New York State Department of Health
Medicaid Redesign 1115 Demonstration Amendment Application:
Continuity of Coverage for Justice-involved Populations
October 31, 2019

Section I – Historical Narrative Summary of the Demonstration

Introduction

New York State is requesting approval from the Centers for Medicare and Medicaid Services (CMS) for an amendment to its Medicaid Redesign 1115 Demonstration to authorize federal Medicaid matching funds for the provision of targeted Medicaid services to eligible justice-involved populations. These Medicaid services are to be provided in the 30-day period immediately prior to release for Medicaid-enrolled incarcerated individuals who have two or more chronic physical/behavioral health conditions, a serious mental illness, or HIV, or opioid use disorder. Coverage for these services is requested for persons incarcerated in county and State facilities.

The objective of the demonstration will be to provide pre-release in-reach transitional services in order to ensure high-risk justice-involved populations receive needed care management, physical and behavioral health services, medication management and medication, and critical social supports upon release into the community. Under this demonstration, the State will be able to bridge relationships between community-based Medicaid providers and justice-involved populations prior to release thereby improving the chances individuals with a history of substance use, serious mental illness and/or chronic diseases receive stable and continuous care. By working to ensure justice-involved populations have a stable network of health care services and supports upon discharge, New York believes it will be able to demonstrate a reduction in emergency department use, hospitalizations and other medical expenses associated with relapse, as well as improvements in health outcomes, including a reduction in overdose rates and deaths.

The covered Medicaid services to be made available in the 30 days prior to release from the correctional facility include:

- Care management to be provided through Health Homes, which will work closely with the individual's managed care organization to expedite enrollment into a plan upon release; care management services will include "in-reach," a care needs assessment, development of a discharge care plan, referrals made to and appointments scheduled for physical and behavioral health providers, and linkages to other critical social services and peer supports;
- Clinical consultation services provided by community-based medical and behavioral health practitioners to facilitate continuity of care post release; and,
- A medication management plan and certain higher priority medications, including long-acting or depot preparations for chronic conditions, (e.g., schizophrenia, substance use disorders); acute withdrawal medications; or suppressive, preventative, or curative medications, including PrEP and PEP (HIV, HCV and SUD) that would support longer term clinical stability post release.

New York State is a national leader in building programs that address the needs of individuals with the most serious and costly physical and behavioral health problems. Such programs include: Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs; integrated Health and Recovery Plans (HARPs) to provide an enhanced managed care benefit to individuals with serious mental illness and substance use disorders; delivery system reform efforts to reduce avoidable hospitalizations and integrate primary care and behavioral health services; and Health Homes to provide intensive care coordination to individuals

with multiple chronic conditions, including, importantly, five State-funded criminal justice health home pilots to identify and engage justice-involved individuals in order to reduce their health care costs and improve the quality of care for this population. Medicaid is the core financing stream for each of these efforts.

The ability to provide Medicaid services to incarcerated individuals during the 30-day period prior to release will complement these initiatives and build-upon the State's current efforts to engage the criminal justice population in health care as they re-enter the community. These initiatives include:

- The Health Home Criminal Justice Workgroup, which is a New York State (NYS) Department of Health (DOH)-sponsored statewide group convened around the opportunities for the Medicaid Health Homes to engage the criminal justice population.
- The Justice and Mental Health Collaboration Program (JMHCP), administered by the NYS Division of Criminal Justice Services (DCJS), in partnership with the NYS Office of Mental Health (OMH) to improve outcomes for individuals with mental illness by enhancing criminal justice and behavioral health collaboration at the local government level.
- Various health care, community provider and criminal justice collaborations working with Criminal Justice-Involved Individuals (CJII) at the local municipality and county level.

In addition to and distinct from the in-reach services to be provided during incarceration under this demonstration, New York State is also requesting approval from CMS for an amendment to the 1115 Demonstration to authorize the provision of a therapeutic residential treatment demonstration/pilot program which is further described on page 8 of this amendment request.

Background on Pre-Release Demonstration

In October 2018, Congress passed the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the "Support Act") in response to the imperative to implement concrete changes to address the opioid epidemic. Per the SUPPORT Act, Congress requires the Department of Health and Human Services (HHS) to convene a stakeholder group to develop best practices for ensuring continuity of coverage and relevant social services for individuals who are incarcerated and transitioning to the community. The legislation also directs HHS to work with states to develop innovative strategies to help such individuals enroll in Medicaid and, within a year of enactment, to issue a State Medicaid Director (SMD) letter regarding opportunities to design section 1115 demonstration projects to improve care transitions to the community for incarcerated individuals who are eligible for Medicaid. New York State is seeking to partner with HHS to develop an innovative demonstration that will help to ensure continuity of care when justice-involved populations transition from incarceration to the community and that could inform the development of the SMD letter required by the SUPPORT Act.

There is ample documentation from across the country that the criminal justice-involved population contains a disproportionate number of persons with behavioral health conditions (i.e., substance use disorders and mental health disorders), as well as HIV and other chronic diseases. Nationally, an estimated 80 percent of individuals released from prison in the United States each year have a substance use disorder or chronic medical or psychiatric condition. [1] Incarcerated individuals have four times the

[1] Shira Shavit et al., "Transitions Clinic Network: Challenges and Lessons in Primary Care for People Released from Prison," *Health Affairs* 36, no. 6 (June 2017): 1006–15.

rate of active tuberculosis compared to the general population, nine to ten times the rate of hepatitis C, and eight to nine times the rate of HIV infection.[2]

In New York, a staggering 83 percent of New York's incarcerated individuals are in need of substance use disorder treatment upon release, according to the New York Department of Corrections and Community Supervision (DOCCS).[3] Meanwhile, the share of individuals in New York City's jails who have mental illnesses has reached nearly 40 percent in recent years, even as the total number of incarcerated individuals has decreased.[4] Of the 29,391 individuals who were discharged from jail in New York City during the 2018 calendar year, 26 percent had mental health problems; 11 percent suffered a severe mental illness; and 63 percent struggled with substance use.[5] These issues are not confined to New York City -- in the 19 counties participating in the New York State County Re-Entry Task Force Program, 26 percent of eligible individuals required mental health treatment, 79 percent required substance use disorder treatment, while 82 percent required social services. [6]

National data indicates that incarcerated individuals with serious health and behavioral conditions use costly Medicaid services, such as inpatient hospital stays, psychiatric admissions, and Emergency Department (ED) visits for drug overdoses at a high rate in the weeks and months immediately after release:

- 1 in 70 individuals are hospitalized within a week of release from prison or jail (2.5 times higher than those never incarcerated), and 1 in 12 are hospitalized within 90 days (nearly twice as high as those never incarcerated).[7]
- Nearly a quarter of justice-involved individuals had a first emergency department visit within one month of release and were more likely than the general population to visit the emergency department due to a mental health condition, substance use disorder, or ambulatory sensitive condition.[8]

These findings are consistent with New York-specific data, which also highlights that there is a major gap in continuity of care for people cycling in and out of jail and that stronger outreach and engagement efforts could improve outcomes and prevent unnecessary utilization of expensive services. For example, in a study of 1,427 Medicaid recipients residing in Brooklyn, New York, with an SMI who had also been released from prison within the past five years, 1,009 (71 percent) met criteria (based on Medicaid claims) suggesting inadequate behavioral health care in the prior year. The project team attempted to contact behavioral health providers who had served these individuals and were able to complete detailed

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[2] Jhamirah Howard et al., *The Importance of Medicaid Coverage for Criminal Justice Involved Individuals Reentering Their Communities* (U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Apr. 2016); Doris J. James and Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates* (U.S. Department of Justice, Bureau of Justice Statistics, revised Dec. 14, 2006); *Behind Bars II: Substance Abuse and America's Prison Population* (National Center on Addiction and Substance Abuse at Columbia University, Feb. 2010); Lois M. Davis and Sharon Pacchiana, *Prisoner Reentry: What Are the Public Health Challenges?* (RAND, May 2003); Henry J. Steadman et al., "Prevalence of Serious Mental Illness Among Jail Inmates," *Psychiatric Services* 60, no. 6 (June 2009): 761–65; and Jennifer C. Karberg and Doris J. James, *Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002* (U.S. Department of Justice, Bureau of Justice Statistics, July 2005).

[3] Identified Substance Abuse, State of New York Department of Correctional Services (Dec. 2007)

[4] Mayor's Task Force on Behavioral Health and the Criminal Justice System: Action Plan (Dec. 2014)

[5] Correctional Health Services, April 3, 2019.

[6] County Re-entry Task Force Program Activity Report: July 2013 – June 2014

[7] A High Risk of Hospitalization Following Release from Correctional Facilities in Medicare Beneficiaries: A Retrospective Matched Cohort Study, 2002 to 2010 (Sept. 2013). Available from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4069256/pdf/nihms-586569.pdf

[8] Emergency Department Utilization among Recently Released Prisoners: A Retrospective Cohort Study (Nov. 2013). Available from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3818565/

treatment histories for 556 individuals. Of these 556 completed case reviews, 406 (73 percent) were confirmed to be disengaged from care and considered at high-risk for adverse events or poor outcomes. Among these 406 disengaged individuals, 176 (43 percent) were found to be re-incarcerated (prison or jail) at the time of review and another 161 (40 percent) were completely lost to care with no provider able to initiate outreach. Outreach was successfully initiated for only 64 (16 percent) of these individuals. This very high-risk population has very high rates of *inadequate* care. [9] A follow-up study to the one above analyzed the population of individuals identified as disengaged from care. The study showed that if a provider was able to initiate outreach, approximately 65 percent of the group of disengaged individuals successfully re-engaged in care within 12 months. However, if no provider connected, or if the individual was incarcerated when reviewed, re-engagement rates remained very low (30 percent re-engaged within one year).[10]

State and local correctional facilities (i.e., prisons and jails, respectively) provide medical services, including medications for medical and mental health conditions. Individuals also re-enter the community with a limited supply of medications. However, medication management for substance use disorders is generally not provided with an eye on release back into the community. The provision of medication for specific conditions occurs within the controlled setting run by the facility. This stability disappears when a person is released into the community. Even under the best of circumstances, when a person is discharged without prior contact with a future care manager/provider or without long-acting depot medications or other addiction/mental health medications as indicated, there is a high risk he/she will establish other priorities and will not engage with critical service providers when they re-enter the community. Contact between service providers and the incarcerated individual needs to occur prior to release to facilitate the continuity of care after discharge and the use of medications appropriate for community-based (rather than jail or prison) settings. The use of depot/long acting and other addiction/mental health medications for treatment of schizophrenia and opioid addiction can support a smoother transition into the community and facilitate the successful linkage to other services that in turn, further maintain stability[11]. The ability to begin the use of depot/long-acting medications prior to release will ensure these medications are clinically appropriate, well tolerated and more likely to remain in use when the individual re-enters the community. For patients for which longer acting medications are less appropriate, other mental health and addiction medications would be indicated.

New York is seeking to build and strengthen the relationship between the care provided inside its jails and prisons and the care offered by Medicaid providers upon release. To facilitate the arrangement of critical services prior to release, the NYS Council on Community Re-Entry and Reintegration was formed to address obstacles faced by individuals transitioning to the community and recommended that NYS reinstate Medicaid benefits 30 days prior to release, without allowing the billing of services, and issue a Medicaid benefit card prior to release. In 2017, the DOH Office of Health Insurance Programs began reinstating Medicaid benefits prior to release across all systems. Further, as part of the Fiscal Year 2016/17 Budget, enacted state legislation directs the state to "seek federal authority to provide medical assistance for transitional services including but not limited to medical, prescription, and care

[9] Smith TE, Appel A, Donahue SA, Essock SM, Thomann-Howe D, Karpati A, Marsik T, Myers RW, Sorbero MJ, Stein BD: Determining engagement in services for high-need individuals with serious mental illness. Administration and Policy in Mental Health 2014; 41:588–597; doi: 10.1007/s10488-013-0497-1

[10] Smith TE, Stein BD, Donahue SA, Sorbero M, Karpati A, Marsik T, Myers RW, Thomann-Howe D, Appel A, Essock SM: Reengagement of high-need individuals with serious mental illness following discontinuation of services. Psychiatric Services 2014; 65:1378-1380; doi:10.1176/appi.ps.201300549 (*This was before NYS had Health Homes, DSRIP, Medicaid Managed Care for behavioral health, and the other resources that now support community-based outreach for these individuals*)

[11] The role of long-acting injectable antipsychotics in schizophrenia: a critical appraisal, S. Brissos et al., Ther.Adv.Psychopharmacol 2014 Oct. 4(5): 198-219

coordination services for high needs inmates in state and local correctional facilities thirty days prior to release."[12]

Because of NYS's progress in suspending coverage and initiating re-activation upon release, the State is well-positioned to identify individuals who would benefit from pre-release in-reach and discharge planning.

Section II. Changes Requested to the Demonstration

Covered Services for Pre-Release Demonstration

The goal of the pre-release demonstration is to ensure a seamless transition to community-based services for incarcerated individuals reentering the community who are high-risk. Thirty days prior to release, the State seeks to provide to justice-involved populations the following Medicaid services:

- Care management to be provided through Health Homes, which will work closely with the individual's managed care organization to expedite enrollment into a plan upon release. Care management will include conducting a care needs assessment; developing an integrated discharge and care plan that will identify the medical, behavioral health and social needs necessary to support a stable and successful community life; making referrals to and scheduling appointments for physical and behavioral health providers upon discharge; and establishing linkages to other critical social services and peer supports in the community where they will be released.
- Clinical consultation services, provided by physician, nurse practitioner, licensed/registered/certified substance use disorder or mental health specialist, to facilitate continuity upon discharge.
- A medication management plan and certain medications, including long-acting or depot preparations for chronic conditions, (e.g., schizophrenia, substance use disorders); acute withdrawal medications; or suppressive, preventative, or curative medications, including PrEP and PEP (HIV, HCV, and SUD) that will facilitate the maintenance of medical and psychiatric stability while facing the challenges of transitioning back to the community.

The three components above, specifically care management, consultation with medical and/or behavioral health providers, and medications (including long-acting depot medications and other addiction/mental health medications as indicated) are covered Medicaid benefits. When a community provider cannot meet directly with the individual and/or discharge planner due to distance from a specific State prison, the majority of State prisons have videoconferencing that should allow services consistent with New York State Medicaid telehealth requirements.

The targeted scope of Medicaid benefits provided to incarcerated individuals 30 days prior to release under this demonstration will increase the efficiency of the discharge planning process. By introducing and linking individuals with serious physical and behavioral health conditions to a comprehensive system of care and transitional supports pre ***and*** post discharge, there is a higher likelihood of connectivity to care at release, leading to more stability once established in the community.

Eligibility

Individuals eligible for this program are those Medicaid enrolled members who have two or more qualifying chronic diseases (such as HCV and diabetes), or one single qualifying condition of either HIV, a serious mental illness, or an opioid use disorder, and who are scheduled to be discharged from a jail or

[12] Chapter 59 of the New York State Laws of 2016, Part B, § 21-a.

prison within 30 days. The State also suggests that providers be allowed to engage individuals in County jails within the first 30 days of incarceration, as long as there is reasonable expectation of discharge within that period. The average length of stay in a local jail is often brief, less than two weeks. It was found that between March and September 2018, two-thirds of Health Home members identified spent less than 72 hours in jail. Allowing care managers to provide service in the first 30 days would encourage community-based providers to collaborate with County jails; support the best practice of including discharge planning as part of jails' medical intake sessions; and ensure individuals maintain their medication-assisted treatment (MAT) without tapering or discontinuation, with linkage to all forms of MAT medication. The State is further exploring continuity of benefits in the pre-sentencing period.

Medicaid services will be provided through Health Homes working closely with the individual's managed care organization, including Health and Recovery Plans.

The State will request changes in the State Plan Amendment (SPA) to add opioid use disorder (OUD) as single-qualifying condition for Health Home enrollment. Please refer to Section X Public Notice for public comments in support of the expansion of Health Home criteria to include OUD.

As shown in the table below, there are 22,276 annual discharges from prisons, and 185,069 annual discharges from jails (42,033 located in New York City, and 128,650 in rest-of-State jails). The State estimates that approximately 48 percent of this population would meet the high-risk eligibility criteria (18 percent serious mental illness; 5 percent with HIV; 25 percent with chronic conditions, which include a SUD or HCV diagnosis) to receive services pre-discharge. A summary of the current incarcerated population is described in Table 1 below.

Table 1: Incarcerated Population in New York State

Aggregate Sites	Average Daily Population	Total Annual Discharges (includes multiple discharges for the same person)
New York City Department of Correction —County Jail (2017)	8,250	42,033
Rest of State – County Jails (2017-2018)	14,664	128,650
New York State Department of Corrections and Community Supervision – State Prison (2017-2018)	50,271	22,276

Enrollment

The State is in the process of implementing a workflow to identify eligible individuals using a memorandum of understanding between DOCCS and DOH. In order to operationalize this demonstration, the State will need to first identify individuals who are currently in a Medicaid suspension status and who meet the high-risk criteria and then connect them to a Health Home to commence the in-

reach 30 days prior to release. The Health Home will work closely with the individual's managed care organization to ensure expedited enrollment in a plan upon release. Currently, reinstating Medicaid 30 days prior to release is more easily accomplished in the State prison system where there is more certainty around release dates and there are systems in place for data exchanges and high-risk identification. The State is now working to create data exchange processes between county jails, State criminal justice agencies and DOH. During the development of those processes, the State will phase in the pre-release demonstration by beginning the program in the State prisons, followed by an expansion to county jails.

DOH will work with counties and DOCCS to provide training around the provisions of the amendment, eligibility requirements, and care management services offered through the Health Home program and managed care plans. Individuals who meet the high-risk eligibility criteria will be identified by the health care providers within the DOCCS prisons and county jail systems. The State will also work with DOCCS and counties to match Health Home eligible lists to members who are approaching the 30-day, pre-release timeframe. The Health Home care manager will be the focal point for discharge planning, and probation and parole officers will be apprised of transitional service plans. The Health Home care manager will be the hub for conducting and maintaining continuity of care with the individual during pre and post discharge to the community.

Network Adequacy and Provider Readiness Analysis

Every county in New York State has at least one active Health Home already interacting with substance use disorder supports, mental health and physical health providers, community-based organizations, and county mental health services (Single Point of Access [SPOA]). A number of these Health Homes are already working with criminal justice-involved individuals and engaged with prisons and jails. The State intends to assign a managed care plan to be the primary point of contact in instances where an individual is identified as meeting the high-risk eligibility criteria but is not enrolled in a Health Home.

Additionally, all Health Homes are working with Health and Recovery Plans, which is a managed care option for individuals with significant behavioral health needs. The ability to identify and link HARP-eligible members prior to release from prison/jail will help facilitate the enrollment of HARP members and, most importantly, link these individuals to an array of home- and community-based services designed to help transition former justice-involved individuals into the community.

DOH is now working to strengthen the health information exchange process between the criminal justice system, Health Homes, managed care plans and the State. While there exists sufficient communication between DOCCS and DOH for the purposes of managing the suspension process, the data exchange capabilities between counties and the State is still in an early stage of development. However, the State is exploring opportunities to create shared systems of communication for the purposes of outreach referral and linkage to Health Home care management.

Residential Incarceration Alternative Demonstration for Mental Health and Substance Use Disorder Treatment Pilot

In addition to and distinct from the in-reach services to be provided during incarceration under this demonstration, New York State is requesting approval from CMS for an amendment to the 1115 Demonstration to authorize federal Medicaid matching funds for the provision of a therapeutic residential treatment demonstration/pilot program.

This pilot is a voluntary alternative to incarceration for individuals accused of but not convicted of felony level crimes, who would choose to receive specialized treatment in a therapeutic residential environment designed to assist with mental health/substance use disorders among the justice involved population.

Public comment on this waiver and discussions in statewide advisory bodies have highlighted the lack of available alternative treatment options that balance treatment needs for behavioral health and substance use conditions with public safety concerns in meeting the needs of the justice involved population. To address this gap and to be responsive to public comment, NY proposes a pilot program that is operated as a transitional, congregate housing facility offering daily and evening therapeutic and clinical services with residential and security staff on site 24 hours a day to provide continuous services and overnight, with an expected length of stay of up to two years.

This demonstration program has been approved by the New York State Office of Mental Health (OMH) under Section 41.35 of the NYS Mental Hygiene Law and is a time limited demonstration program for purposes of evaluating a new method or "arrangements" for serving justice-involved individuals with serious mental illness and co-occurring substance use disorders. NYSOMH will consider creating a permanent category of licensure for the rehabilitative services provided by this program. The state will also authorize an existing Article 31 mental health day treatment provider to operate a satellite day treatment program at the demonstration project site. Both the Article 31 day treatment and OMH-approved rehabilitative residential treatment are required to operate the demonstration.

IV. Requested Waivers and Expenditure Authorities

The State seeks such waiver authority as necessary under the pre-release demonstration to receive federal match on costs not otherwise matchable for certain services rendered to individuals who are incarcerated 30 days prior to their release. The specific additional waivers, if any, that would be needed will be identified in collaboration with CMS.

V. Summaries of External Quality Review Organization (EQRO) Reports, Managed Care Organization (MCO) and State Quality Assurance Monitoring.

The above changes requested to the demonstration do not impact the Medicaid Managed Care Plans or their enrollees. The State will be using the current EQRO contract for any quality review activities.

VII. Financial Data

Authorizing the targeted scope of benefits for this well-defined group of criminal justice-involved individuals will improve health outcomes, and consistent with current delivery transformation goals, reduce avoidable hospitalizations and Medicaid spending. It is anticipated that the overall costs of the amendment taken out in the Budget Neutrality computation will be offset by a reduction in Emergency Department visits, inpatient hospitalizations and other unnecessary services that are avoided as a result of providing a limited scope of Medicaid benefits during the 30-day pre-release period (e.g., a reduction of at least one ED visit at an average cost of about $280 for every member served during the 30-day, pre-release period).

The services that are being requested for coverage during the 30 days prior to release from State and county correctional facilities are currently covered for Medicaid members who are not incarcerated and who are in fee for service or Medicaid Managed Care plans. Services are covered with non-federal and federal matching funds in accordance with the individual's category of eligibility. The State expects savings from drug rebates and from the decrease in unnecessary services (e.g. Emergency Department and inpatient) that would result from the provision of a limited scope of Medicaid benefits. The State will manage the upfront costs to the Global Spending Cap (GSC). Funding is available for this Amendment.

See the attached NY MRT Budget Neutrality – CJ spreadsheet for a detailed Budget Neutrality model for this amendment.

VIII. Evaluation

While this programming has not been previously implemented with this population in New York State and with this service coordination approach, we have expectations based on studies conducted in other states that the detailed benefits are attainable and that New York will experience similar, if not more improved outcomes because of the proposed pre-release interventions. For example, New Mexico established an in-reach pilot project with the Albuquerque jail where managed care plan coordinators met with incarcerated individuals twice to prepare them for discharge. The initiative resulted in reducing emergency department use after release by 64 percent.[13] This amendment will allow CMS and New York to accumulate the data needed to evaluate the improvements in health outcomes for providing critical discharge planning services to incarcerated individuals pre-release.

This amendment will help provide data and analysis regarding the health and wellness outcomes of released individuals. Metrics for analyzing the impact of the amendment will also naturally align with Medicaid Managed Care Plan measures, delivery system reform metrics and value-based payments. It is anticipated that DOH, DOCCS, and county/New York City jails, in collaboration with the Health Home Criminal Justice Workgroup and other stakeholders, will monitor the implementation of the program and its anticipated outcomes. As discussed earlier, the State is working to link Medicaid data and criminal justice information. Medicaid claims data will be used to further evaluate health outcomes after release of individuals covered under this amendment.

This demonstration will be evaluated by tracking individuals during the 30-day, pre-release period and for at least 18 months after their release, beginning with the month they re-enter the community.

IX. Compliance with the Tribal and Public Notice Process

As required by STC Paragraph 17 and state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994), the State conducted Tribal and Public Notice through the following means:

Tribal Notice

Tribal notices on the preliminary proposed waiver amendment draft were sent on March 10, 2019 to all Tribal Chairpersons and Designees of Indian Health Programs. No comments were received during that 60-day period. After incorporating some stakeholder recommendations, tribal notices on the revised proposal were sent on August 14, with comments due on September 14. No comments were received during that period.

Public Notice and Processing

The initial New York State public notice was published in the New York State Register on April 10, 2019, with comments to be received by May 10. Comments were received through the public notice, with some stakeholder recommendations incorporated into the proposal. The revised proposal was posted on the DOH website on August 13, 2019, and another public notice was published in the New York State Register on August 14, with comments due by September 14. Additional comments were received during this comment period, and stakeholder recommendations were incorporated into the proposal.

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[13] J.Guyer, K.Serafi, D.Bachrach, and Alixandra Gould, "State Strategies for Establishing Connections to Health Care for Justice-Involved Populations: The Central Role of Medicaid," The Commonwealth Fund (January 11, 2019).

X. Public Notice

The following summarizes the public comments received during the public comment periods. The State considered all comments received in preparing the amendment request.

1. The State received a comment noting that patients with neurodevelopmental disabilities, who are eligible for Health Home services, would benefit by being included in the waiver amendment.

   Response: The services requested under this waiver amendment would most likely cover individuals with neurodevelopmental disabilities, as most also have co-occurring comorbidities in additional to NDD, making them eligible for Health Home services.

2. The State received suggestions that OUD, Hepatitis C, and SUD be single-qualifying conditions for Health Home enrollment.

   Response: Expanding single qualifiers for Health Home eligibility to include SUD will be evaluated as a potential for future phases of the waiver and Health Home service delivery. Other care management options are generally available to this population. OUD is being prioritized for approval as a single qualifying condition.

3. The State received comments that the waiver should be expanded to cover all Medicaid-eligible incarcerated individuals, pre-trial detainees in county jail, those at risk of homelessness and overdose, and additional high-risk populations.

   Response: At this time, the amendment request covers incarcerated individuals who have two or more chronic conditions, a serious mental illness, or HIV, or opioid use disorder.

4. The State received a comment requesting for the allowance of the presumption of Medicaid eligibility to accelerate the delivery of core services prior to release.

   Response: The State will evaluate the presumption of Medicaid eligibility.

5. The State received comments suggesting the inclusion of detained, pre-sentence individuals, as well as in-reach into local jail during the first 30 days of incarceration to ensure continuity of care.

   Response: The State has indicated that Health Homes will work with Medicaid managed care plans to ensure expedited enrollment in a plan after release, and has also suggested that providers be allowed to engage individuals in County jails within the first 30 days of incarceration.

6. The State received comments that it should prioritize the local jail population in the first phase of waiver implementation, as it is a much larger and more vulnerable population.

   Response: The State has indicated it will begin implementation of waiver services in the State prison system where there is more certainty around release dates, and there are systems in place for data exchanges and high-risk identification. The State is now working to create data exchange

processes between county jails, State criminal justice agencies and DOH, and is open to discussing modifications to the phase-in plan with localities.

7. The State received comments that individuals who qualify for waiver services should be expedited into managed care enrollment in an effort to mitigate the limitations of fee for service Medicaid, and that a billing rates be appropriate for jail in-reach work that requires specially trained staff.

   Response: The State has indicated that Health Homes will work with Medicaid managed care plans to ensure expedited enrollment in a plan.

8. The State received comments to highlight the use of in-person service delivery, and use of Community Health Workers, as well as the importance of Peer Engagement Specialist and peer-led activities as billable services.

   Response: The State will consider a future State Plan Amendment to seek re-imbursement for peer services for justice-involved populations prior to release, but this request is not part of this waiver at this time.

9. The State received comments requesting the waiver allow for all community-based service providers to bill Medicaid, including moment-of-release services as well as initial client consultation, care coordination, and a broad range of medications including PrEP, PEP, and that the waiver address the maintenance of individuals on MAT without tapering or discontinuation.

   Response: The State has noted the importance of including PrEP and PEP as part of medication plans that are necessary to support longer term clinical stability post-release, along with the need to ensure individuals maintain their medication-assisted treatment (MAT) without tapering or discontinuation, with linkage to all forms of MAT medication. Services actuated by this waiver will advantage these goals.

10. The State received a suggestion that it request FMAP for SUD Health Homes, as suggested by the recent bulletin from CMS on the new language in the Support for Patients and Communities Act.

    Response: Expanding single qualifiers for Health Home eligibility to include SUD will be evaluated as a potential for future phases of the waiver and Health Home service delivery. Other care management options are generally available to this population. OUD is being prioritized for approval as a single qualifying condition.

11. The State received comments that there be an examination and discussion of policy frameworks which make SMI medications more accessible than those for SUD, as well as the continuity of MAT as part of the services available under the waiver by making all FDA approved drugs available.

    Response: Process workflows, policies, engagement and training will be addressed through implementation planning including working closely with the State's health home and managed care workgroup. The State welcomes input from all of its stakeholders, as it works to operationalize waiver services.

12. The State received comments which note the need for implementation strategies such as education of Health Home services among justice-involved populations, workforce development, and training for care management staff.

    Response: Process workflows, policies, engagement and training will be addressed through implementation planning including working closely with the State's health home and managed care workgroup. The State welcomes input from all of its stakeholders, as it works to operationalize waiver services.

    13. The State received recommendations for the amendment of language in the waiver for clarity, consistency, inclusion, and accuracy, along with the improvement of performance measures.

    Response: The State revised for clarity and consistency while updating the amendment request.

14. The State received a comment requesting inclusion of a time-limited demonstration project which is an alternative to incarceration for justice-involved individuals who would be better served in a therapeutic residential environment that will help them with their mental health/substance use disorder.

    Response: The State has included a request that CMS authorize federal Medicaid matching funds for this pilot project in its Medicaid Redesign 1115 Demonstration Amendment Application

15. The State received a comment that the waiver would impact employment opportunities for a subset of nurse providers.

    Response: This subset of providers is not responsible for providing any of the outlined waiver services.