Recommendations for Medicaid Payment Models for Opioid Use Disorder Services in Jails and Prisons

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Authors

Ashley DeGarmo, MA
Vice President,
Third Horizon Strategies

Greg Williams, MA
President,
Third Horizon Strategies

Vikki Wachino, MPP
Principal, Viaduct Consulting, LLC
and Executive Director, Health and Reentry Project
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Two companion reports were previously released. *Recommendations for Medicaid Coverage of Opioid Use Disorders in Jails and Prisons* was released in October 2023 and *Recommendations for Medicaid Performance Measures for Opioid Use Disorder Services in Jails and Prisons* was released in November 2023.

**Acronyms used throughout this report:**

- **ACA** – Affordable Care Act
- **APM** – Alternative Payment Model
- **ARTS** – Addiction and Recovery Treatment Services
- **BOP** – Bureau of Prisons
- **CalAIM** – California Advancing and Innovation Medi-Cal
- **CCBHC** – Certified Community Behavioral Health Clinics
- **CHERISH** – Center for Health Economics of Treatment Interventions for Substance Use Disorder, HCV, and HIV – Human Immunodeficiency Virus
- **CMF** – Care Management Fee
- **CMS** – Centers for Medicare & Medicaid Services
- **COE** – Centers of Excellence
- **EHR** – Electronic Health Record
- **EMR** – Electronic Medical Record
- **FDA** – Food and Drug Administration
- **FFP** – Federal Financial Participation
- **FFS** – Fee-For-Service
- **HIPAA** – Health Insurance Portability and Accountability Act
- **IMD** – Institutions for Mental Disease
- **MAT** – Medication-Assisted Treatment
- **MCO** – Managed Care Organizations
- **MHPAEA** – Mental Health Parity and Addiction Equity Act
- **MOUD** – Medications for Opioid Use Disorder
- **OBAT** – Office-Based Addiction Treatment
- **OTP** – Opioid Treatment Program
- **OUD** – Opioid Use Disorder
- **PMPM** – Per Member Per Month
- **PPS** – Prospective Payment System
- **SAMHSA** – Substance Abuse and Mental Health Services Administration
- **SMA** – State Medicaid Agency
- **SOR** – State Opioid Response
- **SUD** – Substance Use Disorder
- **TPA** – Third-Party Administrator
EXECUTIVE SUMMARY

The growing rates of overdose deaths in the U.S. have increased attention to policies that expand access to opioid use disorder (OUD) services inclusive of medications for OUD (MOUD) for individuals who are incarcerated.1 Nationally, overdose deaths have more than doubled since 2015.2 Individuals with a substance use disorder (SUD), including OUD, are disproportionately involved with the criminal legal system and incarcerated at higher rates than the general population.3 While overdose deaths of individuals in jails and prisons have increased, there is an even greater risk of individuals recently released from jail or prison dying from an overdose as compared to the general population.4,5,6,7

People with OUD who are incarcerated, like all people diagnosed with OUD, could greatly benefit from MOUD treatment services, but historically, very few receive it.8,9,10,11,12 Allowing Medicaid to cover OUD services in jails and prisons is one potential policy and financing change that could expand access to OUD services for people who are incarcerated.12 Historically, financing health care services in prisons and jails has been a state and local responsibility. Despite its central role in covering health care services for low-income people in the U.S., Medicaid has been barred from covering services provided to Medicaid beneficiaries when they are incarcerated in jails, except for 24-hour inpatient hospital stays.

Federal Medicaid policy is continually evolving. State Medicaid programs may now, through 1115 Medicaid reentry waivers of federal law, cover OUD services for both youth and adults in prisons and jails in the period immediately prior to an individual’s release.14 In addition, some state and federal policymakers have proposed that Medicaid should cover MOUD or a broader set of health care services during the entirety of a prison or jail stay beyond the pre-release period. Medicaid’s financing power and programmatic standards can expand access to evidence-based OUD services in prisons and jails and improve health outcomes for people with OUD. Doing this successfully requires state Medicaid programs to develop services, standards, performance measures, and payment strategies for OUD services in prisons and jails comparable to those that Medicaid covers in the community. Specifically, state Medicaid programs will need to ensure services are provided to people who are eligible and finance those services in ways that promote access, accountability, and quality aligned with approaches that Medicaid uses in community settings while considering the unique features of correctional settings.

This report outlines recommendations that consider the novel circumstances of Medicaid paying for OUD care while individuals are incarcerated. The recommendations align with two previously released reports that recommend services, standards, and measures for potential Medicaid–covered OUD services: Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons (referred to as “Standards” in this report) and Recommended Medicaid Performance Measures for Opioid Use Disorder in Jails and Prisons (referred to as “Measures” in this report).

The payment recommendations provide four specific options that state Medicaid agencies (SMAs) can consider as models for paying for Medicaid–funded OUD services in correctional facilities. As shown in Table 1 and described in the report, the options have two distinct reimbursement structures, each of which can include a quality incentive achievement component. The first, Model 1, is a fee–for–service (FFS) model. The second, Model 2, is a prospective bundled payment model that can be daily, weekly, or monthly as appropriate for the facility. The payment model options vary
in complexity and consider existing program financing and Medicaid payment practices. The recommended options aim to improve access to quality OUD treatment services within correctional facilities and can be applied to both jails and prisons. However, some key differentiators are needed to implement and operationalize the models, such as security and clearance challenges that do not pertain to community settings. This report explores these considerations in detail and identifies potential approaches to support the infrastructure that prisons and jails will need to provide services and obtain Medicaid payment.

This report is written to inform a wide range of policymakers and stakeholders. The primary audience is state Medicaid program administrators and administrators who oversee health service provision in prisons and jails. Additional audiences for this report include the Centers for Medicare & Medicaid Services (CMS), federal and state policymakers, health care providers, community-based organizations, Medicaid Managed Care Organizations (MCOs), advocates, and people with direct incarceration and OUD experience. If, in the future, Medicaid policy allows states to cover OUD services, including MOUD, in prisons and jails throughout an individual’s incarceration, SMAs could use the report’s recommendations with state and local correctional counterparts to develop Medicaid payment models for those services. While these recommendations can also inform payment decisions for services provided during shorter periods, such as immediately before an individual’s release from prison or jail, they were not developed for that purpose and would require some adaptation and modification.

Table 1. Summary of Payment Model Options for OUD in Jails and Prisons

<table>
<thead>
<tr>
<th>Model 1</th>
<th>Model 1A Fee-For-Service + Quality Incentive Achievement</th>
<th>Model 2 Prospective Bundled Day/Week/Month Rate</th>
<th>Model 2A Prospective Bundled Day/Week/Month Rate + Quality Incentive Achievement</th>
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<tr>
<td>Model 1 reimburses each required or optional service provided to an individual after services are rendered.</td>
<td>Model 1A includes all elements of FFS Model 1 and provides financial incentives for achieving performance or reporting measures.</td>
<td>Model 2 establishes a pre-determined bundled payment rate for all required or optional services on a daily, weekly, or monthly schedule.</td>
<td>Model 2A includes all elements of the bundle in Model 2 and provides financial incentives for achieving performance or reporting measures.</td>
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INTRODUCTION AND SUMMARY OF METHODS

Over the past 15 years, new laws have prompted substantial growth of OUD services covered by Medicaid in community settings.\textsuperscript{15} The passage of the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008 and its subsequent extension in the Affordable Care Act (ACA) in 2010, which included mental health and SUD treatment as an essential health benefit, laid the foundation for millions of Americans to have new or improved access to mental health and SUD coverage. This expansion of coverage for mental health and SUD services, along with increasing overdose death rates, has sparked a growing movement to explore improvements in service delivery, provider capacity, enhanced benefit designs, and increased reimbursement for SUD and OUD in various community settings.\textsuperscript{16} Medicaid now covers a disproportionate share of adults with OUD and is the largest payer of OUD treatment services in the United States.\textsuperscript{17,18,19}

In April 2023, the Bureau of Justice Statistics released a national report on screening for OUD in jails.\textsuperscript{20} The report found that “of the estimated 894,030 persons admitted to local jails between June 1 and June 30, 2019, 64% were screened for OUD at intake, of which 15% screened positive.” Just 19% of the jails in the survey reported they initiated medication-assisted treatment (MAT) for those who screened positive for an OUD, and 28% referred people on MAT to a community provider upon release. Between 2010 and 2018, the number of people who died of an overdose in state prisons rose by 600%.\textsuperscript{21}

Developing the First Medicaid Payment Models for OUD in Jails and Prisons

The Standards report provides recommendations that encourage timely, evidence-based, person-centered OUD services that promote continuity of care. The report identifies five categories of services: screening, assessment, MOUD initiation and continuation, counseling and intensive outpatient care, and reentry services. Across these categories, recommended services were designated as “required” or “optional” (See Table 2). “Required” services are those that policymakers should require jails and prisons to provide in order for Medicaid to cover OUD services within that facility. “Optional” services are those that jails and prisons are recommended but are not required to provide for Medicaid to cover OUD services within that facility.

Table 2. Recommended Medicaid-Covered OUD Services in Jails and Prisons

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<tr>
<td>• Screening</td>
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<tr>
<td>• Clinical assessment</td>
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<tr>
<td>• MOUD initiation for opioid withdrawal</td>
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<tr>
<td>• MOUD initiation for OUD</td>
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<tr>
<td>• MOUD continuation</td>
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<td>• Reentry services</td>
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<th>Optional Services (Not Required)</th>
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<tr>
<td>• Multidimensional assessment</td>
</tr>
<tr>
<td>• Counseling</td>
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<td>• Intensive outpatient</td>
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This report recommends payment models to facilitate the Standards and the Measures in jails and prisons through Medicaid during the entirety of a person’s jail or prison stay. As noted above, for a jail or prison to receive Medicaid reimbursement for OUD services, the facility should provide the required services and the required measures described in detail in the Standards and Measures reports. A menu of payment model options was developed comparable to community-based reimbursement models for OUD services covered by Medicaid.

These payment recommendations consider specific unique circumstances, including historical financing sources, substantial variation, and

\textsuperscript{i} Similar data was not reported for federal prisons.
operational challenges in jails and prisons. The report explores approaches to rate setting and the use of certain recommended measures for bonus incentives, as well as payment mechanics that support post-release reentry needs for individuals.

Although these payment recommendations were written to support Medicaid coverage of OUD services throughout a prison or jail stay, in 2023, CMS established an opportunity for states to cover MAT and other targeted pre-release services up to a 90-day period prior to an individual’s release from prison or jail. This report references the guidance and the experience of the two states that received approval for 1115 Medicaid reentry waivers to provide pre-release service as of January 2024. In January 2023, California was approved as the first in the nation to allow eligible beneficiaries who are incarcerated to receive targeted Medicaid-covered services for up to 90 days before release. In June 2023, Washington State became the second state to receive CMS approval for a reentry wavier.

**Summary of Methods**

Medicaid has never before covered services provided in prisons or jails. There is limited information or analysis available in the public domain on current approaches to accessing OUD services, standards, and payment in prisons and jails. This report used three primary methods to obtain information that is needed to identify considerations involved in developing payment models for OUD services:

1. A national literature review – including a review of publicly available program information, funding sources, and budget documents – was conducted to identify and understand current financing of OUD services in correctional facilities and identify existing program structures, the current breadth of OUD services, and service gaps.

2. A convenience sample of six existing OUD programs, including three prison and three jail-based programs, was identified for further research and a structured interview. The locations were selected based on diversity in programming, geography, and correctional facility type. The interviewed sites are:
   - Colorado, City and County of Denver jails
   - California, state prisons
   - Kentucky, state prisons
   - Maine, state prisons
   - Ohio, Lorain County jail
   - Massachusetts, Middlesex County jail

3. Existing state and federal Medicaid/Medicare FFS payment models and alternative payment structures for community-based OUD services were reviewed and, where possible, compared to practices of existing OUD correctional programs identified during the literature review and site interviews.

Draft recommendations were then prepared and reviewed by an advisory council that included individuals with experience providing SUD services in correctional environments, individuals with lived experience of having had SUD and been incarcerated, and payers, including a former Medicaid director and a Medicaid-managed care executive who administered OUD services for Medicaid beneficiaries. Two external policy experts on the provision of OUD services also reviewed a draft of this report. See Appendix D for members of the advisory council and external reviewers.

An important limitation of this report’s analysis and recommendations is that it only examined prisons or jails known to have OUD programs. The Jail and Prison Opioid Project estimates that as of 2021, approximately 88% of correctional facilities may not offer a form of MOUD to individuals. Conditions or considerations in those prisons and jails may vary substantially from those with OUD programs. The findings from this analysis concerning existing financing structures in jail and prison MOUD programs may have limited applicability in settings that do not currently offer any MOUD services.

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**ii** The specifics of the CMS policy letter to states, *Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who are Incarcerated* are discussed in further detail in Standards report.
Section 1 focuses on existing financing of OUD services in jails and prisons and existing community-based payments for OUD services in Medicare and Medicaid. Section 1 is organized into the following primary topic areas:

- Section 1.a. Existing Financing of OUD Services in Jails and Prisons
- Section 1.b. Existing Community-Based Payments for OUD Services in Medicare and Medicaid

Section 1.a. Existing Financing of OUD Services in Jails and Prisons

The scope and quality of health care services provided in jails and prisons vary widely, reflecting differences in state and local laws, resource commitments, facility size, organizational structures, and policy preferences. Some jails and prisons employ health care providers, while others contract with private correctional health vendors or community providers such as hospitals to provide services inside the facilities. These variabilities may even exist for health services in jails and prisons delivered within the same state, locality, or between individual facilities in similar regions.

Section 1.a.1. Key Literature Review

Findings of Existing Financing Structures

The literature review found that there is currently no consistent federal funding source that jails and prisons access to fund OUD treatment services, which leads to often complicated, fragmented, and unpredictable financing. Significant variations exist in policy, funding, and service delivery approaches by state, region, and facility, and there are key differences between jails and prisons.\textsuperscript{iii}\textsuperscript{,26} Key themes from the literature review were:

- Existing OUD programs are primarily funded through grants and state and local appropriations.
- Current financing approaches differ from health insurance payment structures in fundamental ways.

Existing OUD programs are primarily funded through grants and state and local appropriations.

The OUD programs in jails and prisons reviewed for this report were frequently financed through state or local budget appropriations, Substance Abuse and Mental Health Services Administration (SAMHSA) discretionary and state pass-through grants such as State Opioid Response (SOR) funds, criminal justice program budgets, and, to some extent, philanthropy. An emerging funding source to support OUD programs in jails and prisons is the recent opioid litigation settlement funds.\textsuperscript{iv}

These current primary funding structures for OUD services in jails and prisons differ from financing health services through insurance. Generally, grants and state and local funding operate according to broad requirements set by the funding entity with a pre-determined amount of program funding available. Grants tend to be time-limited, posing sustainability challenges for the ongoing development and operations of providing services. While these financing mechanisms have laid a foundation for OUD service delivery and have been flexible in accommodating the specific circumstances

\textsuperscript{iii} Differences are described in detail in the Standards report.

\textsuperscript{iv} In the settlement agreement for the national multi-district litigation, Exhibit E has two recommended allowable uses relevant to the individuals incarcerated; (1) provide evidence-based treatment and recovery support, including MAT for persons with OUD and co-occurring SUD/Mental Health disorders within and transitioning out of the criminal justice system; and (2) increase funding for jails to provide treatment to individuals with OUD.
of prisons and jails, they differ in fundamental ways from health insurance payments. Health insurance programs, including Medicaid, pay for specific services provided to enrolled beneficiaries. In addition, as an entitlement program, Medicaid provides coverage of the services a state Medicaid program authorizes.\textsuperscript{27} Currently, in existing OUD programs in jails and prisons, funding may not be sufficient to provide services to all who qualify, and quality and access issues may exist.\textsuperscript{28}

**Current financing approaches differ from health insurance payment structures in fundamental ways.**

In some states, OUD services in jails and prisons are included as part of health vendor contracts and in an overall budget for health care services based on the number of persons incarcerated (i.e., per inmate per month). This makes it difficult to determine an average budgeted expenditure per person served specifically for OUD. However, there are some exceptions. As of 2021, the Vermont Department of Corrections reported paying its service provider contracted rates using different components of both Medicare and Medicaid rates for specific services.\textsuperscript{29} In 2020, the Kentucky Department for Medicaid Services submitted an 1115 Medicaid reentry waiver to CMS that proposed reimbursement rates per person for OUD services as weekly bundled payments for different MOUD treatments for individuals incarcerated.\textsuperscript{30} Kentucky is currently revising its proposal.\textsuperscript{31} In California, some correctional facilities that contract with vendors for MOUD treatment are assigned a budgeted amount to provide services for a specified number of people.\textsuperscript{32} The literature review did not identify cases in which OUD programs tied performance measure achievement to payment incentives.

These themes include:
- Budgeting and financing in jails and prisons do not align with Medicaid financing.
- The use of performance measures is limited.
- Physical space and staffing are key constraints.
- The use of electronic health records and claims systems is very limited.
- Lack of predictability in discharge timing poses challenges to accessing care upon community reentry.

**Section 1.a.2. Key Site Interview and Specific Program Review Findings**

Several common themes and challenges with respect to financing were identified across the site interviews and program descriptions.

**Budgeting and financing in jails and prisons do not align with Medicaid financing.**

The interviewed sites manage OUD service programs through multiple funding sources, including the sheriff’s budget allocated from county funds for jails, state funds, and external grants. Some sites receive a dedicated appropriation, while others receive funds based on the number of individuals served.

The site interviewees reported that they do not develop budgets based on per-person expenditures or calculate the total cost of administering OUD services to individuals. California and Maine noted challenges to budgeting OUD services on a per-person basis as the OUD services are incorporated into the overall capitated budgeting approach to health care services for state prisons. The City and County of Denver and Middlesex County stated that administrators are investigating budgeting approaches on a per-person basis. The Middlesex County interviewees discussed directly participating in the development of a budget impact tool led by the Center for Health Economics of Treatment Interventions for Substance Use Disorder, HCV, and HIV (CHERISH) to model per-member per-year costs at a facility level or statewide.\textsuperscript{33}

None of the sites are currently receiving reimbursement from a third-party health payer, and thus have not developed capabilities to bill or submit claims as required in the Medicaid program. However, both Lorain County and Middlesex County expressed experience
obtaining reimbursement for MOUD costs from each of their respective states. Ohio launched the “MAT Reimbursement Program for County Jails,” in which the Ohio Department of Mental Health and Addiction Services provides reimbursement to all county jails directly for the cost of drugs dispensed to individuals of county jails for opioid and alcohol treatment. Jails in Ohio are reimbursed by submitting a MAT entry form that includes the number of prescriptions for each drug and the cost paid by the jail. In Massachusetts, the state legislature set up a trust account whereby the state’s 14 sheriffs get annual appropriations to support MAT programs. Middlesex County aggregates all annual expenses, including spending on medication, to receive reimbursements from this trust account. The county jail provides the expense data to the state, and the state reimburses for the program expenditures.

The use of performance measures is limited.

The California Correctional Health Care Services Integrated Substance Use Disorder Treatment Program and the Maine Department of Corrections interviewees indicated they are using performance measures to track some of the outcomes of the OUD programs. Still, they do not tie any financial incentives to these measures currently.

Program interviewees operating with grant funding stated they are sometimes limited to providing services in alignment with the specific grant requirements. Grants generally operate under a fixed budget cap for the program regardless of the number of people served. Some funding streams have restrictions and conditions that can make it difficult to access and deploy the funds specifically to provide MOUD services to individuals. Also, site interviewees with existing SOR funding in jail and prison programs expressed frustration about the burden placed by the reporting tool used specifically for this federal grant, which they described as not being well-matched to deploying programs in jail and prison settings.

Physical space and staffing are key constraints.

Nearly all interviewees identified physical space and funding for staffing as the most significant impediments to expanding OUD programs. Most of the program staff said that Medicaid funding would help them scale the reach of OUD services to more individuals by enabling them to hire more staff and potentially reinvest funds to expand the physical space. The sites indicated that within a jail or prison setting, providing daily MOUD services can entail moving a significant percentage of individuals incarcerated in a facility each day, requiring additional security and logistics outside of standard correctional facility operations. In addition, the strict security protocols required to supervise multiple individuals receiving OUD services in correctional facilities do not exist in any comparable manner in community-based settings. Interviewees from Maine, for example, stated that program staff face a significant challenge completing SUD assessments because of the number of patients that come through the MOUD program.

The use of electronic health records and claims systems is very limited.

Transitioning to Medicaid reimbursement will necessitate additional Information Technology (IT) infrastructure at most sites. For instance, the City and County of Denver jails do not currently use an electronic health record (EHR). An EHR is an electronic version of a patient’s medical history that automates provider workflow and streamlines tasks such as submitting claims for payment. The absence of an EHR makes it difficult to track services for individuals and measure outcomes systematically. More importantly, it signals a potentially large infrastructure gap that could require substantial new resources if programs were reimbursed by Medicaid – especially for jails with less advanced health care operations when compared to the prison programs interviewed. The City and County of Denver personnel shared that they recognize the limitation posed by not having an EHR and are working towards purchasing, implementing, and training staff on an EHR system.

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v Community–based opioid treatment programs have safety and security guidelines in place which may not be comparable to jail and prisons.
The review identified one site that described having some billing infrastructure. Lorain County uses an Electronic Medical Record (EMR) for health care service tracking but has challenges sharing information with other providers due to the expense of the multiple interfaces needed and Health Insurance Portability and Accountability Act (HIPAA) compliance concerns. Unlike an EHR, an EMR is a digital version of a paper chart with limited interoperability between health care settings. Compliance with HIPAA includes maintaining protected health information and could potentially dictate specific protocols for sharing records between correctional facilities and other health care providers.

**Lack of predictability in discharge timing poses challenges to accessing care upon community reentry.**

Interviewees identified barriers to patients accessing adequate care before release and upon community reentry. They cited that a significant challenge to accessing appropriate care is the inconsistency and unpredictability of discharge. According to the interviews, this is particularly challenging in jail settings, especially for persons who are awaiting trial, which is most of the jail population. Prisons also face challenges due to the unpredictability of discharge, though discharges are more predictable than those in jail settings.

The unpredictability of discharge creates two main issues. First, facilities must ensure an individual has ongoing access to MOUD post-release. Interviewees from Kentucky, for example, shared that they are beginning to offer a long-acting buprenorphine injection that is given once a month from a specialty pharmacy to mitigate this challenge. However, often, when an individual is released earlier than planned, there is insufficient time to order, receive, and administer the medication. Immediate access to ongoing MOUD care outside the facility upon release also poses challenges, especially when people are released after hours or on weekends.

Second, there are barriers to building a comprehensive care plan that includes access to health and social services. Challenges in making community-based referrals are most pronounced when people are discharged after hours, on a weekend, or from a state prison hundreds of miles from where a person intends to settle post-release. The Lorain County interviewees stated that many community partners close at 4 p.m., so staff cannot make warm handoffs to the community after that time. Interviewees from the City and County of Denver jails also shared that discharge unpredictability poses barriers to partnering with community-based providers and limits the ability to build comprehensive discharge plans. Kentucky interviewees noted that accessing social services, such as recovery housing, when transitioning an individual back to the community is challenging.

**Section 1.b. Existing Community-Based Payments for OUD Services in Medicare and Medicaid**

In 2020, CMS released guidance outlining the MOUD treatment requirement Congress imposed in the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act for both Medicaid and Medicare. For Medicare, CMS sets payment rates, covered service requirements, and utilization policies nationally. In Medicaid, while states have some flexibility to determine specific counseling and behavioral therapies required, all three Food and Drug Administration (FDA) approved medications – methadone, buprenorphine, and naltrexone – in all formulations must be covered. Each state has an associated billing fee schedule and utilization management policies for community providers and pharmacies established by the SMA.

In the community, health care services increasingly prioritize paying for value and quality of services in contrast to reimbursing only based on volume. In 2021, 59.5% of health care dollars were paid through a value-based care model. CMS defines value-based care as a focus on quality, provider performance, and the patient experience where providers are paid through alternative financing structures instead of straight FFS. While alternative payment models (APMs)
in the SUD and OUD space remain nascent, the rise in early mortality caused by SUD/OUD, coupled with the comorbidities that drive non-SUD spending significantly higher, has spurred greater exploration of APMs. Several states reimburse SUD treatment services, including MOUD, outside of a traditional FFS structure. States have supported APMs as a method to strengthen service delivery for SUD and OUD services. These models aim to improve the integration of disparate delivery system parts to foster improved coordination, efficiency, and patient retention while reducing overall costs.

To provide a reference point for developing reimbursement recommendations for OUD services in correctional facilities, the following section summarizes and reviews emerging innovative payment efforts for OUD, SUD, or other mental health conditions deployed in community settings financed by Medicare and Medicaid. These models include:

- Medicare: Office-Based SUD Treatment Bundle
- Medicare: OUD Treatment Bundle
- Medicare: Value in Opioid Treatment Initiative
- Medicaid: Rhode Island’s Opioid Use Disorder Health Home Model
- Medicaid: Virginia Care Coordination Case Rate
- Medicaid: Pennsylvania Centers of Excellence for OUD (COE)
- Certified Community Behavioral Health Clinics (CCBHCs)

### Medicare: Office-Based SUD Treatment Bundle

Medicare allows physicians and non-physician practitioners to bill a monthly bundle for a group of SUD services, including overall care management, care coordination, individual and group psychotherapy, and substance use counseling. The monthly bundle categorized for “non-facility” ranges from $388 to $518 per patient excluding pharmaceutical costs, depending on locality.

### Medicare: OUD Treatment Bundle

In January 2020, CMS released a specific Medicare OUD treatment bundle to facilitate MOUD services, including methadone treatment. Unlike the office-based SUD bundle described, only SAMHSA-certified Opioid Treatment Providers (OTP) can qualify for bundled payments. OTP certification is governed by Title 42 of the Code of Federal Regulations, Part 8.

Services in the bundle or included as add-on codes are medications, dispensing and administering MAT, individual and group therapy, toxicology testing, intake activities, and periodic assessments. The program does not reimburse peer recovery support or wraparound case management services. The FY 2024 OUD bundled payment rates (see Appendix C) for services range from $200 to $800 (non-pharmacy spend) per week, depending on the type of program (i.e., medication type) the patient is enrolled in. For orally dispensed MOUD administration, the bundle is paid on the lower end of that range. Medicare beneficiaries can receive services covered under the OTP bundle with no copay.

Compared to the Medicare physician fee schedule for weekly OTP bundled rates, Medicaid rates across states widely varied but, on average, accounted for just 56% of the Medicare fee schedule in 2021. This rate discrepancy between existing Medicaid and Medicare fees for OTPs is larger than payment differentials for some other health services. For example, in 2019, on average, Medicaid paid 72% of Medicare for primary care services.

### Medicare: Value in Opioid Treatment Initiative

In 2021, CMS introduced The Value in Opioid Use Disorder Treatment (Value in Treatment) initiative, a four-year demonstration targeted to FFS Medicare enrollees intended to “increase access of applicable beneficiaries to opioid use disorder treatment services, improve physical and mental health outcomes for such beneficiaries, and to the extent possible, reduce Medicare program...
Recommendations for Medicaid Payment Models for Opioid Use Disorder Services in Jails and Prisons

Medicaid: Rhode Island’s Opioid Use Disorder Health Home Model

In 2020, five states – Maine, Maryland, Michigan, Rhode Island, and Vermont – received CMS-approved Medicaid state plan amendments to implement Medicaid health home models designed to address OUD. Rhode Island introduced its OTP health home model in 2013. This model is available to Medicaid beneficiaries residing in the community who meet the criteria for MAT and are at risk of developing another chronic condition. Subsequently, in 2016, CMS approved the state’s transition of some health homes into enhanced Centers of Excellence (COE) to provide wrap around services to individuals utilizing MAT. OTP health homes must provide the following services: “(1) comprehensive care management; (2) care coordination; (3) health promotion; (4) transitional care from inpatient to other settings, including follow-up; (5) patient and family support; and (6) referral to community and support services.”

Medicaid: Virginia Care Coordination Case Rate

In 2017, Virginia implemented the Addiction and Recovery Treatment Services (ARTS) program to increase access to treatment for Medicaid members living in the community with OUD or other SUDs. The program includes treatment in primary care provider settings, community-based addiction treatment services, and inpatient detoxification and residential SUD treatment coverage. The program also provides coverage for peer support for SUDs.

Eligible providers obtain reimbursement for the ARTS SUD care coordination services by using a designated billing code. This code covers Office-Based Addiction Treatment (OBAT), a program that enables providers to administer buprenorphine and non-methadone MOUD services at a licensed provider office, and care coordination to manage the treatment. As of the 2022 reimbursement fee schedule, the specific bill code was reimbursing $273.38 per member per month for services. This code is designated for specific settings and is ineligible to be billed alongside SUD case management outside of an OBAT or OTP. The reimbursement varies based on medication type, as outlined in Appendix C.

Medicaid: Pennsylvania Centers of Excellence for OUD (COE)

Since 2016, Pennsylvania has also certified COEs for OUD. MCOs in Pennsylvania are directed to pay COEs through a bundled PMPM for OUD and care management services for enrollees living in the community. In 2021, the PMPM rate was $277.22 for community-based care management services. The covered services include screening and assessment, care planning, referrals, monitoring, and making and receiving warm hand-offs. The MCO contracts...
outline 20 measures the state will evaluate via claims analysis but do not specify whether there are quality bonuses for achieving targets.

Certified Community Behavioral Health Clinics (CCBHCs)

First established in the Protecting Access to Medicare Act (PAMA) of 2014 (Public Law 113-93), CCBHCs provide comprehensive outpatient mental health and SUD services to individuals seeking care. CCBHCs can be supported through the CCBHC Medicaid Demonstration, SAMHSA’s CCBHC Expansion Grants, or independent state programs authorized through an 1115 Medicaid waiver or state plan amendment. In June 2022, Congress approved the Bipartisan Safer Communities Act, which expanded CCBHCs, allowing 10 new states to join the demonstration every two years until 2030.

PAMA created CCBHCs as a new provider type, with a required set of services, standards, data and reporting requirements, and quality measures. To become a CCBHC, clinics must provide a comprehensive range of behavioral health services, including MOUD, and have capabilities in other areas, such as staffing and care coordination. In addition to a required set of services, CCBHCs must coordinate with and connect to other providers and systems (e.g., criminal justice, foster care, child welfare, education, primary care, hospitals, etc.).

The SMA pays CCBHCs in respective demonstration states a clinic-specific bundled rate using a daily prospective payment system (PPS-1) or monthly (PPS-2) rate. Each state can award quality bonus payments tied to selected measures under the PPS-1 methodology. However, if the state uses the PPS-2 methodology, it is required to establish quality bonus payments. In 2023, CMS proposed changes to the methodology, introducing PPS-3 (daily rate) and PPS-4 (monthly rate) methodologies. These new methodologies include a new PPS rate for crisis services and a special population rate for PPS-2 and PPS-4, a separate payment “to reimburse CCBHCs for the costs associated with providing all services necessary to meet the needs of higher needs special populations.” Rates must be actuarially sound and are developed on a cost-reimbursement basis. In states with managed care, the state may require the MCO to pay the PPS (with approved directed payment authority from CMS), or that state may directly provide supplementary payments to the CCBHC to achieve the PPS rate.
Section 2 of this report provides an overview of considerations for implementation and operational requirements for payment of Medicaid-covered OUD services in jails and prisons. Section 2 is organized into the following primary topic areas:

- Section 2.a. Fixed Infrastructure Needs for Medicaid Payment for Jails and Prisons
- Section 2.b. Ongoing Administrative Needs for Medicaid Payment for Jails and Prisons
- Section 2.c. Measures and Performance Standards for Payment Models

### Section 2.a. Fixed Infrastructure Needs for Medicaid Payment for Jails and Prisons

Making Medicaid payment for OUD services in correctional settings a reality will require developing infrastructure that is currently limited in jails and prisons. As discussed in this report, the results of the literature and site reviews suggest that jails and prisons lack some of the claims management systems, EHR capabilities, and the ability to track performance measurements that will be needed for Medicaid billing. The results also identified physical space, capacity, and workforce barriers that may challenge the effective provision of Medicaid-covered OUD services. In many correctional facilities, infrastructure investments will be needed to deliver Medicaid-covered OUD services, obtain Medicaid payment, and measure and manage the impact of the services. In addition, there may be ongoing spending on non-clinical services and staffing in a carceral setting that facilitates service provision. This includes additional staff and security personnel to address the logistics for individuals to receive OUD care, which could involve daily medication administration for a significant number of individuals.

This section identifies potential options that state, local, and federal governments may consider for financing the cost of these investments.

#### Section 2.a.1. Potential State and Local Financing Sources

States and local governments have a range of funding streams that could be used to support physical space, IT, and other infrastructure that is needed to provide and bill for Medicaid-covered OUD services. State and local grant funds, local appropriations, and/or opioid settlement funds can potentially be used to support infrastructure development and may also be able to deploy some federal grant funding to develop infrastructure. States may have opportunities to braid funding streams as they implement Medicaid-covered OUD services.

#### Section 2.a.2. Potential Federal Financing Sources

In addition to state and local financing, the federal government could consider financing some infrastructure investments needed to operate Medicaid-covered services in jails and prisons. Recent CMS policy guidance on state Medicaid reentry waivers identifies three ways of supporting infrastructure development associated with implementing services that the state can cover through Medicaid in the period immediately prior to an individual’s release from prison or jail. These options could be utilized to

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vii All Medicaid-covered services referenced in this report are detailed in the Standards report.
Recommendations for Medicaid Payment Models for Opioid Use Disorder Services in Jails and Prisons

support infrastructure development for Medicaid-covered OUD services throughout a prison or jail stay and include:

• Transitional implementation expenditures
• Supporting implementation as part of CMS reinvestment requirements
• Information technology system spending

Transitional implementation expenditures

In its 1115 reentry waiver policy, CMS recognized “significant upfront and/or one-time non-service costs required to bring necessary linkages to Medicaid operations and IT capabilities into the carceral setting.” CMS indicated that it would support financing time-limited expenditures on some new functions and infrastructure that state and local governments need to implement the waiver. Activities that could be supported include developing new business and operational practices, hiring and training staff, outreach, education, and stakeholder convening. States that seek this support must justify their requests and document the need for new spending.

There are two examples of transitional implementation activities that CMS is willing to support. First, CMS approved California’s reentry waiver, which included hiring vendors to support implementation efforts, the procurement of EHRs and other needed information technology systems, workforce development costs for both health care and correctional staff, and modifying the physical infrastructure of correctional facilities to support the implementation of the OUD services. Second, CMS committed to supporting similar activities in its Washington state waiver approval.

Supporting implementation as part of CMS reinvestment requirements

CMS’s reentry waiver policy prohibits Medicaid from funding any existing correctional health care services that were locally or state-funded prior to waiver implementation unless the state agrees to reinvest any state or local funds that are spent on correctional health care services into activities that increase access or improve the quality of services for people who are incarcerated. States must submit reinvestment plans to CMS for its approval that identify how any freed-up state and local funds will be reinvested. To the extent that the state increases access and quality, some infrastructure support may be allowable uses of reinvestment funds. CMS identifies health IT and data-sharing as two investments states can include in reinvestment plans. Addressing ongoing staffing and security needed to expand access to M0UD and the quality of services may also be considered as allowable uses of reinvestment funds.

Information technology system spending

State Medicaid IT system expenditures for implementing 1115 Medicaid reentry waivers may be eligible for enhanced federal financial participation (FFP). States are eligible to request approval for an 90/10 enhanced federal match for enhancing their Medicaid enterprise system initiatives to facilitate the reentry waiver. Examples of this technology include “technology that supports data sharing between state Medicaid agencies, state correctional agencies and participating correctional facilities, such as systems to support eligibility determinations and enrollment.” States can also request a 75/25 enhanced federal match for ongoing operations of approved CMS systems.

Section 2.b. Ongoing Administrative Needs for Medicaid Payment for Jails and Prisons

In each of the payment model recommendations provided in this report, there are various operational considerations connected to the Medicaid program. As discussed, a Medicaid payment approach will be a different process than what a jail or prison currently uses to administer and finance health care services. Thus, the facility may use a variety of administrative strategies described in the following section that
can help facilitate Medicaid-based requirements such as billing and provider credentialing. Topics covered in this section include:

- Medicaid provider enrollment and billing
- Vended services for Medicaid administration
- Medicaid payment flow
- Rate setting

**Medicaid provider enrollment and billing**

To offer services in a jail or prison and bill Medicaid for those services, the jail or prison, their health care vendor, or an authorized third-party administrator (TPA) will enroll as a Medicaid provider in the state. As determined from the site interviews, there is minimal capability or experience among correctional facilities to bill and submit claims. Policies regarding Medicaid provider enrollment are established in federal law and regulation, and include policies such as recordkeeping, record disclosure, reporting of adverse actions, licensing and background checks, provider risk screening, and obtaining a national provider identifier. The SMA establishes and oversees specific state provider enrollment rules. These policies will be new to many jails, prisons, and correctional health care providers. Each SMA will determine the provider-specific Medicaid billing requirements for implementing the standard OUD services and measures in carceral settings.

**Vended services for Medicaid administration**

As described in the literature review summary, using vendors to provide correctional health services is already a common practice that can continue with the implementation of Medicaid-covered services. Jails and prisons with capacity may choose to directly employ and operate health services with Medicaid-enrolled providers and bill Medicaid directly. Alternatively, community providers currently enrolled as Medicaid providers who already meet existing state and federal Medicaid requirements could be well-positioned to expand their Medicaid billable services inside jails and prisons. However, there are substantial logistical complexities for health care providers traveling into facilities, such as obtaining required clearances, passing through security, potentially reduced service volume and productivity rates, and unexpected lockdowns. In its implementation of its 1115 Medicaid reentry waiver, California authorized strategies to mitigate these potential barriers such as setting regular service hours for health providers and leveraging telehealth to minimize in-person visits.

States, jails, and prisons may consider using TPAs to support the OUD services in these new Medicaid settings. TPAs can operate between the provider and the state or designated MCOs to provide Medicaid administrative services required, including submitting claims on behalf of the provider. TPAs can also contract for additional back-end business operations, including pharmacy services and lab services.

**Medicaid payment flow illustration**

Based on existing state Medicaid infrastructure, reimbursement to jails and prison OUD services may come directly from the SMA or through the state’s designated MCOs. States may choose different paths in this regard. Some states do not use managed care to organize and deliver Medicaid services, while other states with managed care programs may carve some populations and services out of their managed care contracts. The specific functions an MCO may or may not be authorized to take on regarding Medicaid financing in jails and prisons will depend on state preferences. For example, in California’s CMS-approved reentry waiver, MCOs do not oversee services provided in carceral facilities; their role begins after release.

Throughout this section, the source of the reimbursement is referred to as the “Medicaid payer” whether it is provided by the SMA directly or an MCO. There are two main approaches that the Medicaid payer can use to direct funds to a jail or prison for reimbursement, as illustrated in Figure 1.

In the first illustrative approach, a TPA may sit between the Medicaid payer and the jail or prison facility-employed health provider to provide
billing and claiming for Medicaid-covered services while collecting an administrative fee. In the second illustrative approach, there is no TPA and the Medicaid payer coordinates directly with a clinical services vendor offering some or all covered services within a jail or prison facility. In both scenarios, reporting and tracking of measures is a bi-directional function of both the Medicaid payer and the jail or prison provider. States that choose to provide payment using Medicaid-managed care may need to modify MCO contracts to facilitate payment for services within correctional settings.

Rate setting

As detailed in this report, there is limited information on the actual cost of providing OUD services on a per-person basis in jails and prisons; this reflects the use of state, local, and grant funding that may lack a requirement for cost accounting in jails and prisons specific to their OUD programs. The lack of cost information poses a challenge to rate development and contrasts with community-based OUD services, which have a history of rate setting in Medicaid and Medicare. States have flexibility in setting payment rates, provided that rates meet statutory requirements and are consistent with the economic and efficient service provision, quality of care standards, and are sufficient to enlist providers to offer services. SMAs have existing processes to determine rates for each allowable service in the state plan—such as, the resource-based relative value scale, adapting a percentage of Medicare’s fee schedule, or a state-developed fee schedule using local factors. States often use adjustment factors, including provider type, geography, site of service, or patient age.

The uncertainty regarding the historical costs of providing the required or optional OUD services to jail and prison populations poses a potential financial risk to providers and to states, as they set initial rates. Rate setting for OUD services not previously covered by Medicaid for correctional facilities may be comparable to SMA experiences transitioning an SUD residential treatment services continuum to Medicaid for institutions for mental disease (IMD). IMDs are programs that have more than 16 beds. Prior to Medicaid coverage of residential treatment for SUD in IMDs, the service did not have an actuarial basis in Medicaid. Thus, states chose to deploy a variety of methods, including cost-based methodology, using non-Medicaid existing public rates, using other payers’ rates, and allowing MCOs to negotiate to set initial reimbursement rates.

Since no historical actuarial claims data exists for the required or optional OUD services in jails and prisons, states may consider using two recommended Medicaid rate-setting approaches.

**Figure 1. Illustrative Funds, Claims, and Measures Flow Approaches**

<table>
<thead>
<tr>
<th>Illustrative Approach 1: State Medicaid Agency or Managed Care Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Submission</td>
</tr>
<tr>
<td><img src="chart1.png" alt="Flow Chart 1" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Illustrative Approach 2: State Medicaid Agency or Managed Care Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Submission</td>
</tr>
<tr>
<td><img src="chart2.png" alt="Flow Chart 2" /></td>
</tr>
</tbody>
</table>

Jail/Prison Facility Contracted Vendor for Services, Labs, or Pharmacy inside a jail/prison facility
as they develop these services. In the following section, two potential approaches to establishing rates are offered:

- Adapting existing or enhanced community Medicare and Medicaid rates
- Applying a cost-based reimbursement approach

### Adapting existing Medicare and Medicaid provider reimbursement rates

One approach SMAs can use in rate development is to adopt existing Medicare and/or Medicaid community rates for OUD services provided in prisons and jails, as described in the Standards. As described earlier, the Vermont Department of Corrections and the CalAIM Justice-Involved Reentry Initiative are using existing community-rate approaches for setting rates for OUD services in jails and prisons.93

Generally, using an existing public rate strategy can mitigate some uncertainty in a rate setting process with no other historical actuarial basis. However, setting rates based on Medicare or Medicaid rates may pose challenges in this circumstance because existing community-based fee schedules may be inadequate for the deployment of the required or optional OUD services in jails and prisons. Not only does the setting present new complex logistical challenges not experienced in the community, individuals who are incarcerated also often have complex chronic and communicable health conditions that drive higher treatment costs.94 If SMAs choose this approach, they may consider matching or exceeding Medicare rates that, on average, exceed the existing state-based Medicaid rates. This is an important consideration given the significant complexity of providing OUD services to individuals who are incarcerated.

In 2016, the U.S. Department of Justice Office of the Inspector General released an evaluation of Federal Bureau of Prisons (BOP) spending on comprehensive medical services provided in federal prisons conducted by health care contractors. The findings identified that BOP contracted rates for these health services were higher than comparable Medicare rates. The reimbursement ranged between 115% and 385% of the Medicare rate for a specific service.95 The report identified that the rationale for exceeding Medicare rates may be to counter balance challenges in cost of provider access and security.

### Developing provider payment reimbursement rates based on actual costs

A second possible payment approach states can consider is a cost-based reimbursement model that provides jails and prison providers funding directly proportionate with budgeted expenditures and then reconciled against actual expenditures. This approach could be used either on an interim basis until costs are well established or an ongoing basis as desired. In Medicaid, this approach has been used for school-based services delivered by a local education authority in some circumstances and has been recommended as the best approach for states moving SUD residential care financing to Medicaid.viii,96,97 Cost-based reimbursement has also been the approach to setting the PPS rates for CCBHC sites in the community.98

It may be challenging for facilities that use aggregate budgets for all health services to identify expenditures that are specific to OUD services. The initial stages of this approach will still require prospective modeling upon implementation as states will not have reliable cost trend data until subsequent performance years of Medicaid payment. The CCBHC PPS model allows rebasing rates in demonstration Year 2 to adjust for unanticipated costs in Year 1 and then rebasing rates every three years thereafter.99 SMAs may choose to adopt a similar approach in jails and prisons or even an annualized rebasing process while actual expenditures begin to normalize year-over-year.

In 2023, CHERISH released a budget impact tool to model per-member per-year costs at a facility level or statewide.100 The tool identifies
the resources required to implement and sustain MOUD programs in jails and prisons and categorizes resources by fixed and time-dependent startup costs and costs associated with labor, therapy, and testing. The tool allows users to include inputs and variations of MOUD they will provide (i.e., which medications to offer) to calculate Year 1, subsequent annual, and per-patient costs. SMAs that choose a cost-reimbursement approach may opt to provide a budgeting template tool similar to this to drive fidelity across facilities.

Section 2.c. Measures and Performance Standards for Payment Models

As outlined in detail in the Measures report of this project, jails and prisons have different experiences providing necessary information to track and report measures. The Measures report recommends specific measures for CMS to require or encourage SMAs to use when assessing efforts to provide OUD services, including MOUD, to Medicaid beneficiaries in jails and prisons and reentering the community. Payment mechanisms are a central tool to support the implementation of the Measures and provide an opportunity to ensure high-quality services and track outcomes longitudinally for each jail and prison.

In Appendix B, Tables B1 through B4 illustrate the specific measures (required and encouraged) and highlight the relationship of the measure to the recommended payment models described in the following section. All required measures will need to be included in any program implementation with Medicaid. The tables in Appendix B also reflect whether the measure can be used for reporting and/or performance achievement incentive payments. SMAs may individually set the associated benchmarks for these incentives and are encouraged to make each incentive payment material for the jails and prisons. Upon program implementation, the incentive payments that tie to the proposed required and encouraged measures primarily incentivize process measures derived through claims data. There may be future opportunities to transition additional incentives to more performance or outcome-based measures as programs become more established. This approach reflects a recognition that jail and prison providers shall not be held to a higher standard than community-based providers for administering OUD services.

As highlighted in the Measures report, SMAs may find it helpful to stratify measures based on demographics to understand and analyze care disparities across population segments. Key demographics used for stratification can include race, gender, and pregnancy status.

Program Integrity and accountability

Accountability and program integrity for Medicaid coverage of the required or optional OUD services in jails and prisons will be vital. In addition to using performance measures, SMAs or designated MCOs can take steps to provide accountability and ensure the quality of the services provided, such as:

- reviewing encounter, financial, and clinical data to ensure payment models meet state Medicaid and/or correctional facility quality and efficiency goals
- establishing and reviewing IT systems to administer payment models to ensure timeliness, accuracy, and interoperability
- routine program integrity reviews and assessment of underlying data to measure performance
- using an accrediting body to certify the provider meets evidenced-based quality standards for the services being provided
- developing standards and fidelity to evidence-based models

These suggestions are in addition to meeting core Medicaid program integrity requirements established by CMS and states.
SECTION 3. RECOMMENDED MEDICAID PAYMENT MODELS FOR JAILS AND PRISONS AND USE SAME FORMAT AS OTHER SECTIONS

Section 3 outlines the four recommended Medicaid payment models SMAs can choose to implement. These models which are shared in greater detail in Table 3 and this section are:

- 3.a. Model 1: Fee-For-Service
- 3.b. Model 1A: Fee-For-Service with Quality Incentives
- 3.c. Model 2: Prospective Bundled Daily/Weekly/Monthly Rate
- 3.d. Model 2A: Prospective Bundled Daily/Weekly/Monthly Rate with Quality Incentive

The recommendations aim to facilitate greater capacity, sustainability, and outcome measurement to improve access to quality OUD treatment services within correctional settings. These payment approaches could be deployed in both managed and non-managed Medicaid states. In states that use MCOs to manage their Medicaid programs, the SMA can choose to facilitate the payments using MCOs. However, if using MCOs, it is recommended that all deployments encourage a multi-payer approach where the jail and prison reimbursement structure, reporting requirements, and billing processes can be consistent across MCOs to reduce provider burden.

Throughout this section, each payment model refers to “providers” as the entity that submits Medicaid claims and receives payment. This may include a jail or prison, a TPA, or a contracted health care vendor. The previous sections of this report identified options and pathways for rate setting, measurement, and approaches to funding infrastructure needs. The following section outlines possible methodologies for paying providers to initiate and administer ongoing OUD services in jails and prisons. These recommendations are general frameworks. Given the complexity of individual state laws and regulations, SMAs will need to develop specific guidance for participating providers regarding how each service will be billed and paid. This guidance should include the specific billing codes to be used, provider enrollment mechanics, and selected measurement incentives that will need to be included in operational guides for providers.

The proposed models are aligned with the well-established Health Care Payment Learning and Action Network (HCPLAN) APM framework (Figure 2). The framework classifies payment models based on four categories across a continuum of clinical and financial risk for provider organizations. The models have been classified using this framework to provide a reference to where each model sits in terms of the baseline architecture.

Since these models have been designed for a new provider setting, the recommended payment models only include opportunities for upside incentive payments and do not include downside risk at this time. After a few years of experience paying for Medicaid-covered OUD services, SMAs may choose to develop downside risk options.

The payment models recommended can be applied to both jails and prisons. However, some key differentiators are needed to implement and operationalize in different settings. For instance, specific measures or bundle architecture may differ due to individuals’ differing lengths of stay in jails compared to prison settings. Furthermore, a state could choose to implement different payment models for jails and prisons. For example, with the more transient nature of the individuals and more unpredictable discharges in jails, it may be more accessible to adopt an FFS model. On the other hand, prisons may have the capabilities and interest to implement the bundled payment options as individuals incarcerated may have more predictable program participation periods.
### Table 3. Payment Model Options for OUD Services in Jails and Prisons

<table>
<thead>
<tr>
<th><strong>Model 1</strong> Fee-For-Service</th>
<th><strong>Model 1A</strong> Fee-For-Service + Quality Incentive Achievement</th>
<th><strong>Model 2</strong> Prospective Bundled Day/Week/Month Rate</th>
<th><strong>Model 2A</strong> Prospective Bundled Day/Week/Month Rate + Quality Incentive Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1 reimburses for each required or optional service provided to an individual after services are rendered.</td>
<td>Model 1A includes all elements of FFS Model 1 and provides financial incentives for achieving performance or reporting measure.</td>
<td>Model 2 establishes a pre-determined bundled payment rate for all required or optional services on a day, week, or monthly schedule.</td>
<td>Model 2A includes all elements of the bundle in Model 2 and provides financial incentives for achieving performance or reporting measures.</td>
</tr>
<tr>
<td>HCPLAN: Category 1</td>
<td>HCPLAN: Category 2A/2B</td>
<td>HCPLAN: Category 4N</td>
<td>HCPLAN: Category 4A</td>
</tr>
<tr>
<td><strong>STRENGTHS</strong></td>
<td><strong>STRENGTHS</strong></td>
<td><strong>STRENGTHS</strong></td>
<td><strong>STRENGTHS</strong></td>
</tr>
<tr>
<td>• Familiar pathway for SMAs</td>
<td>• Strengths of Model 1 with the additional ability to earn funds through achieving and/or reporting measures</td>
<td>• May be more aligned to the existing prison and jail budgeting structure</td>
<td>• Strengths of Model 2 with the additional ability to earn funds through achieving and/or reporting measures</td>
</tr>
<tr>
<td>• Dominant approach in community OUD settings</td>
<td>• Tracking may lead to performance improvement</td>
<td>• A more predictable/consistent funding stream</td>
<td>• Tracking may lead to performance improvement</td>
</tr>
<tr>
<td>• Incentivizes service volume</td>
<td>• Provides additional accountability and a mechanism to incentivize quality care</td>
<td>• Savings can be realized for patients care costs that are lower than the bundle rate</td>
<td>• Provides additional accountability and a mechanism to incentivize quality care</td>
</tr>
<tr>
<td>• Individual service-level data facilities oversight to service provision</td>
<td></td>
<td>• Can reduce some of the administrative burden surrounding billing</td>
<td></td>
</tr>
<tr>
<td><strong>LIMITATIONS</strong></td>
<td><strong>LIMITATIONS</strong></td>
<td><strong>LIMITATIONS</strong></td>
<td><strong>LIMITATIONS</strong></td>
</tr>
<tr>
<td>• Historical concerns about incentivizing service volume over outcomes</td>
<td>• Limitations of Model 1</td>
<td>• Can face financial risk if patients care costs more than the bundle rate</td>
<td>• Limitations of Model 2</td>
</tr>
<tr>
<td>• FFS has not promoted care coordination/linked services in community settings</td>
<td>• Several years of experience to establish a quality baseline is required prior to tying incentive payments to quality achievement</td>
<td>• De-linking payment and service provision creates risk that provider may not be incentivized to provide all required services</td>
<td>• Additional administrative burden for non-claims based measures</td>
</tr>
<tr>
<td>• May produce uneven cash flow and workflow</td>
<td>• Additional administrative burden for non-claims based measures</td>
<td></td>
<td>• Several years of experience to establish a quality baseline is required prior to tying incentive payments to quality achievement</td>
</tr>
<tr>
<td>• Administratively intense as each individual service is billed separately</td>
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</tr>
</tbody>
</table>
As a result, the recommendations provide baseline opportunities for jails and additional options or opportunities that prisons (or advanced jail programs) could leverage. Providers could contract with the SMA directly or designated MCOs in each proposed model.

**Section 3.a. Model 1 – Fee-For-Service**

**Overview:** Providers receive a reimbursement for each required or optional OUD service they provide to an insured individual. This includes all required and optional services (see Table 2), laboratory, pharmacy and reentry services. The specific procedure billing codes or medication billing codes will vary across states and be set forth in operational guidance established by the SMAs. Providers receive reimbursement retrospectively upon submitting a claim to the Medicaid payer. Additionally, the SMA would need to ensure the required or encouraged measures are tracked as part of service provision. However, no reimbursement is tied to this reporting for a jail or prison in Model 1, leaving the SMA to create an alternative enforcement and oversight approach through provider credentialing and ongoing evaluation.
Infrastructure Requirements: Providers, or designated TPAs, must submit claims in accordance with billing guidance provided by the SMA after a service has been rendered. The facility or its vendor must appropriately document in compliance with Medicaid for each service when furnished to an eligible individual.

Strengths: FFS is a familiar payment model to SMAs, and often used for community-based services. By reimbursing for each service, lab, and medication individually, there is a built-in incentive for volume, which may increase the reach of OUD services provided to often underserved individuals in jails and prisons. FFS also requires providers to submit more details on the utilization of specific procedure codes that could lead to enhanced monitoring capabilities for the SMA and strengthen opportunities for future quality and outcome measurement.

Limitations: FFS reimburses for the number of services provided and not the outcomes or benefits of each service. This has led to concerns about FFS incentivizing the volume of community services over the quality of services provided. Paying individual community providers on an FFS basis may also miss opportunities to promote coordination across providers because care coordination is not incentivized. The extent to which these coordination concerns within facilities pertain to correctional OUD services is unclear. FFS billing can also lead to inconsistent cash flow to the provider due to changes in caseload or service mix. Administrative billing requirements associated with FFS models are complex in terms of documentation and claims submission versus bundled payments. If jails and prisons are billing in a Medicaid managed care model, the administrative burden can be compounded as providers may have to manage the billing process for multiple MCOs.

3.b. Model 1A – Fee-For-Service with Quality Incentives

Overview: This model includes all elements of Model 1. However, it ties incentives to the reporting of certain required or encouraged measures included in the program. The payer will reimburse the provider for billed services and provide bonus payments if the provider meets or reports specified performance measures. SMAs can tier quality incentive payments using a percentage method against a target baseline or structure some measure-based bonuses as an “all-or-nothing” option (i.e., did the provider meet the measure: Yes or No). SMAs or MCOs can use submitted claims for several measures, and require providers to submit non-claims-based measures to the payer for tracking and bonus payment. In future years, after a benchmark has been established, providers can receive incentives based on performance metrics such as an increase in the number of beneficiaries at reentry who have filled a prescription or were dispensed a MOUD year over year.

Required and encouraged measures with a respective incentive type for bonus payments are presented in the tables found in Appendix B.

Infrastructure requirements: The infrastructure requirements of Model 1 must be in place as the foundation for operationalizing Model 1A. The key difference is the addition of a mechanism to facilitate bonus payments at an agreed-upon cadence (e.g., quarterly, semi-annually, etc.). For the provider to receive bonus payments, additional reporting requirements will need to be in place. Providers should have access to ongoing data reports from the payers to monitor progress of each measure to enable quality improvement or program intervention as needed. If the program is not meeting target metrics, the SMA and MCOs should develop processes for quality improvement of the program.

Strengths: All strengths in Model 1 apply to Model 1A. Adding incentives for reporting metrics or achieving outcomes in an FFS payment model can incentivize care delivery goals. This financial incentive also provides opportunities for greater care transformation, fidelity across sites, and performance improvement in jails and prisons as they monitor and report metrics. The financial incentives can create additional funds that may be invested to enhance the program attributes,
including the physical space, increased staff, and technological advances, as long as it complies with an approved reinvestment approach a state may take in partnership with CMS. Alternatively, an SMA can set bonus payments to specific activities tied back to improvements in OUD care.

Limitations: Limitations are similar in Model 1A as in Model 1 as the reimbursement to providers remains tied directly to volume. However, there is greater accountability in Model 1A with the addition of incentive payments tied to required or encouraged measures. In the early years of this model, incentives would be focused on pay for reporting as a ramp-up period would be required to establish a baseline for measures as outlined in the Measures report and depicted in Appendix B. As discussed in the literature review, there is no existing national benchmark of OUD quality measures in jails or prisons to determine a baseline prior to implementation. However, in some instances, local jails and prisons have been tracking data related to OUD that can be useful in informing initial goals.

3.c. Model 2 – Prospective Bundled Daily/Weekly/Monthly Rate

Overview: Models 2 and 2A are proposed for either the jail or prison setting and require a rate setting process (see section 2.b) to set a target bundled payment for the services provided outlined in the Standards report. This reimbursement rate can be set using community rates or in a cost-reimbursement model, calculated by the total daily allowable OUD service costs divided by the total number of eligible OUD program participants. The provider can bill this rate when it has provided one or more OUD services to a patient during the defined period. The SMA can choose the period for the bundle at each facility or by the sentencing status of the beneficiary. For instance, in a jail setting the bundle would typically be billed daily, while in a prison setting it would be established weekly or monthly.

As individuals remain in a carceral setting for a more extended period (e.g., sentenced individuals), Model 2 could be reimbursed weekly or monthly. The model described in this section is illustrated weekly (see Table 4) in alignment with Medicare’s current OTP bundled fee schedule approach (see Appendix C). The SMA can choose to create a risk-adjusted bundled payment rate based on the attributes of a patient, the complexities of the patient’s OUD, and the medication dispensed using existing state-specific Medicaid risk-adjustment methodology. Accordingly, the bundle rate could be higher than the average target rate for individuals with more complex needs and comorbidities.

The services included in the bundle will only be those provided after the initial screening establishing an individual as clinically eligible and choosing to engage in OUD care as detailed in the standards. The payer will reimburse for screening services on an FFS basis in this model prior to the bundled payments being triggered.

Following similar model frameworks for OUD provided in the community, as described in the examples provided in the rate setting section (section 2.b), the bundles will vary slightly in reimbursement rate if the patient is initiating MOUD (including initiating as part of withdrawal management) as illustrated in Table 3 or continuing MOUD. If the services include initiation, a slightly higher rate is commensurate with those aligned with initiation. While required service standards are included in the baseline initiation and maintenance bundles, the services identified as optional can be added into the bundle rate if provided to an individual. In some cases reentry services may be carved out from the bundle rate due to the time-limited nature of these activities in contrast to a consistent set of services delivered throughout the incarceration period.

The provider would only bill an initiation bundled claim to Medicaid once per facility admission at the onset of treatment, with subsequent claims paid at the maintenance rate set. Regardless
of whether an individual was initiated first in the community, the jail or prison provider could still bill the initiation bundle upon enrollment and engagement in the program at any point during an incarceration period. It is recommended that only one initiation bundle be allowed per incarceration period to incentivize quality services and facilitate program integrity. A facility transfer during the same sentenced incarceration period for an individual should be considered a new incarceration period for the provider regarding a payment allowance for the initiation bundle.

In a prison setting, once reentry services commence, the provider will trigger a reentry bundle claim to Medicaid. The overall rate for this bundle will be higher than the maintenance bundle as the additional services include each of the reentry services required in the Standards. These services include case management, pre-release in-reach services, recovery support, harm reduction services, and a 30-day supply of MOUD upon release. Ongoing MOUD should continue to be facilitated and reimbursed as a service in the reentry bundle. This separate bundle is mostly relevant for prisons since, in the Standards, jails are required to begin reentry services at intake. Therefore, if the jail pursues a bundled payment model, Model 2 has the option to include reimbursement for reentry services for jails in the base bundle. The exception is, as indicated in the Standards, for individuals who are sentenced to more than 90 days in a jail setting and, therefore, reentry services should resume at a minimum of 90 days prior to release. In this circumstance, reentry service reimbursement remains an add-on service.

**Infrastructure requirements:** Bundled service reimbursement includes similar elements of the FFS infrastructure that are required for claims submission. However, the greatest difference is that the provider is no longer submitting a code for each service provided but rather an all-encompassing code daily, weekly, or monthly for each eligible and enrolled individual. The provider would still need to maintain records of all services in an EHR and would be required to participate in the measures reporting processes. Additionally, in a bundled model, the providers will need to have a more comprehensive method of costing and evaluating the budgeted expenditures related to the prospective reimbursement provided.

**Strengths:** As described in the literature review, a bundled payment model under Medicaid may be more similar to the existing budgeting structure used in carceral OUD programs. Transitioning to a bundled reimbursement model can strengthen operations and link together sometimes fragmented and disjointed clinical care to improve patient outcomes. Jail and prison providers may realize a more consistent cash flow based on a more predictable bundled reimbursement than FFS allows. There are times when actual patient care costs may be less than the bundle rate, allowing for aligned incentives between the facility and the payer that promote quality of care rather than the volume of services. The providers share the potential savings and can reinvest into the program or offset patients with greater expenses than the bundle rate provided. Any such approaches

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**Table 4. Illustrative Weekly Bundle Options for Model 2 and 2A**

<table>
<thead>
<tr>
<th>Bundle Type</th>
<th>Included Services</th>
</tr>
</thead>
</table>
| Initiation bundle      | • Clinical assessment  
                        | • MOUD initiation for opioid withdrawal              
                        | • MOUD initiation for OUD                           |
| Initiation add-ons     | • Multidimensional assessment  
                        | • Counseling                                          
                        | • Reentry services *(jails only)*                    |
| Maintenance bundle     | • MOUD continuation                                     |
| Maintenance bundle add-ons | • Counseling                                      
                        | • Intensive outpatient                               
                        | • Reentry services *(jails only)*                    |
| Reentry bundle         | • MOUD continuation                                     
                        | • Reentry services                                   |

*(prisons only)*
must be consistent with any reinvestment policies agreed upon by states and CMS.108

Limitations: Providers may face some financial risk if the cost of care for an individual exceeds the bundled reimbursement rate. Some individuals will have more complex needs and exceed the bundled rate, while others may cost less than the bundle. A bundled rate that incorporates risk-adjustment methodology can account for this variation in patient costs. Determining a bundled rate that aligns closely with actual costs may require annual rebasing and rate updates in the beginning years of the program as actual costs are identified. SMAs or MCOs may not be able to identify specific services and the dates of services provided to each individual based on claims alone.

SMAs will need to implement an accountability mechanism to ensure quality care is provided. In a bundled payment model without significant quality incentives and program integrity safeguards, there may be a potential for a provider to limit or offer sub-standard services. In contrast to community settings, a model that incentivizes volume initially, like Model 1, may be preferable upon program implementation to incentivize closing the treatment gap immediately.

3.d. Model 2A – Prospective Bundled Daily/Weekly/Monthly Rate with Quality Incentive

Overview: This model is based on Model 2; however, similar to Model 1A, it ties incentives to required or encouraged measures. Providers are eligible for bonuses upon succeeding with designated metrics and reporting requirements. The infrastructure requirements are the same as Model 2, with an increased emphasis on quality measure reporting and tracking.

Strengths: The strengths of this model align with the strengths identified in Model 1A regarding accountability and incentivizing quality, and Model 2 regarding payment provided through a bundled architecture.

Limitations: The limitations of Model 2A are the same as in Model 2. However, importantly, the limitations of accountability in bundled arrangements are mitigated through financial incentives tied to performance. Given the novel nature of the provider setting, there should be no additional downside financial risk imposed on the provider when adding the quality incentive in the early years of implementation.

Reentry Services to Drive Community-Based Outcomes

Upon discharge from a jail or prison to the community, it is essential to assertively link individuals to ongoing care from behavioral health providers in the community. Ideally, payment models would be developed to incentivize coordination and continuity at reentry. However, the complexity of transitions between providers (e.g., jail or prison provider to a community provider) and the variable geography of an individual’s release makes bridging payments across reentry very challenging; for that reason, the recommended payment models do not include a specific approach that can be applicable.

In the instance where an SMA or an MCO manages an individual’s care while incarcerated and post-release in the community, there is a potential opportunity to incentivize both the jail or prison provider and the community provider using the “Follow-Up after Release from a Jail or Prison” measures described in Appendix B. However, when an eligible individual is not covered by the same SMA or MCO vehicle during and after an incarceration period, or when the individual is not returning to a local community where the jail and prison provider has a community provider partnership, the Medicaid payer may have difficulty creating an aligned incentivize that bridges the two settings. In any model that chooses to financially incentivize the continuation of care inside jails and prisons as people return to the community, there may be concerns about limiting patient preference or choice.
As a result of the challenges in bridging payments between correctional and community settings, SMAs can separately consider incentivizing community-based providers to ensure care continuity upon reentry. Financial incentives for community providers could include increased rates or bonuses for successful engagement of MOUD services for individuals leaving jail and prison settings that were receiving OUD services.

**CONCLUSION**

Leveraging Medicaid reimbursement for OUD services to eligible individuals has the potential to reduce significant existing OUD treatment gaps for people who are incarcerated. Providing Medicaid-covered OUD services in jails and prisons advances timely, evidence-based, person-centered OUD services that promote continuity of care; leverage Medicaid as a new financing source to drive significant improvements in access to and quality of OUD services in prisons and jails; reduce spending in other parts of the health and criminal legal systems; and advance progress on national health and public safety goals. If policy shifted and Medicaid’s role were changed to allow states to cover OUD services in jails and prisons throughout an individual’s period of incarceration, the findings of this report and the payment model recommendations could be used by SMAs to make decisions with state and local correctional counterparts about how Medicaid can fund those services.

Any transition to providing, measuring, and paying for Medicaid–covered OUD services in jails and prisons will be challenging. Since jails and prisons currently vary regarding current capability and readiness to receive Medicaid reimbursement, there are significant infrastructure considerations that CMS and SMAs will have to overcome with their correctional health counterparts. The infrastructure and payment option models described in this report are designed to advance the ability of prisons and jails to establish standard OUD services and incentivize the tracking of the measures. These options have been constructed leveraging existing components of current community–based reimbursement models for OUD services while taking into consideration the specific and sometimes challenging circumstances in jails and prisons that are not present in community settings.

When providing OUD services using Medicaid coverage, states and the jail and prison providers can adopt these recommendations from a care delivery perspective and an administrative operations perspective. Both the services and administrative needs can be deployed in contracted models through community health vendors and TPAs to meet the novel requirements of billing Medicaid for jail and prison health services. The payment models vary in complexity, and SMAs should choose to implement the options based on the potential capabilities of the settings, the differences between jails and prisons, and the targeted population of interest.
APPENDIX A:
INTERVIEW SITE OVERVIEW, INTERVIEWEE SCHEDULE, AND SAMPLE QUESTION GUIDE

Interview Site Characteristics

All information in this report was provided from interviews that took place in April of 2023 unless otherwise noted. The table below provides context for each program interviewed.

The approach to staffing in facilities is identified in three ways:
- State, city, or county employees who work in the correctional facility administering MOUD services
- An outside health care vendor contracted for services
- A hybrid approach using correctional facility employees and some vendor services

Table A1: Interview Site Characteristics

<table>
<thead>
<tr>
<th>Site</th>
<th>Average Daily Population of People Incarcerated (Q2 2022)</th>
<th>Number of individuals enrolled in MOUD program</th>
<th>Type of MOUD Offered as of April 2023</th>
<th>Health Staffing Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denver City and County, Colorado</td>
<td>Jail: 1,719</td>
<td>578 individuals completed the MOUD program in 2022.</td>
<td>• Buprenorphine • Naltrexone • Methadone</td>
<td>County and City employees</td>
</tr>
<tr>
<td>California</td>
<td>Jail: 62,593</td>
<td>16,069 individuals received MAT as of April 2023.</td>
<td>• Buprenorphine • Naltrexone • Methadone</td>
<td>Hybrid; State and vendors</td>
</tr>
<tr>
<td></td>
<td>Prison: 98,039</td>
<td>Site indicated MAT rather than MOUD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kentucky</td>
<td>Jail: 23,030</td>
<td>1,135 MAT beds in prisons and 1,464 MAT beds were at capacity in 2022.</td>
<td>• Buprenorphine • Naltrexone • Methadone</td>
<td>State employees</td>
</tr>
<tr>
<td></td>
<td>Prison: 19,861</td>
<td>Site indicated MAT rather than MOUD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maine</td>
<td>Jail: 1,525</td>
<td>1,007 individuals received MOUD in 2021.</td>
<td>• Buprenorphine • Naltrexone • Methadone</td>
<td>Vendor</td>
</tr>
<tr>
<td></td>
<td>Prison: 1,652</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lorain County, Ohio</td>
<td>Jail: 315</td>
<td>Ten percent of the jail residents receive MOUD services as of April 2023.</td>
<td>• Buprenorphine • Naltrexone • Methadone</td>
<td>County employees</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middlesex County, Massachusetts</td>
<td>Jail: 668</td>
<td>Ninety to 100 people per day receive MOUD as of April 2023.</td>
<td>• Buprenorphine • Naltrexone • Methadone</td>
<td>Hybrid; Correctional facility employees and vendors</td>
</tr>
</tbody>
</table>

ix Data pulled from Vera Institute of Justice
## Table A2: Interview Schedule

<table>
<thead>
<tr>
<th>Interview Site</th>
<th>Interviewee</th>
<th>Position</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denver City and County, CO</td>
<td>Holly Witt</td>
<td>Nurse Program Manager for Behavioral Health and Substance Use Disorder for city and county jails</td>
<td>March 1, 2023</td>
</tr>
<tr>
<td></td>
<td>Carmen Kassatly</td>
<td>Registered Nurse and Health Services Administrator Denver Health</td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>Janene DelMundo</td>
<td>Project Director, CalAIM (California Advancing and Innovating Medi-Cal)</td>
<td>March 10, 2023</td>
</tr>
<tr>
<td></td>
<td>Lisa Heintz</td>
<td>Director of Legislation and Special Projects, California Correctional Health Care Services</td>
<td></td>
</tr>
<tr>
<td>Kentucky</td>
<td>Sarah Johnson</td>
<td>Director of Addiction Services, Kentucky Department of Corrections</td>
<td>March 3, 203</td>
</tr>
<tr>
<td>Maine</td>
<td>Anthony Cantillo</td>
<td>Deputy Commissioner, Maine Department of Corrections</td>
<td>March 28, 2023</td>
</tr>
<tr>
<td></td>
<td>Anna Black</td>
<td>Director of Government Affairs and Spokesperson, Maine Department of Corrections</td>
<td>April 5, 2023</td>
</tr>
<tr>
<td></td>
<td>Melissa Caminiti</td>
<td>Director of Recovery and Reentry Services, WellPath</td>
<td></td>
</tr>
<tr>
<td>Lorain County, OH</td>
<td>Andrew Laubenthal</td>
<td>Project Specialist Managing Rapid Re-Entry Services</td>
<td>April 5, 2023</td>
</tr>
<tr>
<td></td>
<td>Capt Jack Hammond</td>
<td>Director Of Corrections</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Margaret Boise</td>
<td>Healthcare Administrator, Lorain County Sheriff's Office</td>
<td></td>
</tr>
<tr>
<td>Middlesex County, MA</td>
<td>Kashif Siddiqi</td>
<td>Director of Fiscal Operations</td>
<td>April 7, 2023</td>
</tr>
</tbody>
</table>

### Interview Guide

#### Program Demographics

1. How many people are served through the program each month/year? What is the average monthly census?

   Services and Staffing

2. What specific services and MOUD are offered (Provide a simple taxonomy)? What reentry services do you provide? What factors were considered in making the decision about what services to offer?

3. Do you have standards for these services? Were these developed by your facility or an external party (e.g. state)?
4. Who is providing services/medications? What factors were considered in making this decision?
   1. If a community-based provider provides services, who is providing payment for services (operationally, what does the fund flow look like)?
   2. Do you have contracts with a community-based provider? If so, what are the major terms and conditions for both the facility and the provider?
5. If the facility operates services, what staff/practitioners (type, credentials, etc.) provide the treatment/support for each type of service?
6. Do services or providers vary by location, if so, what are the key variations and how are those decisions made? Does variation correlate with financing at all?
7. What is the current reentry process regarding the continuation of MOUD services and/or other SUD services being offered?

**Standards and Measure**

8. If the facility operates services, do you use any nationally recognized standards to guide program operations? If yes, which standards for which services?
9. What quality or performance measures, if any, are being tracked today? Are any measures being reported to stakeholders, and if so, who and at what cadence?

**Existing Financing Structure**

10. What is the current payer mix funding the program (proportion of correctional dollars, public health/SSA dollars, or other sources)? Has this mix evolved over the course of the program? If so, what were the biggest changes? How much of the funds are based on state v. federal sources?
11. Do you have a per-member/enrolled person estimate of the cost of the program, either monthly or annually? What is the per capita spending for MOUD services, or the structure of payment received for services today (FFS, Bundle, Capitation, etc.)? Does it cover both clinical program elements and medications?
12. What are the biggest challenges to securing and/or sustaining financing through current funding sources (i.e., grant-based, administrative challenges, funding levels, etc.)?
13. What were your program’s biggest implementation costs at the state and facility levels? What are the highest ongoing operational costs?

**Limitations and Future Expansion**

14. What are the biggest threats to the sustainability of your program financing today?
15. What are the biggest opportunities for program expansion? Are there areas of interest for expanding services that have been limited by existing financing? What areas are they? What are the biggest challenges to overcome when expanding?

**Potential Medicaid Involvement**

16. Discuss the challenges and opportunities involved in authorizing Medicaid and/or Medicaid Managed Care Organizations to provide reimbursement, given the structure in which your program currently operates today. Touch on existing FFS rates in the Medicaid market for MOUD.
17. What would the ideal Medicaid involvement be for the sustainability and financing of your program if it became the dominant source of funding for MOUD individuals in your facilities?
**APPENDIX B:**
**RECOMMENDED MEDICAID PERFORMANCE MEASURES FOR OUD IN JAILS AND PRISONS**

All information on each required and encouraged measure are detailed in the companion report, *Recommendations for Medicaid Performance Measures for Opioid Use Disorder Services in Jails and Prisons*.

**Table B1: Medicaid OUD Measures at Admission**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Setting</th>
<th>Data Sources</th>
<th>Implementation Years 1–3 Potential Incentive Use</th>
<th>Implementation Years 4–6 Potential Incentive Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Medicaid beneficiaries screened for OUD using a standardized screening tool during the measurement period</td>
<td>Jails and prisons</td>
<td>Claims, encounter information, EHR, or jail/prison administrative data</td>
<td>Reporting only</td>
<td>Reporting only</td>
</tr>
<tr>
<td>Percentage of Medicaid beneficiaries who had a documented OUD diagnosis (e.g., on insurance claim or EHR) during the measurement period</td>
<td>Jails and prisons</td>
<td>Claims, encounter information, EHR, or jail/prison administrative data</td>
<td>Reporting only</td>
<td>Reporting only</td>
</tr>
<tr>
<td>Percentage of Medicaid beneficiaries with OUD who initiate MOUD, by type of MOUD (methadone, buprenorphine, or naltrexone) while in a jail or prison</td>
<td>Jails and prisons</td>
<td>Claims, encounter information, or EHR</td>
<td>Reporting only</td>
<td>Performance based</td>
</tr>
<tr>
<td>Percentage of Medicaid beneficiaries continuing community initiated MOUD at admission</td>
<td>Jails and prisons</td>
<td>Claims, encounters and EHRs, state’s prescription drug monitoring programs and/or information collected from community prescribers</td>
<td>Reporting only</td>
<td>Performance based</td>
</tr>
</tbody>
</table>
### Table B2: Medicaid OUD Measures During Incarceration

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Setting</th>
<th>Data Sources</th>
<th>Implementation Years 1-3 Potential Incentive Use</th>
<th>Implementation Years 4-6 Potential Incentive Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of individuals who filled or were prescribed and dispensed an MOUD who received the MOUD for at least six months, overall, and by type of MOUD (methadone, buprenorphine, or naltrexone)</td>
<td>Prisons</td>
<td>Claims, encounter information, or EHR</td>
<td>Reporting only</td>
<td>Performance based</td>
</tr>
<tr>
<td>Number and rate of overdose deaths for Medicaid beneficiaries during incarceration</td>
<td>Jails, prisons, and reentry</td>
<td>State Medicaid beneficiary enrollment data, vital statistics data, and jail and prisons administrative data</td>
<td>Reporting only</td>
<td>Performance based</td>
</tr>
<tr>
<td>Encouraged Measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of Medicaid beneficiaries who change MOUD (by type) while in jail or prison</td>
<td>Jails and prisons</td>
<td>Medicaid claims, encounters, or EHR</td>
<td>Reporting only</td>
<td>Reporting only</td>
</tr>
</tbody>
</table>

### Table B3: Medicaid OUD Measures During Reentry

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Setting</th>
<th>Data Sources</th>
<th>Implementation Years 1-3 Potential Incentive Use</th>
<th>Implementation Years 4-6 Potential Incentive Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of Medicaid beneficiaries with an OUD who were dispensed an MOUD (by type of medicaid: methadone, buprenorphine, naltrexone) and naloxone on the day they re-entered the community</td>
<td>Reentry</td>
<td>Claims, encounter information, or EHR</td>
<td>Reporting only</td>
<td>Performance based</td>
</tr>
<tr>
<td>Percentage of adult individuals leaving incarceration with Medicaid coverage</td>
<td>Jails, prisons, and reentry</td>
<td>State Medicaid beneficiary enrollment data and jail and prisons administrative data</td>
<td>Reporting only</td>
<td>Performance based</td>
</tr>
</tbody>
</table>
### Table B4: Medicaid OUD Measures Post Reentry

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Setting</th>
<th>Data Sources</th>
<th>Implementation Years 1–3 Potential Incentive Use</th>
<th>Implementation Years 4–6 Potential Incentive Use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Required Measures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of Medicaid beneficiaries who received an MOUD for at least 60 and 90 days and by type of MOUD (methadone, buprenorphine, or naltrexone)</td>
<td>Reentry</td>
<td>Claims, encounter information, or EHR</td>
<td>Reporting only</td>
<td>Performance based</td>
</tr>
<tr>
<td>Follow-up after release from a jail or prison: percent of Medicaid beneficiaries released from jails or prisons that result in a follow-up visit or service for OUD within seven and 30 days post-reentry</td>
<td>Jails and prisons</td>
<td>Claims, encounter information or EHR and jail and prison administrative information re: discharges</td>
<td>Reporting only</td>
<td>Performance based</td>
</tr>
<tr>
<td>Number and rate of overdose deaths for Medicaid beneficiaries one month and six months post-reentry</td>
<td>Jails, prisons, and reentry</td>
<td>State Medicaid beneficiary enrollment data, vital statistics data, and jail and prisons administrative data</td>
<td>Reporting only</td>
<td>Reporting only</td>
</tr>
<tr>
<td><strong>Encouraged Measures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of Medicaid beneficiaries who return to jails and prisons post-reentry</td>
<td>Jails and prisons</td>
<td>Jail and prison administrative data and Medicaid enrollment data</td>
<td>Reporting only</td>
<td>Reporting only</td>
</tr>
<tr>
<td>Percentage of Medicaid beneficiaries reporting positive recovery-related outcomes post-reentry</td>
<td>Reentry</td>
<td>Response of a survey administered by a Medicaid MCO or other third party (e.g., university partner or Medicaid External Quality Review Organization)</td>
<td>Reporting only</td>
<td>Reporting only</td>
</tr>
</tbody>
</table>
### Table B5: Other Recommended Medicaid OUD Measures for Jails and Prisons

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Setting</th>
<th>Data Sources</th>
<th>Implementation Years 1–3 Potential Incentive Use</th>
<th>Implementation Years 4–6 Potential Incentive Use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Required Measures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number and percent of jails and prisons that participate as Medicaid providers in the state’s Medicaid program during the 1115 demonstration period</td>
<td>Jails and prisons</td>
<td>Enrollment or other information from the SMA and MCOs (if applicable)</td>
<td>Reporting only</td>
<td>Reporting only</td>
</tr>
</tbody>
</table>
APPENDIX C:
FEE SCHEDULE EXAMPLES

Table C1: Medicare OUD Bundle Rates

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Descriptor</th>
<th>2024 Drug Cost</th>
<th>2024 Non-Drug Cost</th>
<th>2024 Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>G2067</td>
<td>Medication-assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)</td>
<td>$40.71</td>
<td>$219.09</td>
<td>$259.80</td>
</tr>
<tr>
<td>G2068</td>
<td>Medication-assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)</td>
<td>$71.76</td>
<td>$219.09</td>
<td>$290.85</td>
</tr>
<tr>
<td>G2069</td>
<td>Medication-assisted treatment, buprenorphine (injectable); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)</td>
<td>$1,780.17</td>
<td>$226.33</td>
<td>$2,006.50</td>
</tr>
<tr>
<td>G2070</td>
<td>Medication-assisted treatment, buprenorphine (implant insertion); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)</td>
<td>$4,950.00</td>
<td>$483.98</td>
<td>$5,433.98</td>
</tr>
<tr>
<td>G2071</td>
<td>Medication-assisted treatment, buprenorphine (implant removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)</td>
<td>$0.00</td>
<td>$505.85</td>
<td>$505.85</td>
</tr>
<tr>
<td>G2072</td>
<td>Medication-assisted treatment, buprenorphine (implant insertion and removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)</td>
<td>$4,950.00</td>
<td>$730.27</td>
<td>$5,680.27</td>
</tr>
</tbody>
</table>

i 2024 CMS OTP Payment Rates
<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Descriptor</th>
<th>2024 Drug Cost</th>
<th>2024 Non-Drug Cost</th>
<th>2024 Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>G2073</td>
<td>Medication-assisted treatment, naltrexone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)</td>
<td>$1,420.06</td>
<td>$226.33</td>
<td>$1,646.39</td>
</tr>
<tr>
<td>G2074</td>
<td>Medication-assisted treatment, weekly bundle not including the drug, including substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)</td>
<td>$0.00</td>
<td>$207.29</td>
<td>$207.29</td>
</tr>
<tr>
<td>G2075</td>
<td>Medication-assisted treatment, medication not otherwise specified; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>G0137</td>
<td>Intensive outpatient services; minimum of nine services over a 7-contiguous day period, which can include individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law); occupational therapy requiring the skills of a qualified occupational therapist; services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients; drugs and biologicals furnished for therapeutic purposes, excluding opioid agonist and antagonist medications that are FDA-approved for use in treatment of OUD or opioid antagonist medications for the emergency treatment of known or suspected opioid overdose; individualized activity therapies that are not primarily recreational or diversionary; family counseling (the primary purpose of which is treatment of the individual’s condition); patient training and education (to the extent that training and educational activities are closely and clearly related to individual’s care and treatment); diagnostic services (not including toxicology testing); (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure, if applicable.</td>
<td>$0.00</td>
<td>$778.20</td>
<td>$778.20</td>
</tr>
</tbody>
</table>

*2024 CMS OTP Payment Rates*
### Table C1: Medicare OUD Bundle Rates (cont.)

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Descriptor</th>
<th>2024 Drug Cost</th>
<th>2024 Non-Drug Cost</th>
<th>2024 Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>G2076</td>
<td>Intake activities, including initial medical examination that is a complete, fully documented physical evaluation and initial assessment by a program physician, or a primary care physician, or an authorized healthcare professional under the supervision of a program physician, or qualified personnel that includes preparation of a treatment plan that includes the patient’s short-term goals and the tasks the patient must perform to complete the short-term goals; the patient’s requirements for education, vocational rehabilitation, and employment; and the medical, psycho-social, economic, legal, or other supportive services that a patient needs, conducted by qualified personnel (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.</td>
<td>$0.00</td>
<td>$201.73</td>
<td>$201.73</td>
</tr>
<tr>
<td>G2077</td>
<td>Periodic assessment; assessing periodically by qualified personnel to determine the most appropriate combination of services and treatment (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.</td>
<td>$0.00</td>
<td>$123.96</td>
<td>$123.96</td>
</tr>
<tr>
<td>G2078</td>
<td>Take-home supply of methadone; up to seven additional day supply (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.</td>
<td>$40.71</td>
<td>$0.00</td>
<td>$40.71</td>
</tr>
<tr>
<td>G2079</td>
<td>Take-home supply of buprenorphine (oral); up to seven additional day supply (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.</td>
<td>$71.76</td>
<td>$0.00</td>
<td>$71.76</td>
</tr>
<tr>
<td>G2080</td>
<td>Each additional 30 minutes of counseling in a week of medication assisted treatment, (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.</td>
<td>$0.00</td>
<td>$34.79</td>
<td>$34.79</td>
</tr>
<tr>
<td>G2215</td>
<td>Take-home supply of nasal naloxone (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.</td>
<td>$52.74</td>
<td>$2.80</td>
<td>$55.54</td>
</tr>
</tbody>
</table>

Footnote: 2024 CMS OTP Payment Rates
### Table C1: Medicare OUD Bundle Rates

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Descriptor</th>
<th>2024 Drug Cost</th>
<th>2024 Non-Drug Cost</th>
<th>2024 Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>G2216</td>
<td>Take-home supply of injectable naloxone (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.</td>
<td>Contractor-priced</td>
<td>Contractor-priced</td>
<td>Contractor-priced</td>
</tr>
<tr>
<td>G1028</td>
<td>Take-home supply of nasal naloxone; 2-pack of 8mg per 0.1 mL nasal spray (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.</td>
<td>$125.00</td>
<td>$2.80</td>
<td>$127.80</td>
</tr>
</tbody>
</table>

### Table C2: Virginia Addiction and Recovery Treatment Services (ARTS) Reimbursement Structure, 2022

<table>
<thead>
<tr>
<th>HCPC</th>
<th>Service Name</th>
<th>Service Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Community Based Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H0006</td>
<td>Substance Use Case Management (licensed by DBHDS)</td>
<td>Targeted Substance Use Case Management Services—provided by DBHDS licensed case management provider.</td>
<td>$273.38 Month</td>
</tr>
<tr>
<td>T1012</td>
<td>Peer support services – Individual</td>
<td>Non-clinical, relationship-focused collaborative approach using experiential knowledge and experiential expertise to connect and relate to others, integrating person-centered, strength-based best practices to support the development of self-advocacy skills, treating each individual as the lead of his/her rehabilitation and recovery process—individual setting.</td>
<td>$7.31 15 Minutes</td>
</tr>
<tr>
<td>S9445</td>
<td>Peer support services – Group</td>
<td>Non-clinical, relationship-focused collaborative approach using experiential knowledge and experiential expertise to connect and relate to others, integrating person-centered, strength-based best practices to support the development of self-advocacy skills, treating each individual as the lead of his/her rehabilitation and recovery process—group setting.</td>
<td>$3.04 15 Minutes</td>
</tr>
</tbody>
</table>

---

1. 2024 CMS OTP Payment Rates
2. Virginia Addiction and Recovery Treatment Services (ARTS) Reimbursement Structure
### Table C2: Virginia Addiction and Recovery Treatment Services (ARTS) Reimbursement Structure, 2022 (cont.)

<table>
<thead>
<tr>
<th>HCPC</th>
<th>Service Name</th>
<th>Service Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0015 or rev 0906 with H0015</td>
<td>Intensive Outpatient</td>
<td>Structured program delivering 9-19 hours per week, before/after work/school, in evening and/or weekends to meet complex needs of people with addiction and co-occurring conditions.</td>
<td>$281.25  Day</td>
</tr>
<tr>
<td>S0201 or rev 0913 with S0201</td>
<td>Partial Hospitalization</td>
<td>20 or more hours of clinically intensive programming per week with a planned format of individualized and family therapies.</td>
<td>$562.50  Day</td>
</tr>
</tbody>
</table>

### Opioid Treatment Programs (OTP) / Preferred Office Based Addiction Treatment (OBAT)

<table>
<thead>
<tr>
<th>HCPC</th>
<th>Service Name</th>
<th>Service Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0014</td>
<td>Medication Assisted Treatment (MAT) day one induction for OUD or AUD - Physician/Physician Extender</td>
<td>Alcohol and/or drug services; ambulatory detoxification; All non-facility withdrawal management inductions</td>
<td>$157.50  Encounter; limit 3 inductions per calendar year 90 days apart</td>
</tr>
<tr>
<td>G9012</td>
<td>Substance Use Care Coordination</td>
<td>OBAT and OTP Substance Use Care coordination to manage MAT treatment</td>
<td>$273.38  Month</td>
</tr>
<tr>
<td>H0020</td>
<td>Medication Administration</td>
<td>Medication administration by RN / LPN</td>
<td>$9.00    Encounter</td>
</tr>
<tr>
<td>H0004</td>
<td>SUD treatment services – Individual Counseling</td>
<td>SUD Treatment – individual counseling</td>
<td>$27.00  15 Minutes</td>
</tr>
<tr>
<td>H0005</td>
<td>SUD treatment services – Group Counseling</td>
<td>SUD Treatment – group counseling and family therapy</td>
<td>$8.16    15 Minutes</td>
</tr>
<tr>
<td>J3490</td>
<td>Drugs unclassified injection</td>
<td>Medication administration by provider</td>
<td>Identify the drug and total dose; include invoice for pricing.</td>
</tr>
</tbody>
</table>

---

ii Virginia Addiction and Recovery Treatment Services (ARTS) Reimbursement Structure.
Table C2: Virginia Addiction and Recovery Treatment Services (ARTS) Reimbursement Structure, 2022ii (cont.)

<table>
<thead>
<tr>
<th>HCPC</th>
<th>Service Name</th>
<th>Service Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>S0109</td>
<td>Medication administration in clinic</td>
<td>Methadone, oral, 5 mg</td>
<td>$0.26 Unit</td>
</tr>
<tr>
<td>J0570</td>
<td>Medication administration in clinic</td>
<td>Probuphine (buprenorphine implant) 74.2 mg</td>
<td>$1311.75 Unit (6 months)</td>
</tr>
<tr>
<td>J0571</td>
<td>Medication administration in clinic</td>
<td>Buprenorphine, oral, 1 mg</td>
<td>$1.00 Unit</td>
</tr>
<tr>
<td>J0572</td>
<td>Medication administration in clinic</td>
<td>Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine</td>
<td>$4.34 Unit</td>
</tr>
<tr>
<td>J0573</td>
<td>Medication administration in clinic</td>
<td>Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine</td>
<td>$7.76 Unit</td>
</tr>
<tr>
<td>J0574</td>
<td>Medication administration in clinic</td>
<td>Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine</td>
<td>$7.76 Unit</td>
</tr>
<tr>
<td>J0575</td>
<td>Medication administration in clinic</td>
<td>Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine</td>
<td>$15.52 Unit</td>
</tr>
<tr>
<td>J2315</td>
<td>Medication administration in clinic</td>
<td>Naltrexone, injection (depot form), 1mg</td>
<td>$3.43 Unit</td>
</tr>
</tbody>
</table>

ii Virginia Addiction and Recovery Treatment Services (ARTS) Reimbursement Structure
APPENDIX D

Members of the Advisory Council
Robert Ashford, MSW, PhD, Executive Director, Unity Recovery
Justin Berk, MD, MPH, MBA, Assistant Professor, Brown University
Bruce Herdman, MBA, PhD, Chief of Medical Operations, Philadelphia Department of Prisons
Nneka Jones Tapia, MA, PsyD, Managing Director of Justice Initiatives, Chicago Beyond
Daryl McGraw, MA, Associate Director of Social Justice and Recovery, C4 Innovations
Vitka Eisen, MSW, EdD, President and CEO, HealthRIGHT 360
Jami Snyder, MA, Owner, JSN Strategies, LLC.
Jonas Thom, MA, CEO, Beechlands Group

Reviewers
Richard Frank, PhD, Senior Fellow – Economic Studies, Director – Brookings Schaeffer Initiative on Health Policy
Tyler Sadwith, Deputy Director, Behavioral Health, California Department of Health Care Services
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