate Payment exclusion are tailored to advance these goals, or whether instead they simply seek to transfer costs of basic carceral medical care to the Medicaid program. Arkansas' proposal seeks waiver of the exclusion for up to 180 days, double the 90 days CMS has said it would consider approving—which is already three times the 30 days Congress identified for these demonstration programs. The proposal does not limit the services for which federal Medicaid reimbursement will be available to those services that will help incarcerated persons transition to and access services in the community. And the proposal does not provide meaningful detail about how it would implement the waiver to achieve the goals Congress and CMS have identified, including how it would reinvest state funds saved through the federal contribution. For these reasons, we oppose it.

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who appear to be eligible before and while their applications are pending); Centers for Disease Control & Prevention, Hospital Presumptive Eligibility ("Effective January 2014, the Affordable Care Act expanded the scope of the policy to allow hospitals to make presumptive eligibility determinations in every state for all individuals eligible for Medicaid on the basis of modified adjusted gross income.") (last visited Jan. 28, 2024).

<sup>64</sup> Arkansas Section 1115 Proposal at 22.

<sup>65</sup> *Olmstead v. L.C.*, 527 U.S. at 599-00.



We appreciate the opportunity to provide comments on Arkansas' proposal. Should you have any questions about these comments, please feel free to contact me at [lewisb@bazelon.org](mailto:lewisb@bazelon.org) or (202) 467-5730.

Sincerely,

/s/ Lewis Bossing

Lewis Bossing  
Senior Staff Attorney