Utilizing Medicaid to Strengthen Access to Opioid and Other Substance Use Disorder Care Throughout the Criminal Legal System

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Executive Summary

Currently, there are nearly seven million people under the supervision of the United States criminal legal system, with 2.3 million people incarcerated in jails and prisons, 840,000 people on parole, and 3.6 million people on probation. Racism in both the health and criminal legal systems is a major driver of the overrepresentation of Black and brown people in jails and prisons. People with criminal legal system involvement often have an extremely high need for health care, including care for unaddressed mental health or substance use disorders (SUD).

Most people involved in the criminal legal system have a history of a SUD or problematic substance use. Sixty-five percent of all incarcerated individuals meet the criteria for a SUD. Among the high percentage of criminal legal system-involved people with SUD histories, a significant proportion of these individuals have or have had opioid use disorders (OUD).

There is clear evidence of the effectiveness and cost-effectiveness of OUD care in criminal legal settings. Research has shown that evidence-based OUD treatment improves outcomes for people involved in the criminal legal system. In addition to the findings of the major medical, public health, and health policy authorities that recommend evidence-based SUD treatment using addiction medications, criminal legal authorities have also endorsed use of medications for OUD in the criminal legal system.

Despite the clear need, there is extremely poor access to OUD/SUD care in the criminal legal system. Persistent financing barriers, stigma, and discriminatory policies and practices have precluded millions of Americans from receiving the care they need to become and remain well. Lack of resources for SUD and other health care services and medications, such as the Medicaid inmate exclusion provision, has fostered the promulgation of less effective care throughout the criminal legal system.

Better leveraging Medicaid, the single largest payer for SUD and mental health services in the United States, is critical to improving access to OUD/SUD care for people in the criminal legal system. Largely due to the Affordable Care Act’s expansion of Medicaid eligibility, millions of people who are or who have been involved in the criminal legal system are enrolled in or are eligible for Medicaid. Close to 30 percent of people receiving coverage through the Medicaid expansion have a MH and/or SUD.

There are several indicators of growing diverse support to better leverage Medicaid to improve both health and justice outcomes for people in the criminal legal system. States in every part of the country have been doing innovative work in several areas related to Medicaid eligibility and enrollment, delivery system and payment reforms, integrated care, and expanding provider capacity. It is important to learn from their examples so that states can better utilize Medicaid to strengthen OUD/SUD care access for people in the criminal legal system and support needed federal policy reforms.
This Issue Brief identifies:

1. Opportunities to leverage Medicaid to improve opioid and other substance use disorder (OUD/SUD) care access for people in the criminal legal system; and
2. Policy Recommendations on how Medicaid can further strengthen OUD/SUD care access for people in the criminal legal system.

The Scope of the Problem

The Need to Strengthen Access to Opioid/Other Substance Use Disorder Care in the Criminal Legal System

Currently, there are nearly seven million people under the supervision of the United States criminal legal system, with 2.3 million people incarcerated in jails and prisons, 840,000 people on parole, and 3.6 million people on probation.

Most people involved in the criminal legal system have a history of a SUD or problematic substance use. Sixty-five percent of all incarcerated individuals meet the criteria for a substance use disorder. Substance use rates among those on parole and probation are two to three times those of the general population. Among the high percentage of criminal legal system-involved people with SUD histories, a significant proportion of these individuals have or have had opioid use disorders (OUD). People with an OUD are much more likely than the general population to become involved in the criminal legal system, with odds increasing from roughly 16 percent for those with no past-year opioid use to over 50 percent for those with an OUD. As cited by the federal Substance Abuse and Mental Health Services Administration, approximately 17 percent of people incarcerated in state prison and 19 percent of people incarcerated in jails report regular opioid use. Over 30 percent of incarcerated individuals report suffering from serious withdrawal symptoms or an inability to control their use. Each year, over 200,000 people with a heroin use disorder are incarcerated, constituting 24 to 36 percent of the incarcerated population.

There is clear evidence of the effectiveness and cost-effectiveness of OUD care in criminal legal settings.

Research has shown that evidence-based OUD treatment improves outcomes for people involved in the criminal legal system. As summarized by the National Institute on Drug Abuse, numerous studies have demonstrated that providing evidence-based OUD treatment to people in the criminal legal system is cost-effective and improves health and criminal legal outcomes. Although additional research on the provision of OUD and other SUD care in each criminal legal setting is needed, the available research consistently demonstrates that the OUD treatment components identified in the levels of care chapter are effective for criminal legal system-involved people. As asserted in the 2019 National Academies of Sciences, Engineering, and Medicine report, Medications for Opioid Use Disorder Saves Lives, “[m]edication-based treatment is effective across all treatment settings studied to date.”

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In addition to the findings of the major medical, public health, and health policy authorities that recommend evidence-based SUD treatment using addiction medications, including the National Institute on Drug Abuse, the U.S. Surgeon General, the Centers for Disease Control and Prevention, the U.S. Food and Drug Administration, the Substance Abuse and Mental Health Services Administration, the President’s Commission on Combating Drug Addiction and the Opioid Crisis, the Office of National Drug Control Policy, the National Academies of Science, Engineering and Medicine, and the World Health Organization, -- criminal legal authorities have also endorsed use of medications for OUD in the criminal legal system.\textsuperscript{xvi} Treatment using OUD medications is correlated with reduced risk of mortality following release from incarceration. One study found that people with OUD who were receiving medications for opioid use disorder (MOUD) were 75 percent less likely to die and 85 percent less likely to die due to drug overdose in the first month after release.\textsuperscript{xv} Research has also shown that people who receive treatment using methadone and buprenorphine have lower rates of re-arrest and reincarceration.\textsuperscript{xvi}

**Despite the need, there is extremely poor access to opioid and other SUD care in the criminal legal system.**

It is widely known that most people in the criminal legal system who need OUD care, including MOUD, fail to receive it.\textsuperscript{xvii} There are several factors that have led to the disproportionately high number of people who need, but are not receiving, effective OUD care in the criminal legal system. Many of these reasons are due to financing. The community-based health system, largely because of severe lack of resources and the stigma and discrimination against people who use drugs, has failed to effectively address the health needs of people with SUD. Racism in the health care system has been a significant barrier to Black and brown people receiving clinically appropriate SUD care that helps them to secure and maintain long-term recovery. Persistent financing barriers, despite the coverage expansions and consumer protective provisions of the Affordable Care Act and the Mental Health Parity and Addiction Equity Act, have precluded millions of Americans from receiving the care they need to become and remain well. Lack of resources for SUD and other health care services and medications, such as the Medicaid inmate exclusion provision, has fostered the promulgation of less effective care throughout the criminal legal system.

**People in the criminal legal system have multiple complex health needs that are often largely unaddressed.**

The COVID-19 public health emergency has underscored the close relationship between the health of people in prisons and jails, and the health of families and communities. People with criminal legal system involvement often have an extremely high need for health care. For example, incarcerated individuals’ rates of HIV infection are three to five times higher than the general population\textsuperscript{xviii}, and nearly one in five incarcerated individuals are estimated to have hepatitis C\textsuperscript{xix}. The rates of mental illness also are significant: in 2005, according to U.S. Department of Justice data, more than half of all people incarcerated in prisons and jails had a mental illness. Left untreated, these conditions worsen health outcomes, increase the odds of recidivism, and reduce the odds of successful reentry.

People with mental health and substance use disorders who are reentering the community from incarceration are particularly vulnerable; in the first two weeks of reentry, people are 129 percent more likely to die from a drug overdose\textsuperscript{x} and are at significantly higher risk to die by suicide.\textsuperscript{xxi} In this time of heightened stress, isolation, and hardship, rates of mental health and substance use disorder-related crises are increasing.

Due to systemic racism, Black and brown people face significant inequities in health care coverage and access. As a result, they experience poorer health outcomes. Untreated mental health and substance
use disorders, coupled with the continued existence of racial discrimination in the criminal legal system have driven the overrepresentation of Black and Brown people in jails and prisons.\textsuperscript{xxii}

**Medicaid is critical to improving access to opioid and other SUD care for people in the criminal legal system.**

The justice-involved population has disproportionately lacked health insurance coverage to address their health care needs, including SUD care. Before the Affordable Care Act, most justice-involved people were not eligible for Medicaid or other public coverage no matter how low their incomes. In addition, even those individuals who had health insurance often had difficulty accessing quality MH and SUD services and medications.

Medicaid is the single largest payer for SUD and mental health services in the United States.\textsuperscript{xxiii} Largely due to the Affordable Care Act’s expansion of Medicaid eligibility, millions of people who are or who have been involved in the criminal legal system are enrolled in or are eligible for Medicaid. Close to 30 percent of people receiving coverage through the Medicaid expansion have a MH and/or SUD.\textsuperscript{xxiv} Better leveraging of Medicaid is critical to addressing the unmet health care needs of people with OUD and other substance use disorders in the criminal legal system. Strengthening Medicaid access for people in the criminal legal system would also foster racial justice and equity by improving Black and Brown people’s health outcomes and reducing rates and possibilities of involvement and re-involvement with the criminal legal system.

Medicaid can be better leveraged to improve access to OUD/SUD care at every intercept along the criminal legal system continuum. Specifically, connecting people to Medicaid, and the program’s funding and initiatives, can:

- Support additional use of deflection from law enforcement and other diversion programming to community-based OUD/SUD and other health care;
- Expand access to care for people in drug and other specialty court programs;
- Improve OUD/SUD care access in jails and prisons;
- Strengthen access to care at reentry; and
- Help people on community supervision to become healthier and avoid incarceration or re-incarceration.

There are several indicators of growing diverse support to better leverage Medicaid to improve both health and justice outcomes for people in the criminal legal system. States in every part of the country have been doing innovative work in several areas related to Medicaid eligibility and enrollment, delivery system and payment reforms, integrated care, and expanding provider capacity. It is important to learn from their examples so that states can better utilize Medicaid to strengthen opioid and other substance use disorder care access for people in the criminal legal system and support needed federal policy reforms.
Opportunities to Leverage Medicaid

Improving Opioid/Other Substance Use Disorder Care Access for People in the Criminal Legal System

There are several opportunities to better utilize Medicaid to improve care access for people in the criminal legal system with opioid and other substance use disorders. Federal laws, including the Affordable Care Act (which significantly expanded coverage eligibility and established initiatives for people with complex co-occurring health conditions, like the Medicaid Health Home option), and the SUPPORT Act (which included a number of provisions to strengthen Medicaid coverage of substance use disorders), have driven a number of policy reforms at the U.S. Department of Health & Human Services (HHS) Centers for Medicare & Medicaid Services (CMS).

The new policies have given states additional flexibility to expand eligibility for Medicaid coverage and access to opioid and other SUD care through several mechanisms. In addition, changes have been driven by the priorities of the federal administration, such as the Biden-Harris Administration’s focus on enhanced promotion of health equity, for example by improving Black maternal health care indicators, which resulted in CMS’ recent approval of New Jersey’s section 1115 waiver application to extend Medicaid coverage postpartum for 12 months. There are numerous options states have employed, which other states can learn from and either adapt or replicate.

Implementation of The SUPPORT Act

The SUPPORT Act

The SUPPORT Act includes a number of provisions aimed at strengthening Medicaid coverage of SUD services, including for people in the criminal legal system. Specifically, the SUPPORT Act:

* Requires for five-years Medicaid coverage of medication-assisted treatment (Section 1006)
* Require CMS to 1) convene a stakeholder workgroup to develop best practices for states to help people leaving incarceration transition to the community with health care (including through continuity of Medicaid or other insurance coverage) and 2) to issue guidance to the states that identifies opportunities for Medicaid demonstration waivers based on the identified best practices. (Section 5032)
* Prohibits termination of Medicaid eligibility for juveniles who are inmates of public institutions (Section 1001)
* Requires CMS to establish a demonstration project to increase provider SUD treatment capacity (Section 1003)
* Extends the enhanced federal matching rate for expenditures for SUD Health Home services (Section 1006)
* Allows states to receive federal Medicaid payments for outside services that are provided to pregnant and postpartum women who are receiving SUD care in institutions for mental diseases (IMDs) (Section 1012)
* Requires certain Medicaid quality health measures to include behavioral health measures (Section 5001)
* Temporarily allows states to apply for federal Medicaid payment for certain services provided in IMDs for people receiving SUD care (Section 5052)
2020 Medicaid Sub-Regulatory Guidance to Strengthen Coverage of MOUD

A provision of the 2018 SUPPORT Act required states to expand access to medication assisted treatment by providing Medicaid coverage of specific drugs and related counseling services and therapy.xxx As a result, on December 30, 2020, CMS issued further sub-regulatory guidance to the states in a State Health Official (“SHO”) Letter mandating that state Medicaid programs cover all FDA-approved medications used to treat OUD (MOUD) and establishing MOUD as a mandatory benefit for categorically needy Medicaid populations starting October 1, 2020.xxvi

The Medicaid guidance also made clear that, to achieve the goal of increasing MAT access to treat OUD among Medicaid beneficiaries, states must increase the enrollment in Medicaid of Opioid Treatment Programs (OTPs) and other MAT providers and practitioners. CMS emphasized that, since methadone for treatment of OUD can only be provided in OTPs, states that do not already enroll OTPs as Medicaid providers will be expected to take action to conduct provider outreach and enrollment as they prepare to meet the new requirements. The guidance further stated that, if a state has MAT providers operating in the state that are not currently enrolled in the Medicaid program, states are expected to permit any willing and qualified provider to become a Medicaid provider for the newly required MAT benefit, so that beneficiaries may receive these services from the qualified and willing provider of their choice, consistent with Medicaid law.

States have been working to implement these new requirements. For example, in early 2021, CMS approved Oklahoma’s State Plan Amendment to create a mandatory benefit for coverage and reimbursement of medication-assisted treatment in opioid treatment programs and office-based opioid treatment settings.

⇒ Opportunity: Access to MOUD in jails and prisons is extremely limited, in part due to the complicated regulatory structure governing methadone treatment. The recent release of the final mobile methadone rule will hopefully expand access to methadone treatment by community-based providers in rural, underserved communities, and to jails and prisons.

Access to Mental Health and Substance Use Disorder Services for Children and Pregnant Women in the Children’s Health Insurance Program

Section 5022 of the SUPPORT Act amended the Social Security Act to make behavioral health coverage a required benefit for CHIP, specifically requiring that child health and pregnancy related assistance “include coverage of mental health services (including behavioral health) necessary to prevent, diagnose, and treat a broad range of mental health symptoms and disorders, including substance use disorders.” The law also requires that those services be delivered in a culturally and linguistically appropriate manner and that the new benefit requirements apply to all CHIP eligible populations regardless of the type of coverage. A March 2020 Medicaid State Health Officials letter provided guidance to states on implementing this provision and needed covered services for the benefit package, including preventive screenings, medication-assisted treatment, and tobacco cessation services.

⇒ Opportunity: Pregnant people in the criminal legal system who need OUD/SUD care, or who would benefit from preventive screenings, often experience significant barriers to care access. Implementing this provision represents an opportunity for states to remove barriers and help pregnant people to become healthier.

Section 1115 Waivers

Medicaid’s 1115 waiver program permits states to provide or pay for experimental or novel approaches (with federal financial support) in health care services to better serve certain populations in their states.1
In order to accomplish this, states can request that the HHS Secretary not require (or waive) certain mandatory Medicaid program provisions to create the states’ innovative 1115 waiver programs. Medicaid waiver programs continue to be a useful tool for states to design health care coverage and delivery programs to address unmet needs, unmet OUD/SUD care needs for people in the criminal legal system, in their localities.

**Medicaid Section 1115 Waivers**

The Medicaid program operates as a federal/state partnership with the federal government giving states some flexibility to meet the program’s objectives of providing low-income individuals comprehensive health care coverage for health services. After review and approval by the CMS, states are permitted to create proposed programs that fulfill a variety of health care needs of their populations that are not being sufficiently met by the states’ traditional Medicaid programs. **Medicaid Section 1115 waivers** (or demonstration programs) reflect presidential administrative priorities as well as states’ novel approaches to the Medicaid program. Some of these waivable Medicaid requirements include:

* Statewideness (the state can be allowed to operate the program in certain parts of the state);
* Freedom of Choice (states can determine which providers Medicaid enrollees are allowed to visit for healthcare); and
* Amount, Duration, and Scope (states would be able to offer a different set of benefits and services to the 1115 waiver population compared to the traditional Medicaid enrollees) requirements.

- **West Virginia’s Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders Demonstration:** West Virginia’s waiver program allows the state to establish a new SUD benefit and delivery system reforms, by providing SUD services for all Medicaid enrollees (including those in managed care programs and fee-for-service delivery systems). The demonstration expands the SUD benefits package to cover the complete scope of SUD treatment (including through short-term residential treatment services, peer recovery support services, and withdrawal management services) with particular focus on improving access to methadone treatment services provided in Opioid Treatment Programs.

- **New Hampshire’s Substance Use Disorder Treatment and Recovery Access Demonstration:** New Hampshire’s waiver program focuses on expanding access to SUD residential services. In obtaining CMS approval for 1115 waivers of the IMD exclusion, thereby allowing states to receive federal financial participation for Medicaid services provided in residential SUD facilities, states must meet several requirements aimed at ensuring there is a comprehensive continuum of care to address OUD and other SUD care needs. Among these requirements is for residential SUD facilities to provide MOUD services directly or through referral to other programs. In addition to including provisions to strengthen coverage of MOUD services, New Hampshire’s waiver program also includes an assessment of the state’s organizational capacity of MOUD providers.

- **North Carolina’s Medicaid Reform Demonstration:** In 2015, the legislature of North Carolina passed legislation to modify the delivery system of the state’s Medicaid program to a Medicaid managed care program framework. The new Medicaid managed care program’s goals were to improve health outcomes, increase high-value care to sustain the Medicaid program, and reduce rates of SUD. Following review and approval by CMS, North Carolina’s 1115 waiver program seeks to decrease the long-term use of opioids and increase the use of MOUD and other opioid treatment services; decrease the use of hospital emergency departments for non-urgent use and admissions for ambulatory care illnesses; and increase coverage of SUD services by including
residential services for short-stay residents in institutions of mental disease ("IMDs"). The waiver also includes provisions to improve care transitions, including for people with MH, SUD, and developmental disabilities, by expanding case management services. Recognizing the need to support people returning home from incarceration, the waiver requires care managers to develop “working relationships with the justice system and the Division of Social Services to support transitions back to the community.”

- **Washington’s Medicaid Transformation Project:** In November 2020, CMS approved Washington’s section 1115 demonstration, which expands Medicaid coverage of services provided in residential SUD facilities. The demonstration project also seeks to improve care coordination and transitions to community-based care, including by implementing a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings, and to connect beneficiaries who may experience homelessness upon discharge, or who would be discharged to unstable housing, with community providers that coordinate housing services, where available. The demonstration includes additional provisions related to improving transitions to community-based care by requiring intensive pre-discharge, care coordination services to help beneficiaries transition out of residential settings into appropriate community-based outpatient services, including supported employment.

- **Illinois’ Behavioral Health Transformation Demonstration:** In 2018, Illinois received CMS approval for its section 1115 waiver application to strengthen access to mental health and substance use disorder services. Notably, Illinois’ 1115 waiver program added case management as a covered service for people with an SUD who are also involved in the criminal legal system and request diversion into SUD treatment as an alternative to incarceration. The waiver allows for the selection of providers who are licensed by the Illinois Department of Human Services/Division of Substance Use Prevention and Recovery to serve as “designated programs” to receive Medicaid reimbursement for case management services.

- **The District of Columbia’s Behavioral Health Transformation Demonstration:** In early 2021, the District of Columbia received CMS approval for their proposed Behavioral Health Transformation section 1115 waiver program. In addition to a number of provisions aimed at strengthening access to SUD and mental health care, including for people with criminal legal system involvement, DC’s waiver program creates a new reimbursement methodology for Comprehensive Psychiatric Emergency Program and Crisis Response Team mobile crisis and outreach services so that those services can be better accounted for and valued.

- **New Jersey’s FamilyCare Comprehensive Demonstration:** In October 2021, CMS/Medicaid approved New Jersey’s section 1115 waiver program, which includes provisions to extend postpartum Medicaid coverage from 60 days to 12 months post-birth. Under the American Rescue Plan, beginning on April 1, 2022, states will have the option to extend coverage for postpartum individuals beyond the required 60-day postpartum period through the end of the month in which a 12-month postpartum period ends. This coverage extension represents an important opportunity for pregnant people with OUD histories who are involved in the criminal legal system.

### Agency Initiatives Aimed at Improving Health Outcomes

CMS, through its Medicaid program, several initiatives aimed at improving health outcomes through delivery system and payment reforms, strengthening access to integrated care, and improving care
coordination for certain targeted populations, including people with complex co-occurring health conditions.

**Medicaid’s Health Home Initiative**

In 2010, the enactment of the Patient Protection and Affordable Care Act ("ACA") created an optional state benefit to provide health homes for people who had multiple chronic conditions. The State option to provide health home services to Medicaid beneficiaries with chronic conditions became effective on January 1, 2011. This option gave states an enhanced 90 percent share of Federal Medicaid funds (FMAP) to further integrate and coordinate care for primary care, mental health and SUD services, and long-term services and supports for patients with chronic illnesses throughout their life spans by using a “whole person” approach. CMS provided technical assistance and also supported states with existing medical home programs (with similar objectives and frameworks as health homes) to use the Medicaid health homes to complement these programs. Individuals became eligible for a health home if they had two or more chronic conditions, had one chronic condition and were at risk for a second one, and had one serious and persistent mental health condition.

In 2019, Medicaid issued an Informational Bulletin to give states guidance on implementing provisions of the SUPPORT Act which extended the enhanced FMAP period for certain Medicaid health homes for people with SUD. Under the SUPPORT Act, eligible SUD health home participants were required to: 1) be a Medicaid eligible individual with chronic conditions; 2) have a substance use disorder; and 3) not previously received health home services under any other state plan amendment. In 2020, CMS reinforced the use of the Health Home initiative to strengthen access to OUD and other SUD care by releasing policy guidance that added two new SUD measures to the core set of Health Home measures. Focusing on providing evidence-based services, the two measures examined: (1) Use of Pharmacotherapy for Opioid Use Disorder and, (2) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence.

As of October 2021, 21 states and the District of Columbia have a total of 37 approved Medicaid health home models. The CMS December 2020, "Best Practices for Designing and Implementing Substance Use Disorder (SUD)-Focused Health Homes" identified ways states with SUD Health Homes have improved access to integrated care and support for care transitions. State activity to strengthen access to SUD care included:

- In 2018, California implemented a section 1945 health home SPA [state plan amendment] for people with chronic physical conditions and SUD, including individuals experiencing or at risk of experiencing homelessness. California utilized a housing navigator that developed relationships with housing agencies and permanent housing providers, including supportive housing providers, to refer and link Medicaid-eligible participants with community-based housing resources.
• **Michigan’s Health Home Program** consists of an opioid treatment program and office based opioid treatment providers. The health homes program’s goals are to improve care management of enrollees with OUD (including MOUD), improve care coordination between physical and behavioral health care services, and improve care changes between primary, specialty, and inpatient settings.xxxvii

⇒ **Opportunity:** Connect participating health home service providers with local harm reduction service providers including syringe service programs that are working to address complex health needs of people who use drugs.

**Medicaid Opportunities in the Emergency Triage, Treat, and Transport (ET3),** a five-year Center for Medicare & Medicaid Innovation (Innovation Center) payment model is designed to reduce unnecessary transport to hospitals’ emergency departments. Under the model, CMS will pay participants to 1) transport to an alternative destination partner, such as a primary care office, urgent care clinic, or a community mental health or SUD center, or 2) initiate and facilitate treatment in place with a qualified health care partner, either at the scene of the 911 emergency response or via telehealth. Although ET3 is a Medicare payment model, CMS encouraged states in [2019 policy guidance](#) to implement the model across multiple payers, including Medicaid. In 2021, [205 applicants were selected to participate as Model Participants](#) from 36 states and the District of Columbia.

⇒ **Opportunity:** States can leverage this opportunity to develop innovative payment models to support deflection and diversion to community care centers that would serve as “alternative destination partners.”

**Opportunities in Medicaid and CHIP to Address Social Determinants of Health** are discussed in a [January 2021 Medicaid State Health Officials letter](#) which sought to support states in designing programs, benefits, and services that can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid and CHIP programs by addressing the social determinants of health. The guidance detailed various services that are eligible for federal financial participation including case management services and supported employment services provided through a state’s array of Home and Community Based Services. In a discussion about housing, the guidance also made clear that, while federal financial participation is generally not available to state Medicaid programs for room and board, it is generally available for housing-related supports and services that promote health and community integration, including home accessibility modifications, one-time community transition costs, and housing and tenancy supports, such as pre-tenancy services and tenancy sustaining services. In addition, the guidance underscored that states can develop and implement managed care plan procurement and contracting strategies to incentivize care coordination and address the social determinants of health.

The **Medicaid guidance** included the example of states requiring managed care plans, through their plan contracts, to assess enrollee needs related to social determinants of health; referring enrollees to community-based supports and services as needed based on assessment results; tracking referrals to social services; including social or community health workers in care coordination teams; and adding other care coordination initiatives that promote holistic, person-centered care across medical and nonmedical contexts. The guidance further made clear that states can use their position of authority by enrolling beneficiaries into managed care plans that have demonstrated expertise in addressing complex needs, requiring managed care plans to focus on addressing social determinants in performance improvement plans, or requiring managed care plans to report on quality measures related to social determinants. The guidance also underscored that states can require managed care plans to contract
with community-based organizations with expertise in addressing social determinants of health for coordination of care purposes.

⇒ Opportunity: People in the criminal legal system, largely due to systemic racism, face barriers to housing, employment and other life necessities. Better leveraging Medicaid to address the social determinants of health would be critically important to strengthening the health of people with histories of opioid and other SUD who are involved in the criminal justice system.

**Increasing the Treatment Capacity of Medicaid Providers to Deliver Substance Use Disorder Treatment and Recovery Services:** Under Section 1003 of the SUPPORT Act, CMS, in consultation with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Agency for Healthcare Research and Quality, is conducting a 54-month demonstration project to increase the treatment capacity of Medicaid providers to deliver substance use disorder treatment and recovery services. The demonstration project included: 1) $50 million in planning grants to 15 states for 18 months; and 2) 36-month demonstrations with up to 5 states that received initial planning grants. In September 2021, CMS announced that Connecticut, Delaware, Illinois, Nevada, and West Virginia were selected to participate in the post-planning 36-month demonstration and would each receive enhanced federal reimbursement for increases in Medicaid expenditures for SUD treatment and recovery services.

⇒ Opportunity: States can build on the lessons learned by the states that participated in this SUD provider capacity expansion initiative to ensure that Medicaid providers develop greater competence to provide SUD treatment and recovery services to people in the criminal legal system. Additional connections can be made between local reentry service providers, or those organizations serving people who are on community supervision, and federally qualified health centers (FQHCs) and other community health centers. Community health centers can play a key role in bolstering their communities’ capacity in providing OUD and overall SUD care in underserved areas through primary care and integrated care settings.

**Medicaid Flexibilities to Provide SUD Services Via Telehealth** were discussed in an April 2020 Centers for Medicaid and CHIP Services (CMCS) Informational Bulletin. As a method of delivering services and providing health care, telehealth is comprised of using telecommunication technologies and electronic information to establish interactions between patients and providers through real-time

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**Improving network adequacy for MOUD providers:**

Access to critical health care services depends upon both plan coverage of a broad range of services and a network of providers to deliver all covered services. **Network adequacy** refers to whether a health plan contracts with a sufficient number and type of qualified health care providers to ensure members have access to covered benefits within a reasonable travel distance and appointment wait time. Robust networks are essential for consumers to obtain accessible, timely and affordable care. When plans do not have sufficient numbers or types of providers, patients are forced to wait or travel long distances for care, pay higher costs to receive care from an out-of-network provider, or forgo care altogether.

Both federal and state regulators establish network adequacy standards for health plans within their jurisdictions. CMS has established network adequacy standards in health insurance products subject to federal regulation, including Medicare, Medicaid, and qualified health plans (QHPs) subject to the Affordable Care Act. Medicare standards include specific quantitative standards for mental health providers. Medicaid and QHPs standards currently defer to state regulators to establish such standards.
experiences and the exchange of information. The Medicaid Bulletin identified several options states can utilize to receive Federal financial participation to provide SUD services delivered via telehealth such as, including SUD services delivered through telehealth in their managed care contracts and rates; utilizing service delivery mechanisms (e.g., the Health Home benefit or other benefits to create integrated care models, which can include SUD-related Medicaid services); and receiving reimbursement as administrative activities for disease management services (e.g., care coordination and collecting, recording, and reporting on health outcome measures).

⇒ Opportunity: It is unclear whether certain regulatory flexibilities that were granted due to COVID-19 will be extended beyond the pandemic. It is, however, likely that there will be greater focus on ways to further expand access to SUD care provided via telehealth, particularly in rural and underserved communities.

Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services was released in December 2021 through a CMS/Medicaid State Health Official (SHO) letter. The SHO letter was issued as a means of implementing a provision of the American Rescue Plan that required CMS to create a Medicaid state option with enhanced federal funding to provide qualifying community-based mobile crisis intervention services. Under the new law, CMS is authorized to make funding available for implementing, administering, and making planning grants to states to prepare for implementing qualifying community-based mobile crisis intervention services. In September 2021, CMS/Medicaid announced that the agency was awarding $15 million in planning grants to 20 State Medicaid Agencies to develop a state plan amendment (SPA), section 1115 demonstration application, or section 1915(b) or 1915(c) waiver request (or an amendment to such a waiver) to provide qualifying community-based mobile crisis intervention services. The SHO letter discusses qualifying mobile crisis services and provider qualifications, provider payment and delivery systems, and qualifying expenditures for community-based mobile crisis intervention services.

⇒ Opportunity: States can take advantage of this opportunity to prepare for implementation of the national 988 suicide prevention hotline, such as documenting competency requirements for call center operators on opioid and other SUD crisis responses and building sufficient capacity of community-based health care providers with expertise on crisis response.

Forthcoming Medicaid Guidance

• Use of Medicaid to support continuity of care: Section 5032 of the SUPPORT Act required CMS to convene a “best practices” stakeholder group which would inform the development of policy guidance to the states on continuity of care for people in the criminal legal system. In 2021 the administration convened the best practices stakeholder group and HHS is working to develop guidance to the states. In the three years since passage of the SUPPORT Act, the District of Columbia and a number of states (including New York, Washington DC, California, Illinois, Kentucky, Utah, and most recently Montana and Massachusetts) have submitted 1115 waiver applications, asking for CMS approval to use Medicaid dollars to finance transitional care for people preparing to return to the community from incarceration. The proposed waivers identified as priorities several types of in-reach services by community-based providers of SUD, mental health, HIV/AIDS, and other health care services.

State Medicaid Activity to Strengthen Access to OUD/SUD Care

Several states have enacted laws to assist people living with SUD through initiatives that support SUD prevention, Medicaid enrollment, and Medicaid coverage of MAT and MOUD.
In 2020, Utah passed a law requiring the state’s Medicaid agency to seek CMS approval for an 1115 waiver that would allow for federal Medicaid dollars to finance care in the last 30 days of incarceration. Preventing overdose deaths among reentering people was identified as a primary goal of the legislation.

New Hampshire law prohibits Medicaid managed care from utilizing prior authorization requirements for MOUD more frequently than every two years.

A 2019 Ohio law sought to strengthen access to methadone treatment, particularly in rural communities, by expanding the list of entities that could dispense methadone to include FQHCs and other community care settings.

Policy Recommendations

To Better Leverage Medicaid to Strengthen Access to Opioid and Other Substance Use Disorder Care for People in the Criminal Legal System

Better leveraging Medicaid offers a tremendous opportunity to help people with opioid and other substance use disorders throughout the criminal legal system to become healthier and to avoid further contact with the system. There are several actions the federal government can take to make Medicaid coverage more responsive to the needs of people with opioid and other substance use disorders and to support additional state innovation. Specially, CMS should:

- Launch a central initiative to improve Medicaid coverage and access to the full range of effective care for people in the criminal legal system. This initiative should be multi-year and operate across agencies, and should address enrollment, scope of benefits, data exchange, innovation, quality, racial health inequities, delivery reforms, and areas for potential state demonstrations.

- Swiftly implement Section 5032 of the SUPPORT Act, which required CMS, by October 2019, to convene a best practices stakeholder group which would inform the development of policy guidance on continuity of care for people in the criminal legal system. Medicaid guidance should require states to:
  - Implement Medicaid eligibility screening and enrollment throughout the criminal legal system;
  - Indefinitely suspend an individual’s Medicaid during incarceration and reactivate coverage 30 days before the person’s release (for eligible individuals serving more than one year);
  - Activate Medicaid upon admission to jail (for eligible individuals who will be serving a term of less than one year);
  - Provide continuous eligibility for one year after reentry;
  - Ensure that individuals in the criminal legal system are informed about their health coverage options and made aware of community resources for health care (including community health centers), social services, housing, employment, and other essential programs;
  - Provide enrolled individuals with an actual Medicaid card at the time of their release from incarceration.
• Approve the several pending Medicaid Reentry waiver applications to strengthen health outcomes as people leave incarceration.

• Work with the U.S. Department of Justice (DOJ) to strengthen coverage and access to care for people in the criminal legal system. CMS and DOJ should:
  o Ensure that all evidence-based and other effective mental health and SUD services, medications, and supports, including MOUD, are available to people in all criminal legal settings, such as all carceral and community corrections settings in local, state and federal systems.
  o Jointly issue guidance on how people in the criminal legal system (through arrest and other processes) should be screened for SUD, mental health, and health conditions and corresponding care needs, and how to ensure people throughout the criminal legal system receive clinically appropriate mental health and SUD services and medications.

• Work with other HHS agencies to strengthen access to care for people with SUD who are involved in the criminal legal system to:
  o Engage with the Health Resources & Services Administration to strengthen the capacity of FQHCs to address SUD/OUD care needs for people in the criminal legal system;
  o Ensure primary care training on MOUD addresses the needs of people in the criminal legal system;
  o Increase support to and foster greater connections among local harm reduction and health service providers, and reentry organizations that work at the intersection of health and justice and are most effective in intervening to prevent overdose and connect individuals to services, housing, and supports;
  o Increase support for harm reduction strategies, including for people who use drugs and are in the criminal legal system; and
  o Examine how federal discretionary funds have been utilized to strengthen access to SUD care, including for those in the criminal legal system, and consider how more sustainable Medicaid dollars may better support effective interventions and strategies.

• Encourage states to utilize Medicaid waivers and initiatives to support innovative strategies and improve the ability to seamlessly meet the co-occurring physical, mental and SUD care needs of justice-involved people.

• Support the expansion of Medicaid eligibility in those states that have not yet done so, without punitive requirements that serve as barriers to enrollment for individuals with histories of involvement with the criminal legal system.

• Issue guidance to ensure that individuals who are dually eligible for Medicare and Medicaid while on parole, probation, bail, or supervised release are not barred from Medicare coverage under the custody exclusion. CMS removed a similar restriction for Medicaid in 2016 and should do so for Medicare, since the current policy is a significant barrier for dually eligible individuals who have been released from incarceration and are seeking community-based care. CMS should also work with Congress towards discontinuing the current late enrollment policy that penalizes with a lifelong monthly penalty fee those individuals who were eligible for Medicare Part B but were unable to enroll due to being incarcerated.
• Work cooperatively with the HHS Office for Civil Rights (OCR) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to support and strengthen existing confidentiality protections for health records that contain sensitive health information (e.g., SUD, mental health, HIV/AIDS, domestic violence, reproductive health, etc.) to ensure that patients experiencing these health conditions are not discriminated against and can obtain needed health and support services.

• Increase federal enforcement of the Mental Health Parity and Addiction Equity Act.

• Assist in the implementation of the SUPPORT Act provision requiring state Medicaid programs to cover all FDA-approved MOUD and help to address provider shortages, CMS should adopt quantitative network adequacy standards for a wide range of Medicaid eligible MH and SUD providers, including MOUD providers, to improve access to affordable treatment and identify the cause of network gaps. In addition to appropriately addressing cultural competency and language access needs of community residents, these network adequacy standards should comply with the Mental Health Parity and Addiction Equity Act and should include, at a minimum: metrics on appointment wait time, travel distance, and provider-to-enrollee ratios, and the inclusion of essential community providers in networks. CMS should continually monitor compliance with network adequacy standards and utilize numerous compliance tools, including market conduct surveys; collecting and analyzing data on out-of-network claims, MH and SUD provider availability, and reimbursement rates; and consumer surveys and complaints. They should require carriers to explain any disparities and demonstrate that such disparities do not violate the Parity Act.

Conclusion

Optimal use of Medicaid to strengthen access to opioid and other substance use disorder care in the community will help prevent entry into the criminal legal system and help people in the criminal legal system become healthier and avoid re-involvement with the system. States in every region of the United States are reforming their policies to strengthen coverage for and access to care for this population. Learning from their examples is extremely important so that additional states can strengthen access to care and the federal government can advance policy reforms nationally. There is much that states and the federal government can do to further maximize these opportunities and strengthen critically important access to substance use disorder and other essential health care.
Endnotes

i The phrase “criminal legal system” refers to the full continuum of programming provided in the community by law enforcement, in the courts, including drug and other specialty courts, at reentry from incarceration, and though community supervision including parole and probation, and in correctional settings such as jails and prisons at the federal, state and local levels.


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CMS, Health Homes, Medicaid.gov, available at https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html. See also id. Chronic conditions are defined to include mental health, substance use disorder, asthma, diabetes, heart disease, and being overweight. CMS can also consider additional chronic conditions, such as HIV/AIDS to be included for these purposes.