Foundation *for* Opioid Response Efforts

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Issue Brief

Increasing Access to OUD Treatment During and After Incarceration: Moving from Policy to Practice

In late January, the Biden Administration approved an amendment to California's Section 1115 waiver, enabling the state's Medicaid program to begin paying for certain health care services provided to people leaving jails, prisons, and youth correctional facilities. Among them are medications for opioid use disorder (MOUD) and case management services that connect people with opioid use disorder (OUD) to ongoing care.

The amendment will allow the state to tap federal dollars to cover these and other services — including physical and behavioral health consultations, medications, and support from community health workers — in the 90 days before an individual is released from incarceration. Services will be targeted to Medicaid-eligible people at high risk of hospitalization and other adverse health outcomes, including suicide and drug overdoses. Without such a waiver, the Medicaid Inmate Exclusion Rule prevents states and localities from using Medicaid funds to pay for care provided inside of prisons and jails, leaving states to finance such care themselves or limit care access.

The new payment policy is structured as a reentry demonstration that will end in December 2026 unless it's extended. Similar demonstrations and waivers are expected to follow: at least 14 states have sought permission from the Centers for Medicare and Medicaid Services (CMS) to offer pre-release services to people in jails or prisons.

While such waivers have the potential to increase access to OUD treatment, executing them will mean overcoming operational challenges related to staffing and workflow, as well as stigma against MOUD among correctional officers who are concerned about diversion and don't recognize MOUD as evidence-based treatment. Equally daunting is the challenge of bridging two disparate systems of care: correctional facilities that often rely on vendors and local health departments to provide medical services and the community-based providers, pharmacies, and peer recovery specialists who will be tasked with ensuring people leaving jails and prisons have ongoing treatment and recovery supports.

Several FORE grantees have been tackling these obstacles. This issue brief describes the work of two grantees and the lessons their work holds for leaders of correctional facilities and policymakers across the U.S.

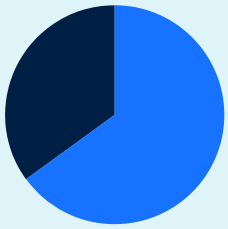
KEY TAKEAWAYS

1 People leaving jails and prisons with untreated opioid use disorder are at high risk of overdose. One study found overdose deaths in North Carolina were 50 times higher in the two weeks after an individual was released from prison than in the state's population.

2 California's reentry demonstration could vastly expand access to OUD treatment if replicated in other states. At least 14 states have sought permission from the Centers for Medicare and Medicaid Services to offer pre-release services to people in jails and prisons.

3 The work of FORE grantees focused on increasing access to OUD treatment in correctional settings shows success depends on strong partnerships between correctional facility leaders, policymakers, and community-based providers.

An increasing number of prisons and jails are offering treatment to people with substance use disorder (SUD), but the practice is not the norm.



65%
of people in jails and prisons are estimated to have a SUD.

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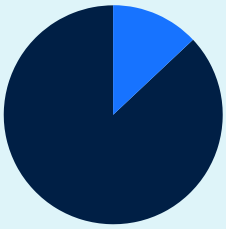


Only 12.6%
of correctional facilities (632 of 5,000) in the U.S. offer some form of medications for opioid use disorder, according to estimates from the Jail & Prison Opioid Project.

USING TELEMEDICINE TO EXPAND ACCESS TO MOUD IN RURAL JAILS

In April 2020, FORE provided funding to addiction medicine specialists at the University of Maryland School of Medicine in Baltimore (UMD) to support three rural jails in Maryland in developing evidence-based treatment programs for OUD. The state had recently enacted a law requiring all county jails to offer MOUD to incarcerated individuals with OUD by January 2023 and the UMD clinicians anticipated that rural jails — with fewer local resources than urban jails — would face added challenges in meeting the requirement.

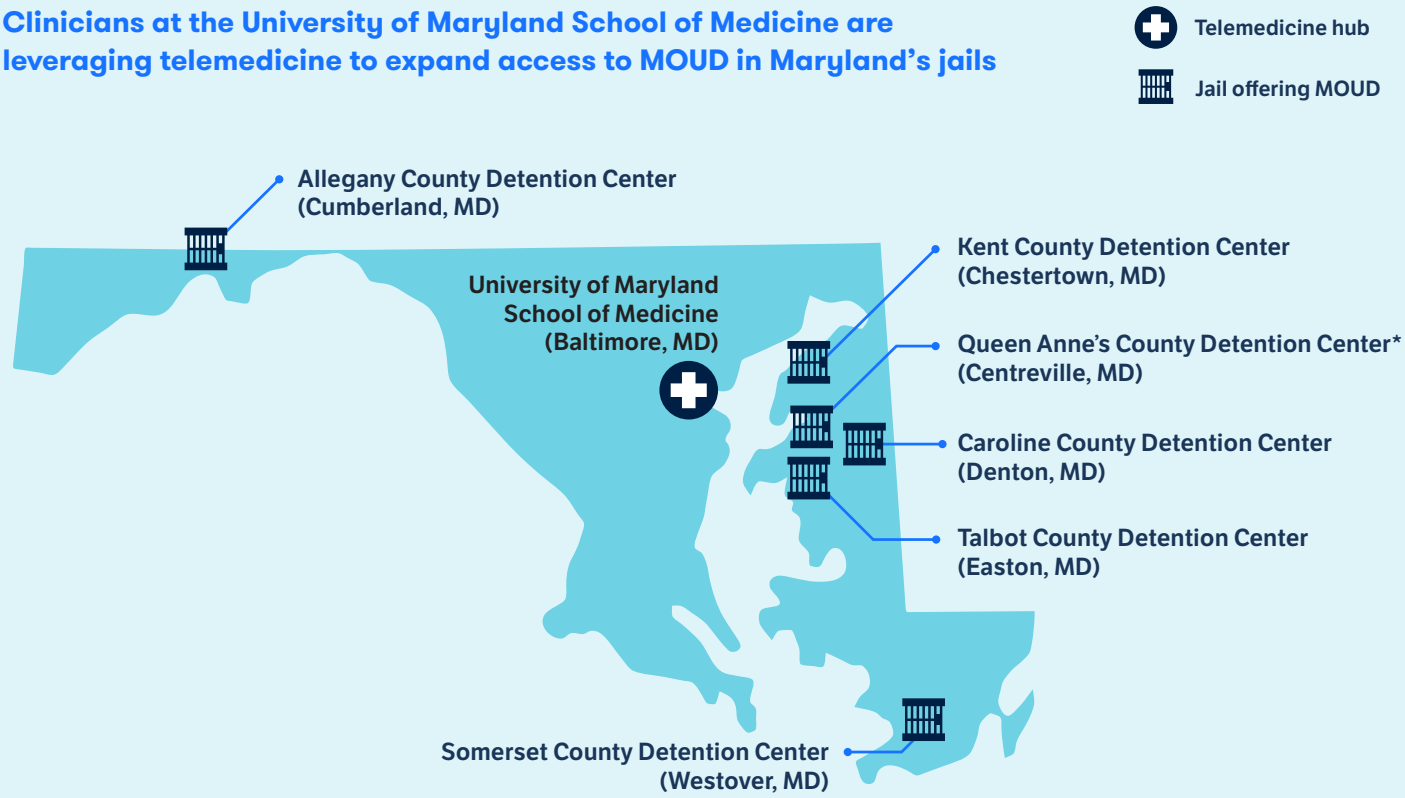
The UMD team, led by Eric Weintraub, MD, a professor of psychiatry, and Annabelle M. Belcher, PhD, assistant professor of psychiatry, offered three jails technical and clinical supports, including protocols for screening individuals for OUD and dispensing medication, as well as 24/7 access to UMD faculty, who could prescribe buprenorphine via telemedicine. Dan Lasher, captain of Allegany County's Sheriff's Office and warden of the county's detention center in Cumberland, Maryland, seized on the opportunity.

Lasher's detention center houses about 180 people at any given time and he estimates that 80 percent are there for drug-related reasons, including possession or distribution of drugs such as heroin, fentanyl, methamphetamine, and cocaine. People who enter the facility in withdrawal are particularly challenging for staff because they are sick, irritable, and sometimes paranoid, Lasher says. He also worries about what will happen to them when they leave. "We don't want people going back out there to overdose and die," he says.

U.S. Rep. David Trone, UMD grantees, and FORE staff visited the Allegany County Detention Center, in Cumberland, Maryland, in April 2022 to see the pilot program firsthand.

Photo credit: FORE

Clinicians at the University of Maryland School of Medicine are leveraging telemedicine to expand access to MOUD in Maryland's jails



Source: University of Maryland School of Medicine

*Program launching in April 2023

At the outset of the program in May of 2021, staff at the jail began asking all incoming residents if they had a problem with opioids. Those who reported problems were given urine drug screenings and scheduled for telemedicine visits, during which UMD clinicians determined if an individual would benefit from MOUD and if so, at what dose.

Grants from the state's opioid settlement funds — $500,000 over two years (ending June 2024) — covered the cost of MOUD and enabled the jail to hire a full-time nurse, who dispenses buprenorphine, naltrexone, or methadone to 30 to 40 patients at any given time. The jail also hired a social worker to act as a reentry coordinator. She communicates with the courts about establishing transfers to rehabilitation facilities, helps people enroll in health insurance, and assists with other supports, including finding housing, transportation, and providers to see when they're released.

The jail also arranged for peer recovery workers from the Maryland Area Health Education Center to meet with people in the program and talk about how they can maintain their recovery.

> "The peers are extremely effective. They lived that life and they've been able to turn it around and speak to people knowing exactly where they came from."

Dan Lasher, captain of Allegany County's Sheriff's Office and warden of the county's detention center in Cumberland, Maryland

Leaving jail or prison with an untreated addiction is perilous. Lack of access to treatment and reduced tolerance for opioids may play a role.

50x

One study found overdose deaths in North Carolina were 50 times higher in the two weeks after an individual was released from prison than in the state's population.

States that have expanded access to treatment within correctional facilities have seen positive results:

Maine now offers MOUD and counseling to anyone in state prison diagnosed with an OUD, regardless of their release date. *Politico* reports that 40 percent of individuals across the prison system are administered drugs to treat MOUD and fatal overdoses have decreased 60 percent since the program started in 2019. Drug smuggling, violence, and suicide attempts in state prisons have also dropped.

In **Rhode Island**, the state has partnered with an opioid treatment provider to screen all incoming people for OUD. The state pays for facilities to offer all FDA-approved medications. One study found overdose deaths fell by 12.3 percent in the first half of 2017, one year after the state required jails and prisons to offer treatment.

In 2022, **New York** also mandated that jails and prisons offer medication-assisted treatment for substance use disorders. One study of people released from jail in New York City found offering methadone and buprenorphine treatment for OUD during incarceration was associated with an 80 percent reduction in overdose mortality risk in the first month after release.

A study conducted by the Justice Community Opioid Innovation Network found rates of probation violations, re-incarcerations, or court charges were 32 percent lower in a rural **Massachusetts** jail that offered individuals treatment compared to another rural facility that hadn't.

RESULTS AND CHALLENGES

Between September 2022 and mid-March 2023, half of the 767 individuals screened at Allegany County's detention center reported opioid use. UMD clinicians prescribed buprenorphine to 319 people (or 270 unique patients) between May 2021 and mid-March 2023. Tracking long-term outcomes has been challenging without access to information about a person's subsequent care, but pharmacy records send an early signal. Of the 69 people treated in the program who were released from jail with a prescription for buprenorphine, 84 percent filled it within five days.

The program has faced several challenges. Because some forms of MOUD can produce euphoria in people unaccustomed to opioids, diversion is a concern. To prevent people from pocketing the drug — or vomiting it up, as has happened — individuals must take their medication and then sit with their hands under their legs for 10 minutes until it dissolves. The jail has also begun doing urine drug screens for every incoming resident, not just those who say they have a problem with opioids. This makes it harder for people to claim they have an OUD months into their stay.

Lasher says using a long-acting injectable version of buprenorphine would eliminate much of the concern about diversion, and put less demand on staff, but this formulation is expensive for the jail, and a high upfront investment for people whom the jail may be paid to house for only a few days.

Another challenge is staffing. Allegany County's detention center relies on vendors for some medical services and on the local health department for other staff, such as counselors. Midway through the program, the health department's counselors left for other jobs, leaving the jail without dedicated substance use counselors.

People who are released from jail with prescriptions for buprenorphine have also encountered roadblocks. Lasher says some pharmacies claim they've given out their allotment for buprenorphine for the month or are suspicious of people who don't have a local address or are presenting a prescription from a UMD physician who works more than two hours away.

Lasher is hopeful that a forthcoming evaluation of the program that will track what happens to people in the year after they leave the jail will not only quantify these challenges, but also the overall effectiveness of the program. He says the data will enable him to refine the program and make a case to the state for permanent funding. Anecdotally, he's seen the greatest success in people who received long-acting forms of MOUD, but longitudinal data are needed to counter concerns among some correctional staff that MOUD merely substitutes one drug for another. "I don't know that you'll change people's minds until they see the results," Lasher says.

The UMD team is now working with five other rural jails to launch OUD treatment programs. "One of the most important things we learned is that every detention center is different," Weintraub says. "Some counties only have one or two peers covering the region [or have] halfway houses and other supports that don't allow people who are taking MOUD to enter," says Kelly Coble, LCSW-C, director of telehealth programs in the Department of Psychiatry at the UMD's School of Medicine, who works with wardens on implementation.

Given the challenges people are likely to encounter and abrupt changes in release dates, it's important to begin developing a plan for care outside of the jail immediately, Weintraub says. "We talk about it on the first day," he says.

LESSONS FOR CALIFORNIA AND OTHER STATES

California's reentry demonstration anticipates and addresses some of these challenges by giving jails and prisons up to three months to provide treatment and prepare people for release. Participants will be assigned a case manager while incarcerated, as well as a community-based care manager once released. The demonstration also allows community-based providers to obtain payment from Medicaid for providing treatment and transition supports.

The waiver also requires the state to get input from currently and formerly incarcerated people on how the program is working. "Getting that kind of input and requiring the state to adapt to make sure people have meaningful access to care and choice is really important in an environment that's characterized by punishment and coercion," says Gabrielle de la Guéronnière, JD, vice president of health and justice policy for the Legal Action Center. The New York and Washington, D.C.-based nonprofit use legal and policy strategies to advocate for people with arrest and conviction records, substance use disorders, and/or HIV or AIDS.

With funding from FORE, the Legal Action Center produced **two issue briefs** outlining ways states can leverage Medicaid to enhance access to OUD treatment and other substance use disorder services throughout the criminal legal system and facilitate enrollment in Medicaid. Many of their recommendations are reflected in California's demonstration. Still, de la Guéronnière is concerned about the short timeframe — 18 months — for evaluating California's program. "With all these systems working together, there's a lot to figure out," she says.

She would like to see federal agencies — CMS, the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and the Department of Justice (DOJ) — take steps to educate people about the policy change, provide technical assistance, and monitor how jails and prisons respond. Because programs like these require coordination between city, state, and county leaders and entail new practices for providers, it may also be helpful to bring policymakers together with people from the health and justice sectors to tackle some of the logistical challenges ahead.

Among the challenges and potential solutions:

Designing evaluation methods that not only assess the effectiveness of expanding access to treatment but detect variation in policies and procedures that contribute to racial disparities in access and treatment outcomes

- Both within and outside of carceral settings, the nation lacks standardized data needed to comprehensively assess the prevalence of OUD and treatment outcomes. Collecting this data is even more challenging in jails and prisons because of the number of private and public providers delivering care. The federal government could require this data collection and analysis, along with transparent reporting.
- States and localities may also need technical assistance in conducting evaluations and determining outcomes, as well as guidance on how to engage people with lived experience of incarceration in the assessment of programs.
- Correctional facilities and states must also be mindful of protecting patient privacy and data as they evaluate the strength and effectiveness of connections made between carceral and community-based providers.

Identifying and spreading best practices for cross-sector coordination and communication

- Building new systems of care for people in jails and prisons will require active collaboration among state and federal policymakers, Medicaid managed care plans, providers, peer recovery workers, and harm reduction organizations, among many others. States could leverage existing task forces and executive and legislative commissions including those working to improve the response to the overdose crisis, as well as stakeholders in health and justice including people with lived experience, to identify and convene needed parties and organizations and develop collaborative approaches.
- Federal agencies, including CMS and DOJ, could convene a joint learning collaborative to support learning among state and local health and corrections decision-makers. They could also use federal dollars to incentivize the adoption of policies and practices that strengthen health and justice outcomes for people leaving jails and prisons.

Developing and spreading best practices and implementation tools

Given the magnitude of change required to transform care for people within carceral settings and ensure a success transition to ongoing care, it will be critically important to develop strategies for:

- Developing the workforce including peers who have lived experience of incarceration and substance use disorders.
- Training staff in jails and prisons and other parts of the criminal justice system, including probation departments, halfway houses, and reentry programs, about evidence-based treatment for OUD and effective strategies for countering stigma.
- Promoting telehealth and other clinical protocols to expand access to care and streamlining referral processes to ensure continuity of care.

"CMS's Medicaid Reentry Demonstration represents a tremendous opportunity to help people leaving prisons and jails, including those with opioid and other substance use disorders, become healthier and avoid additional contact with the criminal legal system," de la Guéronnière says. "Thoughtful, collaborative work is needed to ensure that this opportunity is well implemented. We are excited about what's ahead."

FORE remains committed to expanding access to lifesaving treatment to high-risk populations, including people leaving jails and prisons. "As our grantees have shown, there is no simple fix, but it is possible to bring the systems and services together in an effort to save lives," says Karen Scott, MD, MPH, FORE's president.

For more information, please contact Eric Weintraub, MD, at UMD, and Gabrielle de la Guéronnière, JD at LAC.