HEALTH AND JUSTICE BRIEF: AGING AND REENTRY

Leveraging the Medicaid Reentry Waiver and recent Medicare reforms to strengthen reentry for older adults

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INTRODUCTION

As Older Adults Reenter Communities, Health Gaps Persist. Federal Policy Shifts Offer Options.

Across the country, a growing number of people aged 55 and older are incarcerated. Chronic medical conditions, disabilities, and behavioral health needs are common and more prevalent than in the younger prison population. Even when individuals receive treatment and support while incarcerated, maintaining that care after release is often difficult. Limited coordination between correctional health systems and community providers, along with financial challenges to paying for care, frequently disrupts health care plans as people return to their communities.

Studies consistently find that people of all ages returning from incarceration face heightened mortality risk (Rosen, Schoenbach, & Wohl, 2008) after release, with overdose, suicide, and homicide accounting for a significant share of these deaths (Lim et al., 2012). These risks are exacerbated (Binswanger et al., 2013; Heiss, Somers & Larson, 2016) among the older population due to the longer progression of disease, accelerated aging due to incarceration, and challenges with establishing care in the community.

The first goal of this brief is to expand awareness of recent Medicaid and Medicare policy changes and highlight how they create new opportunities to strengthen reentry strategies for older adults in prison. Between 2023 and 2026, federal policy shifts expanded prerelease Medicaid services, protected Medicaid eligibility during incarceration, and improved Medicare access for individuals under community supervision. Together, these changes can reduce gaps in care at release, support continuity of treatment for chronic and behavioral health conditions, and give correctional systems new tools to link a specialized population (older adults) to healthcare coverage, providers, and medications as they return to the community.

The second goal of the brief is to identify key considerations for reentry planners working with older adults leaving prison. As correctional facilities work to harness expanding resources to improve reentry services, we encourage population-specific strategies that can increase the likelihood of successful stabilization in the community.

This brief was developed through a focused landscape review of work done during the last 10 years to address the reentry needs of older adults in prison, including the review of specific state model approaches (See Appendix A). To supplement this information, approximately 12 experts working in the corrections and community health sectors were interviewed. In a companion brief and subsequent virtual engagements, these topics will be introduced to aging advocates and service providers.

CURRENT SITUATION

Between 2008 and 2022, the population of incarcerated individuals over the age of 55 grew from 102,700 to 171,700 nationwide (Miller et al, 2024), an increase of 67%. Interestingly, the trend differs by state (U.S. Department of Health and Human Services, 2018). The Bureau of Justice Statistics and other sources consistently cite that approximately 95% of incarcerated individuals return to the community, so effective reentry support for this aging population is needed.

Older people who are incarcerated tend to experience more complex physical and behavioral health challenges than both their peers living in the community and younger individuals in prison. Older incarcerated individuals have higher rates of chronic medical conditions such as hypertension and diabetes (U.S. Department of Health and Human Services, 2018), physical disabilities (U.S. Department of Health and Human Services, 2018), infectious diseases (Williams et al., 2006), trauma histories (Haugebrook et al., 2010), and the multi-morbidity of conditions (Nowotny et al., 2016).



Likewise, incarcerated individuals over 55 had higher rates of cognitive impairments (U.S. Department of Health and Human Services, 2018) than older non-incarcerated individuals, including dementia (Kodama, Williams, & Morris, 2023). Further, women have higher rates of mental health conditions and substance use than their male counterparts, at nearly twice the rate (Glaze & James, 2006; National CASA, 2010). Additionally, veterans are overrepresented in the older incarcerated prison population, tend to be in poorer health than older non-veterans (Noonan & Mumola, 2007), and have multiple comorbid conditions with higher treatment and medical needs (Nowotny et al., 2016).

Compounding existing health conditions is the impact of incarceration itself on physical and behavioral health, leading to accelerated aging (Loeb & AbuDagga, 2006), the difference between chronological age and biological age. Research has shown that incarceration is a source of stress-related and infectious diseases (Massoglia, 2008) and may cause or worsen disability or health conditions (Justice in Aging, 2026).

Further, the aging prison population has increased the need for healthcare and has implications for the cost of incarceration (Chiu, 2010): in one study, federal prisons with the highest percentages of older inmates spend five times more per inmate on medical care than those with the lowest percentages (Office of the Inspector General, U.S. Department of Justice, 2016).

Challenges in Reentry Healthcare for Older Adults

Older adults in prison face health needs that differ from those of younger incarcerated people and the general population. Long-term incarceration, common among the older adults, further compounds these issues, worsening both physical and behavioral health, and increasing the consequences of loneliness and social isolation. Community-based substance use treatment and services like housing are limited and may not be accessible for individuals with a history of justice involvement, sometimes due to stigma. Additionally, for individuals with the highest levels of care needs, like older adults, nursing homes and similar facilities are often reluctant to accept people with criminal histories.

Clinical continuity of care requires comprehensive planning prior to release. This continuity helps maintain an individual's health post-release, reduces future criminal activity and recidivism, benefits community health by managing infectious disease, and improves outcomes in employment, housing, and family support (Gates, Artiga, & Rudowitz, 2014; Mallik-Kane, 2005; Mallik-Kane & Visher, 2008).

Health insurance coverage is a key determinant of access to health care in the community (U.S. Department of Health and Human Services, 2018), but older reentrants have faced barriers to service eligibility and access. Without intentional coordination between state corrections, Medicare, and Medicaid agencies, enrollment opportunities may be missed. After release, unstable housing, limited transportation, functional or cognitive challenges, low literacy (both language and technology), and distrust of institutions make it difficult for people to complete enrollment steps.

LEVERAGING MEDICAID AND MEDICARE TO IMPROVE REENTRY

Many people leaving incarceration have little to no income or assets, making a large share of formerly incarcerated individuals eligible for Medicaid in many states (Kirzinger et al., 2024). Many states have long-standing programs to enroll eligible people into Medicaid and build health care reentry using Medicaid reimbursement. Some correctional systems assist people in completing disability documentation for Supplemental Security Income (SSI), which helps cover basic needs like housing and food, and for Social Security Disability Insurance (SSDI).

Recent changes in Medicaid and Medicare policies over the last three years have created new opportunities to strengthen continuity of care for people returning from prison. In 2023, the Centers for Medicare & Medicaid Services (CMS) released guidance for Medicaid Reentry Demonstration waivers. Combined with Medicare policy clarifications in 2025, these changes created substantial opportunities to build stronger reentry health systems.

Together, these changes offer significant and new large-scale mechanisms to connect correctional and community health care, with particular benefits for older adults whose needs and eligibility often span both Medicaid and Medicare.

Why these changes matter for older adults leaving DOC facilities:

- Greater access to Medicaid and Medicare immediately after release can increase an individual's likelihood of improved health outcomes and lowered recidivism rates in the community.
- When low-income individuals are eligible for Medicare, Medicaid can assist by covering Medicare premiums after release. 1115 Medicaid Reentry Waivers allow states to improve health care continuity through expanded reentry planning.

STATE HIGHLIGHT #1
OHIO MEDICAL RELEASE

In a Non-Waiver State, Ohio Leverages Medical Release Pathways and Medicaid to Stabilize Older Adults After Incarceration

Ohio leverages Medicaid to stabilize all individuals, including older adults returning from prison, through a coordinated set of programs. Ohio also has a medical-based release system that allows incarcerated individuals who are terminally ill, medically incapacitated, or in imminent danger of death to be considered for early release through several pathways, including judicial medical release, parole-board medical release, and release as if on parole.

- **Medicaid Pre-Release Enrollment** program reinstates suspended benefits up to 90 days before release, ensuring individuals walk out with an active Medicaid card and uninterrupted access to care. Together, these programs make Ohio one of the most comprehensive states in using Medicaid to support older-adult reentry.

- The **Community Transition Program** at CareSource provides immediate, short-term health benefits so people have medications and critical care while their full Medicaid application is finalized.

- **Returning Home Ohio** uses Medicaid funding to deliver in-home nursing, personal care aides, and medical equipment—allowing medically complex older adults to live independently rather than entering nursing homes.

- **MyCare Ohio** integrates Medicare and Medicaid into a single managed-care plan that coordinates geriatric medical care, behavioral health, and community housing supports upon reentry.

Medicaid & The 1115 Medicaid Reentry Waiver

Medicaid is a federal-state program that offers free or low-cost health coverage to people with limited income and resources. A criminal record does not restrict eligibility for Medicaid, but federal law historically prohibited the use of federal funding to pay for health services during incarceration, with limited exceptions. In the past, this law led states to enact policies that terminated Medicaid at the time of incarceration, requiring individuals to reenroll upon release and creating service delays and administrative burdens. Today, federal law (Consolidated Appropriations Act, 2024) requires states to suspend, rather than terminate, Medicaid eligibility during incarceration.

Designed to build continuity of care for justice-involved individuals, the 1115 Medicaid Reentry Waiver, allows correctional facilities to bill for certain reentry-oriented health care services, up to 60 days prior to release, and expands access to post-release care management services that help people navigate health care and social supports in the community. As of October 2026, the waiver has been approved in 22 states and the District of Columbia.

Approved waivers allow states to reimburse certain health-related services up to 60 to 90 days prior to release. Core requirements include providing:

- Medicaid eligibility screening and application assistance;
- Medication-assisted treatment for substance use disorders;
- Pre- and post-release care management; and
- A 30-day supply of medications at release.

Additionally, in 2025, the Budget Reconciliation Act of 2025 established new eligibility requirements for obtaining or maintaining Medicaid coverage; changes to eligibility and redetermination requirements are scheduled for late 2026 and 2027.

Starting January 1, 2027, work requirements will apply to adults, ages 19 to 64, enrolled in Medicaid expansion. People subject to these requirements must document 80 hours a month of employment, school, and/or volunteer work to gain or retain coverage. The law excludes people dually enrolled in Medicare and people enrolled in Medicaid through a disability pathway from having to comply. It also exempts people during incarceration and for a 3-month period after release. While the law provides an exemption for certain medical and behavioral health conditions, the rules implementing this exemption will require a person to also demonstrate that their condition significantly impairs their ability to meet the community engagement requirement.

This requirement will pose challenges for people leaving incarceration, who already face high unemployment due to significant barriers to hiring (Carson et al., 2021). Older adults may face additional employment barriers, including age discrimination and difficulty meeting job skill requirements. Finding alternative compliance options is important for older adults. Reentry planners will need to educate people leaving prison about these new requirements (including how to maintain healthcare coverage), identify other qualifying activities, and assess eligibility for exemptions.

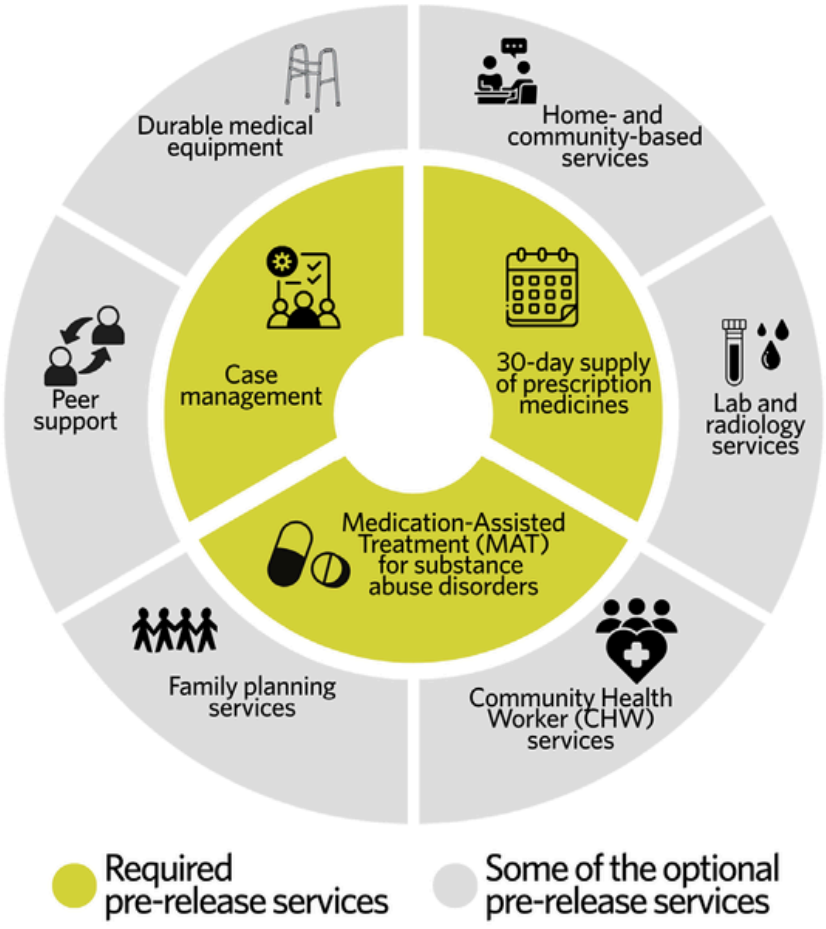


Image Used With Permission. Credit: Community Living Equity Center, Brandeis University; Autistic Self Advocacy Network; and Justice in Aging.

Medicare Enrollment Changes

Medicare is a federal health insurance program primarily for people aged 65 and older and for younger individuals with qualifying disabilities. In general, Medicare will not pay for services for enrollees who are incarcerated in jails, prisons, or similar institutions. In 2023, a new Special Enrollment Period was created for people leaving incarceration to enroll in Medicare without facing late enrollment penalties, including the allowance of retroactive Medicare coverage back to the date of release.

Another change was made in 2024, when CMS narrowed Medicare's definition of "custody." Previously, Medicare treated people on parole, probation, home detention, and halfway houses or transitional facilities placements as still in custody. This generally prevented Medicare from covering their care and required them to wait until the restrictions ended to use a special enrollment period. Due to the changes, individuals in these settings can now access Medicare after confinement, even if they remain under community supervision.

STATE HIGHLIGHT #2 COLORADO'S SPECIAL NEEDS PAROLE

Colorado Links Medical-Based Release With the Medicaid Reentry Waiver to Strengthen Health-Focused Reentry for Older Adults

Colorado established medical-based release and community-based services using Medicaid, and now plans to expand support through its Medicaid Reentry Waiver initiative, M-REACH, to stabilize older adults and medically fragile people returning from prison.

- The **1115 Medicaid Reentry Waiver (M-REACH) and Colorado's Medicaid Reentry and Community Health** program cover targeted case management, medication-assisted treatment, and a 30-day supply of all medications during the 90 days before release.

- **M-REACH** strengthens cross-system coordination, including connections to long-term services and supports (LTSS) for older adults who need community-based care instead of long-stay nursing facilities.

REENTRY CONSIDERATIONS

Targeted reentry planning efforts can help older adults overcome barriers to securing appropriate services after release, regardless of healthcare coverage. Tailored strategies for specific groups of older reentrants—such as veterans— and guidance from community health workers or peer navigators can improve access to coverage and services.

Providing specialized training for staff who develop reentry plans for older adults and people with disabilities—along with training for correctional and parole staff supervising individuals in the community—can significantly improve access to long-term services and supports. This includes equipping staff to assist with benefits applications, navigate eligibility requirements, and connect older adults to the services they need to stabilize in the community.

Beyond elements included in standard release planning, like the need for employment, social supports, housing, identification (state IDs), and transportation, special considerations in release planning for older adults include:

- Providing assistance with Medicaid and Medicare enrollment and SSI/SSDI applications
- Delivering education on new Medicaid and Medicare requirements (including how to maintain healthcare coverage) and providing documentation for medical exemptions
- Assessing needs for the level of medical care or disability support that will be required in the community, considering cognitive and physical functional needs, and medication management.
- Including Home and Community Based Services (HCBS) (available through Medicaid) eligibility screening to allow for non-institutionalized customized care, like for those with intellectual, developmental, or physical disabilities
- Tailoring services based on the length of incarceration, considering challenges like eroded family and social networks
- Making education on current technologies available, like those offered by the Colorado Department of Corrections
- Supporting navigation of housing challenges due to prior justice involvement and its impact on access to nursing or rehabilitative residences

Zoom in on Challenges in Housing for Reentering Older Adults
In our interviews with experts, housing emerged as one of the most significant challenges and needs for reentering older adults. They cited:

- The need exceeds capacity, and most transitional housing programs for older adults operate on a small scale
- Housing placement's connection to the individual's recovery phase and health stability requires coordinated case management
- When state Medicaid programs provide housing supports, they may influence placement options, so specific coordination is needed
- Delays in Medicaid coverage may reduce housing options

Considerations for Reentry Leaders

To improve outcomes for older adults leaving prison or jail, systems should consider:

- **Proactive Reentry Planning:** Building reentry into treatment plans during incarceration to allow for additional time to address complex support needs.
- **Expanded screening and treatment inside facilities:** Increase screening and treatment for common physical, cognitive, and functional impairments among older adults, including dementia, frailty, and chronic medical conditions.
- **Comprehensive, age-responsive release planning:** Develop release plans tailored to older adults' needs, including functional assessments, care coordination, medication continuity, and linkage to long-term services and supports.
- **Front-loaded post-release stabilization supports:** Shift reentry models toward intensive early support, including:
  - immediate access to food,
  - transition and dignity kits,
  - early check-ins within the first 10 days,
  - rapid connection to detox, medical care, and support teams.
- **Age- or condition-related early release:** Compassionate and geriatric release offer alternative supervision options for older or seriously ill incarcerated people — including release to appropriate community health care and early or compassionate release for those nearing the end of life. (See State Highlight #3, New York Medical Parole and Compassionate Release, and Rhode Island Medical and Geriatric Parole in Appendix A)

Major Themes From Key Interviews

- Aging & Medical Complexity: Older adults leaving incarceration often have serious chronic conditions, accelerated aging, and long-term health impacts, making prisons medically inappropriate environments for aging people.
- Isolation & Limited Support: Many older adults return home with deep isolation and weakened family or social ties, underscoring the need for community-based programs and supportive environments.
- Long Incarceration & Rapid Social Change: After decades in incarceration, older adults face significant disorientation as they reenter a society transformed by new technologies, systems, and social norms.
- Community Supports, Housing & Skills: Older adults need wraparound supports, stable, age-appropriate housing, and help with technology and daily living skills to rebuild independence and stay connected to care.

STATE HIGHLIGHT #3 GEORGIA MEDICAL REPRIEVE

Georgia Uses Medical Reprieve and Medicaid Suspension to Support Terminally Ill or Incapacitated Adults Returning From Prison

Georgia suspends (not terminates) Medicaid during incarceration, allowing coverage to be reactivated more quickly upon release. Georgia's Medical Reprieve is a temporary, conditional release for incarcerated individuals who are terminally ill and entirely incapacitated. Once released, the individual is no longer in the Department of Corrections' custody, which allows them to qualify for Medicaid under normal eligibility rules. Older adults re-entering can apply for federal Home and Community-Based Services (HCBS) waivers, so Medicaid can help pay for services, including:

- **Community Care Services Program (CCSP)** for older adults and people with physical impairments who need nursing home–level care but want to remain in the community. It requires application, assessment, Medicaid eligibility, and often waitlist placement.

- **Service Options Using Resources in a Community Environment (SOURCE)** offering ongoing medical monitoring plus functional support for adults with medically intensive needs, allowing them to remain in the community rather than enter a nursing home.

CONCLUSION

Care planning for older adults reentering the community must address the intersectionality of aging, comorbid and chronic health concerns, and the negative impact of incarceration on physical and behavioral health. Older incarcerated adults in incarceration have often spent a significant period of time away from the community, and there is a heightened potential for severe isolation and loneliness, factors that contribute to poorer health outcomes and increased criminal activity and recidivism.

The ultimate goal of this brief and thought-leadership series is to educate leaders in the health and justice systems on options for states to enhance and expand reentry services to improve reentry outcomes. We highlight how states have chosen to integrate Medicaid into their reentry systems. Reentry work can be done in states that have not expanded Medicaid under the Affordable Care Act, as well as those that have. These tools are significantly expanded when states have approved 1115 Reentry Waivers. There is no one-size-fits-all when it comes to states and localities, but local context, needs, and resources must be considered in project planning and implementation.

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APPENDIX A

MEDICAID INTEGRATION IN RE-ENTRY: STATE EXAMPLES

Category	Ohio	Georgia	Colorado	Kentucky	Rhode Island	New York
Unique Medicaid Features	Returning Home Ohio waiver provides in-home supports for medically complex individuals. MyCare Ohio integrates Medicare–Medicaid for coordinated geriatric care.	Medical Reprieve removes DOC custody, enabling immediate Medicaid eligibility for terminally ill, fully incapacitated individuals.	Special Needs Parole is fully community-based, integrating Medicaid with housing, care coordination, and local providers. M-REACH (1115 waiver) provides pre-release case management, MAT, and medication continuity.	Early Medical Consideration requires initiation by the medical provider, DOC review, and confirmation of the Medicaid/Medicare payer source before release.	Medical & Geriatric Parole requires secured placement + verified Medicaid payment source; accelerated timelines (10-day medical report, 7-day decision).	Dual system: Medical Parole + Compassionate Release for individuals with terminal or debilitating conditions. Supported by the State Master Plan for Aging, elder parole legislation is under consideration.
Release Mechanism & Eligibility	Judicial/Parole Medical Release for terminally ill, incapacitated, or end-of-life individuals; physician certification required; care/placement plan needed.	Medical Reprieve for terminal (<12 months), fully incapacitated individuals with 2+ ADL needs and minimal public-safety risk.	Special Needs Parole for seriously ill, incapacitated, or elderly individuals who no longer pose a public-safety risk.	Early Medical Consideration for serious, debilitating, or terminal conditions; DOC reviews prognosis, functional limits, risk.	Medical & Geriatric Parole for terminal, severely ill, permanently incapacitated, or aging individuals.	Medical Parole for terminal or permanently debilitating conditions; Compassionate Release for individuals who served minimum terms + severe medical conditions.

APPENDIX A

MEDICAID INTEGRATION IN RE-ENTRY: STATE EXAMPLES

Category	Ohio	Georgia	Colorado	Kentucky	Rhode Island	New York
Medicaid Status & Pre-Release Actions (Combined)	Suspended during incarceration; reactivated up to 90 days pre-release through Medicaid Pre-Release Enrollment.	Suspended during incarceration; no pre-release activation—Medicaid reactivated only upon release.	Suspended during incarceration; reactivated 90 days pre-release via M-REACH (case management, MAT, 30-day medication supply).	Suspended or terminated depending on incarceration length; reactivation coordinated by Community Care Case Managers.	Suspended during incarceration; Medicaid must be secured as payer source in discharge plan; medical report + discharge plan prepared within 10 days.	Suspended during incarceration; no pre-release activation—Medicaid required as payer source in discharge plan.
Pre- & Post-Release Medicaid Integration	Immediate coverage, medications, behavioral health, SUD treatment; Community Transition Program supports older adults.	Medicaid reactivated at release; access to home health, behavioral health, and nursing home care through HCBS waivers.	Case management + MAT begin 90 days pre-release; 30-day medication supply post-release; strong community-based reentry supports.	Early release requires secured placement, medical care plan, and confirmed Medicaid/Medicare payer source; release discretionary and revocable.	Discharge plan must include secured placement + Medicaid payment source; parole officer assigned for medical monitoring.	Discharge plan includes secured placement + Medicaid funding; medical monitoring continues post-release.

APPENDIX A

MEDICAID INTEGRATION IN RE-ENTRY: STATE EXAMPLES

Category	Ohio	Georgia	Colorado	Kentucky	Rhode Island	New York
Long-Term Services & Supports (LTSS)	MyCare Ohio integrates Medicare–Medicaid; Returning Home Ohio provides in-home nursing, aides, equipment; strong geriatric care coordination.	CCSP and SOURCE provide nursing-home-level care in the community; require assessment, Medicaid eligibility, and often waitlist placement.	M-REACH connects older adults to LTSS waivers (Elderly, Blind, Disabled); strong community-based LTSS integration.	LTSS is accessed through placement planning (nursing facility, hospice, home care) with Medicaid/Medicare funding.	LTSS is accessed through secured placement requirements; Medicaid funds long-term care needs.	LTSS is accessed through placement planning; Medicaid funds nursing facility, hospice, and home-based care.
Medicaid-Funded Services	Short-term health benefits, in-home nursing, personal care aides, medical equipment, geriatric care coordination.	Nursing home care, hospice, behavioral health.	Long-term care, home health, hospice, behavioral health, transportation, benefits access.	Medicaid/Medicare -funded medical care required for release approval; placement supports and supervision.	Medicaid covers hospital, nursing facility, hospice, home-based care; periodic medical exams + parole officer monitoring.	Hospital, nursing facility, hospice, home-based care; ongoing medical monitoring.

Summary of the Project

This project was funded by the RRF Foundation for Aging.

CHJ launched this project to ensure older adults are fully included in reentry planning and to help corrections, health systems, reentry practitioners, and aging-sector partners strengthen age-responsive approaches. With the number of older adults in custody and under community supervision rising—and traditional supervision models often failing to meet their health and functional needs—CHJ identified opportunities to expand alternative supervision options and improve continuity of care. Through a landscape review and expert interviews, the brief outlines actionable policy and practice strategies to reduce unnecessary incarceration, enhance health and stability during reentry, and build community-based pathways that better support older adults returning from prison.

Case studies are based on interviews and publicly available online information. Information was gathered between July 2025 and October 2026.