Access to Home- and Community-Based Services for People with Disabilities Leaving Incarceration: Barriers and Policy Priorities

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Introduction

Each year in the United States, more than 600,000 individuals are released from state and federal prisons, and 9 million people cycle through local jails (Incarceration & reentry, n.d.).

Among them are people with disabilities, people of color, and multiply marginalized groups; populations that are overrepresented in carceral institutions (Gann & Kaeble, 2025; Maruschak et al., 2021). The process of reentry—the transition from prison or jail to living in the community—greatly impacts and may even determine the continued health, wellbeing, and access to support networks for individuals with disabilities after incarceration.

Medicaid plays a critical role for most people leaving incarceration by providing access to healthcare coverage. For people with disabilities, Medicaid is even more important because it can cover home- and community-based services (HCBS) that provide assistance with daily activities ranging from personal care to transportation to employment supports.

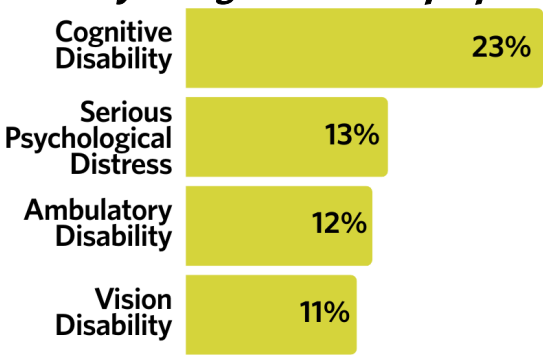
Disabled individuals face considerable barriers to accessing Medicaid and other supports they need at reentry, leaving a setting where their long-term services and supports (LTSS) needs are likely not met and navigating a patchwork of underfunded programs in the community. Moreover, disabled people of color returning to the community experience unique and intersecting discrimination in accessing housing, employment, and community-based support.

This brief examines barriers people with disabilities, including older adults, face when released from incarceration in accessing LTSS. We discuss current policy initiatives to increase Medicaid access, examine gaps in access to HCBS and other supports, and identify promising practices to address those gaps. Based on our research, we propose policy initiatives aimed at supporting disabled people to successfully reenter through improving access to HCBS.

Background

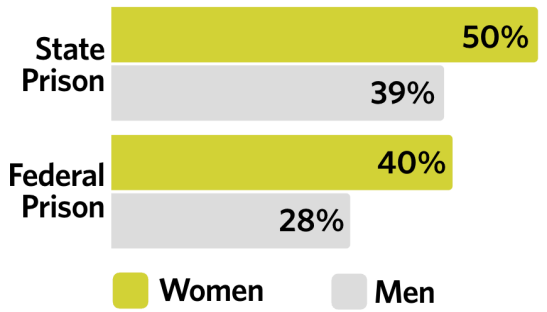
People with disabilities are disproportionally represented among the criminal-legal-involved and incarcerated populations (Morgan & Jensen, 2025). A 2021 report[1] from the Bureau of Justice Statistics found that as of 2016, 38%[2] of state and federal incarcerated individuals reported at least one non-psychiatric disability (i.e., cognitive, physical, sensory, independent living); a proportion that was roughly 2.5 times the share of adults with non-psychiatric disabilities in the U.S. general population (Maruschak et al., 2021a). Of disabilities represented among incarcerated individuals, cognitive disabilities were the most frequently reported (23%), followed by serious psychological distress (13%)[3], ambulatory disabilities (12%), and vision disabilities (11%), (Maruschak et al., 2021a; Maruschak et al., 2021b).

Cognitive disability is the most common disability among incarcerated people



Incarcerated women were more likely to report a disability than incarcerated men in both state (50% vs. 39%) and federal (40% vs. 28%) prisons (Maruschak et al., 2021a); a gender disparity found in previous research (Bronson et al., 2015; James & Glaze, 2006). However, men, especially Black men, compose a disproportionate share of people in prisons and jails (Gann & Kaeble, 2025). Incarcerated women are disproportionately survivors of sexual abuse and assault (Lynch et al., 2012; McDaniels-Wilson & Belknap, 2008), and the traumas they experience as a result of sexual violence may contribute to disability formation (Lynch et al., 2012; Ullman & Brecklin, 2002; Frazier, 1990).

Incarcerated women are more likely to report a disability



[1] These rates may constitute an underestimate of disability prevalence among incarcerated people due to an individual's inability to consent, exclusion to participate based on disability, and/or the Bureau of Justice's use of the American Community Survey questions that rely on a limited definition of disability (Hall et al., 2022).
[2] An analysis of the 2016 Survey of Prison Inmates used a wider definition of disability and estimated that 66% of state and federal incarcerated individuals were disabled (Bixby et al., 2022).
[3] Psychiatric data from the Bureau of Justice Statistics (BJS) is limited. A 2021 BJS report based on the same 2016 Survey of Prison Inmates examined mental health. "Serious psychological distress" is used in our brief to match language from the BJS survey in which incarcerated individuals reported on past 30-day psychological distress (Maruschak et al., 2021b).

The incarcerated population is also growing older (Feinberg et al., 2018). By 2030, older adults—individuals aged 55 and over[4]—are projected to increase to more than 400,000 people and comprise 30% of the incarcerated population in state and federal prisons (Feinberg et al., 2018).

Carceral institutions accelerate the aging process, putting older adults at greater risk of developing a disability. Older adults in prison report a high incidence of chronic conditions, infectious diseases, and physical and mental disabilities including the inability to independently complete activities of daily living (Feinberg et al., 2018). A study of incarcerated older adults, 55 and older, found that 40% had cognitive impairments (Feinberg et al., 2018). Regardless of incarceration, Black and Native American individuals show faster signs of aging[5] due to racial discrimination and structural inequities; an aging process that is compounded upon incarceration (Noren Hooten et al., 2022; Berg et al., 2021).

By 2030, 30% of incarcerated people are expected to be older adults.

Unmet need in carceral institutions such as prisons or jails may also cause or exacerbate disability and health conditions. During incarceration individuals can develop heightened levels of fear, isolation, and trauma, and may experience the spread of infectious disease, unmet healthcare needs, and removal of disability aids and accommodations (Morgan, 2017; Wildeman & Wang, 2017; Kim & Peterson, 2014; Harner & Riley, 2013; Schnittker et al., 2012; Binswanger et al., 2009).

People of color and multiply marginalized individuals are also overrepresented among the criminal-legal-involved. Black, Hispanic, and Native American individuals have higher rates of incarceration than non-Hispanic White people (Gann & Kaeble, 2025; Fox et al., 2023), and Black and Hispanic[6] disabled individuals are more likely to be arrested than White disabled people and non-disabled individuals. (McCauley, 2017"). In addition, Black and Hispanic men receive harsher sentences than White men, and Hispanic women receive the longest sentences among incarcerated women (Reeves et al., 2023). Black and Hispanic individuals also have higher rates of probation and parole than their White counterparts, despite these individuals being less likely to receive a probationary sentence (Reeves et al., 2023). These rates reflect the enduring racial bias and systemic racism within the criminal legal system.

The high rates of disability, aging, and racial disparities among incarcerated individuals indicates the need to address access to long-term services and supports (LTSS) for those who are released and returning to the community.

[4] There is no age in which incarcerated individuals are considered "older adults". Research generally uses 50 or 55 years of age to account for the accelerated aging that individuals undergo in carceral institutions.
[5] More studies need to examine accelerated aging across nativity and Hispanic and Asian nationalities (Noren Hooten et al., 2022).
[6] The authors only examined White, Black, and Hispanic individuals (McCauley, 2017).

The Role of Medicaid

Medicaid is a particularly important benefit for people with disabilities. In addition to providing healthcare coverage, Medicaid is the primary payer of–and often only affordable source of coverage for LTSS that people with disabilities need to live in the community (Chidambaram & Burns, 2024). Medicaid home and community-based services (HCBS) consist of a wide range of services including case management, homemaker, personal care, day services, employment supports, transportation, home modifications, adaptive equipment, and family supports. Every state offers HCBS, but eligibility and services vary from state to state.

Medicaid also plays a critical role in reentry. People leaving incarceration often have very little if any income and resources, resulting in many formerly incarcerated individuals who are eligible for Medicaid (Kirzinger et al., 2024). The Affordable Care Act's (ACA) Medicaid expansion greatly increased coverage for returning individuals (Gates et al., 2014). Medicaid also helps low-income individuals access Medicare at reentry by covering premiums, including for those without sufficient work history to get full coverage (Gershon & Kean, 2025).

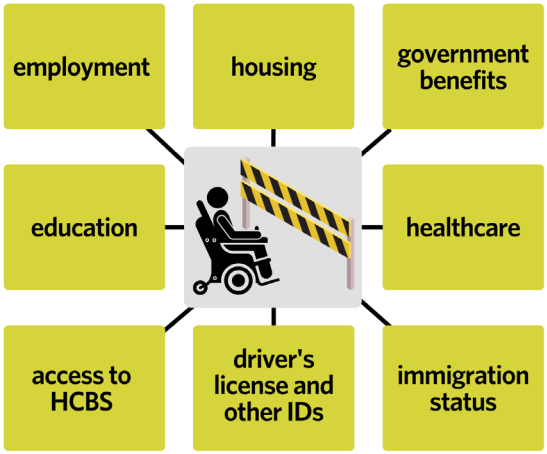
Barriers to Reentry Supports Experienced by Disabled Individuals

People with disabilities face considerable barriers within prisons and jails and upon release to access Medicaid and other supports at reentry. These challenges often start through the inhumane treatment of incarcerated individuals and insufficient services and supports for disabled and aging people while incarcerated (Schlanger, 2017). During imprisonment, people with disabilities may be locked in their cells, isolated in the infirmary or segregated housing, and denied opportunity for early release (Seevers, 2016). In addition, incarcerated individuals face barriers to information and obtaining legal support on civil rights enforcement. For example, while incarcerated individuals are protected by the Rehabilitation Act and the Americans with Disabilities Act (ADA), carceral institutions are slow or simply fail to comply with federal law (Seevers, 2016).

At the time of reentry, many individuals continue to face barriers to community living tied to their criminal legal history, including their conviction, sentence, and conditions of release. These collateral consequences[7] impede access to housing, public benefits, employment, education, and other necessary community-based services and supports. Collateral consequences act as interlocking and compounding barriers to obtain and maintain benefits. For people with disabilities who need long-term services and supports, additional barriers in obtaining accessible housing can be particularly harmful because Medicaid HCBS requires that individuals have a place to live in the community.

[7] The United States Commission on Civil Rights conceptualize collateral consequences as "civil law sanctions, restrictions, or disqualifications that attach to a person because of the person's criminal history" (Culliton-González et al., 2019).

Criminal records create barriers for formerly incarcerated individuals



Although many of these barriers are not solely faced by the disability community, the types and extent of support that people with disabilities need make getting past any barriers a matter of life and death (Dumont et al., 2012). At the same time, disability discrimination can make navigating such barriers more difficult and can be compounded by racism for disabled people of color leaving incarceration.

In addition, returning individuals may lack the qualifying work history necessary for Medicare Part A and Social Security Disability Income (SSDI), (Schlanger, 2017).

Administrative and logistical hurdles impede access to social and disability benefit supports upon reentry. Formerly incarcerated individuals frequently lack vital records including state identification cards, birth certificates, documentation of disability, and financial and health records (The ID divide, 2022)—information necessary to access housing, employment, public assistance, and healthcare programs such as Medicaid HCBS.

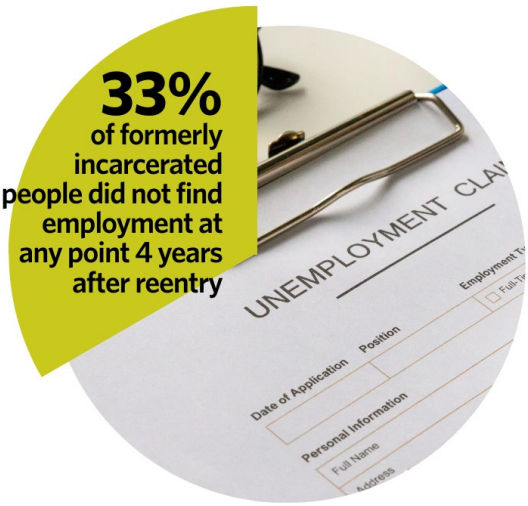
Barriers to Medicaid

While a person's criminal record does not restrict Medicaid eligibility, ensuring formerly incarcerated individuals are enrolled in Medicaid as soon as they are released from prison can be a challenge. People who are incarcerated can be enrolled in Medicaid; however, federal law prohibits states from using federal funding to pay for the health services provided to incarcerated individuals, with limited exceptions for inpatient hospital stays outside of prisons or jails (Morgan, 2017). This Medicaid Inmate Exclusion Policy[8] led some states to adopt a policy of terminating Medicaid for individuals when they become incarcerated. In states that previously terminated Medicaid, returning individuals had to apply for Medicaid once released from incarceration, resulting in additional service delays for accessing Medicaid and HCBS.

Medicaid applications are complex. Disabled individuals may not have access to accommodations such as sign language interpreters and plain language materials, making it difficult to navigate the administrative steps and application forms required to access support services (Advancing equal access, 2025). An individual's disability may not have been diagnosed when incarcerated or upon returning to the community, making them ineligible for certain benefits. To communicate with the Medicaid agency, individuals need the ability to receive mail and have access to a phone and internet. They may also need transportation to the Medicaid office. These administrative hurdles can make enrolling in Medicaid particularly difficult for people with disabilities released from incarceration.

[8] Subparagraph (A) following section 1905(a)(29) of the Social Security Act.

In recent years, Congress and states have taken action to improve access to Medicaid at the time of reentry. Beginning January 1, 2026, federal law requires all states to suspend, not terminate, Medicaid enrollment when any Medicaid enrollee is incarcerated[9] (Public Law No. 118-42, 2024). More than half of states are pursuing a new Medicaid Reentry Section 1115 Demonstration Opportunity that permits waiver of the inmate exclusion policy to allow Medicaid coverage for a limited time prior to an individual's release from incarceration (Medicaid waiver tracker, 2026).



At the same time, however, Congress and states are adding new administrative barriers to Medicaid eligibility and access that will make it more difficult for people returning from incarceration to enroll in Medicaid and maintain coverage. For example, the Budget Reconciliation Act (Public Law No. 119-21, 2025) signed into law on July 4, 2025, requires states to condition Medicaid expansion eligibility on meeting strict work requirements for adults ages 19 to 64.

Work requirements will impede access to Medicaid, especially for formerly incarcerated individuals who already face high levels of unemployment and poverty due to employment barriers (Carson et al. 2021). These barriers to employment are frequently long-term. A 2021 study from the Bureau of Justice Statistics followed more than 50,000 formerly incarcerated individuals in federal prisons and found 33% did not find employment at any point 4 years after reentry (Carson et al., 2021). As such, even short-term exemptions from work requirements following incarceration will be inadequate to ensure continued access to necessary services and health care for individuals.

These requirements will be particularly difficult for disabled people and disabled people of color leaving incarceration to meet given the compounded barriers to employment they already face (e.g., racism and ableism). Individuals employed in fields with irregular hours worked, including seasonal and shift-based hourly employment, will be less likely to meet the minimum 80 hours per month. As these models of work are often the most available to both formerly incarcerated people and individuals with disabilities, we anticipate that returning individuals with disabilities will experience disproportionate burden in meeting these requirements (Manatt Health, 2025; Young, 2025).

In addition, the Budget Reconciliation Act greatly restricts Medicaid funding mechanisms that will limit states' ability to maintain their current Medicaid enrollment and services. HCBS and many other supports that primarily serve people with disabilities are uniquely covered by Medicaid. However,

[9] Congress enacted this requirement in 2018 for incarcerated youth and in 2023 for adults through the Consolidated Appropriations Act.

HCBS are optional for states to provide, meaning states already limit enrollment and services. These funding restrictions are likely to result in more limitations to HCBS, and people leaving incarceration will have to wait longer to get the services they need to live in the community.

These changes to Medicaid funding and eligibility will impact states' efforts to improve access to coverage and care for people leaving incarceration, including the success of the Medicaid reentry demonstrations discussed below.

Medicaid Reentry Demonstrations

In April 2023, the Centers for Medicare & Medicaid Services (CMS) announced a new Medicaid Reentry Section 1115 Demonstration Opportunity[10] with the stated goal to "help Medicaid enrollees establish connections to community providers to better ensure their health care needs are met during their reentry process" (HHS releases new guidance, 2023). Under these waivers, states can cover certain services that Medicaid does not otherwise pay for under the inmate exclusion policy for up to 90 days before an eligible person's expected release from incarceration (Tsai, 2023). As of January 2026, 28 states have applied for Section 1115 waivers to cover certain pre-release services for individuals during a period over 30 days and up to 90 days immediately prior to the incarcerated individual's expected release date[11] (Medicaid waiver tracker, 2026).

The primary focus of the Reentry Demonstration Opportunity is to provide coverage of substance-use disorder (SUD) treatment before a Medicaid enrollee is released and to help connect the person to community-based providers to ensure they can continue their treatment after reentry. In line with this focus, states are required to cover three services pre-release: 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-Assisted Treatment (MAT) for all types of substance use disorders, with accompanying counseling; and a 30-day supply of all prescription medications at the time of release (Hinton et al., 2024).

States can choose to define target populations and establish eligibility criteria. For example, some states focus their demonstration exclusively on SUD services. States may also seek approval to cover additional services. For example, as of January 2026, ten states specify their demonstration will cover durable medical equipment (DME) upon release (Medicaid waiver tracker, 2026). DME includes items such as wheelchairs, respiratory equipment, speech-generating devices and other items people with disabilities may need to live in the community.

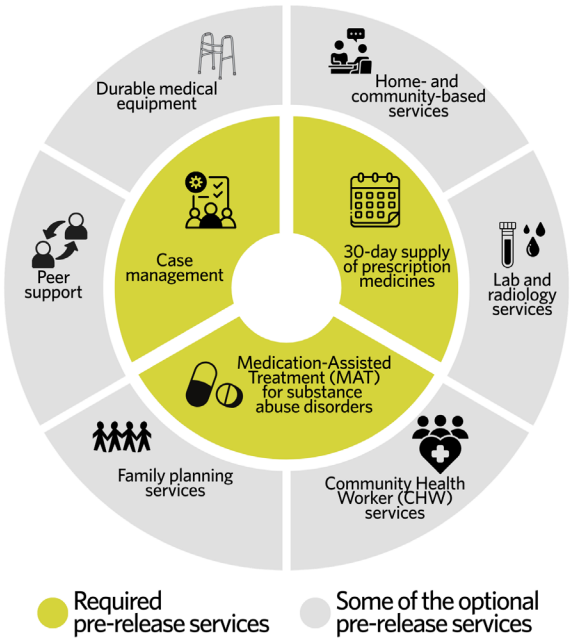
[10] Guidance: https://www.medicaid.gov/sites/default/files/2023-12/smd23003.pdf. HHS announcement (archived): https://public3.pagefreezer.com/browse/HHS.gov/02-01-2024T03:56/https://www.hhs.gov/about/news/2023/04/17/hhs-releases-guidance-to-encourage-states-to-apply-for-medicaid-reentry-section-1115-demonstration-opportunity-to-increase-health-care.html.

[11] CMS has approved reentry demonstrations in the following 19 states: Arizona, California, Colorado, Hawaii, Illinois, Kentucky, Maryland, Massachusetts, Michigan, Montana, New Hampshire, New Mexico, North Carolina, Oregon, Pennsylvania, Utah, Vermont, Washington, West Virginia. Oregon, however, announced it is not moving forward with implementing its reentry demonstration due to funding concerns following passage of the budget reconciliation legislation (Quin, 2025). Nine states have applications still pending CMS approval: Arkansas, Connecticut, District of Columbia, Louisiana, Maine, Minnesota, Nevada, New Jersey, New York (Medicaid waiver tracker, 2026).

However, beyond DME and SUD services, little focus has been paid to the broader range of disability services and supports that people leaving incarceration need. As one example, only a few states have included screening for and connecting people leaving incarceration with HCBS and housing supports.

Whether more states will expand the populations and services they cover under the reentry demonstrations is uncertain. Notably, CMS has also taken steps to limit coverage of health-related social needs services, such as housing and nutrition support through Medicaid demonstrations (Snyder, 2025).

States can cover a variety of services for those re-entering the community



California's Justice-Involved Initiative

California, the first state to apply and receive approval for a reentry demonstration waiver through its larger demonstration waiver, CalAIM, envisioned a comprehensive reentry program through its Justice-Involved Initiative. The Initiative aims to connect people who are otherwise eligible for Medi-Cal with pre-release services, taking a broad view of both covered populations and covered services (CalAim Demonstration, 2023).

The Initiative's eligibility criteria goes beyond covering individuals with mental health and substance use disorders to include those with developmental or intellectual disabilities as well as chronic and significant non-chronic clinical conditions (CalAim Demonstration, 2023). Covered pre-release services include care management, behavioral and physical clinical consultation, community healthcare services, DME, and laboratory services.

California's program leverages the intake process in jails and prisons as an opportunity to connect people to the Medicaid program and services including by assessing their functional needs. The Initiative maps out how an individual will progress through the system—from screening, to connecting to services, to a reentry plan.

Although the Justice-Involved Initiative has a more expansive view of the medical needs of disabled individuals leaving incarceration, assessments and services related to functional needs are more limited. For example, the Initiative includes functional needs assessments in a list of initial screening procedures and mentions HCBS that support activities of daily living (ADL) and instrumental activities of daily living (IADL) can be included in reentry care plans.

But, unlike medical-focused needs such as subscription medications and DME, which must be provided at reentry, the actual provision of HCBS are not required upon reentry. Without a requirement for support services to be provided at release, reentering individuals are left to navigate complex administrative barriers that prevent formerly incarcerated individuals from accessing California's HCBS programs (Dickman & Wilkins, 2024).

Priorities for Reentry Support

Integrating HCBS into Reentry Demonstrations

For people with disabilities and older adults, access to HCBS may be essential for successful reentry as it can provide the support needed to secure stable housing and maintain long-term stability. Access to HCBS requires prior and regular evaluation as well as extensive planning under any circumstance and especially during a change in housing status. Therefore, comprehensive HCBS evaluations and identifying potential support needs must be prioritized for people leaving incarceration. States should be required and supported to include HCBS into their Medicaid reentry demonstrations with the same intentionality that has been given to SUD services.

Medicaid reentry programs should prioritize routinely screening for HCBS needs while the person is incarcerated. These evaluations must consider the vast differences in support with activities of daily living an individual may need while in prisons or jails versus living in the community. Upon release, the individual should have an HCBS needs assessment based on their living situation and circumstances outside of the carceral institution.

Even when screening for HCBS needs is included in the policy, as it is in the CalAIM Initiative, practical barriers exist to accessing these very personalized HCBS that, unlike medication or DME, are not prescribed by a doctor. HCBS applications are complicated and can take weeks or even months to be approved (Dickman & Wilkins, 2024). Applications often require physician certification and other assessments by various state or waiver agencies. Therefore, reentry programs should provide robust support prior to release, requiring that physician certifications and functional assessments be completed through in-reach, and that application supports, including computer and internet access, be provided to complete and apply for HCBS.

In addition, reentry programs must invest in the necessary infrastructure and training to conduct functional assessments. It is critical that the care coordinator or other evaluator be trained in the state's HCBS programs and, ideally, be from an external entity to minimize trust concerns on the part of the incarcerated individual.

Once an individual has been determined as needing HCBS and is eligible for Medicaid, reentry programs must establish the processes to ensure those services are started upon release. For example, it should be the explicit responsibility of care coordinators to connect people to culturally competent HCBS providers who receive training in working with formerly incarcerated individuals. In addition, access to housing and HCBS should be addressed together (Dickman et al., 2025). A person who does not have accessible housing will experience even more barriers to receiving community-based support (Tsai, 2023).

In-reach

A key component of a successful program that connects returning individuals to the community is service in-reach to incarcerated individuals. In-reach consists of engaging incarcerated people with significant health and service needs prior to release to develop detailed reentry and service plans that facilitate continuity of services following return (Jannetta et al., 2018). Most in-reach programs to date have focused on service needs related to housing (Hunter et al., 2022) and behavioral health (Hunter et al., 2022; Buck et al., 2011) in recognition that stable housing and behavioral health stabilization, including substance use-related supports, play an essential role in successful reentry.

While fewer in-reach programs have focused on other disability service needs such as HCBS, some states have piloted in-reach programs for target populations. As one example, North Carolina's Council on Developmental Disabilities has funded a pilot program to provide in-reach and wraparound case coordination for individuals with intellectual and developmental disabilities leaving incarceration (Justice: Release, reentry, and reintegration, n.d.). This program has achieved substantial reductions in recidivism (Wells et al., 2023).

Successful in-reach programs need institutional buy-in within the prison system and rely on the identification of key personnel who can support coordination, and the reduction of barriers between the prison and the community (Brown et al., 2013). As discussed in the above section, familiarity with out-of-prison HCBS systems is important for successful coordination, but "behind-the-walls" coordination with personnel within the prison system, who are best positioned to establish familiarity with individuals' access and support needs, is equally essential.

One model that currently supports individuals transitioning between institutional and community settings, and which can provide a model for prison in-reach approaches, is the Money Follows the Person (MFP) program. MFP is a Medicaid program that provides support to states transitioning individuals from institutions (e.g., nursing homes, intermediate care facilities, etc.) into community settings. MFP is often used to develop durable systems to support transitioning individuals or to provide short-term supports that reduce barriers, such as providing support

with utilities and security deposits or accessibility modifications in the home (Money Follows, n.d.) While prisons and jails are not institutional settings as defined under the MFP program, many of the systems approaches employed under MFP, such as embedding community staff in facilities to provide options counseling, investing in one-time transition costs, information sharing with transition specialists, and forming partnerships with community-based agencies such as housing authorities, aging and disability networks, and housers themselves, can provide models for reentry supports.

Peer support

Enhanced peer support offers a unique opportunity to assist formerly incarcerated individuals with service navigation (Feinberg et al., 2018). Because of the unique barriers to accessing services experienced by people returning from incarceration, service navigation is essential for ensuring access and continuity of care. Peer navigation approaches offer opportunities for individuals familiar with the barriers to community-based services, including access to housing and documentation, to provide service navigation support. Peer support is most beneficial starting in the pre-release process and remains a vital service after reentry (Feinberg et al., 2023). As of January 2026, six[12] states include peer support services in their Medicaid Reentry Demonstrations (Medicaid waiver tracker, 2026).

Peer support models have demonstrated success in housing navigation (Hyde et al., 2022) and improvement in health equity (Shavit et al., 2017) for returning individuals. Peer models serve an important role in disability service navigation and advocacy through Independent Living networks.

Peers can also serve the role of direct care workers, bringing situational and cultural competency to the position. This model can alleviate barriers that formerly incarcerated individuals with disabilities may experience in both finding employment and people willing to care for them. States should consider policies that facilitate formerly incarcerated individuals to work as paid caregivers for their peers, like allowing the person receiving HCBS to waive felony restrictions on care workers. For example, California allows participants in its personal care services program to hire a formerly incarcerated caregiver under certain circumstances (Carroll, 2011).

[12] Approved waivers that offer peer support services: Arizona, Hawaii, New Hampshire, New Mexico, Utah, Vermont; Pending: District of Columbia, Louisiana, Minnesota, Nevada, New York (Medicaid waiver tracker, 2026).

Broader system reforms

In addition to specific interventions to improve system access for individuals returning from incarceration, broad Medicaid improvements are needed to minimize burdens on returning populations and ensure availability of services in the presence of these additional supports. Health has strong implications for reentry outcomes (Link et al., 2019). This puts disabled people and disabled people color, groups with high unmet health needs, at risk when released from incarceration without proper supports.

Most HCBS remain optional under Medicaid meaning service funding and availability fall far short of the needs of the disabled population, including individuals returning from prisons and jails. This contributes to extensive wait lists and service adequacy gaps that further constrain support upon reentry.

To address these unmet needs and barriers to services, it is essential Medicaid HCBS be adequately funded to provide services to all eligible individuals. Reducing administrative barriers to obtaining and maintaining Medicaid more broadly is also important.

An additional path to ensuring access for returning individuals is Medicaid expansion under the ACA (Public Law No 111-148, 2010). Adoption and continued support for Medicaid expansion, particularly in states with high rates of uninsurance and large incarcerated populations, would provide outsized benefits for supporting formerly incarcerated individuals. Medicaid expansion is a critical source of coverage for people with disabilities who cannot immediately access HCBS, either because they are waiting for their applications to be processed and coverage to begin or because they do not qualify based on strict disability and financial criteria. Medicaid expansion would also disproportionately help people of color with disabilities leaving incarceration. Nationally, over six in ten people who are uninsured, because their state has not expanded Medicaid, are people of color (Cervantes et al., 2025).

Conclusion

The criminal legal system disproportionately impacts people of color, people with disabilities, and multiply marginalized people, removing such individuals from their community. Formerly incarcerated individuals face unique barriers to Medicaid HCBS access upon reentry due to economic insecurity, vast collateral consequences, and strict eligibility requirements. While states are increasingly utilizing Medicaid reentry demonstration waivers to support formerly incarcerated individuals, the reentry demonstrations available thus far are narrow in scope and in target population.

Policymakers should require more intentional support for HCBS, and other disability supports, through reentry demonstrations. In addition, states should utilize in-reach and peer support and focus on expanding access to Medicaid.

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