Recommendations for Medicaid Performance Measures for Opioid Use Disorder Services in Jails and Prisons

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Putting policy ideas into practice

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EXECUTIVE SUMMARY

The unprecedented and growing rates of overdose deaths in the U.S. have brought new attention to policies that would increase access to opioid use disorder (OUD) services; in particular, medications for OUD (MOUD) for individuals who are incarcerated. Nationally, overdose deaths have nearly doubled since 2015.[1] Individuals who are incarcerated have higher rates of drug use than the general population.[2] Overdose deaths of individuals in jails and prisons have increased dramatically and individuals recently released from a jail or prison are at extremely high risk of dying from an overdose.[3,4,5] Providing MOUD to individuals in jails and prisons has been found to increase engagement in treatment after reentry to the community.[6,7]

Allowing Medicaid coverage of these services, including MOUD, is a major policy and financing change that will expand access to OUD services in prisons and jails. The addition of Medicaid as a payer for OUD services has the potential to improve health outcomes for many individuals with OUD. In addition, introducing Medicaid service standards and measuring the impact of these services will likely improve the quality of OUD care in jails and prisons in many jurisdictions that now pay for the majority of health care services within them.

Medicaid coverage of OUD services in jails and prisons will necessitate the Centers for Medicare and Medicaid Services (CMS) and state Medicaid agencies (SMAs) to develop 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 re-entering the community. Measures will also have additional effects on Medicaid managed care organizations (MCOs) who can use this information for program improvement for care provided to Medicaid beneficiaries with OUD in jails and prisons and who are released from these settings.

This report recommends performance measures for CMS to require or encourage SMAs to use when assessing their efforts to provide OUD services, including MOUD, to Medicaid beneficiaries in jails and prisons and reentering the community. The measures recommended in this report were significantly influenced by the services and standards established in Task 1: *Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons*. These services include 1) screening, 2) assessment, 3) MOUD, 4) counseling services (including Intensive Outpatient Programs [IOP]), and 5) services to support reentry. Most measures in this report seek to assess whether Medicaid beneficiaries in jails and prisons have access to these critical services initially and on an ongoing basis. States and federal agencies could also undertake additional, broader measurements, such as overdose death rates and the number of individuals returning to prisons or jails, to supplement these service-specific measures.

This report reviews the landscape of OUD measures including community OUD measures, OUD measures recommended by national organizations for individuals in jails and prisons, and state and local efforts to measure OUD care during and after incarceration. The report evaluates those measures for potential use when assessing Medicaid-covered OUD services in prisons and jails, describes the methodology used to select the measures, and recommends that CMS consider requiring or encouraging SMAs to report 15 measures. These measures were grouped by a cascade of care approach to OUD care and services in Task 1: *Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons* (e.g., services provided at admission, during

incarceration, during and post-reentry). In addition to the measures that are recommended as CMS requirements, additional measures are recommended as measures that CMS encourage states to report. Table 1 sets forth the recommended and encouraged measures.

Whether or not SMAs do this will depend in part on the likelihood that SMAs, jails, and prisons have the infrastructure necessary to report the measures initially or at a future date.

The implementation of Medicaid rules, service delivery requirements, coding, documentation, and claims billings will have a major impact on correctional facilities. Operationally, the lack of electronic health records (EHRs) and the technological capacity to submit claims among correctional health care staff represent unprecedented challenges associated with producing requisite data for performance measurement. In addition, the unpredictable

Table 1. Recommended Medicaid Performance Measures for OUD in Jails and Prisons

Medicaid OUD Measures at Admission to a State or Local Correctional Facility	
Measure	**Required or Encouraged**
Percentage of Medicaid beneficiaries screened for OUD using a standardized screening tool during the measurement period	Required
Percentage of Medicaid beneficiaries who had a documented OUD diagnosis (e.g., on insurance claim or electronic health record) during the measurement period	Required
Percentage of Medicaid beneficiaries with OUD who initiate MOUD, by type of MOUD (methadone, buprenorphine, or naltrexone) while in a jail or prison	Required
Percentage of Medicaid beneficiaries continuing community initiated MOUD at admission	Required
Medicaid OUD Measures During Incarceration	
Measure	**Required or Encouraged**
Percentage of individuals who filled or were prescribed and dispensed an MOUD who received the MOUD for at least six months, overall, and by type of MOUD (methadone, buprenorphine, or naltrexone)	Required
Percentage of Medicaid beneficiaries who change MOUD (by type) while in jail or prison	Encouraged
Number and rate of overdose deaths for Medicaid beneficiaries during incarceration	Required
Medicaid OUD Measures During Reentry	
Measure	**Required or Encouraged**
Percentage of Medicaid beneficiaries with an OUD who were dispensed an MOUD by type of medication: (methadone, buprenorphine, naltrexone) and naloxone on the day they re-entered the community	Required
Percentage of adult individuals leaving incarceration with Medicaid coverage	Required

Table 1. Required or Recommended Measures (Cont.)

Medicaid OUD Measures Post-Reentry	
Measure	**Required or Encouraged**
Follow-up after release from a jail or prison: percent of Medicaid beneficiaries released from jails or prisons that result in a follow-up visit or service for OUD within seven and 30 days post-reentry	Required
Number and rate of overdose deaths for Medicaid beneficiaries one month and six months post-reentry	Required
Percentage of Medicaid beneficiaries who received an MOUD for at least 60 and 90 days and by type of MOUD (methadone, buprenorphine, or naltrexone)	Required
Percentage of Medicaid beneficiaries who return to jails and prisons post-reentry	Encouraged
Percentage of Medicaid beneficiaries reporting positive recovery-related outcomes post-reentry	Encouraged
Other Recommended Medicaid OUD Measure for Jails and Prisons	
Measure	**Required or Encouraged**
Number and percent of jails and prisons that participate as Medicaid providers in the state's Medicaid program during the 1115 demonstration period	Required

nature of jails and prisons, their physical structures that are primarily intended to restrict movement of people, operating procedures that prioritize security, staffing shortages, and organizational culture will also present unique challenges for SMAs, jails, and prisons.

Correctional agencies at the state and local level need resources, technical assistance, and significant implementation efforts to amend their contracts or procure new contracts with health care vendors; procure and implement EHRs and billing modules; hire and train staff on billing; and implement standardized screening, assessment, care planning, and documentation requirements. SMAs will need to develop policies and procedures that strike the right balance of being simple enough to facilitate successful operations while also providing SMAs, CMS, and stakeholders with sufficient data to do oversight, undertake quality and performance measurement, monitor program(s), conduct research and evaluation, and maintain program integrity.

This report is intended to inform a wide range of health and criminal justice policymakers and stakeholders. The primary audience is SMAs who will be responsible for reporting information to CMS on various measures for Medicaid beneficiaries in jails, prisons, or upon reentry. SMAs could use this report to make decisions with their state and local correctional counterparts about what information and data is needed to report on these measures. Additional audiences are federal and state policymakers, health care providers and community-based organizations, Medicaid MCOs, advocates, and people with direct experience of incarceration and OUD.

This is the second of three reports regarding Medicaid coverage of OUD services in jails and prisons. The previous report, *Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons*, was released on October 12, 2023. A subsequent companion report regarding reimbursement and payment models that can advance these standards of care in prisons and jails will be issued in early 2024.

INTRODUCTION

Federal Medicaid policy is now evolving, and state Medicaid programs may, through waivers of federal law, cover some services, including OUD services, in prisons and jails in the period immediately prior to an individual's release. In addition, some state and federal policymakers have proposed going beyond the pre-release period to authorize Medicaid to cover MOUD or a broader set of health care services during the entirety of a prison or jail stay. If Medicaid's role were changed to allow states to cover OUD services, including MOUD, throughout an individual's incarceration, the measures recommended or encouraged in this report could be used by SMAs to manage, monitor and evaluate their efforts to transform care for individuals with OUD who are incarcerated, as well as those reentering the community from jails and prisons. This will not only be helpful for SMAs, but it will also have far-reaching effects on Medicaid MCOs, jails, and prisons who can use this information to improve care provided for these individuals. It should be noted that reporting of certain SUD and OUD measures for community services by SMAs will be required based on provisions on the 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act.[9]

Summary of Methods

A multi-phase process was taken to review and develop a proposed measure set for Medicaid beneficiaries in jails, prisons, and/or re-entering the community from these facilities. The first phase collected and reviewed existing and proposed measures currently available and used by the CMS, SMAs, Medicaid network providers, and others to ascertain which community OUD measures currently in use may be most relevant for adults in jails and prisons or re-entering the community. Youth in juvenile justice and other correctional facilities were beyond this project's scope as was the federal Bureau of Prisons.

This phase also reviewed the available and proposed measures for OUD treatment in prisons and jails and for services for individuals re-entering the community from these facilities. This phase included reviewing recent briefs and reports recommending measures for individuals in correctional facilities. In addition, measures collected through interviews with state and local staff responsible for administering OUD initiatives in jails and prisons were measured. Some of these initiatives focused on services and supports necessary for reentry while others focused on outcomes of reentry efforts. Information was collected and reviewed on the characteristics of measures (type of measure, reporting history, and data source). This first phase identified over 150 measures (with some overlap) that could be relevant for OUD services provided in jails, prisons, or for reentry.

The second phase cross-walked measures against criteria developed for the project. A major driver in the criteria was whether current community and proposed measures for correctional facilities aligned with services recommended in Task 1: *Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons*. This included measures focusing on the five service domains in Task 1: 1) screening, 2) assessment, 3) MOUD, 4) counseling services (including IOP), and 5) services to support reentry (several which are required by CMS in their recent reentry guidance). These services followed a cascade of care approach for providing OUD care in jails and prisons. The cascade of OUD care starts at screening (or individuals reporting they have an OUD) and assessment, and is followed by

treatment initiation, then retention in care.[10,11] Additional criteria to select measures included:

- Setting-specific measures in use or recommended for jails and prisons
- SMA's, jails' and prisons' experience with reporting measures
- Reliability of measures that have undergone a rigorous consensus and stakeholder feedback process
- Implications for data sharing and data matching across SMAs and state and local correctional authorities
- Impact that a measure would have on the overall goal and intent of identifying individuals with OUD including assessing the burden of reporting the measure to determine if it is worth the investment of resources needed to collect information to populate the measure
- Importance of the measure to policymakers such as SMAs and CMS as well as other stakeholders who are advocating for OUD services to be provided in a jail or prison setting and improving the quality of care

A third phase included adding measures to address identified measure gaps. As indicated in Section 2.i, existing and proposed measures did not include various structural measures, withdrawal measures, or outcome measures specific to the quality of life of Medicaid beneficiaries post-release.

The fourth phase of the process addressed several technical issues with applying existing community measures to the final measurement set. This included the following issues:

- Measure descriptions were not congruent with specific services activities for each service included in Task 1: *Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons*. Current measures include terms that presented definitional challenges (e.g., screening for "substance misuse" versus OUD).
- Many measures used in the community and recommended for jails and prisons are more broadly applied for services to individuals with an SUD versus OUD.

This effort resulted in 15 measures being proposed for use by SMAs for their Medicaid initiatives in jails and prisons. These measures were organized using the cascade of care approach discussed above for individuals at admission to jails and prisons, while incarcerated, during reentry, and post-release. In addition, the measures were differentiated as measures CMS should require or encourage SMAs ro report. This is consistent with other CMS efforts for SMAs. Measures recommended as encouraged had more significant developmental and operational implications for SMAs, jails, and prisons. These encouraged measures may require the SMA to develop the specifications, contract with third parties to collect and report measures, and test the measures to ensure they are reliable. These encouraged measures also considered that the SMA may need time and resources to match Medicaid data with multiple data sets, some which do not currently exist. Encouraged measures considered the additional operational challenges jails and prisons may face to collect and report information to the SMA (e.g., reporting timely changes in Medicaid enrollment).

These required and encouraged measures were reviewed and discussed with an advisory council that includes individuals with experience strengthening OUD services in jails and prisons, individuals who have lived experience of having had OUD and been incarcerated, and payers including a former Medicaid director and a managed care executive who administered OUD services for Medicaid beneficiaries. Recommendations were then reviewed with two external experts on Medicaid OUD measures. Appendix D provides the representatives from the Advisory Council and the names of the reviewers.

SECTION 1: MEASURES

This section of the report describes key elements of health care measurement, Medicaid's approach to quality measures, the evolution of measurement for OUD services, and the current state of measurement for OUD services in prisons and jails. This information is background and context for the report's analysis and recommendations.

1.a. Background on Measures

The U.S. health care system, driven in large part by CMS, is moving from one that pays for the volume of services to one that considers the quality of services.[12] Quality measures serve several functions: to help measure or quantify health care processes and outcomes, report on the perceptions of individuals receiving care, and track utilization of critical services. Systematic quality measurement provides critical, transparent information to providers and individuals receiving care. In addition, the managed care industry uses measures included in the Healthcare Effectiveness Data and Information Set (HEDIS®).[13]

Quality measures identify changes needed to improve health care processes, value, and outcomes.[14] Measures can be used to identify issues in delivery of health care services and develop and prioritize strategies to address these issues.[15] Developing a measure is time consuming and requires resources to collect and review evidence, identify service gaps, assess feasibility, and testing.[16]

There has been significant work to develop Medicaid measures to assess the quality of care for individuals with OUD who receive services in the community. Much of the early measurement work focused on SUDs. This work recommended measures designed to assess the quality of managed care plans in their ability to identify people with an SUD who needed treatment, initiated treatment, and continued to be engaged in treatment.[17] In addition, other organizations have embarked on efforts to develop SUD measures including CMS, the Agency for Healthcare Research and Quality (AHRQ), and other organizations discussed throughout this report.[18]

There are important factors that often determine whether a measure is effective and should be used on a widespread basis: the type of measure, whether there is a data source for a measure, the existence of technical specifications that can be used to calculate a measure, and the reliability of the measure. Each of these factors is discussed below.

1.a.1. Types of Measures

CMS, states, and health care payers and providers use three main types of measures to assess their health care systems and/or the quality of services their organization(s) provides.[19] Each type is outlined below.

- *Structural measures* are used to track information on a provider's capacity, systems, and processes to provide care. For instance, structural measures can be used to measure the number of facilities or practitioners in facilities that provide OUD services.
- *Process measures* can indicate what a provider or health care system does to maintain or improve health for the general population or those diagnosed with a health care condition. These measures typically reflect generally accepted recommendations for clinical practice. OUD process measures can track the number and percent of individuals who initiate OUD treatment and continue in treatment over a defined length of time. Process measures are the most

commonly used measures by CMS and SMAs.

- *Outcome measures* reflect the impact of the health care service or intervention on the health status of individuals. Outcome measures enable the tracking of changes in symptoms and functioning over time and whether various disease management strategies are effective. The SUD/OUD field does not have any commonly used data to measure outcomes; however, possible outcome measures could include the number and rate of opioid and heroin overdoses, overdose deaths, and reincarceration for individuals in jails and prisons.[20]

1.a.2. Measure Sources

Data on quality measures are collected or reported in a variety of ways, such as administrative data (e.g., claims), medical record review, and experience of care assessment instruments. Each of these sources is discussed briefly below.[21]

Administrative data

Health care organizations generate administrative data such as claims and encounter data that provide specific information on the amount, frequency, and duration of health care services received by individuals. SMAs and their Medicaid MCO partners use claims data to pay providers for services rendered. Encounter data provides similar information as claims data and is often used in capitation arrangements to track information rather than pay for a service. Both claims and encounter information contain common data elements: the type of service, the provider of services, number of units (e.g., days of service), diagnosis and procedure codes for clinical services, location of service, amount billed, and amount reimbursed.

Medical records

Medical records document an individual's medical history and care, usually in the form of EHRs. An organization or facility such as a jail or prison may not have a fully functional EHR that can provide this information. In these instances, it is likely that the individual's file will be comprised of paper or another version of records. Although medical record reviews are labor intensive and have historically been more challenging to undertake than analysis of administrative data, wider use of EHR systems has improved the ease of obtaining and using this information for quality measurement and reporting.

Individual experience of care surveys and measuring outcomes for individuals

Survey instruments can also provide information useful for measuring quality and performance. Surveys can supplement information from administrative or medical records and capture self-reported information from individuals about their health care experiences, including care, service, or treatment received and perceptions of care outcomes. Known as experience of care surveys, these surveys are typically administered by a third-party entity to a sample of individuals by mail, email, or by telephone. Experience of care surveys have rarely been used in jails or prisons and there have been limited efforts to collect outcome information on individuals receiving care in jails, prisons, or upon reentry. The most widely used tool for measuring care experience in the community is the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). A specific tool, the CAHPS® Experience of Care and Health Outcomes (ECHO) Survey, asks health plan enrollees about their experiences with behavioral health care and services.[22] SMAs and MCOs have used the ECHO Survey intermittently to improve the quality of SUD services and evaluate and monitor the quality of community SUD treatment organizations.

1.a.3. Measure Specifications

In addition to measure type, there are specifications needed for each measure.[23] For most measures to be useful to Medicaid and other payers, they must have specifications to use for calculating the measure. For instance, most quality measures will include a:

- *Denominator:* The total population for applying a measure (i.e., the number of people who should have received MOUD while in prisons). The denominator is the lower part of a fraction used to calculate a rate.
- *Numerator:* The individuals in the denominator who received the service (i.e., the number of people that actually received MOUD while in prison). The numerator is the upper part of a fraction used to calculate a rate.
- *Measurement period*: The measurement period is the timeframe in which the intended outcome (e.g., increased use of MOUD by individuals in prisons) may be achieved.
- *Measure identification*: Measure developers and stewards often assign a measure a number. For instance, the National Quality Forum (NQF) and CMS assign an identification number to each measure they have identified to meet certain measure criteria.

As indicated later in this report, specifications for many of the proposed OUD measures for individuals in jails and prisons do not exist and, thus, would need to be developed.

1.a.4. Measurement Timeframes

Many current measures may not always specify the timeframes for measurement reporting. Organizations or agencies that have developed these measures often provide flexibility to the user (e.g., payer) regarding the measurement timeframe. In addition, data reporting for measurement purposes is often reliant on administrative data (e.g., claims and encounter information). This administrative data is contingent on health care providers' timely submission of data. Some payers, such as Medicare, allow health care providers one year from the date of service to submit a claim/encounter.[24] Therefore, CMS and SMAs will need to take these timeframes into account when developing their measurement timeframes.

1.a.5. Measure Strength

Quality measures should be scientifically acceptable and require high data validity and reliability to ensure that comparisons (e.g., across different providers or managed care plans and providers) are fair and that the results represent actual performance rather than a random occurrence.[25]

Use of a quality measure, including OUD measures, often requires endorsement by an external consensus-based entity (CBE) such as NQF. Batelle, an independent science and technology development nonprofit based in Ohio, is currently assuming this CBE function under a recently awarded contract from CMS.[26,27] CBEs bring together public and private sector organizations to reach a consensus on measuring quality in health care, rarely as a measure developer but to review, endorse, and recommend measures for various programs. CBE endorsement is voluntary, but endorsed measures are favored for use in federal programs (e.g., Medicaid and Medicare) and private sector programs because of the rigorous endorsement process.[28] There are many measures CBEs have not endorsed that have been developed by various organizations; for example, CBEs have not yet reviewed many of the homegrown measures that CMS and other national organizations developed independently.

1.b. CMS and SMAs' Approaches to Medicaid Performance Measures

Medicaid and the Children's Health Insurance Program (CHIP) cover more than 90 million children and adults.[29] CMS uses quality measures in its quality improvement and public reporting

efforts in the Medicaid program.[30] For the past 20 years, CMS has established and refined national quality standards and quality measurement programs to improve health care for Medicaid beneficiaries, using processes similar to those that CMS uses for other programs it administers, such as Medicare. CMS has developed a measure evaluation criteria that incorporates many of the factors in 1.a.1:

- Importance to measure and report, including evidence and performance gaps, and priority (i.e., impact);
- Scientific acceptability of measure properties, including reliability and validity;
- Feasibility;
- Usability; and
- Harmonization—comparison to related or competing measures.[31]

Medicaid has been advancing access to SUD services to Medicaid beneficiaries in the community for some time.[32] Now there is an opportunity to further advance MOUD and other OUD treatment services for individuals who are incarcerated and experience high rates of overdose deaths by bringing experience with Medicaid efforts in the community to bear on corrections.

1.b.1. Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

CMS is required by statute to identify and publish an adult core set of health care measures that includes behavioral health care quality measures for adult Medicaid enrollees using state-reported data. CMS is also required to develop such measures for children in CHIP or Medicaid.[33] CMS has developed these measures to measure the quality of health care for Medicaid and CHIP beneficiaries nationally and within states.[34] The adult core set is comprised of quality measures collected at the state level. To be publicly reported, measures must be reported by 25 or more SMAs and the data must meet internal quality standards. The adult core set includes both measures that are CBE endorsed and CMS homegrown measures. These measures tend to be the foundation for what CMS requires or requests SMAs to report on. These measures have detailed specifications and reliable data sources (e.g., claims or encounter information). These state-level data are then used to calculate national estimates. CMS must also publish annual updates to the core sets that reflect new or enhanced quality measures.[35]

CMS includes behavioral health-specific measures in its adult core set, such as community-based SUD and OUD services.[36] It should be noted that these measures pertain to beneficiaries in the community and not in jails or prisons. The adult core set includes SUD and OUD measures in Table 2.

Table 2. CMS Adult Core Set of SUD and OUD Measures

Measure	Measure Type
Initiation and engagement of SUD treatment	Process
Follow-up after emergency department visit for substance use: age 18 and older	Process
Use of pharmacotherapy for OUD	Process
Use of opioids at high dosage in persons without cancer	Process
Concurrent use of opioids and benzodiazepines	Process

1.b.2. Medicaid SUD/OUD Measures for 1115 OUD Demonstration Waivers

CMS has developed additional opportunities for SMAs to measure the quality of community-based SUD and OUD treatment. In some instances, CMS requires states to report these SUD and OUD measures to obtain approval for certain initiatives. The most prominent

CMS measures for SUD and OUD are used in Medicaid 1115 demonstration waivers. Under section 1115 of the Social Security Act, "CMS can waive certain federal requirements so that states can test new or existing ways to deliver and pay for health care services in Medicaid to the extent that the demonstration will likely promote the objectives of the Medicaid program."[37] CMS requires states with 1115 demonstration waivers to conduct monitoring and evaluation activities, including:

- Developing monitoring protocols that set forth the measures to track progress on implementation goals and report data annually or quarterly throughout the demonstration period
- Producing evaluation reports to assess whether the demonstration has achieved the goals of the project and to inform decisions about future policies that were tested under the 1115 waiver

In 2017, CMS released new 1115 demonstration program guidance that specifically focused on improving access to and quality of treatment for Medicaid beneficiaries in the community to combat the ongoing opioid crisis, revising previous guidance issued in 2015.[38] As a condition of its approval, CMS requires or requests states to submit information on 36 measures, 24 that are required and 12 recommended. SMAs must agree on reporting various structural, process, and outcome measures (Table 3).[39] Currently, 34 states and the District of Columbia have an 1115 waiver that focuses on OUD; three additional states have made waiver proposals to CMS.[40] CMS also identifies the subpopulations for reporting measures. A specific subpopulation is individuals in the community who have been involved in the criminal justice system. CMS does not specifically define this population but relies on the SMA for this definition, understanding there is no common definition across states. Table 3 provides information on the required measures for SUD 1115 demonstration waivers.

Over time, state Medicaid programs have advocated that CMS prioritize a smaller set of measures to minimize administrative burdens on states and providers.

Table 3. 1115 Required SUD Measures (2017)

Measure	Measure Type
Assessment of Need for SUD Treatment Services	
Number of beneficiaries with SUD diagnosis (monthly)	Process
Number of beneficiaries with SUD diagnosis (annually)	Process
Number of beneficiaries treated in an IMD for SUD	Process
Access to Critical Levels of Care for OUD and other SUD	
Number of beneficiaries receiving any SUD treatment	Process
Number of beneficiaries receiving early intervention (e.g., SBIRT)	Process
Number of beneficiaries receiving any outpatient services for SUD	Process
Number of beneficiaries receiving IOP or partial hospitalization services	Process
Number of beneficiaries receiving SUD residential and inpatient services	Process
Number of beneficiaries receiving withdrawal management services	Process
Number of beneficiaries receiving MOUD	Process
Average length of stay in IMDs	Process

Table 3. 1115 Required SUD Measures (2017) - Cont.

Measure	Measure Type
Sufficient Provider Capacity at Critical Levels of Care including MAT for OUD	
SUD provider availability	Structural
SUD provider availability – medication-assisted treatment (MAT)	Structural
Initiation and engagement of alcohol and other drug abuse or dependence treatment	Process
Use of opioids at high dosage in persons without cancer	Process
Use of opioid from multiple providers in persons without cancer	Process
Concurrent use of opioids and benzodiazepines	Process
Continuity of pharmacotherapy for OUD	Process
Improved Care Coordination and Transitions between Levels of Care	
Follow-up after emergency department (ED) visit for mental illness or alcohol and other drug dependence	Process
Other SUD-related Metrics	
ED utilization for SUD per 1,000 beneficiaries	Outcome
Inpatient stays for SUD per 1,000 beneficiaries	Outcome
Readmissions among beneficiaries with SUD	Outcome
Number of overdose deaths	Outcome
Rate of overdose deaths	Outcome
Access to preventive/ambulatory health services for beneficiaries with SUD	Outcome

1.b.3. Medicaid Reentry Demonstration Waivers

In April of 2023, CMS released guidance regarding reentry section 1115 demonstration opportunities for SMAs to improve care transitions for individuals exiting from correctional facilities. CMS released this guidance as required by the 2018 SUPPORT Act seeking to promote state innovations to ease transitions to the community for individuals who were incarcerated.[41] The guidance focuses on a subset of this population in correctional facilities—specifically, allowing Medicaid payment for select services rendered to individuals during the reentry period (e.g., the last 90 days before release). The goals of this initiative are to increase Medicaid enrollment for individuals in jails and prisons, improve access to health care (including OUD services prior to release), improve coordination and communication between Medicaid and correctional systems, and improve certain outcomes post-release from these facilities. The guidance includes some general requirements for SMAs to report measures which focus on reentry but does not provide specifications needed to collect data and report measures. In its guidance, CMS indicates SMAs will need to report the following data:

- "Administration of screenings to identify individuals eligible for pre-release services
- Number of participating pre-release service providers
- Utilization of applicable pre-release and post-release services (e.g., primary, behavioral, MOUD, case management)
- Provision of health or social service community referral pre-release
- Participants with established care plans for reentry at release

- Take-up of data system enhancements among participating carceral settings (including new EHR capacity or linkages with state or regional Health Information Exchanges)"[42]

Additionally, CMS will require SMAs to report quality of care and health outcomes metrics that address health equity gaps for Medicaid and CHIP beneficiaries. SMAs will also need to prioritize key outcome measures and their clinical and non-clinical (e.g., social) drivers of health. SMAs will coordinate with CMS to select certain measures for reporting in alignment with a critical set of health equity-focused measures that CMS has yet to release.

1.b.4. Other CMS Reporting Initiatives

In April 2021, the Center for Medicare and Medicaid Innovation (CMMI) introduced Value in Opioid Use Disorder Treatment (Value in Treatment) – a four-year demonstration program to increase access to applicable Medicare beneficiaries (including individuals who are dually eligible for Medicare and Medicaid) who reside in the community.[43] Value in Treatment is intended to test whether the demonstration reduces deaths from opioid overdose, hospitalizations, SUD residential admissions, and ED visits. In addition, the demonstration seeks to increase the use of MOUD and test new payment models for OUD treatment services, including a performance-based incentive based on an individual provider's performance, as well as the use of MOUD and engagement and retention in treatment. CMMI does not require a grantee to use specific measures for the demonstration; however, the agency included several SUD measures, most of which were CBE-endorsed, in its request for application.

CMS has also developed a Medicaid and CHIP (MAC) scorecard for each state.[44] The MAC scorecard is available regarding each state's efforts in eight domains, including behavioral health. There are 24 measures across these domains – two of which focus on OUD measures and have been endorsed by the CMS CBE:

- Use of opioids at high dosages in persons without cancer: age 18 and older
- Initiation and engagement of alcohol and other drug abuse or dependence treatment: age 18 and older

1.b.5. States' Reporting on SUD/OUD Community Measures

CMS collects information regarding the number of states that report the adult core set of SUD and OUD measures for Medicaid beneficiaries receiving services in the community. The report provides information on the changes within and across states regarding these measures. The most recent information on states reporting of these core measures is from federal fiscal year (FFY) 2020.[45] This information indicates:

- Fifty-one states and territories voluntarily reported at least one behavioral health measure included in the adult core set.
- Forty-one states and territories reported on the follow-up after ED visits for alcohol or SUD treatment.
- Forty states and territories reported on the initiation and engagement of OUD treatment.
- Twenty-eight states and territories reported on the use of opioids at high dosages in persons without cancer measure.
- Twenty-eight states reported on the concurrent use of opioids and benzodiazepines.

There have been notable changes in the performance among states measuring the impact of OUD services on Medicaid beneficiaries in the community.[46] For instance:

- Initiation of treatment for OUD or dependence increased from 46.3 to 57.2 percent from FFY 2018-2020.

- The percentage of adult Medicaid beneficiaries (without cancer) who received a prescription for an opioid decreased from 9.6 percent to 3.9 percent.
- The percentage of adults with concurrent use of opioids and benzodiazepines also decreased from 21.6 percent to 11.2 percent.
- The percentage of adult Medicaid beneficiaries who went to an ED and received a follow-up visit for alcohol and SUD in seven days and 30 days significantly increased from 7.8 percent to 20.3 percent (seven days) and from 11.5 percent to 30.1 percent (30 days).

It is expected that reporting of many of these measures will increase given the requirements of the SUPPORT Act requiring CMS to report behavioral health measures, including OUD measures from the adult core set for Medicaid beneficiaries in the community with OUD.

Information regarding patient experience of care for Medicaid beneficiaries with OUD is not available since states are not required to report these types of indicators for core set reporting.

1.c. Other Organizations' Efforts re: OUD Community Measures

Additionally, other organizations have recommended measures for SUD or OUD. CMS's CBE has already endorsed new "homegrown" OUD measures for use by SMAs and other state organizations (e.g., state SUD authority). These newer measures have focused on community-based OUD and SUD services provided to individuals (in some instances, to Medicaid beneficiaries). Almost all of these measures have well defined specifications, reliable data sources (e.g., claims or encounters), and are reported by SMAs or national organizations. Some of these homegrown measures have been recommended by the following organizations:

- Academy Health's Medicaid Outcomes Distributed Research Network (MODRN), a collaborative effort to analyze data across multiple states to facilitate learning among Medicaid agencies, which uses data from existing CMS measures to assess the impact of innovative policies and interventions (see Appendix A.1).[47]
- The Pew Charitable Trusts, which convened an expert panel to identify core OUD treatment measures for states to track OUD. The panel agreed on eight core measures, available in Appendix A.2.[48] The panel also recommended that states report patient outcome measures that focus on measuring improvement in functioning or quality of life.
- Shatterproof's ATLAS program, which contracted with RTI International to develop a set of 23 process and outcome measures that examine whether community addiction treatment programs are delivering care that aligns with Shatterproof's National Principles of Care for SUD Treatment. RTI International developed a rating system that measures quality based on these principles at specialty addiction treatment programs. Information is available to individuals seeking assistance and payers through the ATLAS program launched in 2021.[49] The measures that RTI International recommended were primarily already endorsed by MCOs and SMAs. These measures are provided in Appendix A.3. ATLAS is one of the few organizations that recommended using information from participants and family members regarding their treatment experience.
- Blue Cross/Blue Shield Association, which developed the Blue Distinction Program (BDP) for Substance Use Treatment and Recovery, aimed at improving outcomes for individuals with OUD in various settings including residential, inpatient, IOP, or partial hospitalization. Programs are awarded BDP status based on various quality criteria including performance on outcome measures.[50]
- American Society of Addiction Medicine (ASAM) which developed draft performance standards to assess how and if the ASAM

standards (released in 2014) were used in physician practices in the community. ASAM convened an expert panel that used a consensus decision-making process to select specific measures for evaluation. The panel's goals included developing areas for further research and development.[51] Appendix A.4 includes the ASAM proposed process and outcome measures.

- Pharmacy Quality Alliance (PQA) efforts focus on measures that ensure the safe and appropriate prescribing of opioids. Many of these measures are being used to track individuals in the community for non-cancer-related pain management issues or for individuals seeking and using a significant amount of MOUD. Some of these measures are CBE-endorsed and used for the Medicaid adult core set. These measures are shown in Appendix A.5.

1.d. Performance Measurement for OUD and SUD Services in Jails and Prisons and Upon Reentry

Over the past several years, national organizations have proposed measures for OUD care delivered to individuals in jails and prisons. These measures have yet to be implemented on a wide scale. Federal agencies such as the Department of Justice (DOJ) began to collect and report information in 2019 regarding OUD services, including MOUD, in jails.[53] States and localities are leading the effort in reporting data or measures on OUD treatment, including MOUD, provided to individuals in jails and prisons and tracking salient outcomes post-reentry into the community.

There is limited information on the efforts that federal, state, and local correctional authorities have taken to assess the quality of OUD care. A recent review of quality indicators and performance measures for prison health care provided some information on suggested measures.[54] However, most of these efforts were seven or more years old and did not include some of the more recent community measures that may be applicable to jails or prisons.

1.d.1. Federal Efforts to Measure OUD in Jail and Prison Settings

At the federal level, the DOJ's Office of Justice Programs (OJP) Bureau of Justice Statistics (BJS) routinely collects information through the Census of Jails (COJ) from jails and the 12 Federal Bureau of Prisons detention facilities regarding various physical and behavioral health services provided to individuals in these facilities. In 2019, BJS added information on OUD screening and treatment.[55] Specifically, the COJ collects the following information on jails and federal prisons:

- Number and percent of individuals screened for an OUD
- Number and percent of individuals provided MOUD for opioid withdrawal
- Number and percent of individuals initiating MOUD and continuing MOUD
- Number and percent of individuals provided overdose education

For individuals leaving jail, the COJ collects information on the percent of annual releasees that are provided overdose reversal medications and linkages to MAT providers for use once released.

The COJ is not conducted annually and there is a substantial lag between data collection and public release. BJS reports data that has been collected eleven times over the past 50 years. Data is collected on individuals who remain in jails for more than 72 hours. Data for the COJ is collected from jail administrators through a web-based instrument. The next COJ is projected for 2024. OJP collects information on an annual basis regarding individuals in prisons.[56] However, information regarding OUD services provided in these facilities has yet to be collected.

Independent organizations have collected information on the use of MOUD for individuals incarcerated within prisons. This is discussed in Section 1.d.3.

1.d.2. National Organizations Efforts to Measure OUD in Jail and Prison Settings

There have been efforts at the national, state, and local levels to develop measures for OUD services provided in jails or prisons and at reentry. National organizations have recently launched efforts to identify measures that would specifically apply to individuals with OUD in or being released from jails and prisons. These measures are generally not in use yet and therefore are not being reported by federal agencies or third-party payers, including SMAs.

Some of the measures discussed in the state and local section below (1.d.3.) are in use in jails or prisons. Some of these recommended measures are NQF-endorsed or have similar intent (e.g., initiation and engagement for MOUD). Other measures are more homegrown and tailored to the population in jails or prisons, during reentry into the community, or follow-up after release. Measures recommended or developed by these organizations may not have well developed specifications and may not yet have reliable data sources. Some of these proposed measures align well with services set forth in Task 1: *Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons* including screening, assessment, and provision of MOUD. For instance, some proposed OUD measures focus on:

- Measuring whether individuals in these facilities are screened for SUD/OUD
- The extent to which individuals with an OUD are referred to clinicians to treat their SUD/OUD and then receive MOUD
- Various measures that apply to individuals who reenter the community from jails and prisons

The NQF facilitated a committee in 2020 that identified existing measures, measure concepts, and recommendations for quality measurement for individuals with SUD/OUD and co-occurring behavioral health conditions, including individuals in jails or prisons or soon to be released from these facilities. NQF recommended that these measures, listed in Table 4, be vetted through their endorsement process.[57]

The National Council for Mental Wellbeing (formerly the National Council of Behavioral Health), Vital Strategies, and faculty from

Table 4. NQF Measures for Reentry

Measure	Measure Type
Percentage of individuals inducted and stabilized on a therapeutic dose of MOUD before release from incarceration	Process
Percentage of individuals released from incarceration with insurance coverage in place that includes SUD/OUD and behavioral health services immediately post-incarceration	Process
Percentage of adult individuals leaving incarceration with fully reinstated insurance coverage (e.g., Medicaid)	Process
Percentage of adult individuals leaving incarceration and seeking support for health-related social needs (e.g., housing, food) who received access to services within seven days of release	Process
Percentage of adult individuals leaving incarceration with SUD/OUD and mental health disorders who obtain wrap-around support within seven days of release	Process
Percentage of individuals with identified SUD/OUD and mental illness with MOUD initiated in the ED	Process

Johns Hopkins University, with funding from the Centers for Disease Control and Prevention (CDC) and Bloomberg Philanthropies, developed a toolkit for correctional administrators and health care providers with recommendations to implement MOUD in jails and prisons. The toolkit provides a set of proposed measures that could be used by these administrators and providers for measuring the effectiveness of their efforts in jails and prisons.[58] The proposed metrics are included in Table 5.

The Legislative Analysis and Public Policy Association (LAPPA) under contract to the Office of National Drug Control Policy (ONDCP) identified 12 performance measures for jails and prisons that could be used to measure the effectiveness of their strategies to identify, treat, and monitor individuals who were incarcerated or released from these settings.[59] The measures proposed by LAPPA are in Table 6.

Table 5. National Council on Mental Wellbeing Proposed Measures for Jails and Prisons

Measure	Measure Type
Number of individuals screened for OUD	Process
Number of individuals assessed and diagnosed with OUD	Process
Number of individuals with OUD offered MAT, by medication type	Process
Number of individuals with OUD receiving MAT, by medication type	Process
Number of individuals who remain on MAT at the time of release to the community, by medication type	Process
The average maintenance dose of methadone or buprenorphine/naloxone	Process
Number of individuals who have an appointment scheduled with a community MAT provider when released, by medication type	Process
Number of buprenorphine recipients given a bridging supply or prescription for buprenorphine	Process
Number of individuals insured at the time of release	Process

Table 6. LAPPA Measures for Correctional Facilities

Measure	Measure Type
Universal screening rate	Process
Positive substance misuse indicator rate	Process
Substance use assessment rate	Process
OUD rate	Process
MAT referral rate	Process
MAT induction/retention rate	Process
Non-medication-based treatment participation rate	Process
Continuity of care rate	Process
Rearrest rate	Outcome
Reconviction rate	Outcome
Rebooking rate	Outcome
Post-release fatal overdose rate	Outcome

The Urban Institute, through a grant from the Bureau of Justice Assistance (BJA), issued a performance management strategy and guidance for practitioners and organizations to measure the implementation and ongoing performance of initiatives focused on individuals in jails and prisons. The guidance was to inform initiatives to enroll individuals into Medicaid upon release from incarceration and connect them with needed health care and medications in the community.[60] The Urban Institute proposed 50 structural, process, and outcome measures. While no specific measure was recommended for OUD, several of the measures could be applicable to individuals with OUD who are in jails or prisons. The Urban Institute's proposed list of measures is in Appendix A.6.

1.d.3. State and Local Efforts to Measure OUD in Jail and Prison Settings

A convenience sample of states and localities was conducted that reviewed state and local efforts to measure the effectiveness of OUD services in jails and prisons. This sample included nine states and localities known to provide OUD services, especially MOUD, for individuals in their prison or jail systems. Several states and localities were identified through the survey for Task 3: *Medicaid Reimbursement and Payment Model Recommendations for Opioid Use Disorder Services in Jails and Prisons*, focusing on developing reimbursement and payment models for OUD services in prisons and jails. Several states, such as California, Kentucky, Maine, Rhode Island, and Vermont, track the receipt of MOUD and track information on other services monthly or annually. Other states and local governments (e.g., counties) have participated in studies to determine the effectiveness of their MOUD strategies. All the states and localities that were reviewed track the number of individuals who were offered and received MOUD in jails and prisons. In addition, six of nine jurisdictions reviewed track what happens to individuals who re-enter the community from jails or prisons, focusing on outcomes such as ongoing receipt of MOUD, overdose deaths, and recidivism. Appendix B contains summary information regarding state and local efforts to measure the impact of their efforts to serve individuals with SUD or OUD in jails or prisons. Generally, these measures focus on:

- The number of individuals screened for OUD, assessed, and diagnosed with an OUD
- The number of individuals referred and/or initiated or currently receiving MOUD (during incarceration, in preparation for reentry or post-reentry)
- The number of individuals who receive other OUD services including individual and group counseling
- The timeliness of service delivery against standards developed for jails or prisons (e.g., screenings are performed within X hours of intake)
- Health care utilization (e.g., all cause ED visits and inpatient services) for individuals with an OUD released from jails or prisons

Six of the nine states and localities reviewed have post-release measures, including:

- Percentage of individuals living in stable housing
- Percentage of individuals employed
- Percentage of individuals who have been reconvicted or re-incarcerated
- Percentage of individuals who are enrolled in Medicaid at release
- Percentage of overdoses among individuals recently released from incarceration

Some of the measures currently reported by states and localities for reentry align well with the goals and measure areas referenced in the recent CMS reentry guidance.

1.d.4. State-Proposed Medicaid 1115 Reentry Demonstration Waivers

In addition to the CMS guidance on reentry, proposed 1115 demonstration waivers focusing on individuals in jails and prisons were reviewed, including individuals re-entering the community from these facilities. Recently approved 1115 reentry waivers in California and Washington provide some insight into what CMS may require these SMAs to report. In both waivers, CMS expects SMAs to develop a state monitoring protocol that specifies a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Health Equity Measure Slate.

CMS is specifically requiring California to examine whether its reentry initiative expands Medicaid coverage and allows for the "efficient provision of high-quality pre-release services that promote continuity of care into the community post-release." In addition, California will be required to measure "access to and quality of care in carceral and community settings, preventive and routine physical and behavioral health care utilization, ED visits, and inpatient hospitalizations." CMS is also requiring the state to track and report overdose and overdose-related deaths in the period soon after release. CMS also underscored the need for a beneficiary experience of care survey to assess access to and quality of care for the state's Medicaid beneficiaries.[61]

CMS expects Washington State to monitor the number of beneficiaries served and types of services rendered under the demonstration. CMS expects such metrics to include, but not be limited to, "administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services (e.g., case management, MAT, clinical/behavioral health assessment pre-release and primary and behavioral health services post-release), provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release."[62]

Fourteen additional 1115 waiver proposals that focus on reentry were reviewed. Most of the states that have submitted 1115 demonstration reentry waiver proposals to CMS did not include specific measures in their application. However, they did propose goals for these initiatives that would ultimately need to be measured if the waiver is approved. A number of these goals are consistent with the CMS guidance set forth in their reentry guidance to SMAs. The goals generally included:

- Decrease avoidable hospitalizations and ED visits
- Improve physical health and behavioral health outcomes
- Promote continuity of medication treatment for individuals receiving medications
- Reduce incidents of re-engagement with law enforcement post-release
- Ensure continuous Medicaid enrollment
- Reduce overdose deaths and rates of such deaths
- Promote health equity in the provision of OUD services while in jails, prisons, and during reentry

SECTION 2: REVIEW OF EXISTING MEASURES FOR OUD CARE IN JAILS AND PRISONS

This section discusses how existing measures that were identified in section 1 align with the services in Task 1: *Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons* and also reflects important process and outcome measures that are germane to individuals in jails, prisons, or upon reentry. The evaluation also focused on the strength of the measures, measure types (structural, process or outcome), data source, and technical specifications. In addition, this section provides information on SMAs' efforts to report these measures for Medicaid beneficiaries with OUD in the community and jails and prisons to report measures for individuals currently incarcerated. This section concludes with identified gaps in measures that may be important to report for Medicaid beneficiaries in jails, prisons, and during and post-reentry.

2.a. Overview

Although measurement of OUD is a relatively recent development, there is no shortage of performance measures that assess the quality of SUD or OUD services. As discussed in section 1, the review found over 150 measures (with some overlap) that are being used by SMAs, other state and local agencies, or proposed by national organizations. The work on performance measures over the past 20 years has grown exponentially. However, most of these efforts have focused on the quality of SUD and OUD services provided in the community. Most community measures in use are required or recommended for Medicaid beneficiaries; others are payer-agnostic. The development of corrections-specific measures is more recent; hence those measures are more limited in number. A subset of these measures focuses on assessing the success of in-facility OUD care and pre-release services for reentry into the community. A number of these proposed measures align with the recent CMS guidance regarding coverage of reentry services provided to Medicaid beneficiaries in correctional settings. Other measures focus on outcomes for individuals after release from jails or prisons.

The approach to evaluate whether existing or proposed measures could be considered for jails, prisons, or reentry used a framework incorporating multiple factors. First, the analysis reviewed current measures for services included in Task 1: *Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons*. These standards identify services that would be provided within jails and prisons and during reentry. Second, the analysis compares current measures with the goals of current or proposed correctional initiatives (including the direction set forth in the recent CMS guidance). Most of these focus on reentry, measuring the effectiveness of services and supports provided during transition and post-reentry. The third factor evaluates both the strength of existing or proposed community and correctional measures. The fourth factor highlights the data sources for the measures included in the scan. The fifth factor concerns the type of outcome measure (structural, process or outcome). The analysis also discusses a sixth factor: the presence of and strength of technical specifications.

2.b. Alignment with Task 1 Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons

The types of measures in use or proposed for OUD (community and jails and prisons) align well with the services included in the Task 1 deliverable. These services include: 1) screening,

2) assessment, 3) MOUD, 4) counseling services (including IOP), and 5) services to support reentry. Eighty-three measures concentrate on screening, assessment, MOUD, outpatient services (including IOP services), and reentry services such as care coordination and recovery support. Tables 7 and 8 provide an overview of current and proposed measures for each service identified for Task 1: *Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons*.

Table 7. OUD Community Measures for Task 1 Services

Service	TOTAL MEASURES	CMS SUD 1115 Waiver	Pew	CMS Adult Core Set	NCQA	MODRN	ATLAS
Screening	1		1				
Assessment	1						1
Diagnosis	4	3	1				
Treatment/Medication	20	2	3	2	2	6	5
Service Utilization	8	8					
Care Coordination	7	2	1	1	1	1	1
Recovery Supports	2						2
TOTAL	**43**	**15**	**6**	**3**	**3**	**7**	**9**

Table 8. OUD Measures for Task 1 Services Provided in Jails and Prisons

Service	TOTAL MEASURES	LAPPA	NQF	National Council	States and Localities
Screening	5	2		1	2
Assessment	5	2		1	2
Diagnosis	2				2
Treatment/Medication	19	3	2	5	9
Service Utilization	1				1
Care Coordination	8	1	4	2	1
Recovery Supports					
TOTAL	**40**	**8**	**6**	**9**	**17**

As these tables indicate:

- One community measure and five correctional measures focus on screening for SUD or OUD.
- One community and five correctional measures focus on assessment, including assessments that render a diagnosis.
- Four community measures and two correctional measures are specific to diagnosing SUD or OUD.
- Twenty community and 19 correctional measures focus on OUD specific treatment. Most of these measures focus on MOUD. Few focus specifically on IOP.
- Seventeen measures focus on measuring reentry efforts (nine community and eight correctional measures). Most of these measures (15) focus on care coordination. Two community measures relate to recovery supports.

There is a general alignment of measures with services recommended in Task 1. Some of these measures are in use for community-based OUD care or are proposed for care provided in jails and prisons. However, the details in some metrics and the definition of the measure do not specifically align with measuring the implementation of the standards recommended for Task 1: *Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons*. Generally, performance measures focus on SUD and few specifically use individuals with OUD in their technical specification. The services and standards in Task 1 recommend standards for OUD versus SUD.

2.c. Process and Outcome Measures

While many measures align with the services in the Task 1 report, other measures are currently in use in the community or are recommended for individuals in (or about to be released from) jails and prisons. These measures focus on process and outcome and are generally not service-specific. Tables 9 and 10 provide information regarding these measure areas.

Table 9. Community OUD and SUD Process and Outcome Measures

TOPIC	TOTAL MEASURES	CMS SUD 1115 Waiver	Pew	CMS Adult Core Set	NCQA	MODRN	ATLAS
Concurrent use of Opioids/Benzodiazepine	11	4		2		5	
Health Care Utilization	9	4				4	1
Recidivism							
Overdose Deaths	3	2				1	
Harm Reduction							
Pregnancy/NAS	3					3	
Experience of Care/Outcome	9						9
Other	15	9					5
TOTAL	**49**	**19**		**2**		**13**	**15**

Table 10. Correctional OUD and SUD Process and Outcome Measures

TOPIC	TOTAL MEASURES	LAPPA	NQF	National Council	States and Localities
Concurrent use of Opioids/Benzodiazepine					
Health Care Utilization	1				1
Recidivism	5	3			2
Overdose Deaths	2	1			1
Harm Reduction	3		2		1
Medicaid Enrollment	2				2
Pregnancy/NAS					
Health-Related Social Needs (HRSN)	2				2
Experience of Care/Outcome	1				1
TOTAL	**16**	**4**	**2**	**0**	**10**

Specifically:

- Nine community measures and one correctional measure track health care utilization.
- Two correctional measures focus on the percentage of individuals leaving incarceration with fully instated or reinstated insurance coverage (e.g., Medicaid).
- Five measures focus on recidivism for individuals who leave jail and prison and reenter jail and prison post-release. States and localities report other measures of recidivism such as assessing if the individual has encounters with law enforcement.
- Two correctional measures report on the percentage of individuals leaving incarceration seeking support for health-related social needs (e.g., housing, food) or wrap-around support and who accessed these services within a certain timeframe (e.g., seven days).
- Three community measures and two correctional measures assess the impact of OUD correctional strategies on opioid overdose deaths post-release from a jail or prison.
- Three correctional measures emphasize the use of harm reduction strategies such as the percentage of individuals with OUD discharged from residential treatment or EDs with naloxone.
- Eleven community measures also focus on measuring the state's efforts to develop more robust pain management strategies (e.g., concurrent opioid and benzodiazepine prescribing).
- Three community measures focus on a specific population (e.g., pregnancy and neonatal abstinence syndrome [NAS]).
- Nine community measures and one correctional measure track experience of care or outcomes for individuals.

Measures that assess an individual's experience of care are not widely used in national, state, local, or correctional performance metrics. As indicated in Section 1.a.2, the ECHO Survey, a tool for measuring care experience, is used intermittently by SMAs and Medicaid MCOs to improve the quality of SUD services. State and local correctional agencies irregularly employ measures assessing an individual's experience of care while incarcerated. Some prisons and jails assess outcomes post-release as set forth in Appendix B focusing on stable housing, employment, or re-involvement with law enforcement after release from a jail or prison.

2.d. Measure Strength

Most of the SUD and OUD measures that are used in the community are not endorsed by a CBE. As stated in Section 1, CBEs have endorsed only five SUD or OUD measures that are in widespread use by SMAs. CMS uses a combination of measures endorsed by their CBE and other measures they developed but are not yet endorsed.

Payers may view measures that are not endorsed by CMS CBEs as being less reliable, therefore making comparisons across and within states more difficult. In addition, Medicaid MCOs and network providers may have less interest in reporting these measures due to a reliability concern. Shatterproof's ATLAS rating system received significant pushback from providers in participating states on SUD or OUD measures that were not endorsed. Ultimately, states allowed providers to voluntarily participate in the ATLAS program and report certain measures that were not endorsed.

2.e. Measure Type

Most of the OUD and SUD measures used or recommended for community and correctional OUD programs are process measures. Only 25 of the more than 150 measures in this scan were identified as outcome measures. The outcome measures identified were specific to overdose among Medicaid beneficiaries, re-admission to an inpatient hospital (all-cause), and re-arrest rates for individuals who were previously incarcerated. Some outcome measures focused on desirable outcomes such as stable housing, employment, etc.

While these are important measures, they focus on the consequences for people who reenter the community and may not be directly related to access to high quality OUD community services. For instance, providing naloxone upon release is important but it may be difficult to identify if pre-release naloxone was used to successfully revive an individual or naloxone from another site in the community was used.

There are too few OUD and SUD structural measures in the community, and none are used or proposed for jails or prisons. Structural measures are necessary for newer CMS initiatives (e.g., 1115 reentry waivers) to gauge if jails and prisons are interested in participating in the reentry initiative. If participation is low, SMAs will need to quickly determine and address the reasons for lower-than-expected participation. These structural measures are important proxies in the first year of an initiative when administrative data (e.g., claims) is not readily available to measure utilization statewide and within jails and prisons.

2.f. Data Source

The information sources needed to report the measure vary. Most community-based measures endorsed by CMS CBEs rely on readily available data through claims or encounters submitted by community organizations providing OUD services to SMAs for reimbursement. Claims and encounters provide information on individuals receiving various OUD (and other health care) services. Pharmacy claims data may be available to track the type of medications received. Pharmacy data can also track if the individual was provided medication before release and

could track the number of individuals who filled a prescription for MOUD upon release. CMS has made significant changes to help states improve Medicaid and CHIP data reporting accuracy and completeness of claims and therefore the reliability of Medicaid claims and encounter data has recently improved. In addition, SMAs will have Medicaid eligibility data that can be paired with claims and encounter information to report on various measures while an individual is in a jail or prison, as well as during and post-reentry.

In addition to service claims, EHRs can also provide information regarding services provided and be a reliable data source for measures. A number of states and localities interviewed for this report and the environmental scan for Task 3 of this series were using EHRs in their prisons for intake (that often includes screening for many health care conditions) and for other services such as assessment and the delivery of MOUD and other OUD services. But many jails do not have EHRs, or their correctional health vendor uses its own proprietary system that the county does not own or retain if the county changes health vendors. Adoption of EHRs in jails and prisons may be similar to community providers in that larger healthcare systems have invested in EHRs before smaller ones.[63] Challenges to adopting EHRs in jails and prisons include the wide spectrum of care delivered and the difficulty most facilities would have in developing a health reporting infrastructure without additional resources. The recent CMS guidance regarding reentry communicates that SMAs may require participating correctional health providers to perform certain data sharing activities relating to care coordination regardless of whether they have an EHR. The guidance also allows states to propose requests for time-limited expenditures to support necessary changes required by jails and prisons including new business and operational practices (e.g., health related information technology). This opportunity is discussed in more detail in section 4 of this report.

Prisons and jails collect information regarding the number of admissions, individual demographics, date of discharge, and other measures. While an important source of information, interviewees indicated that this data may be less reliable given there may not be a standardized method to collect and report this information or reporting is less frequent than submitted claims and encounters.

Measures proposed for jails or prisons do not always identify the source or suggest an administrative source that is not claims or encounter based. For instance, the number and percentage of individuals for whom an appointment was made with a community provider would not be included in a claim or encounter. Several of the measure areas in the recent CMS guidance may not be included in claims and encounters such as participants with established care plans at release and provisions of pre-release social service referrals. While extremely important, the number or percent of people for whom a care plan was submitted from the jail to a community provider would rely on fairly sophisticated tracking through an EHR, which jails and prisons likely do not have. State and federal Medicaid policies that require jails or prisons to submit claims or encounter information necessary to measure and reimburse for services provided in jails or prisons have not been developed.

2.g. Technical Specifications

Detailed specifications have not been developed for many correctional-specific measures; some do not have a numerator, denominator, or measurement timeframe. In addition, correctional-specific measures proposed by LAPPA and NQF have not been field-tested and many are in different stages of use and development. This contrasts with the community OUD and SUD measures, which have technical specifications that provide specific information to SMAs for how to report the measures.

2.h. Status of Reporting Efforts

Currently, SMAs are required or requested to report a significant number of the OUD and SUD community measures, including the adult core set, SUD 1115 demonstration waivers, or MODRN. Other organizations recommend measures regardless of payer; however, these measures are not widely used. Some prisons and jails that were identified in Appendix B provide OUD services, including MOUD, and track outcome measures for individuals released from these settings. Some states report information on overdoses, overdose deaths, and re-involvement with community or institutional correctional systems. The majority of local jails did report information to BJS regarding screening, administration of MOUD, and provision of overdose medication at release. However, this information is not being collected on a regular basis.

A major implication is the relative lack of experience in reporting these measures. Some SMAs, Medicaid MCOs, and providers may not have experience reporting requested measures. For instance, reporting on CMS adult core measures set varies. Almost 20 percent of the states and territories do not report on an important measure for individuals with OUD (e.g., follow-up after ED visits for alcohol or SUD treatment or initiation and engagement of OUD treatment).[64] There is no available information nationally on the experience of care of Medicaid beneficiaries with OUD from CAHPS surveys or beneficiary outcomes.

2.i. Gaps in Measures and Measure Use

Existing and proposed measures include a few structural measures for OUD. For instance, CMS does require SMAs participating in SUD 1115 Waivers to report SUD provider availability and SUD provider availability that offer MAT. The Pew Charitable Trusts recommended that states be required to report the MAT measures they recommended.. Other structural measures focused on whether an organization had an EHR, was accredited by a national organization, or whether certain services were provided by the organization. Having a structural measure that specifically looks at the number of jails and prisons that are participating in a Medicaid 1115 demonstration waiver will be critically important to identify several issues. This structural measure, which does not currently exist, will gauge whether jails and prisons are participating in Medicaid. Specifically, SMAs will want to know if low provider participation numbers are directly related to operational challenges for jails and prisons to participate in the state's Medicaid program. Lack of participation may reflect delays by the SMA or MCOs in processing provider enrollments and executing contracts. Uneven participation in the demonstration (e.g., areas of the state where jails and prisons could enroll) may be due to enrollment issues or possible policy direction from the state or local agencies overseeing these facilities.

There are no measures specific to withdrawal management. Some SMAs specifically reimburse for withdrawal management services consistent with ASAM's level of care (e.g., inpatient and residential settings). CMS does not require SMAs to report on withdrawal management provided in these settings. In addition, recently released ASAM program standards embedded withdrawal management in various services rather than establish a separate withdrawal management setting. While diagnoses have been developed for withdrawal from alcohol and psychostimulants, relying solely on behavioral health diagnosis may result in under-reporting of individuals.[65]

There are no measures that specifically address changes to or "switching" MOUD while incarcerated. Tracking medication changes while individuals are in jails and prisons are important. These individuals may have complicated substance use patterns and may need additional support for reentry.[66]

While there are existing community and proposed correctional measures to track continuity of MOUD post-initiation, there is not a measure that assesses the continuity of MOUD at admission to a jail or prison. As indicated in Task 1, BJA set forth standards to ensure continuity of MOUD when an individual was receiving MOUD before incarceration.[67]

In addition, there is a lack of consumer experience of care or quality of life measures in widespread use. Existing consumer experience of measures are not required by CMS and only two national organizations recommend collecting this information from community OUD programs. States and localities are collecting information on outcomes for individuals post-reentry. These efforts sometimes use home-grown tools and are administered by a third party (e.g., university partner).

Lastly, there is a gap in reporting information back to Medicaid MCOs and network providers regarding the impact of providing services to Medicaid beneficiaries with OUD. While CMS does provide reports on individual states' efforts to report the adult core set for SUD and OUD, including the MAC scorecard, information is not often available to OUD Medicaid network providers. There are a few initiatives providing information to OUD or SUD providers (e.g., Shatterproof ATLAS and BDP). These organizations offer information on the various measures reported through claims or encounters and provider or consumer surveys. Providers participating in this initiative are provided agency-specific information across ATLAS measures to validate the information ATLAS will be using and for internal quality improvement processes.

SECTION 3: PROPOSED MEDICAID EVALUATION MEASURES FOR OUD CARE IN JAILS AND PRISONS

This section provides details regarding the process for selecting the proposed set of measures for OUD care in jails and prisons and upon reentry. The discussion focuses on the multiple steps used to select these measures, including specific criteria that could be applied to the universe of existing OUD community measures and OUD measures proposed by national organizations and, in some instances, used by states and local correctional organizations. This section concludes with recommendations for the reporting of measures. These measures are organized by the cascade of care approach (e.g., services provided at admission, during incarceration, during and post-reentry). In addition, there are some measures recommended for CMS to require SMAs to report and others recommended for CMS to encourage SMAs to report. Whether or not SMAs report will depend in part on the likelihood that SMAs, jails, and prisons have the infrastructure necessary to report measures initially or at a future date.

A process was developed to identify a smaller but impactful group of measures that could potentially be used for this population. For several reasons, it makes good sense to have a smaller number of OUD measures for individuals in jails and prisons or re-entering the community from these settings. First, a smaller group of measures would allow CMS and SMAs to create a streamlined dashboard to prioritize quality improvement efforts for these new initiatives focusing on this population. Second, having fewer measures would reduce the administrative burden on jails and prisons and SMAs and align with other CMS initiatives (e.g., MAC scorecard) that seek to identify priority measures and reduce reporting burden. Third, a smaller number of measures will also impact the likelihood or feasibility of jails and prisons being able to report measures.

A multi-step process was used to develop a more targeted list of measures. The first step was to develop and apply criteria for narrowing the 150 plus measures into a more manageable number. This criteria focused on:

- **Alignment with services recommended in Task 1: *Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons***. This included measures focusing on the four service domains in Task 1: 1) screening, 2) assessment, 3) MOUD, 4) counseling services (including IOP), and 5) services to support reentry.
- **Setting-specific measures**. Prioritization was given to OUD-specific measures used in the community or recommended for jails and prisons.
- **Experience with reporting measures**. For some measures, SMAs and their managed care partners have the infrastructure and experience to report OUD measures. These measures may be more likely to be easier to report.
- **Strength of measures**. The extent to which the measure properties are scientifically acceptable (e.g., measures are reliable and valid).
- **Cross system state and local agency implications**. Various measures proposed for individuals with OUD in jails and prisons will require data matching across state Department of Corrections, counties, or local municipalities that oversee jails.

The second step was to create and apply feasibility factors and the importance of each measure to develop a more manageable set of measures. The factors focused on:

- The availability of and the number of data sources for the measure. Currently, almost all processes SMAs use to report measures use a single data source (e.g., claims or encounters). SMAs have current capacity to be able to aggregate data for measurement purposes. Data from multiple sources and agencies will be complex and require sophisticated "matching" to create the measure.
- The likelihood that SMAs, jails, and prisons can report these measures or whether additional resources (which could be substantial) and time would be needed to obtain data to report the measure.
- The measure's impact on the overall goal and intent of identifying individuals with OUD. These measures should address a prevalent and "serious" condition and the burden of collecting the measure should be worth the investment.
- The measure's importance and usefulness to policymakers such as SMAs and CMS as well as other stakeholders who are advocating for OUD services to be provided in a jail or prison setting. These measures should be useful to those who will presumably use them to improve the quality of care.
- Whether the measure is foundational and impacts several other measures (e.g., low facility participation rate likely to impact all measures).

A third step added measures to address identified measure gaps. As indicated in Section 2.i, existing and proposed measures did not include various structural measures, MOUD measures, or outcome measures specific to the quality of life of Medicaid beneficiaries post-release. Therefore, additional measures that addressed these gaps were proposed for consideration. These included measures to address:

- Participation of jails and prisons in the Medicaid program
- Continuing MOUD at admission for Medicaid beneficiaries who received MOUD in the community immediately prior to incarceration
- Changes in MOUD while a Medicaid beneficiary was incarcerated
- Post-reentry measures to assess an individual's recovery across various domains

Measures that would inform an assessment of the outcomes of OUD services were reviewed with a particular focus on overdose deaths and recidivism. It was determined that overdose deaths should be reported for Medicaid beneficiaries. Reporting overdose information for non-Medicaid beneficiaries and focusing on overdose deaths for Medicaid beneficiaries versus suicides was considered. However, neither measure was included due to concerns about the reporting burden on SMAs and the ability of existing claims-based systems to accurately reflect suicide as a diagnosis, respectively.

A measure to assess reincarceration was added. Measuring recidivism is important to determine the impact of a policy change on public safety. However, measuring law enforcement contact may be difficult and be focused on communities concerned about being overpoliced.[68] Reporting this measure may be burdensome on jails and prisons who may not have the staff resources (due to current capacity or turnover) to collect and report data more frequently. For that reason, the recommendations establish semiannual reporting for most measures.

A final step in the process suggested changes in language to address several issues with applying existing community measures to the final measurement set. These issues included:

- Current measures using terms that presented definitional challenges (e.g., screening for "substance misuse" versus OUD) and others

rely on treatment constructs that were not consistent with Task 1: *Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons*. Therefore, existing measures would need to be modified to focus on OUD versus substance misuse.

- Many measures used in the community and recommended for jails and prisons are more broadly applied for services to individuals with an SUD. Changing the measure from SUD to OUD will require a change in technical specifications for existing measures.
- Measures were not exactly congruent with specific service activities for each service included in Task 1. For example, several current community and correctional-specific measures focus on MAT that evaluate whether an individual received a combination of MOUD and counseling. Task 1 breaks out MOUD and other OUD services such as counseling and IOP. Therefore, the proposed measures focused on MOUD versus MAT.

Table 11 provides 15 measures for CMS and SMAs to consider reporting. These measures are organized using the cascade of care approach that represents an individual's pathway for OUD care at admission, during their incarceration, during reentry, and finally their community tenure. Each measure identifies whether CMS should require or encourage SMAs to report.

Appendix C provides more detail regarding these measures. The description begins with information on whether "current" measures exist in the community and whether CMS requires SMAs to report these measures, are recommended by national organization or used by jail and prison systems. This is followed by a "proposed" measure which includes revisions to the current measure's language. Appendix C also makes suggestions to CMS regarding requiring or encouraging each measure. This is followed by measure specifications (e.g., number and measure specifications (numerator, denominator, and timeframe). In addition, Appendix C provides

Table 11. Recommended Medicaid Performance Measures for OUD in Jails and Prisons

Medicaid OUD Measures at Admission to a State or Local Correctional Facility	
Measure	**Required or Encouraged**
Percentage of Medicaid beneficiaries screened for OUD using a standardized screening tool during the measurement period	Required
Percentage of Medicaid beneficiaries who had a documented OUD diagnosis (e.g., on insurance claim or electronic health record) during the measurement period	Required
Percentage of Medicaid beneficiaries with OUD who initiate MOUD, by type of MOUD (methadone, buprenorphine, or naltrexone) while in a jail or prison	Required
Percentage of Medicaid beneficiaries continuing community initiated MOUD at admission	Required
Medicaid OUD Measures During Incarceration	
Measure	**Required or Encouraged**
Percentage of individuals who filled or were prescribed and dispensed an MOUD who received the MOUD for at least six months, overall, and by type of MOUD (methadone, buprenorphine, or naltrexone)	Required
Percentage of Medicaid beneficiaries who change MOUD (by type) while in jail or prison	Encouraged
Number and rate of overdose deaths for Medicaid beneficiaries during incarceration	Required

Table 11. Recommended Medicaid Performance Measures for OUD in Jails and Prisons (Cont.)

Medicaid OUD Measures During Reentry	
Measure	**Required or Encouraged**
Percentage of Medicaid beneficiaries with an OUD who were dispensed an MOUD by type of medication: (methadone, buprenorphine, naltrexone) and naloxone on the day they re-entered the community	Required
Percentage of adult individuals leaving incarceration with Medicaid coverage	Required
Medicaid OUD Measures Post-Reentry	
Measure	**Required or Encouraged**
Follow-up after release from a jail or prison: percent of Medicaid beneficiaries released from jails or prisons that result in a follow-up visit or service for OUD within seven and 30 days post-reentry	Required
Number and rate of overdose deaths for Medicaid beneficiaries one month and six months post-reentry	Required
Percentage of Medicaid beneficiaries who received an MOUD for at least 60 and 90 days and by type of MOUD (methadone, buprenorphine, or naltrexone)	Required
Percentage of Medicaid beneficiaries who return to jails and prisons post-reentry	Encouraged
Percentage of Medicaid beneficiaries reporting positive recovery-related outcomes post-reentry	Encouraged
Other Recommended Medicaid OUD Measure for Jails and Prisons	
Measure	**Required or Encouraged**
Number and percent of jails and prisons that participate as Medicaid providers in the state's Medicaid program during the 1115 demonstration period	Required

timeframes for each measure. Some timeframes align with existing measures. These proposed measurement timeframes account for lags in administrative data (discussed in 1.a.4) or more regular reporting during the initial implementation period to track critical factors such as enrollment of jails and prisons in the Medicaid program. Lastly, Appendix C presents considerations for SMAs when implementing these measures.

There are some approaches SMAs may want to consider as they collect and report information on these measures. First, it may be helpful for SMAs to stratify the measures based on critical demographics to understand disparities across populations. This stratification would include race, gender, and pregnancy status. Second it may be helpful for SMAs to report information on measures that apply to jails and prisons separately. The shorter lengths of stay and the unpredictable nature of jails should be considered when reviewing measures.

SECTION 4: STRATEGIES FOR ADDRESSING OUD MEASURES FOR STATES MEDICAID AGENCIES AND JAILS AND PRISONS

This section provides an overview of issues and opportunities for SMAs to consider when developing strategies to collect and report measures in Appendix C, including a discussion of Medicaid enrollment strategies (provider and beneficiary) and needed administrative system changes (e.g., information technology) for the SMA. This section also suggests steps SMAs can take with jails and prisons participating in the Medicaid program and how SMAs can play a critical role to provide information to jails and prisons for quality improvement. Lastly, this section presents a parallel set of issues and opportunities for jails and prisons who will need to consider changes in how they deliver, seek reimbursement, and provide information to SMAs to report these measures.

4.a. State Medicaid Agencies (SMAs)

Processes for collecting and reporting information to track performance for initiatives focused on providing OUD services to Medicaid-enrolled individuals in jails, prisons, and upon reentry, in many instances, align with existing efforts by SMAs to measure and manage OUD services in the community. As indicated above, almost 75 percent of states have received or are seeking approval for an 1115 demonstration waiver for Medicaid beneficiaries with OUD who are being served in the community. This includes reporting various structural, process, and outcome measures. However, there are many unique features of the Medicaid initiatives that focus on individuals who are incarcerated, most of which stem from the operational circumstances of prisons and jails and the limited role that Medicaid and other insurance programs have historically played in covering services there. For instance, SMAs will need to:

- Develop and implement rules, service delivery requirements, coding, documentation, and claims billing for their correctional initiatives
- Develop policies and procedures for OUD services provided in jails or prisons that strike the right balance of being simple enough to facilitate successful operations while also providing SMAs, CMS, and stakeholders with sufficient data to do oversight, quality and performance measurement, program monitoring, research and evaluation, and program integrity
- Develop a strategy to identify Medicaid-enrolled individuals in jails and prisons to track measures while incarcerated and once they re-enter the community, which may include creating identifiers that would be included as part of their eligibility systems. SMAs may use current strategies for assigning appropriate eligibility categories for individuals in jails and prisons who need inpatient care which is currently reimbursed through states' Medicaid programs.
- Consider substantial investments in infrastructure development including claims submission by jails and prisons. In its April reentry guidance, CMS recognized these needs. CMS incentivized states by providing temporary federal match to SMAs for start-up costs related to implementing these strategies. CMS recognized there are significant upfront and/or one-time non-service costs required to implement

necessary linkages to Medicaid data and enhance jails and prisons information technology and other reporting capabilities. The California reentry demonstration waiver approved by CMS includes time-limited federal financial support for developing such infrastructure and support to jails and prisons that will qualify for federal matching funds. SMAs should have processes in place to assess the infrastructure needs of jails and prisons, develop strategies to support these needs and provide assistance with implementing these systems. In addition to resources, jails and prisons developing capacity may need additional time and SMAs may need to identify alternative methods (e.g., submitting paper claims) for an initial implementation period.

- Develop strategies for integrating data from jails and prisons with their administrative data collection systems to report measures. SMAs, state and local correctional agencies will need to determine if less traditional data are a reliable source for measuring the effectiveness of their strategies to serve individuals with OUD in jails and prisons.
- Have processes for measuring early service interventions, such as the timeliness of screening efforts. This may require complex data matching between information systems across these agencies.
- Account for the rapid and high turnover rate in jails. Turnover may not lend itself well to measuring certain measures such as engagement in other services (e.g., counseling) recommended in Task 1: *Recommendations for Medicaid Coverage of Opioid Use Disorder Services in Jails and Prisons*.
- Support facilities to play appropriate roles in Medicaid eligibility, enrollment, and redetermination processes. In addition, SMAs should provide guidance to jails and prisons regarding making changes to eligibility status at admission and release. SMAs will likely develop a different Medicaid eligibility category for individuals admitted to jails and prisons. In addition, prisons and jails will need to inform the SMA on a timely basis when the individual leaves these facilities since Medicaid eligibility category for these individuals will likely change.
- Deploy strategies to mitigate issues with collecting and reporting data from jails and prisons, such as regular meetings with participating facilities during implementation to identify issues and develop strategies to address these issues. Collecting and tracking information on the percent of individuals who were enrolled in Medicaid at reentry will only be accurate if barriers to Medicaid enrollment process are identified and addressed. Jails may not have the physical space to have individuals' complete application. In addition, jails can be unpredictable and not conducive to completing Medicaid application processes.
- Provide assistance (including third parties) to jails for assisting individuals to apply for Medicaid at admission and complete a Medicaid application prior to reentry. Currently, jails may not have the staff resources to assist with the application process. In addition, jails may need to develop strategies for addressing safety issues for staff from an external organization tasked with assisting individuals with the application process.
- Develop strategies for reporting performance measures, including performance measurement dashboards to individual jails and prisons for their quality improvement efforts. Given policymakers' and other stakeholders' interest, and in some instances scrutiny, regarding OUD-specific measures in jails and prisons, it will be incumbent for facilities to have this performance information for their internal quality improvement efforts.

- Need access to other data sources such as the state agency responsible for vital statistics (e.g., departments of public health) and match Medicaid enrollment data with these vital records statistics.
- Identify a standardized tool to collect data on outcome information. As indicated above, some states that collect outcome information have used homegrown tools. There are some existing standardized tools, such as the Brief Assessment of Recovery Capital (BARC) that measure various domains (e.g., ongoing substance use, physical health, housing, and safety).[69] SMAs will also need to develop a process for collecting and reporting this information. SMAs may use existing Medicaid accountability tools, such as an External Quality Review Organization's (EQRO) Quality Assessment and Program Improvement (QAPI) plan to collect and analyze this information for individuals enrolled in Medicaid.[70]
- Develop strategies for how best to attribute performance across correctional and community providers for individuals who reenter the community from these facilities.

4.b. Jails and Prisons

Jails and prisons have little experience with providing information that will be necessary to populate measures. Operationally, the lack of EHRs, existing EHRs' technological capability to submit claims, and coding and claims submission experience among correctional health care staff all represent unprecedented challenges associated with the production of requisite data for performance measurement. Collectively, these gaps represent a significant hurdle for SMAs and CMS to measure the progress of their various correctional initiatives. Investing in infrastructure and supporting development of quality measurement and management approaches will be central to measuring OUD services in a carceral environment. Facilities, providers, and SMAs will need significant lead time before measurement is feasible.

Despite the newness of bringing Medicaid to bear in a carceral setting, there are precedents for bringing established providers into a Medicaid coverage system that can be built on. For example, there are significant lessons learned from early efforts to include SUD and OUD providers in Medicaid. Before the Affordable Care Act (ACA), almost 40 percent of all SUD providers had no experience seeking reimbursement from third-party payers.[71] These organizations relied on federal Substance Abuse and Mental Health Services Administration block grant funds, other federal discretionary funding, and state and local funds for start-up and operation. With the passage of the ACA, many individuals in states that expanded Medicaid qualified for Medicaid. Therefore, SMAs (and their MCO partners) had to develop strategies for enrolling SUD and OUD providers into their networks, providing them information on how to seek Medicaid reimbursement, and ensuring they had sufficient documentation if audited. Lessons learned from these efforts will have implications for jails and prisons participating in the Medicaid program. The unpredictable nature of jails and prisons, their physical structures that are primarily intended to restrict movement of individuals, operating procedures that prioritize security, staffing shortages, and organizational culture will also present unique challenges for jails and prisons. Therefore, these facilities will need:

- Infrastructure to be able to report information necessary to seek reimbursement, for which reporting measures is key. Specifically, jails and prisons will need the ability to provide claims and encounter information for individuals in these facilities who receive OUD or SUD services. In addition, jails and prisons will need to have consistent information regarding release dates to the state (or third-party entity) to make changes in enrollment status. Similar to

other types of facilities, SMAs will likely have different Medicaid enrollment eligibility status for individuals in jails and prisons and upon reentry. Jails may not have systems that have entry and exit data and this information may not be integrated into EHRs or proprietary correctional health provider systems.

- Resources, technical assistance, and significant implementation efforts at the state and local correctional level to amend their contracts or procure new contracts with health care vendors; procure and implement EHRs and billing modules; hire and train staff on billing; implement standardized screening, assessment, care planning, and documentation requirements.
- Funds to support their infrastructure needs. Lack of start-up funding for these newer correctional initiatives (including start up for services and administration) may discourage jail and prisons from participating in these initiatives.
- Enough facilities participating in a state's Medicaid funded correctional initiative to justify the start-up work required. Smaller facilities may have less incentive to participate in these initiatives.
- Quality improvement processes that incorporate information from the SMA regarding select measures and develop actionable strategies to maintain or improve these measures.

CONCLUSION

National, state, and local measures for assessing the effectiveness and quality of OUD treatment—including MOUD—for Medicaid beneficiaries in the community have been developed, and some are used on a widespread basis. Experience from implementing OUD measures for community programs provides valuable lessons for CMS and SMAs as they develop initiatives that expand Medicaid coverage for OUD services in jails and prisons, with an additional focus on services for beneficiaries from these facilities reentering the community. Assessing the quality of these services and understanding the infrastructure needs of jails and prisons will be critical. Without dependable administrative reporting such as claims and encounters from these facilities, SMAs cannot report critical measures that will support Medicaid-covered OUD services. CMS has provided some direction of measures for Medicaid beneficiaries in jails and prisons, but this direction has been limited to reentry efforts. CMS, other federal agencies, and states will need to assess and support these facilities to provide quality services and report crucial information to track progress beyond these reentry initiatives.

APPENDIX A:
LIST OF PERFORMANCE MEASURES BY ORGANIZATION

A.1. MODRN Measures[72]

Measure	Measure Type
Identification, Initiation, and Engagement Measures	
Initiation & engagement of alcohol and other drug dependence treatment (with sub-analysis of OUD)	Process
Identification of alcohol and other drug services (with sub-analysis of OUD)	Process
Rates of MAT among enrollees with OUD	Process
Medication, Treatment Duration, Counseling, and Monitoring	
Continuity of pharmacotherapy for OUD	Process
Urine drug screens for enrollees with pharmacotherapy for OUD	Process
Behavioral health counseling with pharmacotherapy for OUD	Process
Follow-up and General, Preventive Medical Care	
Follow-up after ED visit for alcohol and other drug abuse or dependence (with sub-analysis of OUD)	Process
Screening for HIV, HCV, HBV among enrollees with an OUD diagnosis	Process
PCP visits among enrollees with OUD diagnosis	Process
Opioid and Benzodiazepine Prescribing	
Any opioid fills among enrollees with OUD diagnosis	Process
Use of opioids at high dosages in enrollees without cancer (not limited to OUD)	Process
Multiple opioid prescribers and pharmacies in enrollees without cancer (not limited to OUD)	Structural
Any benzodiazepine fills among enrollees with OUD diagnosis	Process
Concurrent use of opioids and benzodiazepines in enrollees without cancer (not limited to OUD)	Process
Acute Care Use and Overdose Outcomes	
Inpatient hospitalizations for SUD and OUD, per 1000 member months	Outcome
ED use for SUD and OUD, per 1000 member months	Outcome
Opioid and heroin poisoning overdose events among Medicaid enrollees	Outcome
Pregnancy and OUD/Neonatal Abstinence Syndrome (NAS)	
Number of children 0-12 months diagnosed with NAS at birth & in first year per 1,000 Medicaid-covered births	Outcome
Days in NICU for children 0-12 months diagnosed with NAS at birth hospitalization	Outcome
Percentages of children diagnosed with NAS receiving >= 1 and >=6 well-child visits in first 15 months	Process

A.2. Pew Recommended Core OUD Treatment Measures[73]

Measure	Measure Type
Percent of individuals with an OUD diagnosis	Process
Percent of individuals assessed for OUD using a standardized screening tool	Process
Percent of individuals with an OUD diagnosis who received MOUD	Process
Provider availability—specifically the number of practitioners and treatment programs that provide MOUD	Structural
Continuity of MOUD—the percent of individuals receiving MOUD for at least six months	Process
Initiation of OUD treatment and engagement in OUD treatment	Process
Follow-up after ED visit for SUD	Process
One or more patient-reported outcome measures to be determined by each state	Outcome

A.3. Shatterproof Recommended Measures[74]

Measure	Measure Type
Wait time for treatment: The mean number of days between first contact or assessment and treatment.	Process
Access to treatment: When you needed treatment right away, how often did you see someone from this treatment program as soon as you wanted?	Outcome
Access to treatment: Does your program offer same day access?	Process
Does your program use a valid/reliable assessment instrument, if so, which one (e.g., ASAM, ASI, other)?	Process
During your treatment, were you given information about different kinds of counseling or treatment that are available?	Outcome
Continuous engagement: Continuity of care after residential treatment for SUD.	Process
Continuous adjustments to treatment (measurement-based care): Use of standardized tool or instrument to monitor individual's progress in achieving his or her care, treatment, or service goals. Results are used to inform goals and objectives of the plan for care as needed.	Process
Program Uses an Electronic Medical Record: Please select which of the following statements best describes your facility's highest level of Electronic Health System use (excluding billing)?	Structural
Provision of Mental Health Treatment: Does your program provide mental health treatment either onsite with mental health professionals or through an MOU with mental health professionals?	Structural
Care Coordination with Other Medical Professionals	Process
Connection to Medical Care Providers: Does your program have an MOU with primary care practice(s)?	Process
Evidence of appropriate behavioral interventions for individuals diagnosed with an SUD (e.g., cognitive behavioral therapy, motivational interviewing, family therapy)	Process
Overall rating of treatment program: Using any number from 0 to 10, where 0 is the worst treatment program possible and 10 is the best treatment program possible, what number would you use to rate this treatment program?	Outcome
Evidence of therapeutic alliance: During your treatment, how often did the treatment staff show respect for what you had to say?	Outcome
National accreditation: Is the facility nationally accredited (or, has the facility ever lost its license and/or accreditation)?	Structural
Evidence of OUD medication use among patients with OUD treated at this program	Process

A.3. Shatterproof Recommended Measures[74] (Cont.)

Measure	Measure Type
Continuity of Pharmacotherapy for Opioid Use Disorder: Percentage of adults 18-64 years of age treated at this program with pharmacotherapy for OUD who have at least 180 days of continuous treatment	Process
Availability of medications to treat SUDs	Process
Do you provide the following recovery support services (check all that apply): peer recovery support, employment support, housing assistance, legal aid, transportation assistance, childcare for clients' children, assistance with obtaining social services, domestic violence services?	Structural
Family Support: Have staff in this treatment program talked with you about including your family or friends in your counseling or treatment?	Outcome
Readmission to a higher level of care or admission (ED, hospital admissions, detoxification, residential treatment) to a hospital or community tenure	Outcome
Amount helped by treatment: How much have you been helped by the treatment you got here?	Outcome
Improvement in ability to function: Compared to when you entered this treatment program, how would you rate your ability to deal with daily problems now?	Outcome
Patient Narrative Treatment Experience: Please think about some treatment experiences at this program. What is the program doing right? What could be done to improve this program?	Outcome

A.4. ASAM Proposed SUD and OUD Measures[75]

Measure	Measure Type
Percent of patients prescribed a medication for alcohol use disorder (AUD)	Process
7-day follow-up after withdrawal management	Process
Percent of patients prescribed a medication for OUD	Process
Presence of screening for psychiatric disorder	Process
Presence of screening for tobacco use disorder	Process
Primary care visit follow-up	Process
All cause inpatient, residential re-admission	Outcome

A.5. Pharmacy Quality Alliance OUD Measures[76]

Measure	Measure Type
Use of opioids at a high dosage in persons without cancer	Process
Use of opioids from multiple providers in persons without cancer	Process
Use of opioids at high dosage and from multiple providers in persons without cancer	Process
Concurrent use of opioids and benzodiazepines	Process

A.6. Urban Institute Measure[77]

Measure	Measure Type
Assess and Manage Medicaid Status on Entry to Jail or Prison	
Number and percentage of individuals admitted to jail who matched to Medicaid database	Process
Number and percentage of people with Medicaid and other insurance coverage	Process
Number and percentage of people with Medicaid placed in suspension status within X days of admission	Process
Average number of days from admission to Medicaid suspension	Process
Number and percentage of people whose Medicaid was terminated within X days of admission	Process
Average number of days from admission to Medicaid termination	Process
Enroll Soon-to-Be Released Individuals into Medicaid	
Number and percentage of people whose Medicaid was reactivated after suspension	Process
Average number of days between reinstatement and release	Process
Number and percentage of people who met with outreach staff before release	Process
Average number of days between outreach and expected release date	Process
Average number of days between outreach and actual release date	Process
Staff time spent on Medicaid outreach (hours or equivalent number of full-time employees)	Process
Number and percentage of Medicaid applications submitted	Process
Number and percentage of people for whom a Medicaid application was submitted	Process
Average number of days between application submission and expected release date	Process
Average number of days between application submission and actual release date	Process
Client satisfaction with application process (average rating or percentage that rated service above or below a predetermined threshold)	Outcome
Quality of enrollment sessions (average rating or percentage that rated service above or below a predetermined threshold)	Outcome
Number and percentage of applications approved	Process
Number and percentage of people for whom a Medicaid application was approved	Process
Number and percentage of people with active Medicaid status within X days of release	Process
Number and percentage of applications denied, by denial reason	Process
Average number of days between application submission and enrollment	Process
Average number of days between enrollment and release	Process
Number and percentage of people who chose a primary care physician within X days of enrollment	Process
Number and percentage of people who completed MCO selection within X days of enrollment	Process

A.6. Urban Institute Measure[77]

Measure	Measure Type
Provide Corrections-to-Community Transitional Services upon Release	
Number and percentage of people who met with community provider staff before release	Process
Number and percentage of people for whom an appointment was made with a community provider	Process
Number and percentage of people who kept their appointment with a community provider	Process
Amount of staff time spent on discharge planning (e.g., equivalent number of full-time employees)	Structural
Number and percentage of people who received a prescription at release	Process
Number and percentage of people who received a supply of medication at release	Process
Number and percentage of people for whom a medical record or care summary was transmitted to a community provider within X months of release	Process
Provide Health Services in the Community	
Number and percentage of people who visited a community care provider within x days of release	Process
Average number of days from release to first receipt of non-emergency care in the community	Process
Number and percentage of people who visited an emergency room or were hospitalized within X months or release	Process
Average number of days from release to first emergency room visit or hospitalization	Process
Number and percentage of people reporting excellent, very good, good, fair or poor health when asked to describe their overall health	Outcome
Average self-reported rating of health	Outcome
Number and percentage of people who had two or more visits with the same non-emergency provider within X months of release	Process
Reduce Subsequent Criminal Justice Involvement	
Number and percentage of people arrested within X months of release	Outcome
Number and percentage of people admitted to a jail or prison within X months of release	Outcome
Average number of days from release to rearrest	Outcome
Average number of days from release to reincarceration	Outcome
Provide Community-to-Corrections Care Continuity upon Reincarceration	
Number and percentage of people who received an intake health assessment within X days of admission	Process
Average number of days from admission to assessment	Process
Number and percentage of people who received health services within X days of admission (e.g., medical care, mental health care, substance use treatment services)	Process
Average number of days from admission to first receipt of health services	Process

APPENDIX B:
SUMMARY OF SELECTED STATE AND LOCAL SUD CORRECTIONAL MEASUREMENT EFFORTS

California

The State of California Correctional Health Care Services (CCHCS) operates the Integrated Substance Use Disorder Treatment (ISUDT) for individuals with a substance use disorder (SUD) in the state prison system in California. ISUDT treats individuals with SUD, including opioid use disorder (OUD). ISUDT aims to reduce SUD-related morbidity and mortality and recidivism.[78] ISUDT focuses on several areas for individuals who are incarcerated, including:

- Identifying, screening, and assessing possible participants
- Placing participants into appropriate Cognitive Behavioral Interventions (CBI)
- Prescribing MAT when appropriate
- Creating supportive housing for recovery-focused living while incarcerated
- Providing robust transition planning for people preparing to leave prison
- Forming community partnerships to assist participants after prison
- Monitoring and supporting participants through their release

CCHCS has developed a dashboard for the ISUDT program that provides statewide and correctional facility-specific data on screening, assessment, and the receipt of MAT. In addition, CCHCS tracks information on enhanced pre-release services – specifically the receipt of naloxone at release. The dashboard provides monthly information on individuals in prison. Table B.1 provides the measures from a recent month's dashboard.[79]

Table B.1: California's Integrated Substance Use Disorder Treatment Dashboard

Measure	Measure Type
Percent of individuals who were screened for a SUD (at admission and while in prison)	Process
Percent of individuals assessed for SUD treatment needs based on this screen	Process
Number of individuals evaluated for MAT	Process
Number of individuals who receive MAT	Process
Timeliness of MAT	Process
Percentage of individuals who receive naloxone upon release	Process

In addition, the dashboard provides monthly counts of individuals who overdose while in prison. Specifically, the dashboard provides important information on the monthly trends of individuals who are transferred to an ED or have an inpatient hospital stay due to an overdose.

Kentucky

Since March 2016, the Kentucky Department of Corrections (KYDOC) has operated the Substance Abuse Program (SAP) for individuals with an OUD. SAP provided Vivitrol to individuals in 14 state prisons and 19 jails. In 2019, KYDOC expanded the SAP program to offer medications for addiction treatment. This new program, Supportive Assistance with Medication for Addiction Treatment (SAMAT), provides MOUD and psychosocial therapies for individuals in these correctional settings.[80] In addition, SAMAT provides recovery management and case management to ensure continuity of care after release from a correctional facility. The SAMAT program aims to "increase and improve addiction treatment services, increase treatment participation, reduce recidivism related to substance use relapse, and decrease drug overdose morbidity and mortality." Before 2019, individuals were only offered one form of MOUD, long-acting injectable naltrexone. In 2019, several prisons participating in SAMAT offered individuals the choice between long-acting injectable naltrexone and buprenorphine.

Information from the SAMAT is limited. The most recent information is from December 31, 2021, when the KYDOC conducted a small study of 28 individuals from the three prisons participating in SAMAT (facilities offering a choice of long-acting injectable naltrexone or buprenorphine).[81] The study provided information on the number of individuals who reported having participated in any type of MOUD before being admitted to a correctional facility and the number and presence of individuals who received MAT and other OUD services while in prison. Measures used in this study are provided in Table B.2.

Table B.2: Kentucky's SAMAT Information on MOUD

Measure	Measure Type
Number of individuals receiving MAT 12 months prior to admission to a prison	Process
Number of individuals who initiated long acting injectable naltrexone or buprenorphine while in prison	Process
Number of individuals who did not initiate agonist treatment	Process
Opted for long acting injectable naltrexone	Process
Signed abstinence agreement	Process
Deferred for 12 months (no longer eligible)	Process

In addition to these efforts, the Criminal Justice Kentucky Treatment Outcome Study (CJKTOS) has developed outcomes for individuals who were participating in SUD treatment programs in Kentucky's prisons, jails, and community custody settings.[82] CJKTOS information is collected annually and focuses on tracking outcomes for individuals 12 months after they re-enter the community from a jail or prison. Outcomes are tracked using the measures in Table B.3.

Table B.3: CJKTOS Post-release Measures

Measure	Measure Type
Percent of individuals living in stable housing	Outcome
Percent of individuals referred to aftercare and attended aftercare	Process
Percent of individuals who have not been incarcerated	Outcome
Percent of individuals employed	Outcome
Percent of individuals who did not have a positive drug test	Outcome
Percent of individuals reporting abstinence	Outcome
Percent of individuals who received MAT	Process
Percent of individuals who were re-incarcerated	Outcome
Percent of individuals who considered treatment to be successful	Outcome
Percent of individuals who feel better about themselves	Outcome

Maine

The Maine Department of Corrections (MDOC) provides access to SUD treatment services to all individuals in state prisons meeting diagnostic and clinical criteria regardless of release date. Eligibility for enrollment in SUD treatment programs and selection of MOUD are based upon a shared decision-making model that incorporates past medical history, treatment and substance use history, clinical presentation, and resident treatment goals. OUD medications include buprenorphine-naloxone and naltrexone/injectable naltrexone.[83] However, MDOC admitted 13 residents who were receiving methadone at the time of intake, and each of those residents received ongoing treatment with this medication. In addition, a collaborative effort between MDOC and Maine Department of Health and Human Services ensures individuals have Medicaid (if eligible) in place upon release. Coverage upon release ensures discharged residents receive continuity of care for SUD and other Medicaid covered health and behavioral health services. Table B.4 provides information regarding the measures MDOC tracks for this initiative.

Table B.4: MDOC Measures

Measure	Measure Type
The number and percent of individuals released who have Medicaid in place at the time of their release	Process
The number of individuals with a SUD who participate in the SUD treatment	Process
The number and percent of individuals initiating SUD treatment while in a prison	Process
The number and percent of the total MDOC population had a SUD diagnosis	Process
The number and percent of the total MDOC population had a SUD diagnosis who receive SUD treatment	Process
The number and percent of overdoses for individuals who re-enter the community from a jail	Outcome
Number and percent of individuals continuing SUD care post-release	Process
Number and percent of individuals who received SUD treatment in prisons, were released, and return to custody within one year of release	Outcome
Number and percent of individuals with an SUD who received harm reduction resources	Process

Rhode Island

The Rhode Island Department of Corrections (RIDOC) developed a MOUD program for individuals in correctional settings. Rhode Island has a unified system where there is an integrated state-level prison and jail system. The RIDOC program provides screening for OUD, MOUD treatment, and discharge planning with linkage to care after release for all individuals in Rhode Island's correctional facilities.[84] The RIDOC uses several measures, outlined in Table B.5, to gauge the effectiveness of this effort.

Table B.5: RIDOC Measures

Measure	Measure Type
The number and percent of individuals who are screened for OUD	Process
The number and percent of individuals who receive MOUD while incarcerated (including specific information regarding the type of medications)	Process
The number and percent of individuals who continue to receive MOUD post-incarceration	Process
The length of time someone initiated MOUD in the community post-release	Process

Pennsylvania

The Pennsylvania Institutional Law Project recently released a report, funded by Vital Strategies and Independence Foundation, which examines the availability and accessibility of MOUD for incarcerated people in county jails in Pennsylvania.[85] The researchers obtained information on access to MOUD in jails from 62 jails throughout the state. Each jail was reviewed based on various relevant measures, including:

- Whether the jail offered MOUD
- Types of MOUD available in each jail
- Whether individuals who were receiving MOUD at admission continued MOUD once incarcerated
- Whether individuals who were not receiving MOUD were offered and were receiving MOUD
- Identifying whether certain individuals (e.g., pregnant people) were offered MOUD safely

Philadelphia Department of Prisons

The Philadelphia Department of Prisons (PDP) has an average census of 4,200 or more individuals.[86] PDP has offered methadone maintenance or abstinence programs for over 20 years. In 2017, this program was expanded to also offer Suboxone and long-acting injectable naltrexone, both with optional cognitive behavioral treatment (CBT). Individuals in PDP are referred to these programs generally within four hours of arrival at PDP. Upon release, individuals return to their community providers for care, and those receiving MOUD initiated by PDP receive Medicaid coverage, a warm hand-off to an MOUD prescriber in the community, and a short-term supply of medication to "bridge" the gap between release and the first appointment with a new health care provider. Information was provided by PDP regarding the measures (Table B.6) that PDP collects and reports to prisons in Philadelphia on a regular basis (in some instances daily).

Table B.6: Philadelphia Department of Prisons Measures

Measure	Measure Type
Intakes completed (including an SUD screen) and completed on-time (within four hours)	Process
The number and percent of emergent, urgent, and routine referrals for behavioral health treatment (including SUD)	Process
The number and percent of emergent, urgent, and routine referrals for behavioral health treatment (including SUD) within specific timeframes	Process
The number of behavioral health screening (assessments) scheduled and completed before discharge date	Process
The number of individuals offered a SUD group session and the number and percent of sessions that occurred	Process
The number of individuals who attended a SUD group session	Outcome
The number of individuals with an initial MAT appointment scheduled and seen on time	Process
The number of individuals with a follow up MAT appointment scheduled and seen on time	Outcome
The number of individuals with an initial MAT appointment scheduled and discharged before appointment date	Process
The number of ED visits and ED visits/1000	Process
The number of individuals admitted (all cause) to an inpatient unit inpatient admission/1000	Process

Vermont

The Vermont state legislature passed "The War on Recidivism Act" (Act 41) to curtail the growth of the state's correctional population and reduce recidivism.[87] Similar to Rhode Island, Vermont has a unified jail and prison system. Act 41 authorized the Vermont Department of Corrections (DOC) to conduct a study regarding who could best provide quality health services to individuals in state prisons for less cost. The recommendations from this study were included in a subsequent Request for Proposal (RFP) to provide health services to individuals in state prisons.[88] Table B.7 below provides information on relevant OUD measures from the RFP.

Table B.6: Vermont DOC OUD Measures

Measure	Measure Type
Number of individuals admitted to prison whose medication list was received within four hours of admission	Process
Number of individuals in prison whose records were shared electronically with a Primary Care Medical Home (PCMH) upon discharge	Process
Number of individuals discharged from prison who were referred to PCMH, Federally Qualified Health Center, or community-based SUD treatment organization upon reentry	Process
Number of individuals enrolled into Medicaid or an exchange-purchased policy upon discharge from correctional facilities	Process
Total number of initial health assessments completed within seven days of admission, or reviews if released and readmitted within 90 days	Process
Number of individuals who received a follow-up visit after an admission to an inpatient hospital provider	Process
Number of individuals who received Screening, Brief Intervention and Referral to Treatment, group, or individual SUD treatment	Process
Number of individuals who received a random drug screening	Process
Number of individuals with prescriptions who re-entered the community with insurance coverage (Medicaid or other) and who received prescription(s) for all necessary medications to be filled at a pharmacy of their choosing	Process

Massachusetts

In 2015, the Middlesex Sherriff's Office (MSO) launched the Medication Assisted Treatment and Directed Opioid Recovery (MATADOR) program. This voluntary program helps individuals with an OUD in jails to avoid relapse and potentially future involvement with law enforcement. Since 2019, the MATADOR program offers all three forms of MOUD prior to release and post-release recovery support navigation from MSO staff. MATADOR also collects data to inform program performance.[89] Measures used by MSO for the MATADOR program are included in Table B.8.

Table B.6: MATADOR OUD Measures

Measure	Measure Type
The number and percent of individuals enrolled in the MATADOR program	Process
The number and percent of individuals who were enrolled and successfully completed the MATADOR program	Process
The number and percent of individuals with an SUD referred to withdrawal management at intake	Process
The number and percent of individuals with an OUD at intake	Process
The number and percent of individuals enrolled in Medicaid at release	Process
The number and percent of individuals who are reconvicted, re-incarcerated, and/or a violate probation	Outcome

The Sheriff's Department in Essex County provides OUD treatment including availability of all three forms of MOUD. Their initiative includes three key components: allowing individuals to maintain their MOUD regimens while incarcerated, connecting individuals to MOUD at pre-release and during reentry, and a new treatment center in its jail to provide easier access to MOUD. Specific performance measures were not reported for Essex County.

Since 2016, the Franklin County Jail in Greenfield, Massachusetts, has offered MOUD to individuals in their facility. Initially, the jail offered buprenorphine to individuals identified as having an OUD. The jail does not provide methadone since it is not an OTP and does not contract with an OTP. Efforts to measure the effectiveness of Franklin County's MOUD efforts have primarily focused on measuring recidivism, specifically:

- The number and percent of individuals who were re-arraigned post-release
- The number of individuals who were re-incarcerated
- The number of individuals who died (all cause)

Michigan

Michigan's Wayne State University Center for Behavioral Health and Justice (CBHJ) has assisted six Michigan jails to implement OUD services, including MOUD in their facilities. CBHJ has identified and tracked the following outcomes:

- Percent of individuals who were screened for OUD upon admission to a jail
- Percent of individuals who screened positive for an OUD
- Percent of individuals with an OUD who received MOUD

Additionally, CBHJ provides information regarding demographics, including race, when analyzing these outcomes.

APPENDIX C:
MEDICAID MONITORING AND EVALUATION MEASURES FOR OUD CARE IN PRISONS AND JAILS

Medicaid OUD Measures at Admission

Measure C.1 Individuals Screened for an OUD

Current Measure Description	Percentage of individuals who were screened/assessed for SUD treatment needs using a standardized screening tool during the measurement period
Proposed Measure Description	Percentage of Medicaid beneficiaries screened for OUD using a standardized screening tool during the measurement period
Measure Type	Process
Area of Focus	Services: Screening
Applicability	Jails and prisons
ID and Name	None
Required or Encouraged	Required
Organization Recommending/ Using Measure	CMS 1115 SUD Waiver The Pew Charitable Trusts
Denominator	Number of Medicaid beneficiaries provided a screening an intake
Numerator	Number of Medicaid beneficiaries who were screened for OUD treatment needs using a standardized screening tool during the measurement period
Measurement Period	Every six months
Data Sources	Claims, encounter information, EHR or jail/prison administrative data
Considerations	States will need to determine if they will establish a separate service code for screening or have alternative ways for jails and prisons to report screening (e.g., EHRs)
Feasibility and Purposefulness	• Detailed specifications exist but measures are not CBE endorsed • Currently reported by SMAs under SUD 1115 Waivers • Critical to identify individuals who will need OUD services • Most prisons and jails have this information. As of 2019, sixty-three percent of jails screen for OUD at intake. • Can be used by policymakers (e.g., SMAs) to determine the number of Medicaid beneficiaries with OUD who will need follow-up services • Measure is likely to be reported by states re: progress toward initiative and potential resources needed for services • May not be critical to stakeholders who may want to know more about available services versus screenings in a jail or prison • Measure is foundational and impacts many other measures. If the number and percent of screenings performed are low, SMAs and facilities will not be able to determine the need for OUD services.

Measure C.2: Individuals with an OUD diagnosis

Current Measure Description	Percentage of individuals who had documented SUD diagnosis and an SUD related service during the measurement period
Proposed Measure Description	Percentage of Medicaid beneficiaries who had a documented OUD diagnosis (e.g., on insurance claim or EHR) during the measurement period
Measure Type	Process
Area of Focus	Services: Assessment
Applicability	Jails and prisons
ID and Name	None
Required or Encouraged	Required
Organization Recommending/ Using Measure	CMS 1115 SUD Waiver The Pew Charitable Trust
Denominator	Number of Medicaid beneficiaries in the population during the measurement period
Numerator	Number of Medicaid beneficiaries with an OUD diagnosis on a claim
Measurement Period	Every six months
Data Sources	Claims, encounter information, EHR or jail/prison administrative data
Considerations	No additional considerations
Feasibility and Purposefulness	• Specifications for measures exist but are not CBE-endorsed • Currently reported by state SMAs • Critical to identify Medicaid beneficiaries who will need OUD services and likely to be a requirement for medical necessity for OUD services • Will be more challenging for jails and prisons to provide information that do not have claims systems or EHRs • Can be used by policymakers to determine the number of individuals with OUD who may need services • Measure is likely to be reported by states to assess progress towards the goals of the initiative and potential resources needed for services • May not be critical to stakeholders who may want to know more about available services versus a diagnostic assessment in a jail or prison • Measure is foundational and impacts many other measures. If the number and percent of individuals with OUD are not available, SMAs and correctional facilities will not be able to measure the need for OUD services.

Measure C.3 Initiation of MOUD

Current Measure Description	Percentage of individuals who initiate MAT or retained on MAT while in custody[96]
Proposed Measure Description	Percentage of Medicaid beneficiaries with OUD who initiate MOUD, by type of MOUD (methadone, buprenorphine, or naltrexone) while in a jail or prison
Measure Type	Process
Area of Focus	Services: MOUD
Applicability	Jails and prisons
ID and Name	None
Required or Encouraged	Required
Organization Recommending/ Using Measure	ONDCP
Denominator	The number of Medicaid beneficiaries with OUD in a jail or prison during the measurement period
Numerator	The number of Medicaid beneficiaries with OUD who initiate MOUD and by type of MOUD (methadone, buprenorphine, naltrexone) while in jail or prison during the measurement period
Measurement Period	At admission and every six months
Data Sources	Claims, encounter information, or EHR
Considerations	SMAs may want to track and report separately individuals who initiated MOUD immediately after intake and individuals who initiated MOUD during their jail or prison stay.
Feasibility and Purposefulness	• Specifications do not exist and would need to be developed • May require that jails and prisons confirm the individual has not been prescribed MOUD (e.g., review PDMP) • Is not currently reported by state SMAs but is in use by some states Department of Corrections and local jails and sheriff organizations • Some jails are able to report the number and percent of individuals with an OUD who initiated MOUD • May be more challenging for jails/prisons to provide this information if they do not have claims systems or EHRs • Critical to determine the number of individuals receiving MOUD initially • An important measure for policymakers to identify access issues to MOUD • Would be critical to stakeholders who would seek MOUD services or want to know if individuals were initially getting MOUD • Measure impacts several other measures (e.g., continuity of MOUD and overdose risk)

Measure C.4: Percent of Individuals who Continue MOUD At Admission

Current Measure Description	New measure
Proposed Measure Description	Percentage of Medicaid beneficiaries continuing community initiated MOUD at admission
Measure Type	Process
Area of Focus	Services: MOUD
Applicability	Jails and prisons
ID and Name	None
Required or Encouraged	Required
Organization Recommending/ Using Measure	ONDCP
Denominator	Number of individuals who received MOUD and by MOUD type (methadone, buprenorphine, naltrexone) within 30 days prior to intake during the measurement period
Numerator	The number of Medicaid beneficiaries with OUD who continue MOUD and by type of MOUD (methadone, buprenorphine, naltrexone) while in jail or prison during the measurement period
Measurement Period	Every six months
Data Sources	Claims, encounters and EHRs, state's PDMPs, and/or information collected from community prescribers
Considerations	Certain medications are not available in PDMPs (e.g., methadone).
Feasibility and Purposefulness	• Measure specifications do not exist • There are data sources for this measure including claims and information from PDMPs • PDMP information does not include methadone • Not currently in use by SMAs • Would require jails and prisons to collect this information at screening, confirm current prescription (e.g., reviewing PDMP or contacting the community prescriber) and enter this information in EHRs • An important measure for policymakers to identify access issues to MOUD initially • Would be critical to stakeholders who would want to know if individuals were continuing on MOUD by type of MOUD at admission

Medicaid OUD Measures During Incarceration

Measure C.5: Continuity of MOUD in Prisons

Current Measure Description	Percentage of individuals who were filled a prescription or were dispensed an MOUD who received the MOUD during the measure year, overall, and by type of MOUD (methadone, buprenorphine, or naltrexone)[97]
Proposed Measure Description	Percentage of individuals who filled or were prescribed and dispensed an MOUD who received the MOUD for at least six months, overall, and by type of MOUD (methadone, buprenorphine, or naltrexone)
Measure Type	Process
Area of Focus	Services: MOUD
Applicability	Prisons
ID and Name	NQF 3175
Required or Encouraged	Required
Organization Recommending/ Using Measure	CMS Core Measure The Pew Charitable Trust
Denominator	Number of Medicaid beneficiaries who had a diagnosis of OUD and at least one claim for an OUD medication
Numerator	Number of Medicaid beneficiaries in the denominator who had at least 180 days of continuous pharmacotherapy with a medication prescribed for MOUD without a gap of more than seven days
Measurement Period	Every six months
Data Sources	Claims, encounter information, or EHR
Considerations	No additional considerations
Feasibility and Purposefulness	• Specifications for measures exist and is CBE endorsed • Reported by SMAs • Not recommended for jails given the length of time the measure covers and the rapid discharges from jails. Individuals are released from jails and continue or discontinue MOUD will be included in Measure #6 • Critical to determine the number of individuals who continue to receive MOUD post-release in addition to individuals who no longer receive MOUD. If the number of individuals who stopped MOUD is significant, SMAs, jails and prisons will want to collect more information on why individuals are no longer receiving MOUD • Important for policymakers to identify impact on other reentry measures such as overdose • May be critical to stakeholders • Measure impacts many other several other measures (e.g., lower likelihood of overdose)

Measure C.6: Percent of Individuals Who Have a Change in Medications During Incarceration

Current Measure Description	New measure
Proposed Measure Description	Percentage of Medicaid beneficiaries who change MOUD (by type) while in jail or prison
Measure Type	Process
Area of Focus	Services: MOUD
Applicability	Jails and prisons
ID and Name	None
Required or Encouraged	Encouraged
Organization Recommending/ Using Measure	None
Denominator	Number of Medicaid beneficiaries who receive MOUD in a jail or prison
Numerator	Number of Medicaid beneficiaries who had a change in MOUD in a jail or prison
Measurement Period	Every six months
Data Sources	No additional considerations
Considerations	Medicaid clams, encounters, or information from EHRs
Feasibility and Purposefulness	• Measure specifications do not exist • There are data sources for this measure • Not currently in use by SMAs • Would require jails and prisons to submit claims or document change in MOUD in EHRs • An important measure for policymakers to identify concerning correctional staff influencing medication choice, availability of certain medications (e.g., methadone) or MOUD changes to address diversion • Would be critical to stakeholders who would want to know if individuals were reentering jails and prisons post-reentry

Measure C.7: Number and rate of overdose deaths for Medicaid beneficiaries while incarcerated

Current Measure Description	Number and rate of overdose deaths for Medicaid beneficiaries during the measurement period[98]
Proposed Measure Description	Number and rate of overdose deaths for Medicaid beneficiaries during incarceration
Measure Type	Outcome
Area of Focus	Other area
Applicability	Jails, prisons, and reentry
ID and Name	None
Required or Encouraged	Required
Organization Recommending/ Using Measure	CMS 1115 SUD Waiver
Denominator	Number of Medicaid beneficiaries in the designated population (e.g., jails, prisons, or reentered the community during the measurement period)
Numerator	Number of overdose deaths among Medicaid beneficiaries in either prison or post-reentry population
Measurement Period	Every six months
Data Sources	State Medicaid beneficiary enrollment data, vital statistics data, and jail and prisons administrative data.
Considerations	SMAs should consider breaking this by two cohorts: individuals who overdose while in jails and prisons and individuals who overdose at 30 days post-reentry.
Feasibility and Purposefulness	• Measure specifications do exist but are not CBE endorsed • Multiple data sources would be required to calculate this measure • Measure would identify sentinel outcome for individuals with an OUD released from jails or prisons • Measure would be very important for policy makers to determine if providing MOUD and other OUD services is having the desired outcome of fewer overdose deaths • Measure is important for stakeholders to determine if providing MOUD and other OUD services is having the desired outcome of fewer overdose deaths • This is a seminal outcome measure

Medicaid OUD Measures During Reentry

Measure C.8: MOUD Provided at Reentry

Current Measure Description	Percentage of individuals who were filled a prescription at reentry or were dispensed an MOUD after reentry and who received the MOUD for at least six months, overall, and by type of MOUD (methadone, buprenorphine, naltrexone)[99]
Proposed Measure Description	Percentage of Medicaid beneficiaries with an OUD who were dispensed an MOUD (by type of medication: (methadone, buprenorphine, naltrexone) and naloxone on the day they re-entered the community
Measure Type	Process
Area of Focus	Services: MOUD
Applicability	Reentry
ID and Name	None
Required or Encouraged	Required
Organization Recommending/ Using Measure	National Council on Mental Wellbeing Urban Institute
Denominator	Number of Medicaid beneficiaries who had a diagnosis of OUD and re-entered the community
Numerator	Number of Medicaid beneficiaries in the denominator who had MOUD by type of medication) on the day of reentry
Measurement Period	Every six months
Data Sources	Claims, encounter information, or EHR
Considerations	There are certain medications where claims may not provide sufficient information including vivitrol and dispensing of methadone for OUD care.
Feasibility and Purposefulness	• Specifications for measures do not exist • Data would be available to SMAs to report measures (claims and eligibility information) • Consistent with CMS's expectations regarding MOUD provided on day of discharge • Critical to determine the number of individuals who receive MOUD at release • Important for policymakers to identify impact on other reentry measures such as overdose • May be critical to stakeholders • Measure impacts many other several other measures (e.g., lower likelihood of overdose)

Measure C.9: Medicaid Enrollment at Reentry

Current Measure Description	Percentage of adult individuals leaving incarceration with Medicaid coverage[100]
Proposed Measure Description	Percentage of adult individuals leaving incarceration with Medicaid coverage
Measure Type	Process
Area of Focus	Other area
Applicability	Jails, prisons, and reentry
ID and Name	None
Required or Encouraged	Required
Organization Recommending/ Using Measure	NQF Urban Institute, Justice Policy Center
Denominator	Number of individuals with OUD re-entering the community from the facility
Numerator	Number of individuals with an OUD enrolled in Medicaid have Medicaid reinstated
Measurement Period	Every six months
Data Sources	State Medicaid beneficiary enrollment data and jail and prisons administrative data
Considerations	SMAs may want to track ongoing enrollment in Medicaid and timely enrollment in managed care delivery systems if part of the program's design.
Feasibility and Purposefulness	• Measure specifications do not exist • There are data sources for this measure • Not currently in use by SMAs • Measure would be important for policy makers to determine if jails and prisons are actively enrolling individuals into the Medicaid program • Measure would not include individuals who were potentially eligible for Medicaid but not enrolled • Measure may be important for stakeholders to monitor if jails and prisons were enrolling individuals into the Medicaid program • Measure has impact on most measures given information from Medicaid claims or encounters will be needed to calculate the measure

Medicaid OUD Measures Post-Reentry

Measure C.10: Follow-up Post-Release

Current Measure Description	Follow-Up after High-Intensity Care for SUD (FUI): Percent of acute inpatient hospitalizations, residential treatment, or detoxification visits for a diagnosis of SUD that result in a follow-up visit or service for SUD: percent with follow-up for SUD within seven and 30 days after discharge[101]
Proposed Measure Description	Follow-up after release from a jail or prison: percent of Medicaid beneficiaries released from jails or prisons that result in a follow-up visit or service for OUD within seven and 30 days post-reentry
Measure Type	Process
Area of Focus	Other area
Applicability	Jails and prisons
ID and Name	NCQA
Required or Encouraged	Required
Organization Recommending/ Using Measure	CMS 1115 SUD Waiver
Denominator #1	Number of Medicaid beneficiaries with an OUD and released from a jail or prison during the measurement period
Numerator #1	Number of Medicaid beneficiaries with an OUD and receive a follow-up visit with any practitioner (including all behavioral health services) within seven days of release from a correctional facility during the measurement period
Denominator #2	Number of Medicaid beneficiaries with an OUD and released from a jail or prison during the measurement period
Numerator #2	Number of Medicaid beneficiaries with an OUD and receive a follow-up visit with any practitioner (including all behavioral health services) within 30 days of release from a correctional facility during the measurement period
Measurement Period	Every six months
Data Sources	Claims, encounter information, or EHR and jail and prison administrative information re: discharges
Considerations	No additional considerations
Feasibility and Purposefulness	• Measure specifications exist, are not CBE endorsed, and would require modification • Existing measure is reported by SMAs who have SUD 1115 Waivers • Prisons may need to provide data for this measure • Current measure reported by SMAs • Measure would confirm follow up services are occurring after release • Measure would be important for policy makers to understand if (and any barriers) individuals are receiving services after reentry • Measure may not be as important for stakeholders • Measure impacts other measures (e.g., a follow-up visit is protective against overdose)[102] • Measure will need to account for some MOUDs (e.g., Vivitrol and Sublocade) that are provided in jails and prisons at release which may not require an appointment for MOUD within seven days

Measure C.11: Number and rate of overdose deaths for Medicaid beneficiaries post-release

Current Measure Description	Number and rate of overdose deaths for Medicaid beneficiaries during the measurement period[103]
Proposed Measure Description	Number and rate of overdose deaths for Medicaid beneficiaries one month and six months post-reentry
Measure Type	Outcome
Area of Focus	Other area
Applicability	Jails, prisons, and reentry
ID and Name	None
Required or Encouraged	Required
Organization Recommending/ Using Measure	CMS 1115 SUD Waiver
Denominator	Number of Medicaid beneficiaries in the designated population (e.g., jails, prisons, or reentered the community during the measurement period)
Numerator	Number of overdose deaths among Medicaid beneficiaries in either prison or post-reentry population
Measurement Period	Every six months
Data Sources	State Medicaid beneficiary enrollment data, vital statistics data, and jail and prisons administrative data
Considerations	SMAs should consider breaking this by two cohorts: individuals who overdose while in jails and prisons and individuals who overdose at 30 days post-reentry
Feasibility and Purposefulness	• Measure specifications do exist but are not CBE endorsed • Multiple data sources would be required to calculate this measure • Measure would identify sentinel outcome for individuals with an OUD released from jails or prisons • Measure would be very important for policy makers to determine if providing MOUD and other OUD services is having the desired outcome of fewer overdose deaths • Measure is important for stakeholders to determine if providing MOUD and other OUD services is having the desired outcome of fewer overdose deaths • This is a seminal outcome measure

Measure C.12: Continuity of MOUD Post-Reentry

Current Measure Description	Percentage of individuals who were filled a prescription at reentry or were dispensed an MOUD after reentry and who received the MOUD for at least six months, overall, and by type of MOUD (methadone, buprenorphine, naltrexone)[104]
Proposed Measure Description	Percentage of Medicaid beneficiaries who received an MOUD for at least 60 and 90 days and by type of MOUD (methadone, buprenorphine, or naltrexone)
Measure Type	Process
Area of Focus	Services: MOUD
Applicability	Reentry
ID and Name	NQF 3175
Required or Encouraged	Required
Organization Recommending/ Using Measure	CMS Core Measure The Pew Charitable Trust
Denominator	Number of Medicaid beneficiaries in the denominator who had MOUD by type of medication) on the day before reentry
Numerator	Number of Medicaid beneficiaries in the denominator who received 60 and 90 days of pharmacotherapy post-reentry.
Measurement Period	First and second month post-reentry and every six months post-reentry into the community
Data Sources	Claims, encounter information, or EHR
Considerations	No additional considerations
Feasibility and Purposefulness	• Specifications for measures exist and is CBE endorsed • Reported by SMAs • SMAs will have eligibility and claims information to report measure • Jails and prisons will be required to provide information to change Medicaid eligibility on a timely basis. Critical to determine the number of individuals who continue to receive MOUD post-release initially and ongoing and to identify MOUD access issues in the community. • Important for policymakers to identify impact on other reentry measures such as overdose • May be critical to stakeholders to have information regarding continuity of MOUD post-release • Measure impacts many other several other measures (e.g., lower likelihood of overdose) • Measure will also allow SMA to identify gaps in access to MOUD prescribers in the community

Measure C.13: Percentage of Individuals who are Reincarcerated

Current Measure Description	Number and percentage of people admitted to jail or prison within X months of release[105]
Proposed Measure Description	Percentage of Medicaid beneficiaries who return to jails and prisons post-reentry
Measure Type	Process
Area of Focus	Other area
Applicability	Jails and prisons
ID and Name	None
Required or Encouraged	Encouraged
Organization Recommending/ Using Measure	ONDCP
Denominator #1	Number of Medicaid beneficiaries with OUD who were released from a jail or prison in the past six months
Numerator #1	The number of Medicaid beneficiaries with OUD who were released from a jail or prison in the past six months and were admitted to a jail or prison
Denominator #2	Number of Medicaid beneficiaries with OUD who were released from a jail or prison in the past 12 months
Numerator #2	The number of Medicaid beneficiaries with OUD who were released from a jail or prison in the past 12 months and were admitted to a jail or prison
Denominator #3	Number of Medicaid beneficiaries with OUD who were released from jail or prison in the past 36 months
Numerator #3	The number of Medicaid beneficiaries with OUD who were released from a jail or prison in the past 36 months and were admitted to a jail or prison
Measurement Period	Every six months
Data Sources	Jail and prison administrative data and Medicaid enrollment data
Considerations	No additional considerations
Feasibility and Purposefulness	• Measure specifications do not exist • There are data sources for this measure • Not currently in use by SMAs • Would require jails and prisons to report this information to SMAs upon reentry • An important measure for policymakers to identify intended program goals were being met • Would be critical to stakeholders who would want to know if individuals were reentering jails and prisons post-reentry

Measure C.14: Outcomes Post-Reentry

Current Measure Description	New measure
Proposed Measure Description	Percentage of Medicaid beneficiaries reporting positive recovery-related outcomes post-reentry
Measure Type	Outcome
Area of Focus	Other area
Applicability	Reentry
ID and Name	None
Required or Encouraged	Encouraged
Organization Recommending/ Using Measure	State and local correctional authorities
Denominator	Number of Medicaid beneficiaries with OUD reporting information using the Recovery Capital Index, Brief Assessment of Recovery Capital (BARC) or a standardized tool identified by the SMA
Numerator	Number of Medicaid beneficiaries with an OUD who report having improved outcomes in identified domains post-release using a standardized tool (at six- and 12-months post-reentry)
Measurement Period	Every six months
Data Sources	Response of a survey administered by a Medicaid MCO or other third party (e.g., university partner or Medicaid External Quality Review Organization)
Considerations	None
Feasibility and Purposefulness	• Measure specifications do not exist • Would require a third party to conduct the survey • Measure would assess outcomes for individuals with an OUD recently released from jails or prisons • Measure would be used for policy makers to measure the impact OUD services have on individuals with OUD reentering the community • Measure is important for stakeholders to know if providing OUD services during and post-incarceration has on individuals with OUD reentering the community

Other Recommended Medicaid OUD Measure for Jails and Prisons

Measure C.15 Number of Participating Jails and Prisons

Current Measure Description	Number of Medicaid providers that have enrolled in Medicaid or qualified to provide SUD services during the enrollment period
Proposed Measure Description	Number and percent of jails and prisons that participate as Medicaid providers in the state's Medicaid program during the 1115 demonstration period
Measure Type	Structural
Area of Focus	Other
Applicability	Jails and prisons
ID and Name	None
Required or Encouraged	Required
Organization Recommending/ Using Measure	CMS 1115 SUD waiver
Denominator	Total number of jails and prisons in the state
Numerator	Number of jails and prisons (separately) that have enrolled in the state's Medicaid program
Measurement Period	Monthly during first year and annually thereafter
Data Sources	Enrollment or other information from the SMA and MCOs (if applicable)
Considerations	States will need to determine if jails and prisons will be required to enroll if they render services or identify if services were delivered by an external vendor through claims submission (e.g., place of service)
Feasibility and Purposefulness	• Detailed specifications for the original measure exist but are not CBE endorsed • Current measure reported by SMAs • Critical to determine if and how many jails and prisons are participating in the initiative and if there are barriers or policies that are contributing to low or uneven provider enrollment • Can be used by policymakers (e.g., SMAs) to determine if jails and prisons are engaged and understand challenges to correctional facilities participating in the initiative • Measure is likely to be reported by states regarding progress toward initiative • Stakeholders may want to know if jails or prisons offer OUD treatment • Measure is foundational and impacts many other measures. If the number and percent of participating correctional facilities is low all other measures will be impacted

APPENDIX D

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