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

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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.[4,5,6,7,8]

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.[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.[13] 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

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

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.[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.[16] Medicaid now covers a disproportionate share of adults with OUD and is the largest payer of OUD treatment services in the United States.[17,18,19]

In April 2023, the Bureau of Justice Statistics released a national report on screening for OUD in jails.[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%.[i,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

Required
• Screening • Clinical assessment • MOUD initiation for opioid withdrawal • MOUD initiation for OUD • MOUD continuation • Reentry services
Optional Services *(Not Required)*
• Multidimensional assessment • Counseling • Intensive outpatient

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

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.[22] 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.[ii] 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.[23] In June 2023, Washington State became the second state to receive CMS approval for a reentry wavier.[24]

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.[25] 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.

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. EXISTING FINANCING STRUCTURES FOR OUD SERVICES IN JAILS, PRISONS, AND COMMUNITY-BASED SETTINGS

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.[iii,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.[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

iii Differences are described in detail in the Standards report.

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.[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.[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.[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.[30] Kentucky is currently revising its proposal.[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.[32] The literature review did not identify cases in which OUD programs tied performance measure achievement to payment incentives.

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. 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.

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.[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.[34] 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.[35] 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.[36]

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.[37,38]

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.[v] 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.[39] 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.

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.[40] 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.[41,42] 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.[43] 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.[44] In 2021, 59.5% of health care dollars were paid through a value-based care model.[45] 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.[46] 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.[47] Several states reimburse SUD treatment services, including MOUD, outside of a traditional FFS structure.[48] States have supported APMs as a method to strengthen service delivery for SUD and OUD services.[49] 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.[vi,50] The monthly bundle categorized for "non-facility" ranges from $388 to $518 per patient excluding pharmaceutical costs, depending on locality.[51]

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.[52]

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.[53] 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.[54] 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.[55]

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

vi The set of office-based activities included in this bundle are broader than the services required in the Standards report since they include counseling and also apply to the treatment of non-OUD SUD conditions.

expenditures."[56] The program established two new payment elements for reimbursing OUD treatment providers accompanying the individual bundled payments (which vary by medication) for the MOUD services provided. Medicare provides associated research and justification for these new benefits in the Request for Application:[57]

1. A per beneficiary per month (PMPM) care management fee (CMF) of $125 is used to fund care delivery and infrastructure needed to manage the patient population effectively.[58]
2. A performance-based incentive as a portion of the CMF (0% in performance Year 1; 5 percent in performance Year 2; and 10% in each performance year thereafter) payable based on the provider's performance on specified quality metrics, including retention in treatment, patients' emergency department utilization, use of pharmacotherapy for OUD, follow-up after a patient's emergency department visit for alcohol and other drug use or dependence, and initiation and engagement of alcohol and other drug use or dependences.[59]

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.[60] Rhode Island introduced its OTP health home model in 2013.[61] 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."[62]

Any OTP health home provider certified as a COE can bill for a weekly bundle. The 2019 COE rates for one-time induction ranged from $400.00 to $600.00, while the COE weekly services were reimbursed at $125.00 per week and did not include medication costs.[63]

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.[64] 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.[65] 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.[66] 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.[67] 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.[68,69] 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.[70]

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.).[71,72]

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.[73] 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.[74]

SECTION 2. RECOMMENDATIONS FOR MEDICAID PAYMENT IMPLEMENTATION AND OPERATIONS FOR OUD SERVICES IN JAILS AND PRISONS

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.[vii] 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.[75]

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

vii All Medicaid-covered services referenced in this report are detailed in the Standards report.

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."[76] 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.[77] Second, CMS committed to supporting similar activities in its Washington state waiver approval.[78]

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.[79] 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.[80] Addressing ongoing staffing and security needed to expand access to MOUD 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).[81] States are eligible to request approval for a 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."[82] States can also request a 75/25 enhanced federal match for ongoing operations of approved CMS systems.[83]

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.[84] 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.[85] 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.[86]

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.

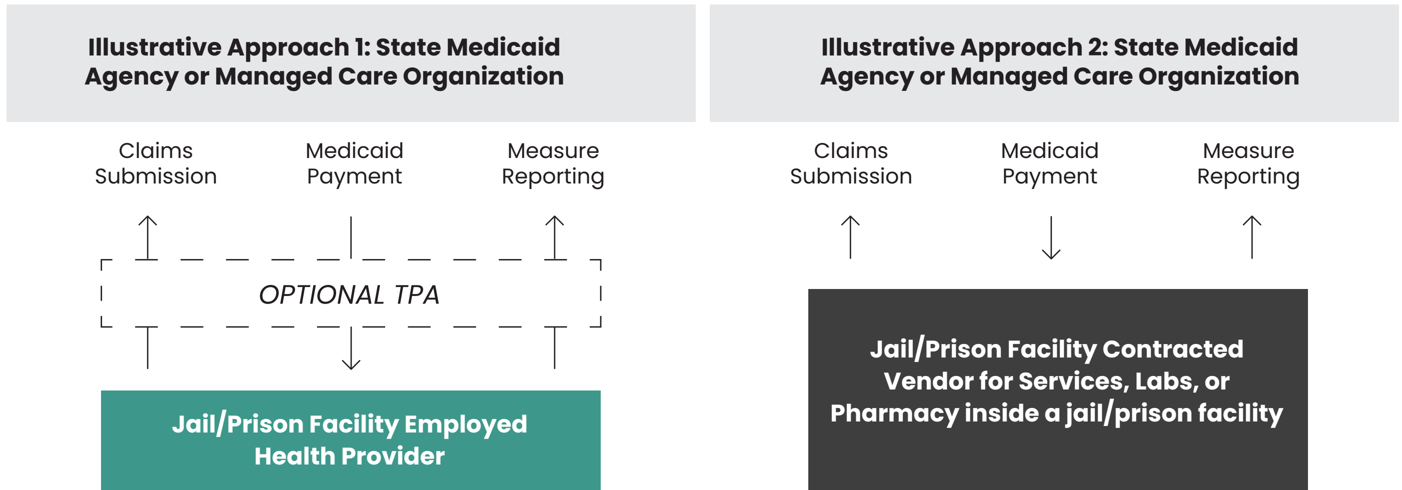
Medicaid payment flow illustration

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.[87]

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

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



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.[88] 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.[89] States often use adjustment factors, including provider type, geography, site of service, or patient age.[90]

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.[91] 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.[92]

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

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

viii As indicated in a 2019 report titled State Approaches to Developing the Residential Treatment Continuum for Substance Use Disorder.

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.[101]

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.[102]

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.[103]

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.[104] The models have been classified using this framework to provide a reference to where each model sits in terms of the baseline architecture.

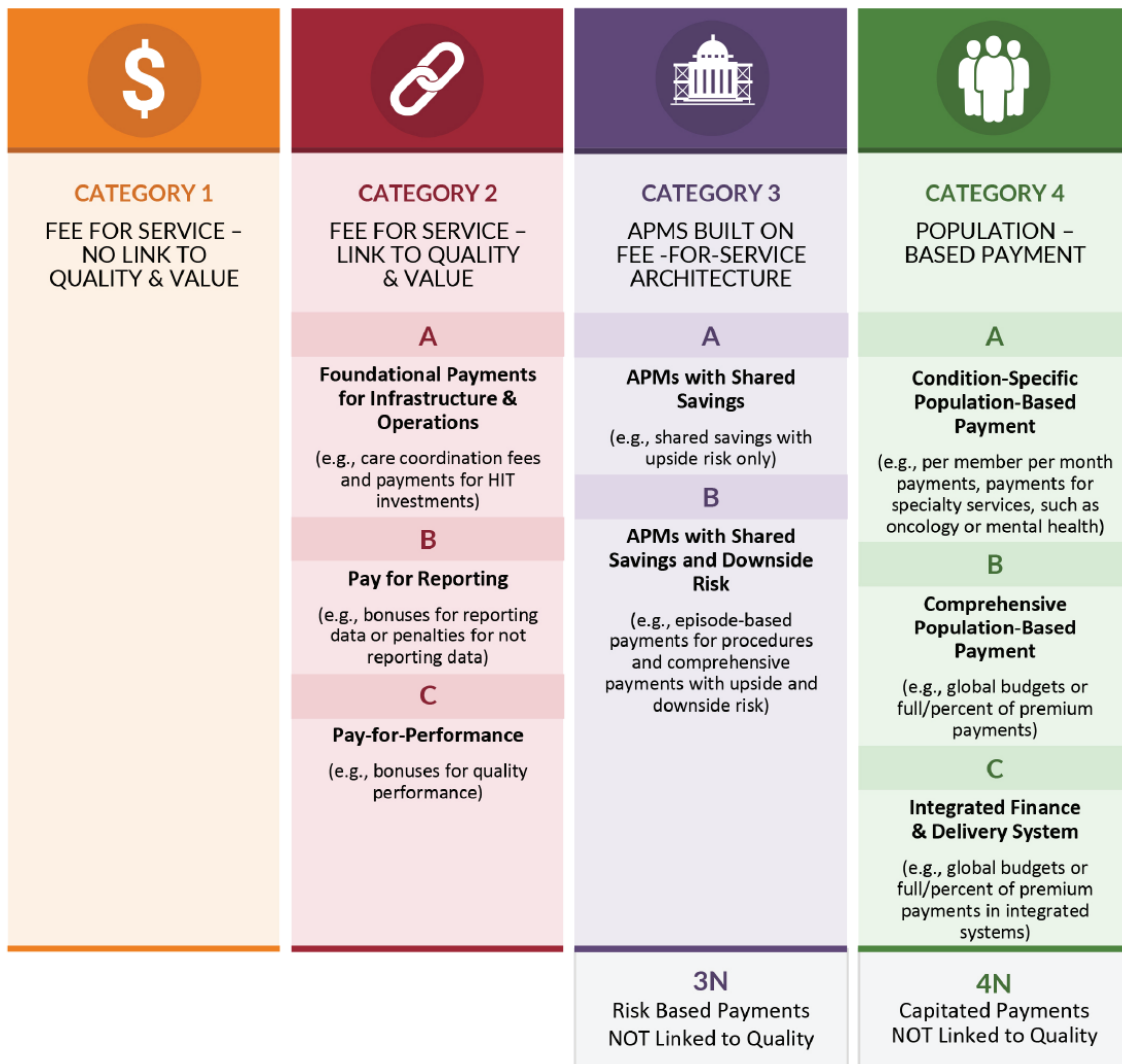
Since these models have been designed for a new provider setting, the recommended payment models only include opportunities for upside incentive payments and do not include downside risk at this time. After a few years of experience paying for Medicaid-covered OUD services, SMAs may choose to develop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

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

Figure 2. HCPLAN APM Framework



HCPLAN The Updated APM Framework

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.[105] 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.[106] 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.[107] 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

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

Bundle Type	Included Services
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 *(prisons only)*	• MOUD continuation • Reentry services

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

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

Site	Average Daily Population of People Incarcerated (Q2 2022)[ix]	Number of individuals enrolled in MOUD program	Type of MOUD Offered as of April 2023	Health Staffing Model
Denver City and County, Colorado	Jail: 1,719	578 individuals completed the MOUD program in 2022.	• Buprenorphine • Naltrexone • Methadone	County and City employees
California	Jail: 62,593 Prison: 98,039	16,069 individuals received MAT as of April 2023. *Site indicated MAT rather than MOUD*	• Buprenorphine • Naltrexone • Methadone	Hybrid; State and vendors
Kentucky	Jail: 23,030 Prison: 19,861	1,135 MAT beds in prisons and 1,464 MAT beds were at capacity in 2022. *Site indicated MAT rather than MOUD*	• Buprenorphine • Naltrexone • Methadone	State employees
Maine	Jail: 1,525 Prison: 1,652	1,007 individuals received MOUD in 2021.	• Buprenorphine • Naltrexone • Methadone	Vendor
Lorain County, Ohio	Jail: 315	Ten percent of the jail residents receive MOUD services as of April 2023.	• Buprenorphine • Naltrexone • Methadone – not offered as of time of interview but adding in 2023	County employees
Middlesex County, Massachusetts	Jail: 668	Ninety to 100 people per day receive MOUD as of April 2023.	• Buprenorphine • Naltrexone • Methadone	Hybrid; Correctional facility employees and vendors

ix Data pulled from Vera Institute of Justice

Table A2: Interview Schedule

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

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

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

Table B2: Medicaid OUD Measures During Incarceration

Measure	Measure Setting	Data Sources	Implementation Years 1-3 Potential Incentive Use	Implementation Years 4-6 Potential Incentive Use
Required Measures				
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)	Prisons	Claims, encounter information, or EHR	Reporting only	Performance based
Number and rate of overdose deaths for Medicaid beneficiaries during incarceration	Jails, prisons, and reentry	State Medicaid beneficiary enrollment data, vital statistics data, and jail and prisons administrative data	Reporting only	Performance based
Encouraged Measures				
Percentage of Medicaid beneficiaries who change MOUD (by type) while in jail or prison	Jails and prisons	Medicaid claims, encounters, or EHR	Reporting only	Reporting only

Table B3: Medicaid OUD Measures During Reentry

Measure	Measure Setting	Data Sources	Implementation Years 1-3 Potential Incentive Use	Implementation Years 4-6 Potential Incentive Use
Required Measures				
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	Reentry	Claims, encounter information, or EHR	Reporting only	Performance based
Percentage of adult individuals leaving incarceration with Medicaid coverage	Jails, prisons, and reentry	State Medicaid beneficiary enrollment data and jail and prisons administrative data	Reporting only	Performance based

Table B4: Medicaid OUD Measures Post Reentry

Measure	Measure Setting	Data Sources	Implementation Years 1-3 Potential Incentive Use	Implementation Years 4-6 Potential Incentive Use
Required Measures				
Percentage of Medicaid beneficiaries who received an MOUD for at least 60 and 90 days and by type of MOUD (methadone, buprenorphine, or naltrexone)	Reentry	Claims, encounter information, or EHR	Reporting only	Performance based
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	Jails and prisons	Claims, encounter information or EHR and jail and prison administrative information re: discharges	Reporting only	Performance based
Number and rate of overdose deaths for Medicaid beneficiaries one month and six months post-reentry	Jails, prisons, and reentry	State Medicaid beneficiary enrollment data, vital statistics data, and jail and prisons administrative data	Reporting only	Reporting only
Encouraged Measures				
Percentage of Medicaid beneficiaries who return to jails and prisons post-reentry	Jails and prisons	Jail and prison administrative data and Medicaid enrollment data	Reporting only	Reporting only
Percentage of Medicaid beneficiaries reporting positive recovery-related outcomes post-reentry	Reentry	Response of a survey administered by a Medicaid MCO or other third party (e.g., university partner or Medicaid External Quality Review Organization)	Reporting only	Reporting only

Table B5: Other Recommended Medicaid OUD Measures for Jails and Prisons

Measure	Measure Setting	Data Sources	Implementation Years 1-3 Potential Incentive Use	Implementation Years 4-6 Potential Incentive Use
Required Measures				
Number and percent of jails and prisons that participate as Medicaid providers in the state's Medicaid program during the 1115 demonstration period	Jails and prisons	Enrollment or other information from the SMA and MCOs (if applicable)	Reporting only	Reporting only

APPENDIX C:
FEE SCHEDULE EXAMPLES

Table C1: Medicare OUD Bundle Rates[i]

HCPCS	Descriptor	2024 Drug Cost	2024 Non-Drug Cost	2024 Total Cost
G2067	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)	$40.71	$219.09	$259.80
G2068	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)	$71.76	$219.09	$290.85
G2069	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)	$1,780.17	$226.33	$2,006 .50
G2070	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)	$4,950.00	$483.98	$5,433.98
G2071	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)	$0.00	$505.85	$505.85
G2072	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)	$4,950.00	$730.27	$5,680.27

i 2024 CMS OTP Payment Rates

Table C1: Medicare OUD Bundle Rates[i] (cont.)

HCPCS	Descriptor	2024 Drug Cost	2024 Non-Drug Cost	2024 Total Cost
G2073	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)	$1,420.06	$226.33	$1,646.39
G2074	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)	$0.00	$207.29	$207.29
G2075	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)	$0.00	$0.00	$0.00
G0137	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.	$0.00	$778.20	$778.20

i 2024 CMS OTP Payment Rates

Table C1: Medicare OUD Bundle Rates[i] (cont.)

HCPCS	Descriptor	2024 Drug Cost	2024 Non-Drug Cost	2024 Total Cost
INTENSITY ADD ON CODES				
G2076	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.	$0.00	$201.73	$201.73
G2077	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.	$0.00	$123.96	$123.96
G2078	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.	$40.71	$0.00	$40.71
G2079	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.	$71.76	$0.00	$71.76
G2080	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.	$0.00	$34.79	$34.79
G2215	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.	$52.74	$2.80	$55.54

i *2024 CMS OTP Payment Rates*

Table C1: Medicare OUD Bundle Rates[i] (cont.)

HCPCS	Descriptor	2024 Drug Cost	2024 Non-Drug Cost	2024 Total Cost
G2216	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.	Contractor-priced	Contractor-priced	Contractor-priced
G1028	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.	$125.00	$2.80	$127.80

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

HCPC	Service Name	Service Description	Rate
Community Based Care			
H0006	Substance Use Case Management (licensed by DBHDS)	Targeted Substance Use Case Management Services- provided by DBHDS licensed case management provider.	$273.38 Month
T1012	Peer support services - Individual	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.	$7.31 15 Minutes
S9445	Peer support services - Group	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	$3.04 15 Minutes

i *2024 CMS OTP Payment Rates*
ii *Virginia Addiction and Recovery Treatment Services (ARTS) Reimbursement Structure*

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

HCPC	Service Name	Service Description	Rate
H0015 or rev 0906 with H0015	Intensive Outpatient	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.	$281.25 Day
S0201 or rev 0913 with S0201	Partial Hospitalization	20 or more hours of clinically intensive programming per week with a planned format of individualized and family therapies.	$562.50 Day

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

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

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

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

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

APPENDIX D

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REFERENCES:

1. Center for Disease Control and Prevention. Products - Vital Statistics Rapid Release - Provisional Drug Overdose Data [Internet]. CDC. 2022. Available from: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm
2. National Institute on Drug Abuse. Drug Overdose Death Rates [Internet]. Rockville, MD. National Institutes of Health. [Updated June 30, 2023; Accessed August 7th, 2023]. Available from: https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates.
3. Bronson J, Stroop J, Zimmer S, Berzofsky M. Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics Special Report. June 2017, revised August 2020. NCJ 250546. https://bjs.ojp.gov/content/pub/pdf/dudaspji0709.pdf.
4. Binswanger IA, Blatchford PJ, Mueller SR, Stern MF. Mortality after prison release: opioid overdose and other causes of death, risk factors, and time trends from 1999 to 2009. Annals of internal medicine. 2013 Nov 5;159(9):592-600.
5. Ranapurwala SI, Shanahan ME, Alexandridis AA, Proescholdbell SK, Naumann RB, Edwards D, Marshall SW. Opioid overdose mortality among former North Carolina inmates: 2000–2015. American journal of public health. 2018 Sep;108(9);1207-13.[Fix page range to 1207-13.]
6. Pizzicato LN, Drake R, Domer-Shank R, Johnson CC, Viner KM. Beyond the walls: Risk factors for overdose mortality following release from the Philadelphia Department of Prisons. Drug and alcohol dependence. 2018 Aug 1;189:108-15.
7. Carson, EA. "Mortality in Local Jails, 2000-2018 – Statistical Tables." U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. April 2021. NCJ 256002. https://bjs.ojp.gov/content/pub/pdf/mlj0018st.pdf. Figure 5.
8. Carson, EA. "Mortality in State and Federal Prisons, 2001-2018 – Statistical Tables." U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. April 2021. NCJ 255970. https://bjs.ojp.gov/content/pub/pdf/msfp0118st.pdf. Figure 3.
9. Nunn A, Zaller N, Dickman S, Trimbur C, Nijhawan A, Rich JD. Methadone and buprenorphine prescribing and referral practices in US prison systems: results from a nationwide survey. Drug and alcohol dependence. 2009 Nov 1;105(1-2):83-8.
10. Nowotny KM. Race/ethnic disparities in the utilization of treatment for drug dependent inmates in US state correctional facilities. Addictive Behaviors. 2015 Jan; 40:148-53.
11. Rich JD, Boutwell AE, Shield DC, Key RG, McKenzie M, Clarke JG, Friedmann PD. Attitudes and practices regarding the use of methadone in US state and federal prisons. Journal of Urban Health. 2005 Sep;82:411-9.
12. Wakeman SE, Rich JD. Addiction Treatment Within U.S. Correctional Facilities: Bridging the Gap Between Current Practice and Evidence-Based Care. Journal of Addictive Diseases. 2015 Jun 15;34(2-3):220–5.
13. Camhi N, Mistak D, Wachino V. Medicaid's Evolving Role in Advancing the Health of People Involved in the Justice System [Internet]. The Commonwealth Fund. (Updated, November 18, 2020; Accessed August 7, 2023). Available from: https://www.commonwealthfund.org/sites/default/files/2020-11/Camhi_Medicaid_role_health_justice_system_ib.pdf.
14. Saunders H, Panchal N. Addressing the Opioid Crisis: A Look at the Evolving Landscape of Federal OUD Treatment Policies [Internet]. San Francisco, CA. KFF. [Updated July 11, 2023; Accessed September 11, 2023]. Available from: https://www.kff.org/mental-health/issue-brief/addressing-the-opioid-crisis-a-look-at-the-evolving-landscape-of-federal-oud-treatment-policies/. In addition, statutory changes that require Medicaid to cover some services provide to youth take effect in all states in 2025.
15. Abraham AJ, Andrews CM, Grogan CM, D'Aunno T, Humphreys KN, Pollack HA, et al. The Affordable Care Act Transformation of Substance Use Disorder Treatment. American Journal of Public Health [Internet]. 2017 Jan;107(1):31–2. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5308192/
16. Schulman M, O'Brien J, Pierre-Wright M, Thomas-Henkel C. Exploring Value-Based Payment to Encourage Substance Use Disorder Treatment in Primary Care [Internet]. Available from: https://www.chcs.org/media/VBP-for-SUD_Final_June-2018.pdf
17. The Mental Health Parity and Addiction Equity Act (MHPAEA) | CMS [Internet]. www.cms.gov. (Updated September 06, 2023; cited October 19 2023)Available from: https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity
18. Orgera K, Tolbert J. The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment [Internet]. 2019 [cited 2023 Oct 19]. Available from: https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/;4.
19. Clemans-Cope L, Lynch V, Payton M, Aarons J. Medicaid professional fees for treatment of opioid use disorder varied widely across states and were substantially below fees paid by Medicare in 2021. Substance Abuse Treatment Prevention and Policy. 2022 Jul 6;17(1).
20. Opioid Use Disorder Screening and Treatment in Local Jails, 2019[Internet]. [cited 2023 Oct 19]. Available from: https://bjs.ojp.gov/library/publications/opioid-use-disorder-screening-and-treatment-local-jails-2019
21. Carson EA. Mortality in State and Federal Prisons, 2001-2018 – Statistical Tables. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, April 2021, NCJ 255970, https://bjs.ojp.gov/content/pub/pdf/msfp0118st.pdf.

22. Center for Medicaid and CHIP Services, Letter to State Medicaid Director, SMD # 23-003 RE: Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who are Incarcerated, April 2023, https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf.
23. California Department of Health Care Services, Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative [Internet]. 2023 [cited October 32 2023]. Available from: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf; 13
24. Letter to Charissa Fotinos, MD Washington State Medicaid Transformation Project 2.0 Approval Letter. [Internet].2023 [cited October 25 2023]. Available from: https://www.medicaid.gov/sites/default/files/2023-06/wa-medicaid-transformation-ca-06302023.pdf; 7
25. Jail & Prison Opioid Project. About JPOP [Internet].2023 [updated on 7/30/21, cited November 2023 11/7/21]. Available from: https://prisonopioidproject.org/#fn3/
26. Center for Medicaid and CHIP Services, Letter to State Medicaid Director, SMD # 23-003 RE: Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who are Incarcerated, April 2023, Available from: https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf.;7
27. Weizman S, El-Sabawi T, Perez J, Baney M, Manoff I. National Snapshot: Access to Medications for Opioid Use Disorder in U.S. Jails and Prisons (2021). [Internet]. July 2021. [cited October 19 2023]. Available from: https://oneill.law.georgetown.edu/publications/national-snapshot-access-to-medications-for-opioid-use-disorder-in-u-s-jails-and-prisons/
28. Congressional Research Service.Medicaid: An Overview [Internet], February 2023.[cited October 19 2023] Available from: https://crsreports.congress.gov/product/pdf/R/R43357
29. Weizman S, El-Sabawi T, Perez J, Baney M, Manoff I. National Snapshot: Access to Medications for Opioid Use Disorder in U.S. Jails and Prisons (2021). [Internet]. July 2021. [cited October 19 2023]. Available from: https://oneill.law.georgetown.edu/publications/national-snapshot-access-to-medications-for-opioid-use-disorder-in-u-s-jails-and-prisons/
30. Mette E, Manz J. Opioid Use Disorder Treatment: How Vermont Integrated its Community Treatment Standards into its State Prisons [Internet]. 2021 [cited 2023 Oct 19]. Available from: https://www.nashp.org/wp-content/uploads/2021/05/VT-DOC-report-4-29-2021.pdf;6.
31. Kentucky Department of Medicaid Services 1115 SUD Demonstration Proposed Amendment Continuity of Care for Incarcerated Members. [Internet].2020 [cited October 19 2023]. Available from: https://www.chfs.ky.gov/agencies/dms/Documents/1115Amendment.pdf;15
32. Johnson, S. Interview Follow-Up: Medicaid payment guidance for MOUD in prisons and jail. Message to: DeGarmo, A. October 27 2023. [cited October 30 2023].
33. Interview with Third Horizon Strategies project team, 2023
34. Ryan DA, Montoya ID, Koutoujian PJ, Siddiqi K, Hayes E, Jeng PJ, et al. Budget impact tool for the incorporation of medications for opioid use disorder into jail/prison facilities. Journal of Substance Use and Addiction Treatment. 2023 Mar; 146:208943. Available from: https://pubmed.ncbi.nlm.nih.gov/36880906/
35. Dewine M, Criss L. MAT Reimbursement Program Guidelines and Assurances SFY 2023 [Internet]. MHA.Ohio.gov. [cited October 31 2023]. Available from: https://www.maine.gov/corrections/sites/maine.gov.corrections/files/inline-files/MAT_Year_One_ReviewFinal.pdf
36. MAT in Jails Entry Form [Internet]. [cited October 31 2023]. Available from: https://mha.ohio.gov/wps/wcm/connect/gov/8eef1e68-e220-44d5-a5ee-247ef9ea5146/MAT+in+Jails+Entry+Form.xlsx?MOD=AJPERES&CVID=nNWnx0g
37. MassHealth Section 1115 Demonstration Amendment Request. [Internet].August 2023. [cited Oct 19 2023].Available from: https://www.mass.gov/info-details/1115-masshealth-demonstration-waiver
38. ISUDT Dashboard [Internet]. CCHCS 2023. [cited October 19, 2023] Available from: https://cchcs.ca.gov/isudt/dashboard/
39. Liberty R, Thornell R. Maine Department of Corrections Medication Assisted Treatment Services First Year Review [Internet]. December 2020. [cited October 19 2023]. Available from: https://mha.ohio.gov/static/CommunityPartners/criminal-justice/jailprogramming/SFY23-Guidelines-and-Assurances-MAT-Drug-Reimbursement-Program.docx
40. Medical Practice Efficiences & Cost Savings. [Internet]. Healthit.gov . Available from: https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/medical-practice-efficiencies-cost-savings#:~:text=Many%20health%20care%20providers%20have,storage%2C%20and%20re%2Dfiling%20costs
41. EMR vs EHR – What is the Difference? [Internet]. Health IT Buzz. 2011. Available from: https://www.healthit.gov/buzz-blog/electronic-health-and-medical-records/emr-vs-ehr-difference/
42. Mandatory Medicaid State Plan Coverage of Medication-Assisted Treatment. [Internet].2020 [cited October 19 2023]. Available from: https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf
43. Section II.G.: Medicare Coverage for Opioid-Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs) [Internet]. [cited 2023 Dec 5]. Available from: https://downloads.asam.org/sitefinity-production-blobs/docs/default-

source/advocacy/mpfs-2020-section-iig.pdf?sfvrsn=9e284fc2_0

44. Ibid
45. Werner R., et al.The Future of Value-Based Payment: A Road Map to 2030 [Internet]. Penn LDI. 2021. [cited October 19 2023]. Available from: https://ldi.upenn.edu/wp-content/uploads/2021/07/PennLDI-Future-of-Value-Based-Payment-WhitePaper.pdf?_ga=2.53978600.1784586575.1693339128-1626887975.1693339128;2
46. APM Measurement 2022 Methodology and Results Report.[Internet].2022 [cited October 19 2023]. Available from: http://hcp-lan.org/workproducts/apm-methodology-2022.pdf
47. Value-Based Care | CMS [Internet]. www.cms.gov. [cited October 19 2023]. Available from: https://www.cms.gov/priorities/innovation/key-concept/value-based-care
48. Griffin ML, Bennett HE, Fitzmaurice GM, Hill KP, Provost SE, Weiss RD. Health-related quality of life among prescription opioid-dependent patients: Results from a multi-site study. The American Journal on Addictions. 2015 Mar 24;24(4):308–14. Available from: https://pubmed.ncbi.nlm.nih.gov/25808055/
49. Change citation to: Substance Abuse and Mental Health Services Administration: Exploring Value-Based Payment for Substance Use Disorder Services in the United States. HHS Publication No. PEP23-06-07-001 Rockville, MD: Center for Substance Abuse Treatment. Substance Abuse and Mental Health Services Administration, 2023. [Cited December 1 2023] Available from: https://store.samhsa.gov/product/exploring-value-based-payment-substance-use-disorder-services-united-states/pep23-06-07-001
50. Kaye N. How States Are Leveraging Payment to Improve the Delivery of SUD Services [Internet]. NASHP. 2022 [cited October 19 2023]. Available from: https://nashp.org/how-states-are-leveraging-payment-to-improve-the-delivery-of-sud-services/
51. Office-Based Substance Use Disorder (SUD) Treatment Billing | CMS [Internet]. Cms.gov. 2020. [cited October 10 2023]. Available from: https://www.cms.gov/medicare/payment/opioid-treatment-programs-otp/billing-payment/office-based-substance-use-disorder-sud-treatment-billing
52. Search the Physician Fee Schedule. | CMS [Internet]. www.cms.gov. [cited October 20 2023]. Available from: https://www.cms.gov/medicare/physician-fee-schedule/search?Y=0&T=4&HT=0&CT=3&H1=G2086&M=5
53. Medication Assisted Treatment for Opioid Use Disorders [Internet]. [cited October 20 2023]. Available from: https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-8?toc=1
54. Revisions to Payment Policies under the Medicare Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2023. 2022. [Internet]. www.cms.gov. [cited October 20 2023]. Available from: https://www.federalregister.gov/documents/2022/11/18/2022-23873/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other
55. Clemans-Cope L, Lynch V, Payton M, Aarons J. Medicaid professional fees for treatment of opioid use disorder varied widely across states and were substantially below fees paid by Medicare in 2021. Substance Abuse Treatment Prevention and Policy. 2022 Jul 6;17(1). Available from: https://pubmed.ncbi.nlm.nih.gov/35794626/
56. Medicaid-to-Medicare Fee Index [Internet]. KFF 2023. [cited October 20 2023]. Available from: https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
57. Value in Opioid Use Disorder Treatment Demonstration Program | CMS Innovation Center [Internet]. innovation.cms.gov. [cited October 20 2023]. Available from: https://www.cms.gov/priorities/innovation/innovation-models/value-in-treatment-demonstration
58. Value in Opioid Use Disorder Treatment Demonstration Program Request for Applications (RFA) [Internet]. [cited October 20 2023]. Available from: https://innovation.cms.gov/media/document/vit-rfa
59. Ibid
60. Ibid
61. Best Practices for Designing and Implementing Substance Use Disorder -Focused Health Homes.[Internet]. 2020 [cited October 19 2023]. Available from: https://www.medicaid.gov/state-resource-center/downloads/best-practices-health-homes-support-act-section-1006a.pdf
62. Collaborative Models For Medication-Assisted Treatment: Key Elements of Rhode Island Opioid Treatment Programs Health Home Model [Internet]. 2019 [cited October 20 2023]. Available from: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/mat-key-elements-ri.pdf
63. Ibid; 3
64. Ibid
65. Addiction and Recovery Treatment Services [Internet]. DMAS - Department of Medical Assistance Services.2023. [cited October 20 2023] Available from: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/
66. Frequently Asked Questions From Preferred Office-Based Addiction Treatment (OBAT) Manual Updates Training [Internet]. 2022 [cited October 202023. Available from: https://www.dmas.virginia.gov/media/4672/frequently-asked-questions-

fromobat-training-final-05-31-2022.pdf

67. Addiction and Recovery Treatment Services (ARTS) Reimbursement Structure **ARTS Specific Service Codes [Internet]. [cited October 20 2023]. Available from: https://www.dmas.virginia.gov/media/4040/arts-reimbursement-structure-03-09-2022.pdf
68. COEs Transition to Managed Care FAQs.[Internet].. [cited october 20 2023]. Available from: https://www.dhs.pa.gov/about/Documents/Find%20COEs/c_291269.pdf
69. Pitts JR. H.R.4302 - 113th Congress (2013-2014): Protecting Access to Medicare Act of 2014 [Internet]. www.congress.gov. 2014. [cited October 20 2023]. Available from: https://www.congress.gov/bill/113th-congress/house-bill/4302
70. Substance Abuse and Mental Health Services Administration. Certified Community Behavioral Health Center (CCBHC) Certification Criteria. Published February 2023. Accessed [October 20 2023] at Section 223 Demonstration Program for Certified Community Behavioral Health Clinics | SAMHSA. Available from: https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf
71. Ll S. 117TH Congress 2D Session A Bill: Bipartisan Safer Communities Act [Internet].[cited October 20 2023]. Available from: https://www.murphy.senate.gov/imo/media/doc/bipartisan_safer_communities_act_text.pdf
72. Pitts JR. H.R.4302 - 113th Congress (2013-2014): Protecting Access to Medicare Act of 2014 [Internet]. www.congress.gov. 2014. [cited October 20 2023].Available from: https://www.congress.gov/bill/113th-congress/house-bill/4302
73. Substance Abuse and Mental Health Services Administration. Certified Community Behavioral Health Center (CCBHC) Certification Criteria. Published February 2023. Accessed [October 20 2023] at Section 223 Demonstration Program for Certified Community Behavioral Health Clinics | SAMHSA. Available from: https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf
74. Certified Community Behavioral Health Clinic (CCBHC) Prospective Payment System (PPS) Guidance. [Internet]. 2023. [cited October 20 2023]. Available from: https://www.medicaid.gov/medicaid/financial-management/downloads/ccbh-pps-prop-updates.pdf;4
75. Guth M, et al. How do States Deliver, Administer, and Integrate Behavioral Health Care? Findings from a Survey of State Medicaid Programs. [Internet]. May 2023. [cited October 25 2023]. Kaiser Family Foundation. Available from: https://www.kff.org/mental-health/issue-brief/how-do-states-deliver-administer-and-integrate-behavioral-health-care-findings-from-a-survey-of-state-medicaid-programs/#:~:text=States%20use%20a%20combination%20of,(MCOs)%20in%20recent%20years
76. O'Brien J, et. al., State Approaches to Developing the Residential Treatment Continuum for Substance Use Disorders . [Internet]. 2019 [cited October 25 2023]. Available from: https://www.tacinc.org/wp-content/uploads/2020/02/arnold_state-approaches-to-residential-sud-care-continuum_2019.pdf;32
77. Center for Medicaid and CHIP Services, Letter to State Medicaid Director, SMD #23-003 RE: Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who are Incarcerated, April 2023, https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf
78. California Department of Health Care Services, Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative [Internet]. 2023 [cited October 32 2023]. Available from: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf;29
79. Letter to Charissa Fotinos, MD Washington State Medicaid Transformation Project 2.0 Approval Letter. [Internet].2023 [cited October 25 2023]. Available from: https://www.medicaid.gov/sites/default/files/2023-06/wa-medicaid-transformation-ca-06302023.pdf;78-80
80. Centers for Medicaid and CHIP Services, Letter to State Medicaid Director, SMD #23-003 RE: Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who are Incarcerated, April 2023, https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf.; 32
81. Ibid.
82. Center for Medicaid and CHIP Services, Letter to State Medicaid Director, SMD #23-003 RE: Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who are Incarcerated, April 2023, https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf; 28
83. Ibid
84. Ibid
85. Code of Federal Regulations. Title 42 Subpart E. [Internet]. unblock.federalregister.gov. 2023 [cited December 20 2023]. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E
86. State plans for medical assistance [Internet]. www.ssa.gov. [cited October 25 2023] Available from: https://www.ssa.gov/OP_Home/ssact/title19/1902.htm
87. California Department of Health Care Services, Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative [Internet]. 2023 [cited October 31 2023]. Available from: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf; 134
88. Ibid; 150
89. State plans for medical assistance [Internet]. www.ssa.gov. [cited October 31 2023]. Available from: https://www.ssa.gov/

OP_Home/ssact/title19/1902.htm

90. Medicaid and CHIP Payment and Access Commission (MACPAC). Medicaid Physician Fee-for-Service Payment Policy [Internet]. 2017. [cited October 31 2023]. Available from: https://www.macpac.gov/publication/states-medicaid-fee-for-service-physician-payment-policies/; 1-2
91. Ibid; 2
92. O'Brien, J. et. al., State Approaches to Developing the Residential Treatment Continuum for Substance Use Disorders [Internet]. TAC 2019. [cited October 20 2023]. Available from: https://www.tacinc.org/wp-content/uploads/2020/02/arnold_state-approaches-to-residential-sud-care-continuum_2019.pdf; 29-30
93. Ibid
94. California Department of Health Care Services, Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative [Internet]. 2023 [cited October 31 2023]. Available from: https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf; 136
95. The Pew Charitable Trusts. Prison Health Care: Costs and Quality [Internet]. The Pew Charitable Trusts 2017. [cited December 9 2023 Dec 6]. Available from: 1.Urahn S, Thompson M. Prison Health Care: Costs and Quality [Internet]. The Pew Charitable Trusts. 2017. Available from: https://www.pewtrusts.org/-/media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf
96. Office of the Inspector General,The Federal Bureau of Prisons' Reimbursement Rates for Outside Medical Care [Internet]. 2016. [cited October 25 2023]. Available from: https://oig.justice.gov/reports/2016/e1604.pdf; i
97. Delivering Services in School- Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming [Internet]. 2023. [cited October 31 2023]. Available from: https://www.medicaid.gov/sites/default/files/2023-07/sbs-guide-medicaid-services-administrative-claiming-ud.pdf
98. Adolpho N. State Approaches to Developing the Residential Treatment Continuum for Substance Use Disorders [Internet]. TAC 2019. [cited October 25 2023]. Available from: https://www.tacinc.org/wp-content/uploads/2020/02/arnold_state-approaches-to-residential-sud-care-continuum_2019.pdf; 29
99. Substance Abuse and Mental Health Services Administration. Prospective Payment System (PPS) Reference Guide [Internet]. 2023. [cited October 20 2023]. Available from: https://www.samhsa.gov/certified-community-behavioral-health-clinics/section-223/certification-resource-guides/prospective-payment-system
100. Tse, B. Budget Impact Tool for the Incorporation of Medications for Opioid Use Disorder into Jail/Prison Facilities. [Internet]. February 2023. [cited October 31 2023]. Available from: https://cherishresearch.org/news-and-events/news/budget-impact-tool-for-the-incorporation-of-medications-for-opioid-use-disorder-into-jail-prison-facilities/
101. Ryan, DA, et. al., Budget impact tool for the incorporation of medications for opioid use disorder into jail/prison facilities. [Internet]. March 2023. [cited October 31 2023]. Available From: https://www.jsatjournal.com/article/S2949-8759(22)00014-5/fulltext#secst0080
102. O'Brien J, Wachino V. Recommendations for Medicaid Performance Measures for Opioid Use Disorder Services in Jails and Prisons [Internet]. 2023 [cited December 8 2023]. Available from: https://healthandreentryproject.org/wp-content/uploads/2023/11/Recommendations-for-Medicaid-Performance-Measures-for-Opioid-Use-Disorder-Services-in-Jails-and-Prisons.pdf;
103. Program Integrity. [Internet]. Medicaid.gov. [cited October 31 2023]. Available from: https://www.medicaid.gov/medicaid/program-integrity/index.html
104. Health Care Payment Learning and Action Network, The APM Framework. [Internet]. 2017. [cited October 31 2023]. Available from: https://hcp-lan.org/workproducts/apm-framework-onepager.pdf
105. MACPAC The Medicaid Fee-for-Service Provider Payment Process [Internet]. 2018. [cited October 25 2023].Available from: https://www.macpac.gov/publication/medicaid-fee-for-service-provider-payment-process
106. MedPAC. Care coordination in fee-for-service Medicare [Internet]. 2012. [cited October 31 2023].Available from: https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun12_ch02.pdf; 49,51.
107. Unique Cash-flow Issues Facing Health Care Companies. American Bankruptcy Institute [Internet]. www.abi.org.[cited October 31 2023]. Available from: https://www.abi.org/abi-journal/unique-cash-flow-issues-facing-health-care-companies
108. Agarwal R, Liao JM, Gupta A, Navathe AS. The Impact Of Bundled Payment On Health Care Spending, Utilization, And Quality: A Systematic Review. Health Affairs. 2020 Jan;39(1):50–7. https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00784

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