Serving People with Opioid Use Disorder During Reentry

A Resource for States

HARP

THE HEALTH AND REENTRY PROJECT

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Overview

Historically, an estimated 58% of individuals in state prisons and 63% of individuals in jails have met the criteria for drug dependence or abuse.[1] Nationwide, 40% of correctional facilities currently provide some type of substance abuse treatment service onsite to inmates with a substance use disorder (SUD), including opioid use disorders (OUDs).[2] Expanding the availability of OUD services in correctional facilities and community settings is crucial to support individuals with OUD during and after incarceration. Recent Medicaid Section 1115 demonstration waivers — which allow Medicaid to cover targeted services for up to 90 days before a Medicaid beneficiary is released from prison or jail — create a significant new opportunity to expand access to SUD and OUD services.

As of August 2025, 19 states have received federal approval to implement Medicaid reentry waivers, and 8 additional states and the District of Columbia have waiver proposals under review by the federal Centers for Medicare & Medicaid Services (CMS). Providing OUD services through the waivers will increase the number of individuals receiving OUD treatment for up to 90 days before reentry, at reentry, and as people return to communities. This access to services can promote public safety, reduce mortality, and avoid some spending in emergency rooms, prisons, and jails. Overall, these new waiver policies will increase access to and continuity of pre-release and post-release care, supporting individuals' successful return while enhancing communities' public safety.

The Health and Reentry Project (HARP) developed this toolkit to help state Medicaid agencies (SMAs) and their state and local correctional partners as they implement Medicaid reentry waivers to effectively expand access to OUD treatment for Medicaid beneficiaries returning to the community from incarceration. Implementing Medicaid coverage of pre-release OUD services requires building continuity of care to bridge the health and criminal justice system, navigate variation across correctional facilities, and address differences in health care access and quality between community health and correctional health.

This toolkit is designed to advance implementation of Medicaid reentry waivers, specifically by assisting SMAs, which oversee implementation, in designing and implementing the OUD services component of their 1115 reentry waivers, as well as other pre-release services that are important to people with OUD. Officials in correctional facilities, who play a key role in reentry waiver implementation, can also turn to this toolkit as they build out operational plans to support implementation.

This toolkit builds upon recent HARP products written to support effective implementation of Medicaid and reentry policies, including:

- Eight Key Considerations for Successful Implementation of New Medicaid Reentry Policies
- From Policy to Practice: Seizing the Moment to Transform Health and Reentry
- HARP's products supporting correctional facilities' implementation of new continuity of care requirements for incarcerated youth

The toolkit translates key policy recommendations into actionable steps for state and local-level implementation. You can use the toolkit to find more information about:

- Design considerations for getting started
- Models for delivering pre-release services
- Medicaid enrollment
- Pre- and post-release service delivery
- Transitions in care
- Technical assistance and training
- Developing and measuring demonstration effectiveness
- Reimbursement and infrastructure

For each of these topics, the toolkit identifies specific implementation goals and high-level strategies to achieve those goals. To facilitate learning and application, real-life implementation examples are included to illustrate each goal and strategy. These examples focus on activities that are part of Medicaid reentry waiver implementation, as well as approaches state and local governments have advanced to expand OUD services outside the context of Medicaid reentry waivers. HARP gathered these examples from its implementation work with leading state and local practitioners and experts across the country. Each example can support state and local efforts to implement expanded access to OUD services under Medicaid reentry waivers.

Acknowledgements

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This toolkit was informed by 3 reports that HARP published in 2023 and 2024. These reports recommended services and standards, performance measures, and payment strategies for Medicaid coverage of OUD services in prisons and jails. The recommendations were based on input and insights from a wide range of health and criminal justice policymakers and stakeholders, including those who would receive services. The reports are as follows:

- Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons, which defines the services and standards Medicaid could support for incarcerated individuals with OUD, separated into 5 key service areas that promote continuity of care — screening, assessment, medication for opioid use disorder (MOUD) initiation and continuation, counseling and intensive outpatient care, and reentry services.

- Recommendations for Medicaid Performance Measures for Opioid Use Disorder in Jails and Prisons, which outlines 15 clear goals, measurable objectives, and metrics to monitor and evaluate how well states, their managed care partners, and providers (including jails and prisons) meet the intended objectives — and ultimately improve care and results — for Medicaid beneficiaries with OUD, both in jails and prisons and during community reentry.
- Recommendations for Medicaid Payment Models for Opioid Use Disorder Services in Jails and Prisons, which proposes 4 different payment systems for states to consider as models for Medicaid-funded OUD services for individuals who are incarcerated.

Those products were developed for The Pew Charitable Trusts, the Johns Hopkins Bloomberg School of Public Health, and Global Health Advocacy Incubator with funds provided by Bloomberg Philanthropies.

References

[1] Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2020, August 10). *Drug use, dependence, and abuse among state prisoners and jail inmates, 2007-2009* [Special report]. https://bjs.ojp.gov/content/pub/pdf/dudaspji0709.pdf

[2] Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2002). *National Survey of Substance Abuse Treatment Services (N-SSATS): 2000. Data on substance abuse treatment facilities*. DASIS Series: S-16, DHHS Publication No. (SMA) 02-3668. https://www.samhsa.gov/data/sites/default/files/2000_nssats_rpt.pdf

Section 1:

Design Considerations

Goal

Develop a program design based on a facility's experience and capacity to provide required services before, during, and after reentry

Why is this important?

Although access to opioid use disorder (OUD) services in prisons and jails is growing, many correctional facilities have not had much experience with medications for OUD (MOUDs).

In 2019[3]

63% of local jails screened for OUDs at intake

19% started any medication-assisted treatment (MAT) for individuals found to have an OUD

24% of local jails continued MAT for individuals in custody

25% provided naloxone to individuals upon release

To deliver the expanded services covered by Medicaid, each facility must tailor their approach to service provision based on their experience and capacity. To get started, leaders of correctional facilities that offer MAT can first identify the top 10 considerations for creating a design and implementation plan[4]:

1. Anticipated population size
2. Distance to the nearest Opioid Treatment Program (OTP)
3. Facility layout
4. Medication line scheduling
5. Staffing configuration
6. Information technology (IT) system integration
7. Licensing
8. Accreditation
9. Medication inventory
10. Associated dispensary costs

Initiating pre- and post-release case management and providing a 30-day supply of prescribed medications at release are also new activities for most correctional facilities. To offer these services, facilities will need to invest in detailed design and implementation planning.

Strategy

Develop a tailored design and implementation plan for each facility. The facility's plan should describe relevant service models, staffing, and resource needs. Creating an effective design and implementation plan can involve the following steps:

1. Identify key stakeholders to provide input and review approaches to key policy and issues — and give some thought to a broader stakeholder engagement process to support implementation.
2. Conduct service mapping of each facility that will participate in the Medicaid 1115 reentry demonstration and create a facility profile with key information on the correctional facilities' existing capacity and community resources. To do this, analyze the facility's existing capacity for each of the required pre-release services and identify the ones they are interested in providing directly through the reentry demonstration and how they intend to provide the services they do not deliver.

3. Provide a guide for facilities to use in assessing their administrative and clinical capacity to implement and manage the reentry demonstration, including assessing security considerations and physical plant constraints.
4. Evaluate staffing requirements and options across 4 provider types — correctional staff, consulting practitioners, correctional health care vendors, and community providers — to determine the best fit for each reentry service.
5. Determine which MOUDs (and their forms) are available locally or through telehealth before deciding which medications the facility will provide — to promote continuity between pre- and post-release medications.
6. Establish a set of clinical standards for MAT that can guide practice. These standards will need to be updated regularly and should address issues like:
    - Confidentiality and privacy
    - Medication use during withdrawal
    - Continuation of community medications (MOUDs that are prescribed by a community-based provider)
    - Criteria for recommending 1 of the 3 MOUDs (methadone, buprenorphine, or naltrexone)
    - Denial or limiting of MOUDs
    - Voluntary use of counseling with MOUDs
    - Self-referrals for clinical assessments
    - Shared decision making that includes the individual in decisions about medication and dosing
    - MAT and pregnancy
    - Circumstances under which withdrawal management is offered to individuals[5]
7. Establish — through contracts or other agreements — confidentiality and privacy policies regarding OUD services and sharing of information.

Examples

Example #1: Maine

Maine has conducted extensive community engagement with jails and prisons, correctional health care providers, community service providers, and justice-impacted community members to build relationships and trust as the state develops its justice initiatives.

Read: State Highlight: Maine, slides 6–8

Example #2: Maine

As part of Maine's reentry demonstration planning, the state conducted site visits to all prisons and jails and met with community providers throughout Maine to understand the service capacity in each county, for each correctional facility, and community system.

Check out: State Highlight: Maine, slide 9

Example #3: Oregon

Oregon requires facilities that wish to participate in the reentry demonstration to complete a detailed readiness assessment on:

- Current capacities and processes in key functions
- Barriers to performing those functions

The state uses the results to determine what assistance the facility will need to participate.

Browse: Correctional Facility Baseline Readiness Assessment

Examples

Example #4: Oregon

Oregon has created a companion to its facility readiness assessment: the Local Health Provider Survey. The sections and services in this survey align with those in the readiness assessment and support matching local service providers with correctional facilities' identified service gaps.

Access: Local Health Provider Survey

Example #5: New York

New York has developed a toolkit for implementing MOUD in correctional settings. It describes activities that correctional facilities can undertake to implement MOUD delivery.

Explore: Medication for Opioid Use Disorder (MOUD): Correctional Health Implementation Toolkit, especially clinical guidelines on pages 50–56

References

[3] Bureau of Justice Statistics, Office of Justice Programs. (2023, April 12). *Opioid use disorder screening and treatment in local jails, 2019* [Press release]. https://bjs.ojp.gov/press-release/opioid-use-disorder-screening-and-treatment-local-jails-2019

[4] Hurley, L., Flynn, T., Steinberg, R., Alvanas, D., Clarke, J., & Brathwaite, R. (2020, January 29). *Plenary 1b: Models of delivery* [Conference session]. Opioid Response Network Summit, Providence, RI. https://www.youtube.com/watch?v=6IgCeiToI_0&list=PLcJZ9JaFtvDebwT4uGhKOK4LQO22au_Wy&index=11&t=3s

[5] Krawczyk, N., Bandara, S., Merritt, S., Shah, H., Duncan, A., McEntee, B., Schiff, M., Ahmad, N. J., Whaley, S., Latimore, A., & Saloner, B. (2022). Jail-based treatment for opioid use disorders in the era of bail reform: A qualitative study of barriers and facilitators to implementation of a state-wide medication treatment initiative. *Addiction Science & Clinical Practice, 17,* 30. https://ascpjournal.biomedcentral.com/articles/10.1186/s13722-022-00313-6

Section 2:

Models for Delivering Pre-Release Services

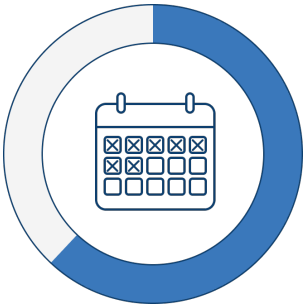
Goal

Develop strategies and models for providing required Medicaid OUD services efficiently while accommodating short stays, long stays, and unpredictable release dates

2.1 Short Stays

Why is this important?

70% of people in jail are being held pre-trial[6]



62% of people who are detained spend a week or less in jail[7]

In this context, jails often have limited time to deliver pre-release services. This situation is complicated by the fact that release dates are unpredictable for people being held pre-trial.

Strategy

As part of the planning process, correctional facility staff can estimate the percentage of releases that occur within 1 week of intake by analyzing a sample of stay lengths during a specific period of time, like the previous calendar year. Additionally, they can assess how many releases happened in specific timeframes after admission, like:

- Within 24 hours, 48 hours, 72 hours, and 96 hours
- Between 96 hours and 2 weeks
- Within 30 days, 60, and 90 days

Correctional facility staff can also:

- Implement a rapid assessment and linkage model that begins on the first day of detention, connects individuals to MOUD, and establishes linkages to community post-release services during the first week of the individual's jail stay.
- Use the National Association of Boards of Pharmacy (NABP) PMP Interconnect® to verify an individual's community medication.

NABP PMP InterConnect®

This national network of prescription drug monitoring programs (PDMPs) enables the sharing of PDMP data across state lines. All states except Missouri have a statewide PDMP. Missouri has not yet adopted a statewide program but does have localized initiatives that cover most of the state and are counted as a state PDMP. Learn more from PDMPWorks.

Examples

Example #1: Short stay MAT initiation model

The following example describes how to initiate MAT and connect an individual to case management during a typical short stay of 7 days.

During the intake health screen, the intake screener:

- Screens for OUD and withdrawal
- Obtains the necessary consent to disclose personal information
- If the individual is receiving an MOUD, arranges for the facility's U.S. Drug Enforcement Administration (DEA)-registered practitioner to continue the individual's medication

Immediately after intake, if the screen is positive, the DEA-registered practitioner:

- Conducts a MAT assessment and initiates MOUD on the same day, if the individual wants to begin medication
- Provides a supply of naloxone at this time and either trains the individual on how to use it or provides instructions

Within 1 to 2 days of admission, the pre-release case manager:

- Meets with the individual to help them choose a community MAT provider
- Provides an electronic referral to the community MAT provider through an electronic health record (EHR)

On the third day after admission, staff at the correctional facility assign a facility navigator who will connect the individual to a specific community case management provider for post-release services

...continued on next page

Examples

On the fifth day after admission, facility staff:

- Identify the specific post-release care manager
- If possible, arrange a telephonic or telehealth warm handoff

On the day before release, facility staff provide the individual with information about their community provider

On the day after release, facility staff send the complete discharge summary to the MAT and case management community provider

In the short stay model, the pre-release case manager is responsible for monitoring the process as a whole. This includes projecting a targeted release date, if possible, and adjusting activities if the length of stay is shorter than expected, like by arranging for the correctional facility navigator to continue working with the individual after release.

Example #2: Philadelphia, Pennsylvania

The Philadelphia Department of Prisons uses NABP PMP InterConnect® to verify individuals' community medications. They've also developed a network of community providers for post-release case management and MAT. Each provider signs a memorandum of understanding (MOU) committing to offering 1-day intakes and accepting walk-ins. Each provider also designates a point of contact to facilitate appointments and manage coordination of care.

Prison staff meet with individuals shortly after intake to help them choose a post-release community provider. Staff then send a secure, electronic secure referral to that provider and a complete discharge summary at the time of the individual's release.[8]

Examples

Example #3: California

California has developed both required and recommended timelines for a short stay model that provides pre-release services within 30 days.

Check out: Short-Term Model for Clinical Service Provision Tied to Minimum Incarceration Stay to Develop Guidance on Best Practices for Facilities

Example #4: Massachusetts

To mitigate short stay challenges, Massachusetts' MassHealth intends to provide clinical guidance that requires facilities to conduct clinical assessments and implement plans for needed medications (including MAT) within a short timeframe from the date of incarceration. This will ensure that all MassHealth members have a plan for medications early in their incarceration period. The clinical guidance will also set timeframes for when care management and other pre-release services need to be offered.

Browse: Reentry Demonstration Initiative Implementation Plan, pages 17–20

Example #5: Washington

Washington has developed a short stay model that requires:

- Medicaid eligibility and/or application and health screening on Day 1
- Continuation of existing medications and evaluation and initiation of new medications on Day 2
- Case management assignment on Day 3

Examples

- Health assessment on Day 4
- Reentry care plan and coordination on Day 5

In this model, warm handoff can occur at any point before release and no later than 7 days post-release. For individuals' whose incarceration lasts 2 days or longer, reentry medication occurs at release.

Browse: Reentry Initiative Policy and Operations Guide, pages 26, 27, and 45

2.2 Unpredictable Release Dates

Why is this important?

As discussed for short stays, most individuals in jails have an unpredictable release date.

An unknown percentage of individuals incarcerated in prisons also have unpredictable release dates. This unpredictability is caused by a variety of factors, including:

- Indeterminate sentencing
- Parole boards' ability to decide release dates
- The potential for "good time" credits to shorten a sentence

In this context, correctional facilities must quickly initiate pre-release services for individuals whose release dates aren't known until shortly before release.

Strategy

Correctional facilities can:

- Activate the rapid assessment and linkage model described for short stays when an individual has been identified as having an unpredictable release date
- Consider creating a methodology to proactively predict release dates for individuals expected to be released within 6 months

2.3 Long Stays

Why is this important?

Centers for Medicare & Medicaid Services (CMS) guidance requires that MAT, case management, and connection to post-release case management be provided within the 90-day pre-release period. It also requires that medications be provided to individuals at release.

Strategy

Correctional facilities must adopt a long stay model that begins 90 days before release.

Examples

Example #1: Washington

Washington has developed a long stay model that requires:

- Medicaid eligibility and application, health screening, care manager assignment, reentry health assessment, and reentry care plan and coordination during Days 61 to 90
- Continuity of medication and evaluation for and initiation of new MOUD on Day 90
- Warm handoff 14 days before release and no later than 7 days post-release
- Medication provision at release

Access: Reentry Initiative Policy and Operations Guide, page 25

References

[6] Zeng, Z. (2025, April). *Jail inmates in 2023–Statistical tables*. U.S. Department of Justice, Office of Justice Programs.https://bjs.ojp.gov/library/publications/jail-inmates-2023-statistical-tables/web-report

[7] Horowitz, J., & Velázquez, T. (2020, June 23). *Small but growing group incarcerated for a month or more has kept jail populations high.* Pew. https://www.pewtrusts.org/en/research-and-analysis/articles/2020/06/23/small-but-growing-group-incarcerated-for-a-month-or-more-has-kept-jail-populations-high

[8] B. Herdman (personal communication, February 18, 2025)

Section 3:

Medicaid Enrollment

Goal

Help individuals apply for Medicaid and, once enrolled, maintain Medicaid eligibility to support continuity of care

Why is this important?

Short stays compromise a jail's ability to suspend and then lift the suspension for Medicaid enrollment.

Strategy

Given the volume of short stays in jails, for individuals who are enrolled in Medicaid at the time of detention, facilities can work with the state Medicaid agency (SMA) to maintain the individuals' Medicaid enrollment for 30 days, rather than suspending and then reactivating their Medicaid enrollment. Note that facilities that adopt this practice must establish markers and edits in the claims processing system to deny claims for excluded services.

For individuals who are not enrolled in Medicaid at the time of detention, correctional facilities can begin the application process at intake or as early as possible. SMAs may consider activating presumptive eligibility to support timely access to coverage. Presumptive eligibility is a provision that allows certain individuals to receive temporary Medicaid coverage based on a preliminary assessment of their eligibility. This means that if an individual is presumed to meet the eligibility criteria, they can access health care services immediately while their full Medicaid application is being processed.

To promote continuous coverage for all lengths of stay:

- Support individuals in applying for Medicaid or renewing their coverage at any time during their incarceration

- Leverage navigators, application assisters, or eligibility workers to assist individuals in applying for Medicaid coverage — and facilitate meetings with these navigators, either in person or by telephone or telehealth
- Consider using correctional staff to enroll individuals and interact with the Medicaid eligibility and enrollment system

SMAs can establish a specialized Medicaid eligibility unit dedicated to processing applications for justice-involved individuals.

Correctional facilities can provide information and education to individuals in custody about Medicaid eligibility, the application process, and covered benefits.

Examples

Example #1: Virginia

Virginia established an eligibility unit to process applications, reapplications, and benefit suspensions and reactivations for justice-involved individuals. Daily data transmission from correctional facilities to the eligibility unit started with state prisons and has since been expanded to 67 jails.

Check out: Chapter 3: Access to Medicaid Coverage and Care for Adults Leaving Incarceration, page 73

Example #2: Arizona and Connecticut

Arizona and Connecticut have units dedicated to linking justice-involved individuals to Medicaid.

Learn more: Connecting the Justice-Involved Population to Medicaid Coverage and Care: Findings from Three States, pages 6 and 7

Examples

Example #3: Ohio

Ohio has established a pre-release enrollment program that provides individuals with peer-to-peer Medicaid enrollment and renewal education.

Access: Ohio's Medicaid Pre-Release Enrollment Program

Example #4: New Hampshire

New Hampshire uses a tablet-based tool to share resources and information with individuals in correctional facilities. The state shares materials about the benefits of Medicaid and the reentry demonstration through this tool.

Read: New Hampshire Reentry Implementation Plan, page 16

Example #5: California

When an individual's stay will last fewer than 28 days, California doesn't suspend their Medi-Cal benefits.

Browse: Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative, page 45

Example #6: Rhode Island and New Mexico

These 2 states use presumptive eligibility to expedite and address barriers to enrollment upon release.

Explore: Chapter 3: Access to Medicaid Coverage and Care for Adults Leaving Incarceration, page 73

Examples

Example #7: Washington

In Washington Department of Corrections facilities, individuals who aren't current Medicaid beneficiaries may apply for benefits at any time during their incarceration. Coverage is automatically placed into a suspended status.

Learn more: SSB 6430: Medicaid Suspension and Care Coordination

Example #8: Washington

Washington Department of Corrections staff inform individuals who are incarcerated about Medicaid and its benefits. They also assist individuals with the application process, including completing and submitting the application for eligibility determination.

Read: SSB 6430: Medicaid Suspension and Care Coordination

Example #9: Massachusetts

In Massachusetts, correctional staff have been trained as Certified Application Counselors to explain Medicaid benefits and assist individuals nearing release with completing the Medicaid application.

Check out: Connecting the Justice-Involved Population to Medicaid Coverage and Care: Findings from Three States, page 6

Section 4:

Pre-Release Provider System

Goal Ensure that enough providers are available to provide access to required services

Why is this important?

It's common for both correctional and community providers to deliver pre-release services. However, having community providers on-site presents security and logistical concerns that must be managed to minimize disruption to the correctional environment.

Because large correctional facilities serve larger numbers of individuals who are eligible for pre-release services, when community providers offer these services, the facility may also need greater provider capacity. This can result in obstacles for coordinating care. And although CMS's reentry guidance identifies "in-reach" pre-release services as the preferred approach, it also recognizes the operational complexities this approach can present.

Pre-release service challenges in smaller jails

Compared to larger facilities, smaller jails may face more challenges in offering a broad range of pre-release services because of their smaller populations. Thirty-four percent of jail jurisdictions have an **average daily population (ADP) under 50**[9], and most smaller jails are located in rural areas, which are likely to be **service deserts** — geographical areas that lack access to services and service providers.

Strategy

For smaller prisons and jails, contract with 1 community provider for each required pre-release service who can handle the projected volume of eligible individuals. This strategy can help to:

- Minimize administrative burden on the correctional facility

- Streamline the coordination required for initiating and scheduling pre-release interactions with community providers

For large correctional facilities requiring a significant number of community-based providers to meet demand, create affiliations among the organizations that could provide pre-release services. Putting these affiliations in place can make it easier to share important clinical information, coordinate care across services, and reduce individuals' navigational burden. Prisons will also need to identify the communities to which significant numbers of individuals who are released will return, so that providers in those communities can be recruited to provide telehealth pre-release services.

For most correctional facilities, a hybrid model of service delivery — involving both carceral and community providers — may be the most feasible approach for pre-release services.

Goal

Jails and prisons should screen for opioid withdrawal and provide withdrawal management

4.1 Screening for and Managing Withdrawal

Why is this important?

63%
of sentenced individuals in jail have a substance use disorder (SUD)

50%
report substance use in the 30 days before incarcination[10]

Given the risks inherent in withdrawal, correctional facilities should identify individuals who are in withdrawal and then medically supervise the withdrawal process.

Because correctional facilities conduct booking 24 hours per day, screening for OUD and the risk or presence of withdrawal symptoms must be available around the clock.

Strategy

Jails should screen for OUD and withdrawal risk during intake. Prisons may consider screening for withdrawal risk periodically, especially at the beginning of the 90-day Medicaid reentry period, given the high rates of overdoses in correctional facilities.

Jails and prisons should:

- Develop screening protocols in which trained health care staff or trained correctional officers identify serious withdrawal symptoms and transfer affected individuals to the nearest hospital or urgent care center.
- Use a brief, standardized screening instrument like the Rapid Opioid Dependence Screen (RODS) to identify individuals with OUD. RODS includes 8 items, has been assessed in correctional settings, and can be administered in several minutes by a non-clinician.[11]
- Use the Clinical Opiate Withdrawal Scale (COWS) to assess the severity of withdrawal.
- Ensure that withdrawal management for OUD, if offered, is provided under medical supervision and managed with methadone or buprenorphine according to the American Society of Addiction Medicine's guidelines.[12]

Staffing and resource considerations

In February 2022, the Bureau of Justice Assistance advised jails to consider the following in establishing staffing and resources for withdrawal management:

- "Designate a 'responsible health care authority' who arranges and coordinates all health services.
- Provide adequate medical coverage for assessment and treatment planning. Clinical support can be accomplished through any combination of on-site health staff, remote coverage, telemedicine, and transfer to facilities that can provide a higher level of care.
- Clarify responsibilities so that staff understand the limits of their roles.
- Review contracts with medical and behavioral health services for withdrawal management practices."[13]

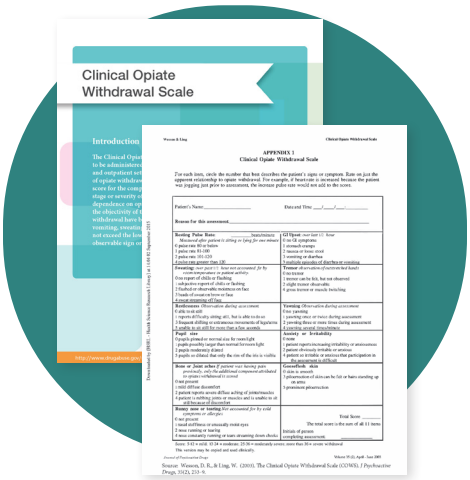
Examples

Example #1: Delaware

Delaware's Department of Corrections has a comprehensive policy that requires staff to be trained on recognizing OUD and includes specific guidelines for observing individuals in withdrawal and providing medical supervision of the process.

Read: Policy F-04: Medically Assisted Withdrawal and Treatment

Example #2: Philadelphia, Pennsylvania



The Philadelphia Department of Prisons intake process starts with detainees being screened for withdrawal symptoms at the police district office. Individuals with serious symptoms are immediately transported to the nearest hospital. Individuals who are sent to jail are screened again at the front door through a series of questions and a physical examination to identify withdrawal. The COWS is used during withdrawal to quantify the severity of symptoms and guide treatment intensity. Health care staff then manage opioid withdrawal symptoms with Subutex and use comfort medications to support withdrawal from other drugs.

Explore: The Complexity and Strengths of the Department of Prisons' Program to Prevent Overdoses

Examples

Example #3: Washington

According to a survey of 47 of Washington's 57 jails, almost all jails screen for opioid withdrawal at booking. This screening is most commonly done by correctional officers or nurses using the COWS.

Additionally, in Washington jails, individuals are most commonly monitored for opioid withdrawal by either health care staff or correctional officers. Two-thirds of jails use buprenorphine for opioid withdrawal management: 20% initiate buprenorphine, and the remainder start a buprenorphine taper or implement a combination of buprenorphine initiation and taper.

Read: The Status of Medications for Opioid Use Disorder (MOUD) Provision in Washington State Jails, 2021

4.2 Telehealth

Why is this important?

Telehealth can play an important role in delivering quality health care in correctional systems.

Benefits include[15]:

- Reduced wait time for medical referrals
- More access to outpatient services
- No need for transportation to appointments
- Lower costs for transportation, security and personnel

However, expanding telehealth in correctional environments may require addressing longstanding barriers, like Wi-Fi access and space that allows privacy.

50%

of ambulatory care visits could safely and reliably be accomplished via telemedicine[14]

Strategy

Correctional facilities can:

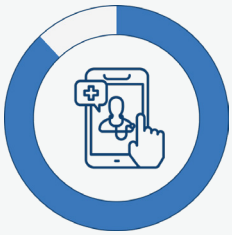
- Maximize the use of telehealth, as feasible. In small, rural jails with limited availability of either MAT or case management providers, telehealth could be considered the standard of care.
- Create structural changes to facilitate reentry activities, like adding interview spaces at intake and spaces for individuals to receive services and meet with post-release care managers, in person or via telehealth.
- Provide telehealth tablets for individuals' use. Connect the tablets to closed systems to protect security and enhance access to community providers.

Consider partnering with federally qualified health centers (FQHCs).

As of 2024[16], the number of centers offering general SUD treatment was

66%

96% of FQHCs offer telehealth



88% offer virtual SUD treatment

Examples

Example #1: New Hampshire

New Hampshire will make infrastructure improvements to facilitate access to community health care providers via telehealth. Future plans will further increase access by procuring new telehealth pod structures (spaces where individuals can access telehealth care in private).

Browse: New Hampshire Reentry Implementation Plan, page 2

Examples

Example #2: Washington

Washington is extending Wi-Fi coverage by installing telehealth pods for patient privacy in correctional living units. The pods will be equipped with secure tablets to provide telehealth access. This investment will minimize the need to escort individuals to other parts of the facility.[17]

Goal

Ensure pre-release plans are person centered and aligned with CMS reentry guidance

4.3 Case Management

Why is this important?

Pre-release case management providers should become familiar with the case management expectations established in CMS's April 2023 Reentry Guidance. This is especially important for correctional case managers who may have previously provided this service in ways that aren't fully consistent with CMS's guidance.

Strategy

Correctional facilities can:

- Develop requirements for pre-release case management that reflect CMS's guidance—and the 4 functions of case management:
  1. Assessment
  2. Planning
  3. Referral and linkage
  4. Monitoring and coordination
- Provide in-reach pre-release services through managed care organizations (MCOs) or community providers to establish care connections
- Require MCOs to provide pre-release care management for individuals with extensive health needs and to identify a specific care manager to ensure that individuals have immediate appointments and access to services post-release

Examples

Example #1: New Hampshire

In New Hampshire, eligible individuals are enrolled in MCOs during the pre-release period. The MCOs initiate care management activities, including creating a person-centered plan for each individual. Then, the pre-release case manager schedules a warm introduction with the post-release case manager and the individual during the first week of their reentry participation (90 days before release).

Browse: New Hampshire Reentry Implementation Plan, page 4

Example #2: Massachusetts

Through the MassHealth Behavioral Health Supports for Justice Involved Individuals program, navigators:

- Work with individuals pre-release to develop personalized support plans
- Provide intensive supports post-release, including daily contacts for the first month and 24/7 on-call support as needed

Access: MassHealth Behavioral Health Supports for Justice Involved Individuals (BH-JI)

Goal Offer MOUD to all individuals with an OUD at least 90 days before reentry

4.4 MAT with Buprenorphine and Naltrexone

Why is this important?

Most prisons and jails don't offer buprenorphine and naltrexone or only provide limited forms of these medications.[18] In a recent report, 44% of jails offered MOUD to at least some individuals, and just 13% offered these medications to anyone with an OUD who requested them.

Strategy

The process for deciding which MOUDs to initially offer involves first identifying the MAT provider's location and what MOUDs are available in that location, so the facility can ensure that pre-release medications will be available post-release. For prisons, their referral system of OUD organizations may include providers who are located some distance from the facility since most individuals released from incarceration return to their home communities, which may be 100 miles or more from the prison.

Correctional facilities may consider using a hybrid mix of practitioners to provide MAT, including carceral staff, staff of the carceral health care vendor, county or state health departments, and community prescribers.

If correctional facilities can't meet the need for MOUD using existing health care staff or vendors, they and SMAs will need to identify community-based providers to provide MAT services within the facility. Community-based providers include community health centers (CHCs), medical practices, office-based opioid treatment providers, and individual medical practitioners, like medical doctors (MDs), advanced practice registered nurses (APRNs), nurse practitioners (NPs), and physician assistants (PAs).

Examples

Example #1: Boston, Massachusetts

Boston Medical Center's Office-Based Addiction Treatment program works in partnership with the South Bay House of Corrections, providing in-facility presentations on the center's services. For those interested in office-based addiction treatment, center staff meet with them individually, establish a relationship, and make direct linkages at release. The center's clinic also prioritizes post-release walk-ins during all clinic hours.

Check out: New Approaches to Disseminating Treatment: Technology, Low Barrier MAT and Prison Health, slides 20–23, page 4

Example #2: Maine

In Maine's prisons and juvenile facilities, 2 providers of pre-release linkage services are responsible for facilitating access to post-release MAT, either by providing it directly (Groups Recover Together) or through referral arrangements (Day One).

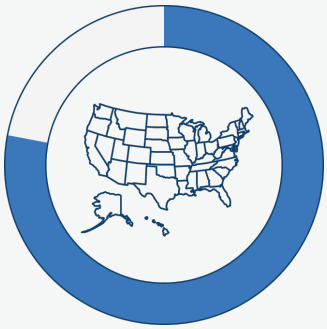
Learn more: Medication Assisted Treatment Services First Year Review

4.5 MAT with Methadone

Why is this important?

Regulatory restrictions on methadone delivery by OTPs create significant barriers to access.

Given the high prevalence of OUDs in correctional facilities and the presence of fentanyl in the drug supply, methadone should be available as soon as possible to individuals who are incarcerated. It should also be noted that compared to buprenorphine and naltrexone, methadone is associated with less opioid use, lower mortality and criminality, and improved quality of life.[20]



In 2024, **78%** of counties nationwide had no OTP.[19]

Strategy

SMAs can begin discussions with the Single State Agency (SSA, the state agency responsible for SUDs) and the State Opioid Treatment Authority (SOTA, which is responsible for overseeing OTPs) to develop a plan to make methadone available in correctional facilities. As part of this planning, the state should evaluate all possible methadone delivery models to determine which one(s) could offer facilities an opportunity to provide access to methadone.

For most correctional facilities, the most feasible models may include:

- Registering with the DEA as a hospital or clinic
- Transporting methadone from a certified OTP
- Operating a medication unit under the auspice of a certified OTP
- Having a certified OTP provide services onsite

Medication units are an underutilized option for expanding the reach of methadone treatment, both for rural areas in general and correctional facilities in particular. Locating medication units in CHCs — which have broad distribution across the United States and are, therefore, likely located near to correctional facilities — can significantly expand access to methadone.

The SSA, with its SOTA, could also create prototype models for accessing methadone for specific types of facilities, like small rural jails, large county or urban jails, or prisons.

Medications for the Treatment of Opioid Use Disorders rule

Using the new flexibilities available through the April 2024 Medications for the Treatment of Opioid Use Disorders rule can assist correctional facilities in providing access to methadone. Specifically:

- The pre-admission screening examination may be conducted outside of an OTP and by a licensed practitioner who isn't an OTP practitioner
- A non-OTP practitioner may complete a full examination of the individual's health status
- Both the screening and full examination may be completed via telehealth
- Updated stability criteria and expanded time-in-treatment parameters allow for greater access to take-home dosing

Examples

Example #1: Arizona

In Arizona, Community Medical Services, a private OTP provider, supports methadone treatment for over 7,000 individuals who were previously enrolled in a community OTP and who are incarcerated in Maricopa County jails. Community Medical Services also provides methadone for the duration of individuals' jail stays in Pima, Yuma, Mohave, and Santa Cruz counties.

Explore: Access to Medications for Opioid Use Disorder in U.S. Jails and Prisons: Litigation, Legislation, and Policies, page 5

Example #2: Washington

Washington has established a process to allow correctional facilities to[21]:

- Work with external OTPs
- Have a medication unit on site
- Register as a hospital or clinic and provide methadone

Examples

Example #3: New Mexico

Recovery Services of New Mexico (now MedMark Treatment Centers), a certified OTP, provides methadone in New Mexico's Bernalillo County Detention Center.

Read: A Review of Medication Assisted Treatment (MAT) in United States Jails and Prisons

Example #4: Alleghany County, Pennsylvania

Allegheny County contracts with Pittsburgh Comprehensive Treatment Center, a certified OTP, to manage its methadone treatment unit. This unit also connects patients with a community provider upon release from the jail and refers individuals to the county's Department of Human Services for reentry and peer-support services.

Access: Allegheny County Expands Jail's Opioid Use Disorder Treatment Program

Example #5: Clark County, Washington

The Clark County Sheriff's Office provides methadone as a "satellite site" of Acadia Healthcare, a licensed OTP.

Learn more: Medications for Opioid Use Disorder (MOUD) In Jails Program, page 5

Examples

Example #6: Pierce County, Washington

Pierce County Alliance, a SUD treatment organization, administers the MOUD program at the Pierce County Jail and partners with the Tacoma/Pier County Health Department to provide courtesy methadone dosing. All other jail medical services are provided by a correctional health vendor.

Explore: Providing Medication to Treat Opioid Use Disorder in Washington State Jails, pages 10–12

Example #7: Franklin County, Massachusetts

The Franklin County Sheriff's Office provides all 3 MOUDs and is a licensed OTP. During the COVID-19 pandemic, the office began administering MOUDs in housing units and then pivoted to using telehealth. Essential case workers and clinical staff placed individuals in front of a designated telehealth computer to engage with sheriff's office case workers or clinicians working from home and community addiction treatment partner agencies. Smart TVs and tablets also connected individuals with community partners pre-release, and the office uses technology to complete community pre-release assessments and provide warm handoffs at release.

Check out: COVID-19 and Treating Incarcerated Populations for Opioid Use Disorder

4.6 MAT with All MOUDs

Why is this important?

For many correctional facilities, MAT is a new addition to their health care services. Creating the facility's model for MOUD provision may require new types of arrangements with correctional health care vendors and community providers.

Strategy

Correctional facilities can assess the ability of health care vendors and community providers to provide some or all MOUDs and create delivery models that maximize the facility's ability to provide MAT.

Examples

Example #1: Franklin County, Ohio

The Franklin County Corrections Center relies on:

- Community Medical Services to provide methadone
- NaphCare to provide buprenorphine prescriptions

Read: Access to Medications for Opioid Use Disorder in U.S. Jails and Prisons: Litigation, Legislation, and Policies, page 16

Example #2: New Hampshire

New Hampshire has identified 5 counties that contract with the same medical provider. The state has begun to work with this vendor to form a partnership for enhanced MAT service delivery.

Access: New Hampshire Reentry Implementation Plan, page 4

Examples

Example #3: Maine

Maine began making MOUD universally accessible among resident populations in all jails, prisons, and juvenile facilities in November 2021. For prisons and juvenile facilities, in-facility MAT is provided by Wellpath. Pre-release linkages are provided by Groups Recover Together, an opioid treatment provider throughout Maine, and Day One, a substance use and mental health provider in southern Maine.

Learn more: Medication Assisted Treatment Services First Year Review

Example #4: Philadelphia, Pennsylvania

The Philadelphia Department of Prisons has provided MAT in all city jails for over 12 years. Specifically, methadone is provided through a partnership with a community provider, while the jails provide Suboxone® (buprenorphine and naloxone) and Vivitrol® (extended-release naltrexone).

Browse: Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings, page 44

4.7 MAT with Naloxone

Why is this important?

Given the risk of in-facility overdose events and deaths, naloxone should be part of facilities' MAT programs. The National Institutes of Health's HEALing Communities Study identified an evidence-based practice — overdose education and naloxone distribution[22] — that can reduce the risk of overdose deaths both in correctional facilities and post-release.

Strategy

Using the overdose education and naloxone distribution framework, correctional facilities should make naloxone available through a variety of methods, including:

- Issuing Narcan® (naloxone) to correctional officers to carry while on duty
- Placing Narcan® supplies throughout facilities in locations that staff and individuals can access
- Distributing Narcan® directly to all individuals who are receiving MAT

Examples

Example #1: Michigan and Cook County, Illinois

Jails in Michigan and the Cook County Jail in Illinois provide naloxone free of charge through vending machines in their lobbies.

Learn more:

- Naloxone Vending Machines in County Jail
- Cook County Health to Place Narcan Vending Machines at Cook County Health Hospitals, Cook County Jail, Cook County Courthouses

Example #2: California and Cook County, Illinois

In California prisons and the Cook County Jail in Illinois, pre-release planning includes distributing naloxone kits and training on administering the medication.

Explore:

- A Review of Medication Assisted Treatment (MAT) in United States Jails and Prisons, page 19
- Cook County Jail to Expand Medication-Assisted Treatment for Opioid Addiction

Examples

Example #3: Philadelphia, Pennsylvania

Through the Philadelphia Department of Prisons, all correctional officers are trained to use naloxone — and they carry naloxone and administer it throughout the jail when necessary. What's more, naloxone is available throughout jail facilities, so health care staff have quick access to it.

Read: Narcan Now Being Used in Philadelphia Prisons by Trained Officers and Has Already Saved Lives of Incarcerated Individuals

Example #4: Maine

In Maine prisons, the Department of Corrections provides naloxone kits and hands-on education on responding to an overdose. Each kit also contains an educational resource on overdose response for family and friends.

Check out: Medication Assisted Treatment Services First Year Review, page 2

References

[9] Zeng, Z. (2023, December). *Jail inmates in 2022 – Statistical tables.* U.S. Department of Justice, Office of Justice Programs. https://bjs.ojp.gov/document/ji22st.pdf

[10] Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2020, August 10). *Drug use, dependence, and abuse among state prisoners and jail confined persons, 2007–2009*. U.S. Department of Justice, Bureau of Justice Statistics. https://bjs.ojp.gov/content/pub/pdf/dudaspji0709.pdf

[11] Pinals, D. (2020). *MAT or MOUD in correctional settings: Considerations for implementation.* Opioid Response Network Summit, Providence, RI.

[12] American Society of Addiction Medicine. (2020). *The ASAM national practice guideline for the treatment of opioid use disorder: 2020 focused update.* https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/guidelines/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2

[13] Bureau of Justice Assistance. (2022, February). *Managing substance withdrawal in jails: A legal brief*. https://bja.ojp.gov/doc/managing-substance-withdrawal-in-jails.pdf

[14] Young, J. D., & Badowski, M. E. (2017). Telehealth: Increasing access to high quality care by expanding the role of technology in correctional medicine. *Journal of Clinical Medicine, 6,* 20. https://www.mdpi.com/2077-0383/6/2/20

[15] Williams, K. S., Singh, M. J., Elumn, J. E., Threats, M., Sha, Y., McCall, T., Wang, K., Massey, B., Peng, M. L., & Wiley, K. (2024). Enhancing healthcare accessibility through telehealth for justice impacted individuals. *Frontiers in Public Health, 12.* https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2024.1401950/full

[16] Larson, C. (2024, August 16). *MAT access up 66% in community health centers.* Behavioral Health Business. https://bhbusiness.com/2024/08/16/mat-access-grew-68-in-community-health-centers-provider-shortage-worsens/

[17] L. Flynn (personal communication, February 21, 2025)

[18] Balawajder, E. F., Ducharme, L., Taylor, B. G., Lamuda, P. A., Kolak, M., Friedmann, P. D., Pollack, H. A., & Schneider, J. A. (2024). Factors associated with the availability of medications for opioid use disorder in US jails. *JAMA Network Open, 7,* e2434704. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2823908

[19] U.S. Department of Health and Human Services, Office of Inspector General. (2024, September 23). *Medicare and Medicaid enrollees in many high-need areas may lack access to medications for opioid use disorder*. https://oig.hhs.gov/reports/all/2024/medicare-and-medicaid-enrollees-in-many-high-need-areas-may-lack-access-to-medications-for-opioid-use-disorder/

[20] Wakeman, S. E., Larochelle, M. R., Ameli, O., Chaisson, C. E., McPheeters, J. T., Crown, W. H., Azocar, F., & Sanghavi, D. M. (2020). Comparative effectiveness of different treatment pathways for opioid use disorder. *JAMA Network Open, 3*, e1920622. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032

[21] J. Blose (personal communication, March 27, 2025)

[22] Doe-Simkins, M., & Wheeler, E. J. (2025). Overdose education and naloxone distribution: An evidence-based practice that warrants course correcting. *American Journal of Public Health, 115*, 6–8. https://ajph.aphapublications.org/doi/10.2105/AJPH.2024.307893

Section 5:

30-Day Supply of Medications

Goal

Provide all individuals reentering from correctional facilities with a 30-day supply of medications

Why is this important?

Because individuals who have been incarcerated have high rates of chronic diseases, continuous management of their conditions post-release is critically important.[23] Maintenance medications are a key component of this management. Although some states "provide individuals with a limited supply of medications upon release, this is not a consistently adopted practice."[24] Little is known about jails' provision of post-release medications.

Strategy

Correctional facilities must establish efficient mechanisms for either their in-house or a contracted community pharmacy to provide the 30-day supply of medications on the day an individual is released. This also requires the facility to create mechanisms for medical staff to quickly issue prescriptions when necessary. And this 30-day supply of post-release medication should include a naloxone kit.

Examples

Example #1: Washington

Washington's current policy requires the Department of Corrections to provide a 30-day supply of medications at release, although they have the ability to prescribe less under certain conditions.

Read: DOC 650.035: Medications for Transfer and Release

Example #2: Washington

Before individuals who may be released directly from court actually go to court, Washington jails participating in the state's MOUD and MAUD in Jails Program inform them that they may request to be transported back to jail by staff to receive their supply of post-release medication.

Additionally, when medications cannot be provided upon release, like because of an unscheduled release at a time when medical staff are not present, Washington jails:

- Inform the individual that they may either return to the jail the following day to receive bridge medications
- Or if no medical staff will be present the following day, have medical staff call in a prescription for the same bridging medication at a local pharmacy

Check out: Medications for Opioid Use Disorder (MOUD) and Medications for Alcohol Use Disorder (MAUD) in Jails: Standard of Care Guidelines, pages 4–5

Examples

Example #3: California

California's requirements for a 30-day supply of medications at release include:

- Providing a full supply of medications in hand upon release from the correctional facility pharmacy, with prescriptions for refills in place, as clinically appropriate.
- Using a Medi-Cal pharmacy to fill medications provided upon release.
- Complying with Medi-Cal's prior authorization and utilization management requirements.
- Supporting overdose prevention by providing naloxone upon release, as well as a clinically appropriate supply of MAT with follow up.
- Ensuring that an individual diagnosed with an SUD (e.g., OUD) receives a supply that's deemed appropriate and takes into account the date of their next follow-up appointment. For example, an individual who is on a stable treatment dose and who has a follow-up appointment with their SUD treatment provider within 2 weeks of release should receive at least a 14-day supply of buprenorphine.

The pre-release care manager also works with the post-release care manager (if different) to support the individual in transferring medication refill orders to the individual's preferred community pharmacy, as necessary.

Explore: Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative, pages 119–123

Example #4: Maine

At discharge, the Maine Department of Corrections provides a naloxone kit and hands-on education on responding to an overdose.

Access: Medication Assisted Treatment Services First Year Review

References

[23] American Academy of Family Physicians. (2022, January). *Incarceration and health: A family medicine perspective (Position paper).* https://www.aafp.org/about/policies/all/incarceration.html

[24] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2023, January). *Health care transitions for individuals returning to the community from a public institution: Promising practices identified by the Medicaid Reentry Stakeholder Group* [Report to Congress]. https://aspe.hhs.gov/sites/default/files/documents/d48e8a9fdd499029542f0a30aa78bfd1/health-care-reentry-transitions.pdf

Section 6:

Transitions in Care

Goal

Ensure strategies exist for transitioning individuals between facilities and community OUD MAT providers

Why is this important?

Effective transitions are key to successful reentry initiatives, but they can present challenges that aren't encountered in typical health care transitions. For example, individuals being released from correctional facilities have high behavioral and medical needs and have often lost connection to their communities and families. As a result, communication and connection are even more important when bridging from correctional facilities to communities.

Strategy

Transitions in care must be carefully managed by a designated individual or team. An effective transition begins with a personal, in-person (including telehealth) meeting that includes the individual whose care is being transitioned. The transition process should ensure timely access to services through same-day, walk-in appointments or telephone/telehealth visits.[25]

The easiest way to minimize disruptions during care transitions is to have the same providers work with an individual both pre- and post-release. Nationally, 11% of all county health departments play a role in providing correctional health care through a dually based model — in which providers in the jail also serve patients in the community, thereby easing transitions in care when individuals are released.

Referral system considerations

SMAs can consider developing a technology-enabled closed loop referral system — similar to North Carolina's NCCARE360 — for health-related social needs demonstrations for providers to:

- Refer individuals to behavioral health and social service organizations
- Receive confirmation that the individual was successfully connected to care[26]

Examples

Example #1: Franklin County, Ohio

The Rapid Resource Center, launched in 2021, plays a key role in linking individuals leaving incarceration to a variety of services and treatment. With hours that span morning, afternoon, and evening, individuals can, upon release, meet in person with staff members to learn about their options, including linkage to MOUD. Individuals can also contact the center later, after their initial consultation, to learn more about their options and opportunities.

Learn more: Supporting Incarcerated People's Recovery: Linkage to Care Policies for People Entering and Exiting Incarceration with Substance Use Disorder, page 5

Example #2: Camden County, New Jersey

The Camden County Jail's MOUD program includes navigators who provide face-to-face coordination post-release, assisting with connections to community treatment providers, pharmacies, and other supports.

Check out: Evaluating the Camden County Correctional Facility's Medications for Opioid Use Disorder Program, page 7

Examples

Example #3: Multnomah County, Oregon and Hampden County, Massachusetts

These counties' dually based models allow community providers to access (with the individual's permission) health records from during and before incarceration.

Download: Jails: Inadvertent Health Care Providers, page 5 and 15

Example #4: New York City, New York

NYC Health + Hospitals operates the Point of Reentry and Transition (PORT) program, an initiative of the city's Correctional Health Services. PORT practices are located at 2 public hospitals (Bellevue and Kings County) and are staffed by primary care providers who usually work in city jails, alongside practitioners who work in the 2 community hospitals. Community health workers within the 2 hospitals serve as bridges to services. This model creates opportunities for individuals released from jail to see the same providers who treated them during their incarceration.

Read: NYC Health + Hospitals Launches Correctional Health Services Point of Reentry and Transition Practices at NYC Health + Hospitals/Bellevue and NYC Health + Hospitals Kings County

Example #5: Rhode Island

The Rhode Island Department of Corrections established 12 community-based Centers of Excellence (COEs) in MOUD to ensure continuity of care and treatment post-release. To create these COEs, the state repurposed existing outpatient facilities located throughout Rhode Island. Individuals choose the center for their treatment.

Learn more: Health Care Transitions for Individuals Returning to the Community from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group, page 20

Examples

Example #6: Franklin County, Massachusetts

Franklin County changed their post-release programming to provide telehealth options, such as recovery management checkups, a peer-recovery telehealth group, and a mobile texting application (Textedly) to "connect with, educate and motivate individuals to access community treatment and resources."

In addition, the major behavioral health provider in Franklin County (Behavioral Health Network) has an embedded staff person who works at the jail, collaborating with the reentry team on identifying treatment options, making electronic referrals, and scheduling first community appointments.

Check out:

- COVID-19 and Treating Incarcerated Populations for Opioid Use Disorder
- An Evaluation of Telehealth for Opioid Use Disorders in a Correctional Setting, page 8

Example #7: Massachusetts

Massachusetts provides reentry support for individuals receiving MAT by matching individuals preparing for release with Recovery Support Navigators, who are trained to provide non-clinical peer support services. These navigators ensure that individuals connect with an outpatient treatment program within 24 hours of release and maintain contact for a year to provide ongoing support.

Read: Connecting the Justice-Involved Population to Medicaid Coverage and Care: Findings from Three States, page 8

Examples

Example #8: Washington

Health engagement hubs serve as all-in-one locations where people in Washington can access a range of medical and social services. The Washington State Health Care Authority, in collaboration with the Department of Health, oversees this effort to ensure efforts align with cross-agency goals around expansion of services and resources through public health and behavioral health systems.

Explore: Health Engagement Hub

6.1 MAT with Buprenorphine and Naltrexone

Why is this important?

While buprenorphine is the most frequently prescribed MOUD, there is still insufficient provider supply to meet the need, and adding the justice-involved population to the existing population requiring treatment will widen the access gap. In addition, like methadone, buprenorphine is significantly less available in rural areas than in more densely populated communities.

Providers must use innovative, person-centered practices to engage and retain individuals who are released from correctional facilities — consistent with the needs of others receiving MOUD.

Strategy

With the exception of Vermont, most counties and states have far fewer DEA-registered providers than the number required to meet existing need. SMAs, SSAs, and Medicaid Health Plans will need to consider developing plans and approaches to increase access to both buprenorphine and methadone.

As recommended for pre-release MAT, post-release MAT must maximize telehealth use to increase engagement and retention in treatment. In fact, research has shown that starting buprenorphine through telehealth is associated with an increased likelihood of staying in treatment longer compared to starting in a non-telehealth setting.[27]

Correctional facilities can establish relationships with agencies offering telehealth buprenorphine bridge programs, so that post-release MAT is rapidly available as a connection to long-term treatment if there are time or geographic gaps in access.

SMAs and/or their correctional partners can encourage MCOs to

- Designate providers who offer telehealth for MOUD as preferred providers to facilitate increased access to treatment
- Increase retention in treatment by identifying MAT providers using mobile digital technology to support individuals during treatment and after providing access to crisis alerts, e-therapy for recovery skill development, clinical support, and connection to peer specialists

Examples

Example #1: Washington, New York, New Jersey, and Pennsylvania

Modelled after hospital bridge clinics, organizations in several states are offering rapid linkages to buprenorphine telehealth providers or directly providing rapid initiation of buprenorphine. Examples of these organizations include Telebup in Washington and the MATTERS (Medication for Addiction Treatment and Electronic Referrals) Network, which covers New York, New Jersey and Pennsylvania.

Explore:

- New Tele-buprenorphine Hotline Now Serving King County
- MATTERS Network

Examples

Example #2: Pennsylvania and Illinois

The University of Pittsburgh Medical Center Telemedicine Bridge Clinic and Penn Medicine's Care Connect in Pennsylvania and Medicated Assisted Recovery (MAR) in Illinois:

- Facilitate rapid engagement of individuals with OUD
- Initiate MOUD
- Refer them to appropriate health and recovery programs

All three programs provide telephonic prescriptions and buprenorphine induction.

Learn more:

- Pittsburgh Telemedicine Bridge Clinic
- Medication Assisted Recovery (MAR) Expansion

Example #3: Niagara and Dutchess Counties, New York

Jails in these counties have partnered with the MATTERS Network, whose referral network connects community providers and correctional facilities to treat individuals via telemedicine. Individuals can select the location and time for follow-up MOUD care that work best for them.

Access: Medication for Opioid Use Disorder (MOUD): Correctional Health Implementation Toolkit, page 38

Example #4: Middlesex, Massachusetts

The Middlesex Jail and House of Correction operates an in-facility MAT program and coordinates post-release treatment transitions with the Lowell Community Health Center.

Browse: Essential Connections: Community Health Centers' Role in Facilitating Healthy Transitions Out of Incarceration

6.2 MAT with Methadone

Why is this important?

The same regulatory restrictions that create barriers to pre-release methadone provision apply to post-release access. These barriers include regulatory restrictions on who can deliver methadone and the presence of fentanyl in the drug supply. In this context, it's crucial that methadone be available to individuals who are incarcerated as soon as possible.

Strategy

States must employ similar strategies for creating access to treatment post-release as for MAT with methadone pre-release, in terms of both:

- The delivery models used, like medication units
- The adoption of the 2024 regulatory flexibilities, especially take-home dosing

Notably, directly observed therapy with methadone has been shown to be safe and effective in increasing retention in treatment and take-home dosing privileges while reducing barriers related to daily in-clinic dosing. Directly observed therapy can combine video-observed dosing and an electronically controlled pill dispenser for administering and monitoring methadone.[28]

SMAs can encourage MCOs to identify OTPs that offer telehealth for MOUD and greater use of take-home dosing, which could drive increased patient acceptance and lower treatment burden.

Examples

Example #1: Illinois

MAR NOW, a telehealth buprenorphine provider, offers same- or next-day appointments for methadone treatment at 14 OTPs throughout Illinois.

Learn more: Medication Assisted Recovery (MAR) Expansion

References

[25] Network for Improvement in Addiction Treatment (NIATx), Bureau of Justice Assistance, & Council of State Governments Justice Center. (2011). *Bringing NIATx to corrections: Lessons learned from three pilot studies.* https://csgjusticecenter.org/publications/bringing-niatx-to-corrections/

[26] Drake, C., McPeek Hinz, E., Granger, B. B., Granados, I., Rader, A., Pitcher, A., McNeil, S., Bleser, W. K., Avery, C., Bettger, J. P., Tenenbaum, E., Shepherd-Banigan, M., Wertman, E., McNerney, L., Mortiboy, M., Purakal, J., Sangvai, D., & Spratt, S. (2024). Implementation of NCCARE360, a digital statewide closed-loop referral platform to improve health and social care coordination: Evidence from the North Carolina COVID-19 Support Services Program. *North Carolina Medical Journal, 85*(2). https://ncmedicaljournal.com/article/94877-implementation-of-nccare360-a-digital-statewide-closed-loop-referral-platform-to-improve-health-and-social-care-coordination-evidence-from-the-north

[27] National Institute on Drug Abuse. (2023, October 18). *Telehealth supports retention in treatment for opioid use disorder.* https://nida.nih.gov/news-events/news-releases/2023/10/telehealth-supports-retention-in-treatment-for-opioid-use-disorder

[28] Hallgren, K. A., Darnton, J., Soth, S., Blalock, K. L., Michaels, A., Grekin, P., Saxon, A. J., Woolworth, S., & Tsui, J. I. (2022). Acceptability, feasibility, and outcomes of a clinical pilot program for video observation of methadone take-home dosing during the COVID-19 pandemic. *Journal of Substance Use & Addiction Treatment, 143*, 108896. https://www.jsatjournal.com/article/S0740-5472(22)00178-7/fulltext

Section 7:

Post-Release Provider System

Goal Ensure that provider systems are adequate to offer OUD services post-reentry

Why is this important?

Given that jails cover cities and counties, their post-release provider systems can often cover the same geographic area. But this isn't true for prisons.

In fact

more than **60%** of people in state prisons are incarcerated at least **100 miles** from their homes.[29]

Because incarcerated people almost always return to the communities they came from, a prison's post-release provider system must have broader geographic reach than a jail's.

Jails' access to community providers

In contrast to prisons, 34% of jail jurisdictions have an ADP of 50 or less, and for 54% of jails, the ADP is 100 or less. As a result, they likely have **limited access to community providers** for both MAT and case management.

Geography also plays a role in service access. For example, most small jails are located in rural areas, which may be **service deserts**. And while jails in large cities or counties likely have sufficient availability of community providers for case management, they may face difficulties in identifying sufficient MAT providers and accessing methadone.

Strategy

Prisons must identify the communities of origin for their population and develop provider systems in high-volume communities. In addition, these facilities must decide whether post-release case management providers should be local to the prison or located in the communities to which individuals will return.

As for pre-release services, telehealth should play a large role in providing access to post-release services, especially for rural prisons and jails, given the lack of community providers.

7.1 Services

Why is this important?

While only case management and MAT are required pre-release, post-release, individuals will still need access to a broad array of behavioral health, health, and health-related services that are delivered by diverse providers.

Strategy

Reentry provider systems should include CHCs, primary care practices, and community-based organizations addressing health-related social needs (e.g., housing, housing assistance), in addition to behavioral health providers.

SMAs, MCOs, or their correctional partners may be able to:

- Create affiliations between specific correctional facilities and CHCs, which have broad geographic reach,[30] to provide health services and MAT, if possible.
- Designate CHCs as Medicaid Health Homes to coordinate primary and specialty care for individuals with chronic conditions. Medicaid Health Homes coordinate care for people with Medicaid who have chronic conditions. Medicaid Health Home providers are expected to operate under a whole-person philosophy — integrating and coordinating all primary, acute, behavioral health, and long-term services and supports.
- Determine whether specific correctional facilities are located near to CHCs, Transitions Clinic Networks, or other providers who offer reentry-focused models of care and prioritize these providers as potential reentry contractors.

- Identify potential reentry providers who can make peer specialists or community health workers with correctional lived experience available to support individuals during and after the care transition period.
- Implement community care hubs that coordinate health and behavioral health services with community social services and supports.

Examples

Example #1: New Hampshire

New Hampshire identified a list of intended community provider partners, including peer support services, and shared it with its MCOs that are currently expanding provider networks to incorporate additional community options for the reentry initiative. The state has also designated individuals reentering from correctional facilities as a priority population for core behavioral health providers. This priority population designation will continue for a year after reentry.

Read: New Hampshire Reentry Implementation Plan, pages 11–13

Examples

Example #2: District of Columbia

The District of Columbia is implementing a program to provide health care to unhoused individuals. Unity Health Care contracts with the District of Columbia's jail to provide comprehensive health care for individuals who are incarcerated. As part of this program:

- Unity staff conduct an evaluation as part of the intake process
- Some of Unity's primary care providers work within the jail full time, while others spend 2 days per week in the jails and 3 days in one of Unity's 20 locations throughout the District
- For individuals who continue care with Unity post-release, EHRs are shared between the jail and health center
- Unity partners with other housing and service providers to provide a broad array of post-release services

Learn more: Stopping the Revolving Door: How Health Centers Can Serve Justice-Involved Populations, page 4

Example #3: Washington

Washington is establishing Community Care Hubs under the auspices of Accountable Communities of Health (ACH). These hubs will coordinate health, behavioral health, and social services supports for individuals post-reentry.

Browse: ACH Community Care Hubs

Examples

Example #4: Michigan

The Michigan Prisoner Reentry Initiative, a statewide coordinated care program, employs community health workers to help individuals access health care and social services in the community.

Explore: Health Care Transitions for Individuals Returning to the Community from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group, page 19

Example #5: New York

New York implemented a criminal justice pilot program under the state's Health Home state plan option. The Department of Health and the Division of Criminal Justice Services share data to identify eligible individuals and coordinate a warm handoff at discharge to connect returning community members to Health Home care managers.

Access: Health Care Transitions for Individuals Returning to the Community from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group, page 27

Example #6: California

La Clinica, a Transitions Clinic in California, provides a medical home for formerly incarcerated community members with chronic health conditions, mental health disorders, and/or SUDs. Community health workers begin engagement while potential clients are incarcerated, offering virtual case management services in the county jail. Individuals are also assessed for other needs, like food insecurity, housing, employment, and skills development.

Read: Stopping the Revolving Door: How Health Centers Can Serve Justice-Involved Populations, page 3

Examples

Example #7: Franklin County, Massachusetts

The Franklin County Sheriff's Office collaborates closely with a group of community providers who develop relationships with jail residents during incarceration and continue to provide support post-release. This provider system includes a CHC, a behavioral health provider, an office-based addiction treatment program, and a peer advocacy agency.

Check out: Improving Continuity of Care for Justice-Involved Individuals: Lessons from the Field, slides 27–28

7.2 MAT with Buprenorphine and Naltrexone

Why is this important?

While buprenorphine is the most frequently prescribed MOUD, there is still insufficient provider supply to meet the need, and adding the justice-involved population to the existing population requiring treatment will widen the access gap. In addition, like methadone, buprenorphine is significantly less available in rural areas than in more densely populated communities.

Providers must use innovative, person-centered practices to engage and retain individuals who are released from correctional facilities — consistent with the needs of others receiving MOUD.

Strategy

With the exception of Vermont, most counties and states have far fewer DEA-registered providers than the number required to meet existing need. SMAs, SSAs, and Medicaid Health Plans will need to consider developing plans and approaches to increase access to both buprenorphine and methadone.

As recommended for pre-release MAT, post-release MAT must maximize telehealth use to increase engagement and retention in treatment. In fact, research has shown that starting buprenorphine through telehealth is associated with an increased likelihood of staying in treatment longer compared to starting in a non-telehealth setting.[31]

Policymakers can:

- Establish relationships with agencies offering telehealth buprenorphine bridge programs, so that post-release MAT is rapidly available as a connection to long-term treatment if there are time or geographic gaps in access
- Encourage MCOs to designate providers who offer telehealth for MOUD as preferred providers to facilitate increased access to treatment
- Increase retention in treatment by identifying MAT providers using mobile digital technology to support individuals during treatment and after providing access to crisis alerts, e-therapy for recovery skill development, clinical support, and connection to peer specialists

Examples

Example #1: Washington, New York, New Jersey, and Pennsylvania

Modelled after hospital bridge clinics, organizations in many states are offering rapid linkages to buprenorphine telehealth providers or directly providing rapid initiation of buprenorphine. Examples of these organizations include Telebup in Washington and the MATTERS Network, which covers New York, New Jersey and Pennsylvania.

Explore:

- New Tele-buprenorphine Hotline Now Serving King County
- MATTERS Network

Examples

Example #2: Pennsylvania and Illinois

The University of Pittsburgh Medical Center Telemedicine Bridge Clinic and Penn Medicine's Care Connect in Pennsylvania and MAR in Illinois:

- Facilitate rapid engagement of individuals with OUD
- Initiate MOUD
- Make referrals to appropriate health and recovery programs

All three programs provide telephonic prescriptions and buprenorphine induction.

Learn more:

- Pittsburgh Telemedicine Bridge Clinic
- Medication Assisted Recovery (MAR) Expansion

Example #3: Niagara and Dutchess Counties, New York

Jails in these counties have partnered with the MATTERS Network, whose referral network connects community providers and correctional facilities to treat individuals via telemedicine. Individuals can select the location and time for follow-up MOUD care that work best for them.

Access: Medication for Opioid Use Disorder (MOUD): Correctional Health Implementation Toolkit, page 38

Example #4: Middlesex, Massachusetts

The Middlesex Jail and House of Correction operates an in-facility MAT program and coordinates post-release treatment transitions with the Lowell Community Health Center.

Browse: Essential Connections: Community Health Centers' Role in Facilitating Healthy Transitions Out of Incarceration

7.3 MAT with Methadone

Why is this important?

The same regulatory restrictions that create barriers to pre-release methadone provision also apply to post-release access. These barriers include regulatory restrictions on who can deliver methadone and the presence of fentanyl in the drug supply. In this context, it's crucial that methadone be available to individuals who are incarcerated as soon as possible.

Strategy

States may consider employing similar strategies for creating access to treatment post-release as for MAT with methadone pre-release, in terms of both:

- The delivery models used, like medication units
- The adoption of the 2024 regulatory flexibilities, especially take-home dosing

Notably, directly observed therapy with methadone has been shown to be safe and effective in increasing retention in treatment and take-home dosing privileges while reducing barriers related to daily in-clinic dosing. Directly observed therapy can combine video-observed dosing and an electronically controlled pill dispenser for administering and monitoring methadone.[32]

SMAs and SSAs can encourage MCOs to identify OTPs that offer telehealth for MOUD and greater use of take-home dosing, which could drive increased patient acceptance and lower treatment burden.

Examples

Example #1: Illinois

MAR NOW, a telehealth buprenorphine provider, offers same- or next-day appointments for methadone treatment at 14 OTPs throughout Illinois.

Learn more: Medication Assisted Recovery (MAR) Expansion

References

[29] Rabuy, B., & Kopf, D. (2015, October 20). *Separation by bars and miles: Visitation in state prisons.* Prison Policy Initiative. https://www.prisonpolicy.org/reports/prisonvisits.html#lf-fnref:9

[30] Across the country, 1,400 FQHCs operate 15,000 clinic sites.

[31] National Institute on Drug Abuse. (2023, October 18). *Telehealth supports retention in treatment for opioid use disorder*. https://nida.nih.gov/news-events/news-releases/2023/10/telehealth-supports-retention-in-treatment-for-opioid-use-disorder

[32] Hallgren, K. A., Darnton, J., Soth, S., Blalock, K. L., Michaels, A., Grekin, P., Saxon, A. J., Woolworth, S., & Tsui, J. I. (2022). Acceptability, feasibility, and outcomes of a clinical pilot program for video observation of methadone take-home dosing during the COVID-19 pandemic. *Journal of Substance Use & Addiction Treatment, 143,* 108896. https://www.jsatjournal.com/article/S0740-5472(22)00178-7/fulltext

Section 8:

Technical Assistance and Training

Goal

Ensure correctional providers understand OUD and OUD service delivery and community providers understand how to provide services in correctional facilities

Why is this important?

Most community providers haven't had experience serving individuals who are incarcerated or providing services inside correctional facilities. Conversely, correctional facility staff and health care vendors may not be familiar with best practices for case management or MAT.

Furthermore, there's a general lack of standardization of MOUD practices in correctional facilities. In some cases, clinical care may not be aligned with best practices. And stigma and misconceptions about OUD care persist, which can compromise clinical care.

Both partners in reentry work would benefit from training and technical assistance. For example, prison system staff have identified needs training on how to[33]:

- Prevent MOUD diversion
- Screen for OUD
- Determine what type of MOUD to prescribe
- Coordinate with community providers

They also agreed that more resources are necessary to address stigma and negative attitudes about MOUD treatment.

Strategy

SMAs can[34]:

- Develop a technical assistance marketplace that provides resources and direct assistance to community organizations that want to provide pre- or post-release services and become an enrolled Medicaid provider.
- Require providers and provider staff to receive appropriate training before delivering services under the reentry demonstration. For example, offer promising practice trainings to support care coordination
- Recommend a suggested training curriculum, including a booster curriculum, for correctional staff and health care vendors.
- Leverage correctional staff at facilities that have implemented MAT to provide peer education and help to make the case that MAT improves the safety environment at facilities.

Examples

Example #1: New Jersey

The New Jersey Department of Human Services established 2 centers whose mission is to increase statewide capacity to provide standard-of-care treatment for individuals with SUD. These centers provide one-on-one education and training to jail clinicians on how to deliver relevant medications.

Read: What New Jersey's Experience Tells Us About Correctional Treatment Programs

Example #2: California

California requires that all providers and provider staff, including providers in correctional facilities, have relevant experience and receive appropriate training before furnishing services under the reentry demonstration.

Access: Report to Congress on Medicaid and CHIP, page 79

Examples

Example #3: Washington

Washington contracts with the University of Washington Addictions, Drug and Alcohol Institute to provide technical assistance and training to jail partners. This includes ongoing guidance and support related to medical staff, medication and supplies, correctional staff, and systemic needs.

Explore: Medications for Opioid Use Disorder (MOUD) in Jails Program

References

[33] Scott, C. K., Dennis, M. L., Grella, C. E., Mischel, A. F., & Carnevale, J. (2021). The impact of the opioid crisis on U.S. state prison systems. *Health & Justice, 9*, 17. https://healthandjusticejournal.biomedcentral.com/articles/10.1186/s40352-021-00143-9

[34] Bandera, S., Hendricks, A. K., Merritt, S., Saloner, B., Krawczyk, N., Alvarez, J., Sue, K., Berk, J., Wachino, V., & Taylor, K. (2021). *Medications for opioid use disorders in jails and prisons: Moving toward universal access.* Bloomberg American Health Initiative. https://americanhealth.jhu.edu/sites/default/files/2021-07/JHU-014%20OUD%20in%20Jail%20Report%20%28FINAL%29.pdf

Section 9:

Metrics

Goal

Develop strategies to measure the impact of and improve the quality of OUD services before, during, and after incarceration

Why is this important?

There is little information available for assessing the process of delivering OUD care or the impact of delivering OUD care to Medicaid beneficiaries before and after release from correctional facilities.

Furthermore, while national and state organizations have developed reentry OUD metrics, these are not Medicaid specific. However, at the federal level, CMS is developing measures for Reentry 1115 Demonstration Waivers.

Strategy

States will want to know whether efforts to serve individuals with OUD before and during reentry are having the intended impact. SMAs should consider developing a concise set of measures for OUD care that can be used to assess impact.

Steps for designing measurement efforts

After identifying an appropriate set of measures, states can consider taking these steps:

1. Develop a data dictionary for the selected measures
2. Craft a data use plan that provides policymakers with information to make changes to the Medicaid reentry effort
3. Create a strategy for providing feedback to correctional facilities, community providers, and MCOs about the quality of OUD services

These measures can serve as the basis for the monitoring protocol and reports that states will submit to CMS.

Examples

Example #1: HARP's list of reentry measures

HARP has developed a list of measures to evaluate OUD services for individuals before and after reentry — including measures based on Medicaid reentry initiatives.

Review: Metrics for Evaluation and Monitoring

Example #2: Kentucky

The Commonwealth of Kentucky received approval for the monitoring protocol for their 1115 Reentry Demonstration. This document sets forth both quantitative and qualitative measures for this demonstration.

Read: Kentucky Reentry 1115 Demonstration Monitoring Protocols, pages 3–26

Example #3: New York

New York's Department of Health has developed a toolkit to support MOUD implementation in correctional facilities. This toolkit provides an evaluation strategy and also cites several measures for correctional reentry initiatives.

Access: Medication for Opioid Use Disorder (MOUD): Correctional Health Implementation Toolkit, page 40

Example #4: Kentucky

The Criminal Justice Kentucky Treatment Outcome Study provides information for states to consider for developing their own monitoring protocols for pre- and post-release outcomes.

Explore: CJKTOS: Criminal Justice Kentucky Treatment Outcome Study

Examples

Example #5: Allegheny County, Pennsylvania

Allegheny County has developed a dashboard to track metrics on MOUD provision to individuals pre-release and outcomes post-release, like overdose deaths and utilization of health care services.

Check out: Medication for Opioid Use Disorder (MOUD) in Allegheny County Jail (ACJ) Dashboard

Example #6: Santa Clara County, California

Santa Clara County Custody Health Services has collected and analyzed initial measures to leverage early lessons to inform and strengthen implementation across correctional facilities across California. These initial measures focus on:

- The extent to which individuals are actively shaping the goals in their reentry plans
- Efficient processes before release, such as case conferences
- Tracking release dates and whether individuals receive a 30-day supply of medications (including MOUD) at release

Read: Report from Custody Health Services Relating to Operational Updates

Section 10:

Reimbursement and Infrastructure

Goal

Establish reimbursement rates for services provided to individuals with OUD that:

- Are efficient
- Promote accountability
- Account for factors that are unique to correctional facilities

10.1 Reimbursement Rates and Staffing Costs

Why is this important?

A major obstacle to ensuring access to care is the difficulty in recruiting and retaining qualified and motivated staff with OUD competencies in correctional facilities. Safety concerns, lack of exposure to correctional work, the demanding nature of the work, facility locations, and stigma against incarcerated populations often deter staff from working in these environments. As a result, correctional facilities experience high staff turnover rates and frequently face inadequate staffing ratios, further hindering appropriate access to care. Indeed, the parallel behavioral health workforce shortages for providing OUD services observed in the community further exacerbate the ability of jails and prisons to recruit knowledgeable and competent staff.

Strategy

Correctional facilities may need to offer salaries that provide incentives to help recruit and retain staff. Reimbursement strategies may also include other benefits, like health care benefits, student loan reimbursement, pensions, and retirement. To attract and retain a qualified workforce, states and local jurisdictions may consider offering salaries to staff providing OUD services in correctional facilities that are higher than those earned by similar staff in community settings.

Steps to address staffing disparities

States and jurisdictions may take the following steps to resolve disparities in staffing between correctional facilities and community providers offering OUD services:

- Analyze the required correctional behavioral health facility staff compared to the Bureau of Labor and Statistics average for behavioral health professionals in their state's relevant rural or metropolitan area
- Consider awarding bonuses for recruitment, relocation, retention, and student loan repayment to incentivize clinical staff
- Prioritize filling vacancies based on impact on correctional health operations, and direct recruiting and retention efforts toward filling those roles first

Examples

Example #1: California

California prisons increased compensation levels for medical staff by between 5% and 64% to address staffing challenges. These salary increases were expedited through executive authority, which waived state laws based on the urgent need to fill the vacancies.

Access: Overview and Update on the Prison Receivership

Example #2: Federal Bureau of Prisons

The Federal Bureau of Prisons secured approval to implement an alternative pay structure that offered additional salary incentives specifically to aid in recruiting psychiatrists.

Check out: Review of the Federal Bureau of Prisons' Medical Staffing Challenges, pages 7–16

10.2 Operational and Support Costs

Why is this important?

Delivering OUD care inside jails and prisons is often more complex than in the community. Complications include the logistics involved in the movement of individuals throughout a secure facility and getting various health professionals inside the facility.

Additionally, facilities may or may not know their costs for providing additional supports, including the cost of security, information and data sharing, billing, and reimbursement.

Strategy

SMAs can develop a strategy and use reinvestment funds to support eligible operational and support costs. CMS identifies health IT and data-sharing as two investments states can include in reinvestment plans. Addressing the ongoing staffing and security resources needed to expand access to MOUD and improve the quality of services may also be considered as allowable uses of reinvestment funds.

Historically, CMS has provided states with 1115 demonstration reentry waivers capacity grant funds. States awarded these funds to participating jails and prisons, among other agencies, to build capacity and support infrastructure. Federal funding sources, such as CMS Continuity of Care grants, as well as state and local funds may be used to support these facilities in their efforts to address capacity and infrastructure issues.

States may also seek alternative funding sources to finance operational and support costs. For example, several states have used opioid settlement funds to enhance or expand existing MOUD services in prison and jail settings.

Examples

Example #1: California

The California Department of Health Care Services is making three rounds of one-time-only grants to local jails to address some of the costs for suspension, eligibility determination, and development of pre-release services.

Explore: Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative, pages 20–29

Examples

Example #2: Michigan

The Michigan Department of Health and Human Services is funding a 3-year, $1.5 million contract to provide technical assistance for county jails to implement or expand MOUD services. Up to 24 county jails will receive grants funds to cover costs associated with expanding MOUD.

Check out: A Braided Funding Approach: Leveraging Opioid Settlement Funds to Strengthen Supports for Justice-Involved Populations

Example #3: Washington

Washington has invited interested facilities to apply for capacity building awards. The award amounts will be based on the facility's population size. Facilities can be awarded funds for both capacity building and IT infrastructure. Awardees can't use capacity building funds for construction or refurbishment — but they can use the funds to support other service accommodations, such as movable walls, desks, and chairs.

Access: 3 Ways a Carceral Facility Can Receive Medicaid Funding

10.3 Consideration: Developing Alternative Reimbursement Methodologies

Why is this important?

There are different ways to structure reimbursement for OUD services within the correctional setting, like fee for service (FFS) or an alternative payment model (APM). These options are modeled in the community setting across different payer types. FFS is generally the structure that most new systems and services start from and then evolve over time as their experience grows.

FFS and APM defined

Fee for service (FFS) is a reimbursement model — generally used in health and behavioral health care — where providers are reimbursed for the volume of services or procedures they perform.

Alternative payment models (APMs) in health care focus on rewarding quality and efficiency rather than the volume of services provided — with the aim of improving patient outcomes and reducing costs.

Notably, the reimbursement methodology can use payment as a lever to incentivize or discourage different actions or behaviors in care delivery.

Strategy

SMAs and their MCO partners can reimburse using FFS, a familiar payment model that's often used for community-based services. In this model, payments are directly associated with each service provided, which can strengthen oversight of service provision. By reimbursing each service, lab, and medication individually, this model builds in an incentive for volume. In a correctional context, this may increase the reach of OUD services provided to often-underserved individuals.

Alternatively, SMAs or MCOs can consider using an APM for Medicaid OUD services in correctional facilities. This reimbursement model may strengthen operations and link fragmented and disjointed clinical care to improve patient outcomes.

Either FFS or an APM can include bonus payments for achieving or reporting performance measures — incentivizing providers to deliver high-quality care and greater accountability.

Examples

Example #1: California

California Advancing and Innovating Medi-Cal (CalAIM) has developed five care management bundled payment approaches to deploy for jails and prisons. These approaches minimize the administrative burden on correctional facilities and streamline billing for flat bundles of care management activities. Each bundle requires documentation and accountable process steps for billing.

Learn more:

- Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative, page 138–148
- CalAIM Justice-Involved Initiative: Care Management Bundles, slides 7–8

Example #2: Maine

In 2023, MaineCare, Maine's Medicaid program, began piloting an incentive payment that encourages providers to connect with individuals being released from incarceration within 2 calendar days of their release.

Read: MaineCare Announces Post-Incarcerated Incentive Payment Pilot

Goal

Develop infrastructure for billing operations like claim submissions to receive reimbursement for OUD services

Why is this important?

Correctional facilities and their health care vendors generally have:

- No or limited claims management systems to bill Medicaid
- Limited EHR capabilities to generate the information needed to develop and submit claims
- No existing systems to track accounts receivable information and ensure alignment between billing and receiving
- Limited data available for monitoring Medicaid performance measures

Strategy

Correctional facilities must determine whether to build internal billing and claiming capacity or procure services through partnerships or vendors. First, facilities must assess whether the state will provide reimbursement to jails and prisons directly or through Medicaid MCOs. The entity or entities the correctional facility must contract for reimbursement will determine the operational capabilities required.

Second, to facilitate billing mechanisms, state and local correctional facilities may leverage existing partnerships with local or county health departments that may already have established Medicaid billing systems. Facilities can formalize these collaborations through interagency agreements or MOUs, allowing them to submit claims and receive reimbursement.

Another option is using a third-party administrator (TPA) to assist:

- Correctional providers that don't create their own claims management system in submitting information to create claims
- The facility with reconciliating revenues from these claims

In addition, correctional facilities can develop an enhanced closed loop referral system that allows jail and prison providers to refer individuals to community-based services upon release. This system can also potentially support community invoicing processes for billing and claiming.

Examples

Example #1: Infrastructure elements

Developing a billing and claiming plan for each facility and detailing specific record procedures, technology capabilities, and policies required to submit claims, receive payments, and report any required measures is a critical task. Following these steps can help:

1. Assess the ongoing average volume of individuals who would qualify for Medicaid OUD services
2. Determine which current and new services can be billed to Medicaid
3. Assess the state requirements for becoming a Medicaid correctional provider, and develop a strategy to pursue qualification directly or through partnership or collaboration
4. Determine how to collect and document the required information in an EHR for billing and claiming
5. Develop an infrastructure plan with initial start-up costs required for the facility to build capacity to submit and receive claims based on the model chosen
6. If using a partnership or intermediary, develop an MOU or contract detailing roles and responsibilities, including the financial arrangement between parties

Examples

Example #2: Washington

Washington issued a request for proposals (RFP) in January 2025 soliciting proposals from organizations interested in serving as the TPA for the Health Care Authority's Reentry Demonstration Initiative. The TPA's role includes several critical responsibilities. Primarily, the TPA will act as a claims clearinghouse, managing Medicaid billing and reimbursement processes for participating carceral facilities. Additionally, the TPA will provide technical assistance to these facilities, supporting credentialing and ensuring compliance with initiative requirements. This support is designed to ease administrative burdens and facilitate the effective delivery of pre-release services.

Review: RFP for Third-Party Administrator for Reentry Services

Example #3: North Carolina

North Carolina added functionalities to NCCARE360, its referral platform, so that the state can now accept invoices from community providers and create claims for submission to Medicaid.

Check out: Building Community Care Hubs to Address Health-Related Social Needs: Lessons from New York and North Carolina Medicaid, slides 9–12 (5:58–14:15 in the video recording)

Goal

Develop a strategy for enrolling correctional facilities or correctional health providers as Medicaid providers

Why is this important?

To bill for Medicaid-eligible OUD services, correctional facilities and their health care vendors must enroll (or be enrolled) as Medicaid providers in the state. However, jails, prisons, and their health care vendors have little to no experience enrolling in state Medicaid programs.

Strategy

For correctional facilities and their health care vendors, SMAs can create new Medicaid provider types specific to jails and prisons that allow greater flexibility.

Community-based Medicaid providers that provide OUD services inside jails and prisons should be required to enroll in Medicaid under existing Medicaid provider types.

Examples

Example #1: California

In California, correctional facilities and are enrolled through the state's enrollment system for FFS providers. Specifically, correctional facilities' clinics are enrolled as a "clinic exempt from licensure" provider type. However, correctional facilities' pharmacies enroll as pharmacies using the current Medi-Cal provider type for pharmacy. Therefore, each facility will have 2 enrolled providers: exempt from licensure clinic and pharmacy

Check out: Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative, pages 135–136

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