1115 WAIVERS AND THE REENTRY POPULATION: A Resource for Viral Hepatitis Coordinators

NASTAD

Introduction

States are now allowed—through Reentry Section 1115 Demonstrations—to use Medicaid *before* release from incarceration to improve care transitions, especially for people with complex health needs such as substance use disorders and chronic conditions. This major shift from the long-standing rule that Medicaid cannot pay for health care during incarceration is designed to reduce gaps in treatment, and to strengthen continuity of care during reentry. The opportunity to use Medicaid before release from incarceration has important implications for viral hepatitis prevention and care.

What is an 1115 Waiver?

Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to approve experimental, pilot, or demonstration projects that are likely to advance Medicaid program goals. These projects give states greater flexibility to design and improve their Medicaid programs by testing and evaluating state-specific policy approaches. All demonstrations must be "budget neutral" for the federal government, meaning federal Medicaid spending during the project cannot exceed what it would have been without the demonstration. Typically, Section 1115 demonstrations are approved for an initial five-year period and may be extended for an additional three to five years, depending on the populations served. States often request and receive further five-year extensions. This brief from the KFF Kaiser Family Foundation offers a helpful overview of the history and examples of 1115 Waivers.

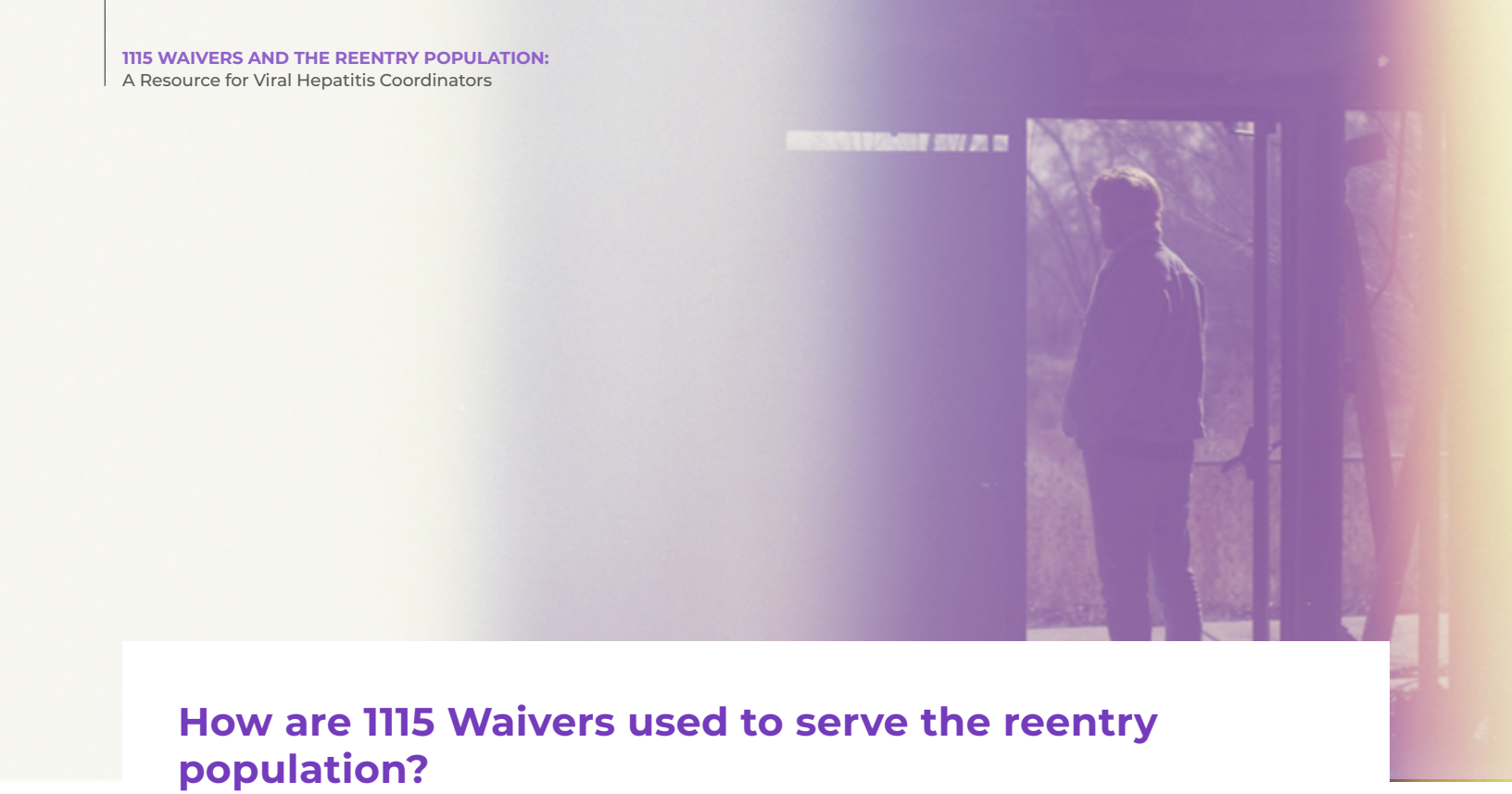
1115 WAIVER POLICY UPDATE

On Friday, June 11, 2026, the Trump administration issued new guidance for Section 1115 Medicaid waivers. The guidance implements a new approach to budget neutrality designed to reduce federal expenditures. This approach modifies the traditional, long-standing policy of ensuring federal costs do not increase under the waivers to a new policy of ensuring waivers intentionally cut Medicaid spending.

Certain services won't count against budget neutrality calculations, including:

- Some inpatient treatment for substance use disorders
- Some behavioral health services
- Certain health services for the reentry population – people leaving jails or prisons

The new approach will apply to all new demonstration projects, renewals, and amendments issued on or after January 1, 2027. You can read a full analysis on Georgetown University McCourt School of Public Policy's Center for Children & Families blog.



How are 1115 Waivers used to serve the reentry population?

Under longstanding federal rules, Medicaid cannot pay for most services delivered inside jails or prisons. As a result, Medicaid is suspended during incarceration. The incarcerating jurisdiction—a municipality or state corrections system—must pay for all health care. Because correctional budgets are limited, systems often rely on cost containment, which can restrict access to specialty care, chronic disease management, behavioral health treatment, and medications for opioid use disorder (MOUD). This creates a predictable gap: people leave incarceration with untreated or destabilized health conditions, and the risk of overdose, hospitalization, and death spikes immediately after release.

To address this gap, the Centers for Medicare & Medicaid Services (CMS) issued guidance for states to design Reentry Section 1115 Demonstrations. These demonstrations allow Medicaid to cover certain pre-release services for individuals who are incarcerated, are otherwise Medicaid eligible, and are within a defined period before release (up to 90 days in most approvals). The purpose is to strengthen care transitions and reduce the abrupt loss of treatment continuity that often occurs at release.

States have flexibility to create eligibility criteria. For example, the demonstration can only cover people with specific conditions (e.g., substance use disorders, severe mental illnesses, chronic diseases, traumatic brain injury, HIV, hepatitis C) or states may consider making all Medicaid-enrolled individuals eligible.

CMS requires 1115 Demonstrations cover at least a minimum set of pre-release services:

- Case management to assess physical, behavioral health, and health-related social needs (HRSN) and assist people who are incarcerated in obtaining both pre- and post-release services (including setting up post-release appointments);
- Medication treatment for all types of substance use disorders, with accompanying counseling; and
- A 30-day supply of all prescription medications at the time of release.

States may request to cover other services including, for example, family planning services, behavioral health or preventive services (including peer support), and/or hepatitis C treatment. (KFF, Section 1115 Waiver Watch: Medicaid Pre-Release Services for People Who Are Incarcerated)

Improving pre-release care transitions is expected to:

- Reduce overdose deaths during the high-risk post-release period
- Increase engagement in behavioral health and primary care
- Reduce emergency department use
- Improve stability in housing, employment, and social supports
- Support more coordinated, integrated care systems

Several states have applied for and received approval for Reentry Section 1115 Demonstrations (see Table 1). Each state's model varies, but all share the goal of improving pre-release care and post-release continuity. These demonstrations are testing innovative approaches to coverage and quality to improve care transitions, starting pre-release, for individuals who are incarcerated, thereby facilitating improved continuity of care once the individual is released. States approved for these demonstrations can test new approaches to:

- **Initiating** or **continuing MOUD**
- Conducting **clinical assessments** and **treatment planning**
- Providing **care coordination** and **case management**
- Ensuring **medication access** at release
- Connecting individuals to **community providers**
- Supporting stabilization of chronic physical and behavioral health conditions

These services are not meant to replace correctional health care. Instead, they bridge the gap between incarceration and community-based Medicaid services.

Why should viral hepatitis coordinators have 1115 Waivers on their radar?

People in correctional settings have some of the highest hepatitis B and C prevalence in the country. Incarceration presents an important opportunity for diagnosis and treatment. If treatment is not feasible during incarceration, linkage to community health care for evaluation and follow-up upon release is critical.

Reentry 1115 waivers open a door that has never existed before. For the first time, Medicaid can cover pre-release services for people in jails and prisons. For viral hepatitis programs this means viral hepatitis programs can reach people during the highest-prevalence period (incarceration), ensure continuity of hepatitis B and C treatment at release, and reduce post-release loss to follow up, which is one of the biggest barriers to cure. These waivers finally create a mechanism to reach people with hepatitis B or C before release, start or continue treatment, and ensure they don't fall through the cracks during reentry—the exact population where hepatitis transmission, morbidity, and mortality are highest.

CMS approvals differ across demonstration projects and Reentry 1115 waivers vary by state. Thus, they do not automatically cover all hepatitis services. Depending on individual state Reentry 1115 waiver approvals, Medicaid may cover pre-release services that directly advance viral hepatitis elimination goals, such as:

- Hepatitis screening and testing,
- Initiation or continuation of treatment, including medications such as direct acting antivirals (DAAs)
- Vaccination services

Treatment continuity is often broken at release. Without a structured transition plan people may lose medications, miss appointments, lose insurance coverage, and/or lose contact with health care providers. The waiver allows Medicaid to fund care coordination, case management, and treatment planning—the exact services needed to prevent treatment interruption.



DAAs are expensive, and correctional budgets often restrict access because of cost. Under the waiver Medicaid can begin the treatment plan pre-release, Medicaid can ensure medication access immediately post-release, and treatment timing can align with release dates in order to initiate treatment pre-release and continue treatment post-release as needed. This reduces the burden on correctional budgets and increases access to curative therapy.

Behavioral health services and MOUD access improve hepatitis outcomes. The waiver explicitly supports MOUD initiation, behavioral health stabilization, and care coordination. Since hepatitis C transmission is strongly linked to injection drug use, improving MOUD access reduces reinfection risk and supports long-term viral suppression or cure.

Reentry 1115 demonstrations require defined care transition workflows, data exchange between corrections and Medicaid, and rerelease enrollment or reactivation. This has the potential to give care coordinators new visibility into who is being released, who is midtreatment, who needs follow up, and where to focus outreach.

Hepatitis elimination goals depend on reaching high-priority populations, including people who are incarcerated. National, state, and local elimination plans emphasize screening, treatment, linkage to care, and reaching disproportionately affected groups. Reentry 1115 waivers create a scalable, sustainable mechanism to reach one of the most important populations for hepatitis elimination.

This is a chance to integrate hepatitis into broader reentry health systems. The waiver is not disease specific. Viral hepatitis coordinators can work with Medicaid programs to embed hepatitis services into reentry care coordination, pre-release clinical workflows, Medicaid enrollment processes, and community provider networks.

The waiver shifts hepatitis care from reactive to proactive. Instead of waiting for people to show up in community clinics—often months after release—they can be identified pre-release, start treatment, schedule appointments, be linked to medication, and be tracked for completion of treatment. This is one of the most powerful hepatitis elimination tools jurisdictions have had in years.

EXAMPLE

What Washington State built: a real-time hepatitis C reentry identification system.

In early 2026, with the advent of several jails opting into the 1115 reentry waiver in Washington State, the Washington State Department of Health began to link publicly available jail rosters to hepatitis C surveillance data in the Washington Disease Reporting System (WDRS). WDRS is an electronic disease surveillance system that allows public health staff in Washington State to receive, enter, manage, process, track and analyze disease-related data. Through an automated program that runs daily, information about people who appear to have untreated hepatitis C who are incarcerated in local jails is securely transmitted to the relevant local health jurisdictions (LHJs). Those LHJs that are working with participating jails are then able to coordinate with jail health staff to outreach to the patient to offer hepatitis C treatment pre-release. Because several LHJs and jails have already begun this work, in just a few months, dozens of people have started hepatitis C treatment, several have completed treatment, and more are now being identified daily. Washington's approach—linking jail rosters to hepatitis C surveillance data and pushing daily notifications to LHJs—is one of the most innovative, high impact uses of the Reentry 1115 waiver in the country. It operationalizes something viral hepatitis programs have struggled with for years: *finding people with untreated hepatitis C at the exact moment when treatment access becomes possible*. This model turns surveillance data into action and is the kind of early success CMS envisioned when approving reentry demonstrations.

How can viral hepatitis coordinators get involved?

Viral hepatitis coordinators can play a central role in Reentry 1115 implementation by shaping screening and treatment workflows, building correctional–community linkages, embedding hepatitis services into care transition models, and ensuring that hepatitis B and C are fully integrated into the state's pre-release Medicaid benefit design.

Six high impact ways viral hepatitis coordinators can get involved:

1. **Outreach to your state's Medicaid program. Ask questions (see the text box) and join the state's 1115 implementation workgroups.** Most states have steering committees, clinical subgroups, data and reporting groups, and reentry operations teams. Viral hepatitis coordinators can contribute expertise on topics such as screening recommendations, treatment timelines, lab requirements, and linkage to care standards.

2. **Shape pre-release clinical workflows.** Reentry 1115 waivers allow Medicaid to cover clinical assessments, treatment planning, care coordination, and medication management. Viral hepatitis coordinators can help define when hepatitis screening should occur, how to identify people mid-treatment, how to time DAA therapy around release, and how to ensure medication access on day 1 post-release.

3. **Build correctional–community linkage pathways.** The waiver requires states to connect people to community care before release. Viral hepatitis coordinators can map hepatitis providers statewide, identify clinics with rapid start capacity, create warm hand off protocols, and work with care coordinators to ensure appointments are scheduled pre-release.

Questions to Ask Your Medicaid Agency

Does our state have an approved Reentry 1115 demonstration?
If the answer is yes:

- Which correctional facilities are participating?
- What services are covered during the pre-release period?
- Is hepatitis screening included?
- Are DAAs included?
- How are care coordinators identified?
- What data-sharing systems are being developed?
- Who oversees implementation?
- What evaluation metrics are being collected?
- What is the timeline for full implementation?

4. **Integrate hepatitis into care coordination models.** Care coordinators funded under the waiver need disease-specific guidance. Viral hepatitis coordinators can develop tools like hepatitis care transition checklists, standardized release packets, medication continuation plans, lab follow-up schedules, and reinfection prevention messaging.

5. **Use data to identify and track priority populations.** Reentry 1115 demonstrations require data exchange, reporting, and quality metrics. Viral hepatitis coordinators can help design flags for

people with hepatitis B or C, alerts for those midtreatment, post-release follow up tracking, and metrics tied to cure rates and linkage.

6. **Train correctional and community partners.** Coordinators can provide training on topics such as screening guidelines, DAA treatment basics, vaccination for hepatitis A and B, reinfection prevention, and linkage to care best practices. Training ensures hepatitis is embedded across the entire reentry ecosystem.

Limitations of Reentry 1115 Demonstrations

- Waivers do not automatically fund all hepatitis services.
- Services vary by state.
- CMS approval differs across demonstrations.
- Some correctional settings may not participate, even if the state has CMS approval.
- Correctional facilities still maintain responsibility for most health care during incarceration.
- Medicaid eligibility requirements still apply.
- Data sharing agreements between and among governmental public health agencies, the Medicaid agency (if different), and correctional settings may still be required..

An Example Care Continuum for Viral Hepatitis Services through an 1115 Reentry Demonstration

Note: This is an example of how viral hepatitis services could look through an 1115 reentry demonstration. This is not a definitive explanation of how it will look in every context.

Pre-Release (Up to 90 Days Before Release from Jail or Prison	
1. Medicaid Eligibility Assessed	Individual identified as eligible for the Medicaid-covered reentry waiver services.
2. Clinical Assessment	Comprehensive clinical assessment of physical, behavioral, and social needs.
3. HCV/HBV Screening & Testing	Screening and testing for HCV/HBV (and other infectious diseases, such as HIV and syphilis) with results available to guide care.
4. Care Coordination	Care coordinator engages individual, connects with health care providers, and addresses barriers to care.
5. Treatment Planning	Individual treatment plan developed, including HCV/HBV treatment initiation or continuation, as appropriate.
6. Medication Access Planning	Plan for continuity of medications, including prior authorizations and medications at release (e.g., 30-day or remainder of prescription at release, linkage to pharmacy and/or community clinic).
Release	
7. Release	Individual release from incarceration with a treatment plan in place.
Post-release	
8. Medicaid Coverage Active	Medicaid coverage active in the community to support continued access to care and services.
9. Care Coordination & Community Follow-Up	Care coordinator follows up as needed to support continuity of care and the individual attends community appointments and continues treatment and support services.

Appendix: Re-entry initiative success stories

Resources

- KFF, Section 1115 Waiver Watch: Medicaid Pre-Release Services for People Who Are Incarcerated
- National Viral Hepatitis Roundtable, Medicaid Reentry Section 1115 Waivers
- Georgetown University McCourt School of Public Policy's Center for Children and Families. Blog: Trump Administration Issues Section 1115 Medicaid Waiver Financing Guidance Which Goes Far Further Than H.R. 1 (Again)

Table 1. Approved States

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
Maine	Maine Whole Person Care Waiver
Maryland	Maryland Health Choice
Massachusetts	MassHealth Medicaid and Children's Health Insurance Plan (CHIP) Section 1115 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	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

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