Kentucky Department of Medicaid Services
1115 Waiver Application: Improving Health Outcomes for Individuals with Serious Mental Illness and Health Related Social Needs

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Section I - Program Description

Executive Summary

The Kentucky Department for Medicaid Services (DMS) is requesting an amendment to the Commonwealth's Section 1115(a) Demonstration, entitled "Kentucky Helping to Engage and Achieve Long Term Health" (KY HEALTH) (Project Nos. 11-W-00306/4 and 21-W00067/4). At present, the waiver consists of the following components:

- Coverage to former foster care youth who are under 26 years of age, who were in foster care under the responsibility of another state or tribe on the date of attaining 18 years of age (or such higher age as the state has elected), and who were enrolled in Medicaid on that date.
- Substance use disorder (SUD) program available to all Kentucky Medicaid beneficiaries.
- Waiver of non-emergency transportation (NEMT) to and from providers for all Medicaid beneficiaries, to the extent the NEMT is for methadone treatment services.
- Alignment of beneficiaries' annual redetermination period with their employer-sponsored insurance open enrollment period.

On September 30, 2022, Kentucky requested to extend the KY HEALTH demonstration for a five-year period. This request is still pending Centers for Medicare and Medicaid Services (CMS) approval; however, there are two new components that require amendment to the demonstration. Specifically, the Commonwealth is requesting authority to: (1) reimburse medically necessary short-term, defined as a state-wide average length of stay no longer than 30 days, inpatient treatment services within settings that qualify as institutions for mental diseases (IMDs) for Medicaid-eligible adults with serious mental illness (SMI); (2) implement a pilot program to provide Health Related Social Needs (HRSN) services, specifically recuperative care services, also known as medical respite care, to adult beneficiaries who are homeless or at risk of homelessness, and need additional medical support and care coordination.

Through various initiatives and partnerships, the Commonwealth has undertaken significant efforts to address challenges for the SMI population. Gaps in care and challenges include lack of transitional housing for recovery post discharge from inpatient and institutional settings, restrictions on timeframes for inpatient treatment for mental health, and limitations for intensive care coordination. DMS covers a wide array of services and works collaboratively with sister agencies to fill the gaps in services, however despite best efforts to date, gaps in the health care system remain for individuals with SMI. Coverage gaps can lead to missed opportunities for treatment and result in an experience of care that is often fragmented, leading to sub-optimal levels of treatment and poor outcomes for individuals with SMI, particularly in care coordination. DMS is optimistic that providing these additional acute services, individuals with SMI will

receive improved and more consistent care resulting in diversion from emergency departments and hospital inpatient stays, while improving health outcomes.

Legislative Background

In recent years, federal and state legislation has highlighted the need for a comprehensive and targeted method to provide services to individuals with SMI. In 2021, a Severe Mental Illness Task Force was proposed by House Concurrent Resolution (HCR7)[1]. The Taskforce prepared a report which included several recommendations and directions to the Cabinet for Health and Family Services (CHFS) and the Department for Medicaid Services (DMS).

Following the report from the SMI Task Force in 2022 Senate Joint Resolution 72 (SJR72)[2] established a requirement for DMS to pursue a waiver for individuals with SMI. Specifically, the resolution directed DMS to apply for a waiver that provides for supportive housing, supported employment, and medical respite services.

DMS has several Technical Advisory Committees or TACs. The TACS act as advisors to the Advisory Council for Medical Assistance. Each TAC represents a specific provider type or are individuals representing Medicaid beneficiaries. The TACs are created by Kentucky Revised Statute 205.590.[3] One of the TACs, the Behavioral Health TAC, works towards enhancement of behavioral health services for Medicaid beneficiaries in Kentucky including the SMI Population.

Kentucky Revised Statute (KRS) 210.005 (2) [4] defines “Mental illness" as a diagnostic term that covers many clinical categories, typically including behavioral or psychological symptoms, or both, along with impairment of personal and social function, and specifically defined and clinically interpreted through reference to criteria contained in the most recent version of *The Diagnostic and Statistical Manual of Mental Disorders*. Further, KRS 210.005 (3) defines "Chronic" as clinically significant symptoms of mental illness that have persisted in the individual for a continuous period of at least two (2) years, or that the individual has been hospitalized for mental illness more than once in the last two (2) years, and that the individual is presently significantly impaired in his ability to function socially or occupationally, or both.

Overview of Kentucky efforts to improve the continuum of care for the SMI population

Caring for the SMI population is of great importance and priority to the state of Kentucky. This is evidenced by the work of many ongoing statewide initiatives,

[1] House Concurrent Resolution (2021) https://apps.legislature.ky.gov/record/21rs/hcr7.html.
[2] State Join Resolution 72 (2022) https://apps.legislature.ky.gov/record/22rs/sjr72.html.
[3] KY. REV. STAT. § 205.590 (2022) https://casetext.com/statute/kentucky-revised-statutes/title-17-economic-security-and-public-welfare/chapter-205-public-assistance-and-medical-assistance/miscellaneous-health-coverage-provisions/section-205590-technical-advisory-committees.
[4] KY. REV. STAT. § 210.005 (2023) https://casetext.com/statute/kentucky-revised-statutes/title-18-public-health/chapter-210-state-and-regional-mental-health-programs/section-210005-definitions-for-chapter.

collaborations, committees, and organizations in addition to the services offered through Medicaid State Plan.

Department for Medicaid Services Behavioral Health Services Overview

Kentucky is committed to caring for and engaging people with SMI in effective, evidence-based treatment. In 2014, Kentucky expanded Medicaid and has since broadened overall access to behavioral health services. There are many state plan covered services for beneficiaries with SMI; a full list of state plan services can be found on the DMS Website[5]. Services specifically related to SMI range from early intervention to inpatient as evidenced by ***Image 1*: *Behavioral Health Continuum and Initiatives*** below. DMS also has a range of approved provider types to support the delivery of these services.

Department for Medicaid Services Initiatives

Alongside services covered by state plan, DMS engages in innovative initiatives to continue improving service provision and outcomes for beneficiaries.

Mobile Crisis Intervention Services Implementation

Currently, Kentucky is in the process of Mobile Crisis Intervention Services (MCIS) Implementation after receiving funding for a one-year Mobile Crisis Intervention Services Planning Grant which was completed in 2022. This one-year planning grant directed DMS and 19 other state awardees to reduce law enforcement and first responder involvement in community-based behavioral health crisis responses. The goal of implementation is to increase behavioral health preparedness for complex and high acuity individuals, like individuals with SMI, and decrease the overuse of law enforcement responding to behavioral health crisis calls.

Certified Community Behavioral Health Clinic (CCBHC) Demonstration

In August 2020, Kentucky was selected to participate in the Certified Community Behavioral Health Clinic (CCBHC) Demonstration to improve overall health by bolstering community-based mental health and addiction treatment and advance behavioral health care to the next stage of integration with physical health care.

Kentucky has opened four regional CCBHC's and is in the implementation phase of the demonstration which began on 1/1/2022. The four participating CCBHC's must provide a comprehensive range of behavioral health services to vulnerable individuals, like individuals with SMI, to: increase access to services, stabilize people in crisis, and provide the necessary treatment for those with the most serious, complex mental illnesses and substance use disorders. CCBHC's are available to any individual in need of care, including (but not limited to) people with SMI, SED, long-term chronic addiction,

[5] KENTUCKY STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT MEDICAL ASSISTANCE PROGRAM (Apr. 27, 1990) https://www.chfs.ky.gov/agencies/dms/Documents/StatePlanr1.pdf.

mild or moderate mental illness and substance use disorders, and complex health profiles. CCBHC's will provide care regardless of ability to pay or place of residence, providing care for those who are on Medicaid, underserved, homeless, have low incomes, or are insured/uninsured.

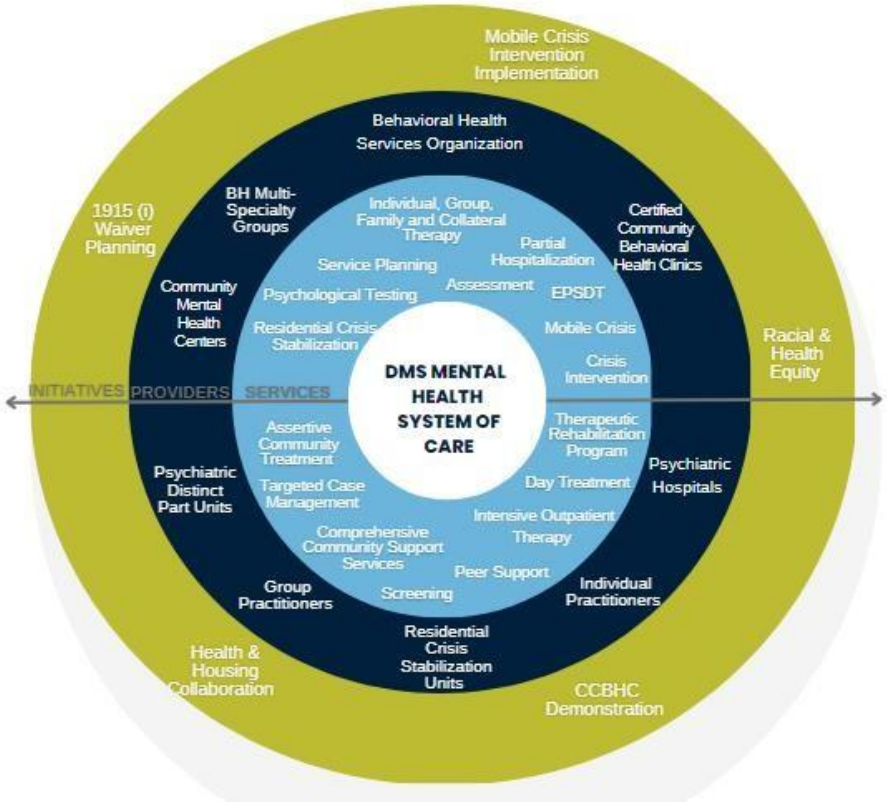
Racial Equity Action Plan

Injunction with the Cabinet's initiative to enhance racial equity, DMS established a racial equity core team to lead the charge on a racial equity action plan for Medicaid collectively. Each division within DMS now utilizes the Government Alliance on Racial Equity (GARE) Tool[6] for accountability in decision making. Each division has also created their own goals and objectives specific to improving racial and health equity within their division and to address health and racial disparities among beneficiaries in Kentucky. This specifically impacts individuals with SMI as they have more health-related social needs and limitations in resources because of their impairment in daily functioning. Kentucky is placing an intentional focus on racial and health disparities to address these needs for all beneficiaries including individuals with SMI.

Image 1: Behavioral Health Continuum and Initiatives

Despite a wide array of services, Medicaid enrolled provider types for the provision of mental health services, efforts to integrate care, and DMS driven initiatives to support the continuum of care for the SMI population, gaps in care remain. DMS collaborates with other state agencies and organizations to find ways to fill these gaps in care. **Image 1** below captures services, provider types, and initiatives within the behavioral health continuum of care across the commonwealth specifically geared to address the complex needs of individuals with SMI.

[6] https://racialequityalliance.org/wp-content/uploads/2015/10/GARE-Racial_Equity_Toolkit.pdf



Additional State Services and Initiatives

Department for Behavioral Health and Developmental Intellectual Disabilities Initiatives

The Department for Behavioral Health and Developmental Intellectual Disabilities (DBHDID) is a sister agency and is the behavioral health authority for the state of Kentucky. Specifically, DBHDID receives and disseminates federal Community Mental Health Services Block Grant funds through the Substance Abuse and Mental Health Services Administration (SAMHSA) and other grant funding to assist KY's fourteen (14) Community Mental Health Centers (CMHCs) with providing treatment services for the SMI population as the state's behavioral health safety network. These grant funds are used in a variety of ways to supplement prevention and treatment programs in Kentucky. The following initiatives are specifically geared towards the needs of individuals with SMI, but not each initiative is covered by each CMHC, therefore, not all the following initiatives are statewide.

DBHDID Prevention and Early Intervention Initiative

The *iHOPE Program* for Early Intervention for First Episode Psychosis is a prevention intervention specific to SMI. The mission of the *iHOPE program* in Kentucky is to significantly increase access to specialized evidence-based services and supports,

including outreach services, to youth and young adults (aged between15-30) with, or at risk of, First Episode Psychosis and their families.

DBHDID SMI Treatment Initiatives

A specific program to address the needs of the SMI population is the *Direct Intervention: Vital Early Responsive Treatment System* (DIVERTS). DIVERTS is offered to adults with SMI who are institutionalized or at risk of institutionalization, regardless of payor. DIVERTS services are developed and made available to assist persons with SMI in transitioning to living in integrated settings in the community, while receiving appropriate evidence-based treatment and support services.

Projects for Assistance in Transition from Homelessness (PATH)

The PATH program is a federal formula grant distributed annually to all U.S. states and territories. The PATH program supports the delivery of services and resources to individuals who have SMI, may include a co-occurring substance use disorder, and are homeless or at imminent risk of homelessness. PATH funds are used to provide a menu of allowable services, including street outreach, case management, and services that are not supported by mainstream mental health programs.

SSI/SSDI Outreach Access Recovery (SOAR)

The SOAR program is designed to increase access to Social Security Administration (SSA) disability benefits such as Supplemental Security Income and Social Security Disability Insurance (SSI/SSDI), for eligible adults who are experiencing or at risk of homelessness and have a mental illness, medical impairment, or a co-occurring disorder. The SOAR Program is designed to speed up securing support services for those in need of housing assistance.

Second Amended Settlement Agreement

The Second Amended Settlement Agreement with Protection & Advocacy, effective October 22, 2018, was to extend the agreement and expand efforts to support adults with SMI who desire to live in the community instead of a personal care home. The goal is to assist people transitioning into the community and to support their recovery with evidence-based services such as Assertive Community Treatment, Supported Employment, Supported Housing, and Peer Support.

In State Housing Collaborations

A major known barrier to recovery for individuals with SMI and co-occurring disorders is homelessness. To become more innovative regarding expansion of housing options, Kentucky recently entered the Advancing Housing-Related Supports for Individuals with Substance Use Disorders State Medicaid Learning Collaborative. This Learning Collaborative through CMS under Section 1018(a) of the SUPPORT for Patients and

Communities Act[7] involved working with other states and learning about best practices in the areas of housing, supports, and care coordination under Medicaid to individuals with SUD. Although this learning collaborative was focused on SUD, we know that a large percentage of homeless with SUD also have co-occurring behavioral health disorders including SMI and concepts learned from the collaborative can be directly applied to medical respite services.

From this learning collaborative experience, an ongoing working group known as the Health and Housing Collaborative was formed. This group consists of individuals from DBHDID, DMS, Kentucky Housing Cooperative (KHC), the Center for Supportive Housing (CSH), and the Department for Aging and Independent Living (DAIL). The focus of this group has been enhancing the support services and processes that are available to homeless Kentuckians. Also, a focus has been to identify a matched population within Kentucky of individuals who are homeless and who are Medicaid beneficiaries to analyze prevalence and outcomes for this population in Kentucky.

Recuperative Care Services in Kentucky

Kentucky has several Recuperative Care providers across the state that address the needs of homeless individuals requiring acute care for recovery. As part of the waiver application process, DMS collaborated with current operating Medical Respite programs across the state. Current providers are funded by braided funding such as local hospital donations, donations from local shelters, private grants, and funds from local councils for homelessness. The programs provide varying levels of care to individuals, have varying services from one another, and take place in a variety of settings. Much of the program designs are based upon funding sources and resources that happen to be in their geographic area. Of the four in state Recuperative Care Providers, roughly 350 individuals received Recuperative Care with those providers in 2022.

Despite all efforts across Kentucky to address the needs of individuals with SMI and homelessness, gaps in care remain and needs continue to be unmet. Individuals with SMI continue to suffer from homelessness, lack of care coordination, and unnecessary readmission to inpatient and acute care settings. The request for the services in this waiver amendment application are part of Kentucky's comprehensive plan to expand support services. Kentucky is also applying for a 1915 (i) waiver through CMS to request supportive housing, supported employment, behavioral health respite services, and other community support services to assist individuals with SMI and HRSN.

Objective and Rationale

The Substance Abuse and Mental Health Administration () defines SMI as someone over 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or

[7] https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/support-act-innovative-state-initiatives-and-strategies-for-providing-housing-related-services-and-supports-sections-1017-and-1018/index.html

limits one or more major life activities[8]. According to the 2022 National Survey on Drug Use and Health report through SAMHSA and the US Department for Health and Human Services, 14.1 million Americans aged 18 and older had SMI in 2021. Of those 14.1 million Americans with SMI, 51.5% reported a perceived unmet need for mental health services[9]. Many individuals with SMI receive treatment and services, but still have unmet needs. This gap is evident in Kentucky as well. Each state's mental health authority that receives block grant funds from SAMHSA to supplement their mental health programs submits data annually as part of the application process known as the Uniform Report System (URS). According to the 2021 URS Mental Health Data Results, 43,254 individuals with SMI age 18 and older were served in Kentucky by the state mental health authority[10]. Of those individuals, 1,610 were served by state psychiatric hospitals in Kentucky. Among individuals served through Kentucky's 14 Community Mental Health Centers and state psychiatric hospitals, the SMI population has higher utilization rates than national average of psychiatric inpatient facilities and higher than average state hospital readmissions within 180 days. Kentucky also reports a lower percentage of utilization of evidence-based practices like assertive community treatment, supportive housing, and supported employment that specifically benefit the SMI population. This indicates that Kentucky's SMI population are being treated at a higher rate in inpatient settings with less access to or utilization of other supportive services to help them navigate their daily lives thus decreasing impairment in functioning. Additionally, according to this report, the SMI population in Kentucky also has higher rates of homelessness and sheltered homelessness than the national average indicating an even greater need for the expansion of support services to include services that address HRSN.

Kentucky references KAR 907:15:060[11] to define individuals with SMI for TCM services as individuals with schizophrenia spectrum and other psychiatric disorders, bipolar and related disorders, depressive disorders, and post-traumatic stress disorders listed in the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5)[12]. Along with meeting the diagnostic criteria for these diagnoses, the individual must exhibit persistent disability and significant impairment in major areas of community living with clinically significant symptoms which have persisted for a continuous period of at least 2 years. Individuals with SMI have great difficulty navigating their day to day lives due to their illness and the longevity and severity of symptoms. Kentucky is seeking ways to improve and increase support services for individuals with SMI to improve their quality of life, access to treatment, and integration into the community, while

[8] Substance Abuse and Mental Health Services Administration, *Mental Health, and substance use disorders* (Last Updated Nov. 22, 2022) https://www.samhsa.gov/find-help/disorders#:~:text=Serious%20mental%20illness%20is%20defined,or%20more%20major%20life%20activities.
[9] Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health* (Dec. 2022) https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf.
[10] Substance Abuse and Mental Health Services Administration, *2021 Uniform Reporting System (URS) Output Tables* https://www.samhsa.gov/data/sites/default/files/reports/rpt39401/Kentucky.pdf
[11] 907 KY. ADMIN. REGS. 15:060 https://apps.legislature.ky.gov/law/kar/titles/907/015/060/.
[12] Tanya de Sousa et al., *The 2022 Annual Homelessness Assessment Report (AHAR) to Congress* (Dec. 2022) https://www.huduser.gov/portal/sites/default/files/pdf/2022-AHAR-Part-1.pdf.

simultaneously decreasing hospital admissions, readmissions, and emergency department visits. Increasing the number of days individuals can receive acute treatment in IMDs for mental health services will increase the opportunity for care coordination to meet the specific HRSN of individuals in treatment. Additionally, it will allow more time and increase the likelihood of providing effective psychiatric, medical, and behavioral health treatment for those individuals prior to discharge from services to help them stabilize effectively.

Due to the complex needs of individuals with SMI, oftentimes achieving housing and food security can be an insurmountable barrier. Lack of resources like food and housing negatively impact health outcomes and deepen health disparities.[13] Kentucky recognizes the need for improving health equity by addressing beneficiaries' HRSN through coverage of short-term, upstream, clinically appropriate HRSN interventions[14]. This is a driving force behind the proposed Recuperative Care pilot program. People have the basic rights of safety, shelter, food, and clean water to heal properly from surgery and illness just as they have the right to receive proper healthcare. Providing recuperative care services will accomplish both for Kentuckians in need. The co-occurrence of SMI and homelessness is a real issue that Kentuckians are facing. According to the *2022 Annual Homelessness Assessment Report (AHAR) to Congress* "127,768 people experiencing homeless as individuals in January 2022 were reported to have chronic patterns of homelessness, which is nearly 30% of all individuals experiencing homelessness"[15]. Chronic patterns of homelessness means that these individuals experience homelessness for extended periods of time and have a disability. According to this same study in KY, 670 individuals were estimated to have chronic patterns of homelessness which makes up 20-29% of all individuals reported nationally. Many homeless individuals with a disability or severe impairment in functioning have SMI and/or SUD or complex health profiles. These complex, wholistic needs cannot be addressed comprehensively by behavioral health treatment alone. Health related social needs must be addressed to achieve whole person treatment and HRSN.

Through a collaborative effort, DMS and the Kentucky Housing Corporation (KHC) were able to conduct a matched data study in 2022. Between the years of 2017 and 2021, 72,969 individuals were identified as homeless in KY through the Homeless Management Information System (HMIS). Of those homeless individuals 65,843 were matched within the Medicaid Management Information System (MMIS). Over five (5) years of time, roughly 88% of homeless individuals within this data set were enrolled in Medicaid. Of those matched individuals, 13% (8,610 distinct individuals) utilized services to treat SMI and 11% (7,540 distinct individuals) utilized services to treat an SMI/SUD co-occurring disorder. Also, 45% had at least one emergency department visit with an average of 6 visits per year per beneficiary. The highest annual cost of these

[13] U.S. Dept. of Health & Human Services, Healthy People 2023 https://health.gov/healthypeople.
[14] https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf
[15] HUD 2022 Annual Homeless Assessment Report Finds Unsheltered Homelessness on the Rise | National Low Income Housing Coalition (nlihc.org)

emergency department visits was $15,906,307.10. Recuperative care services will provide homeless individuals a clean, safe, nurturing environment to heal while also providing much needed medical and behavioral health services to improve health outcomes and divert them from emergency rooms and unnecessary hospital readmissions therefore decreasing Medicaid expenditures. Recuperative care services will also link individuals to other support services that they need to have overall positive health outcomes medically, behaviorally, and socially.

In sum, there are many individuals in Kentucky with SMI who have unmet treatment and health related social needs. Due to current limitations of treatment options for these individuals, there are higher rates of utilization of emergency departments and readmission to inpatient treatment facilities which are costly services. DMS predicts that increasing the number of days of stay and facility options for individuals with SMI, as well as offering recuperative care services will address many unmet needs for these individuals. Therefore, improving outcomes for individuals with SMI and decreasing expenditures for Medicaid.

Requested Waivers

Introduction

Kentucky is requesting authority from CMS to expand services that will benefit high need individuals and individuals with SMI. Specifically, the Commonwealth is requesting authority to: (1) reimburse medically necessary short-term, defined as a state-wide average length of stay no longer than 30 days, inpatient treatment services within settings that qualify as institutions for mental diseases (IMDs) for Medicaid-eligible adults with serious mental illness; (2) implement a pilot program to provide Health-Related Social Needs (HRSN) services, specifically recuperative care services, also known as medical respite care, to adult beneficiaries who are homeless or at risk of homelessness, and who need additional medical support and care coordination. Currently, neither of these services are reimbursable by Medicaid in Kentucky.

Demonstration Goals and Objectives

Kentucky proposes the following evaluation plan, which has been developed in alignment with the CMS evaluation design guidance for SMI 1115 demonstrations. The State will contract with an independent evaluator to conduct this review. The State's goals are aligned with those of CMS for this waiver opportunity as indicated in SMDL #18—011[16]. The specific component goals and hypotheses will be outlined below within each respective service description.

Institution for Mental Disorders (IMD) Extension

Currently, Kentucky covers up to 15 days for inpatient mental health treatment in IMDs through In Lieu of Services (ILOS). Through this amendment, Kentucky is requesting to

[16] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

reimburse medically necessary short-term, defined as a state-wide average length of stay no longer than 30 days, inpatient treatment services within settings that qualify as institutions for mental diseases (IMDs) for Medicaid-eligible adults with serious mental illness. Kentucky plans on implementing the increase in length of stay in IMDs for mental health treatment immediately following the approval of this amendment.

DMS proposes the following goals and hypotheses to evaluate this component of the waiver:

Table 2: Increased days in IMD's for Mental Health Hypotheses		
Goal 1: Reduce utilization and lengths of stay in ED's among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings.		
Hypothesis 1	**Potential Measurement(s)**	**Data Source(s)**
The demonstration will result in reductions in utilization of stays in emergency department among Medicaid beneficiaries with SMI while awaiting mental health treatment.	ED use among Medicaid beneficiaries with SMI and their lengths of stay in ED.	Claims data
Goal 2: Reduce preventable readmissions to acute care hospitals and residential settings.		
Hypothesis 2	**Potential Measurement(s)**	**Data Source(s)**
The demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.	Readmissions to inpatient psychiatric or crisis residential settings.	Claims data
Goal 3: Improve availability of crisis stabilization services including services made available through call centers and mobile crisis teams, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state.		
Hypothesis 3	**Potential Measurement(s)**	**Data Source(s)**
The demonstration will result in improved availability of crisis stabilization services throughout the state.	Rates of involuntary admissions to treatment settings, suicide, or overdose death within 15 days of discharge from an inpatient facility or residential setting for treatment for an SMI.	Claims data, Annual assessment of availability of mental health services
Goal 4: Improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI including through increased integration of primary and behavioral health care.		

Hypothesis 4	Potential Measurement(s)	Data Source(s)
Access of beneficiaries with SMI to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and behavioral health care.	Patient referral into treatment by specified care setting, access to preventive/ambulatory health services for Medicaid beneficiaries with SMI, evidence of availability of community-based services and alternatives to inpatient and residential services in each geographic region of the state.	Claims data, Annual assessment of availability of mental health services
Goal 5: Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.		
Hypothesis 5	**Potential Measurement(s)**	**Data Source(s)**
The demonstration will result in improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	Medication continuation following discharge, follow up after ED visit for mental illness or alcohol and other drug use dependence.	Claims data

Recuperative Care Pilot Program Description

Kentucky's current Recuperative Care Services are provided by a variety of providers utilizing multiple braided funding streams in a variety of settings. Recuperative Care Services in Kentucky are not currently reimbursable by Medicaid. DMS is requesting authorization to implement a recuperative care pilot program through this demonstration opportunity to provide more consistent and robust recuperative care services to Kentuckians. The proposed model of recuperative care for the pilot will include the basic essential services of recuperative care as set forth by *The National Institute for Medical Respite Care*[17] (NIMRC) and will also include more integrated and comprehensive services to further address the medical needs, health related social needs, and behavioral health needs of beneficiaries who are homeless or at risk of homelessness. Individuals will be eligible for recuperative care services through the pilot program if they are 18 years of age and older, enrolled in Medicaid and:

1. are homeless, or at risk of homelessness who meet criteria based upon definitions in 24 CFR 91.5[18] , and
2. are at risk of hospitalization and/or readmission with a medical need
    - Following discharge from acute care facility or Emergency Department OR

[17] National Institute for Medical Respite Care (Last visited Fe. 24, 2023) https://nimrc.org/.

[18] https://www.ecfr.gov/current/title-24/subtitle-A/part-91/subpart-A/section-91.5

- Have a planned medical procedure requiring preparation care OR
- Have a planned medical treatment (i.e.: chemotherapy treatment) requiring care prior to or following the treatment AND

3. Must have a primary medical Diagnosis

The DMS model of recuperative care is proposed to include, at minimum, the following components:

- 24-hour staffed program
- 3 meals a day
- Arrange transportation to any/all aftercare appointments
- Access to a phone for telehealth and/or communications related to medical needs
- Safe and secure space to store personal items
- Wellness check at least 1x every 24 hours by medical professional
- Safe and secure (preferably double locked) space to store medications in patient's room
- Nursing assessment within 24 hours of admission
- Medication monitoring supervised licensed clinical staff
- On-Site or access to community behavioral health services for behavioral health screening and brief intervention and referral as needed
- Care coordination plan to be completed within 72 hours of admission
- Onsite Care Coordination
- Required trainings for clinical and non-clinical staff

Programs interested in participating in the pilot should be established programs who are already providing recuperative care services. These programs will be required to meet qualifications for providing the model of Recuperative Care outlined by DMS. Prior to providing recuperative care services reimbursable by Kentucky Medicaid, each program will also be expected to list their Recuperative Care programs on the official directory through NIMRC. DMS proposes to reimburse up to 20 beds at any given time to provide up to 45 days of service/care per beneficiary. Approved settings considered for the recuperative care pilot programs are proposed to be Interim housing facilities with additional on-site support, separate units of shelter beds with additional on-site support, and converted homes with additional on-site support. Kentucky plans on implementing the Recuperative Care Pilot one year following the approval of this amendment. The demonstration is projected to occur over a 5-year timeframe.

As aforementioned, this waiver application is part of a complex, comprehensive plan to increase community support services to address HRSN for individuals with SMI/SUD and complex needs, including applications to other waiver authorities for additional community support services.

DMS proposes the following goals and hypotheses to evaluate the recuperative care pilot program:

Table 3: Recuperative Care Hypotheses	
Goal 1: Reduce utilization of avoidable high-acuity healthcare services through improved access to other continuum of care services.	
Hypothesis 1	Among beneficiaries receiving recuperative care, beneficiaries will experience fewer3emergency department visits.
Hypothesis 2	Among beneficiaries receiving recuperative care, beneficiaries will experience a reduction in inpatient days.
Hypothesis 3	Among beneficiaries receiving recuperative care, beneficiaries will experience a reduction in hospital readmission rates.
Hypothesis 4	Among beneficiaries receiving recuperative care, beneficiaries utilize services at lower levels of care.
Potential Measures	Utilization of: ED visits; inpatient days; outpatient services and 30-day hospital readmission rates.
Data Source	Claims data
Goal 2: Reduce health disparities by improving beneficiary physical and behavioral health outcomes.	
Hypothesis 1	Beneficiaries who receive recuperative care are more likely to utilize preventative, routine, and primary care services.
Hypothesis 2	Beneficiaries who receive recuperative care are more likely to utilize behavioral health services.
Hypothesis 3	Beneficiaries will report better physical and behavioral health outcomes.
Potential Measures	Utilization of healthcare screenings; annual check-up visits; vaccinations; primary care visits; behavioral health visits, and patient satisfaction surveys.
Data Source	Claims data and beneficiary surveys
Goal 3: Reduce health disparities by improving access to community-based services to address health related social needs.	
Hypothesis	The demonstration will increase connections to community-based services for beneficiaries receiving recuperative care.
Potential Measures	Referrals to community-based services such as: housing, food, social services, transportation, employment.
Data Source	Claims data and medical records.
Goal 4: Ensure long-term fiscal sustainability of recuperative care services.	
Hypothesis	Beneficiaries who receive recuperative care will accrue lower healthcare cost than those who do not receive recuperative care services.
Potential Measures	Total expenditures and per member per month cost of services.
Data Source	Claims data

Section II - Demonstration Eligibility

All Kentucky Medicaid enrollees eligible in mandatory, optional, or expansion eligibility groups, approved for full Medicaid coverage and between the ages of 21 – 64, with Federal Poverty Limit of up to 218% depending on eligibility and type of assistance, would be eligible for acute inpatients stays for the proposed 30 days in an IMD if they have an SMI diagnosis, and the inpatient stay is a medical necessity.

All Kentucky Medicaid enrollees eligible in mandatory, optional, or expansion eligibility groups, approved for full Medicaid coverage, ages 18 or older, and are homeless or at risk of homelessness, with Federal Poverty Limit of up to 218% depending on eligibility and type of assistance, would be eligible for the recuperative care services proposed under the waiver. The following is the eligibility criteria for services under the proposed Recuperative Care Pilot Program for beneficiaries who are 18 years of age and older:

1. Individuals who are homeless, or at risk of homelessness who meet criteria based upon definitions in 24 CFR 91.5 AND
2. Individuals who are at risk of hospitalization and/or readmission with a medical need:

- Following discharge from acute care facility or Emergency Department OR
- Have a planned medical procedure requiring preparation care OR
- Have a planned medical treatment (i.e.: chemotherapy treatment) requiring care prior to or following the treatment AND

3. Must have a primary medical Diagnosis

Only the eligibility groups outlined below in **Table 4** will not be eligible under the proposed waiver, as they receive limited Medicaid benefits, are in receipt of Long-Term Care services and supports, or do not meet the age criteria.

No Medicaid eligibility changes or modifications to the current Kentucky Medicaid fee-for-service or managed care arrangements are proposed through this amendment; all enrollees will continue to receive services through their current delivery system. Additionally, payment methodologies will remain consistent with those currently approved in the Kentucky Medicaid State Plan.

Table 4: Eligibility Groups

Eligibility Groups	Social Security Act and CFR Citations	2023 Federal Poverty Limit
Qualified Medicare Beneficiaries	1902(a)(10)(E)(i) 1905(p)	100% FPL
Specified Low Income Medicare Beneficiaries	1902(a)(10)(E)(iii) 1905(p)(3)(A)(ii)	120% FPL

Qualifying Individuals	1902(a)(10)(E)(iv) 1905(p)(3)(A)(ii)	135% FPL
Qualified Disabled and Working Individuals	1902(a)(10)(E)(ii) 1905(s) 1905(p)(3)(A)(i)	200% FPL
Mandatory Poverty Level Related Infants	1902(a)(10)(A)(i)(IV) 1902(l)(1)(B)	200% FPL
Mandatory Poverty Level Related Children aged 1-5	1902(a)(10)(A)(i)(VI) 1902(l)(1)(C)	147% FPL
Mandatory Poverty Level Related Children aged 6-18	1902(a)(10)(A)(i)(VII) 1902(l)(1)(D)	147% FPL
Deemed Eligible Newborns	1902(e)(4) 42 CFR 435.117	-NA-
Institutionalized Individuals Continuously Eligible Since 1973	42 CFR 435.132	-NA-
Limited Services Available to Certain Aliens	42 CFR §435.139	-NA-
Individuals Receiving Home and Community Based Services under Institutional Rules	42 CFR 435.217 1902(a)(10)(A)(ii)(VI)	-NA-
Individuals Participating in a PACE Program under Institutional Rules	1934	-NA-
Institutionalized Individuals Eligible under a Special Income Level	42 CFR 435.236 1902(a)(10)(A)(ii)(V) 1905(a)	Subject to Special Income Standard
Medically Needy Children under 18	1902(a)(10)(C)(ii)(I) 42 CFR 435.301(b)(1)(ii)	-NA-

Projected Medicaid Enrollment

The requested 1115 waiver amendment is not anticipated to impact Kentucky Medicaid enrollment over the course of the five-year demonstration, as there are no waiver-specific eligibility criteria included.

Below in **Table 5**, DMS has identified the number of adult individuals enrolled in Medicaid in 2022 to be used for projected enrollment of the same population for 2023 for the demonstration.

Table 5: Number of Adult Individuals enrolled in Medicaid 2022	
Enrollment Total	1,483,133
Adult Total	1,250,532
Total of MAGI Enrollment	802,272
Total of Non-MAGI Enrollment	176,028
Total	140,431

Section III - Demonstration Benefits and Cost Sharing Requirements

Benefits provided under this demonstration do not differ from those provided under Medicaid State Plan. Kentucky Medicaid does not currently have cost sharing for beneficiaries. No modifications are proposed through this waiver application for cost sharing.

Section IV - Delivery System and Payment Rates for Services

Through this amendment, the state seeks a waiver of the IMD exclusion for all Medicaid SMI beneficiaries aged 21-64 and Recuperative Care Services for beneficiaries aged 18 and up regardless of delivery system. No modifications to the current Kentucky Medicaid fee-for-service or managed care arrangements are proposed through this amendment; all enrollees will continue to receive services through their current delivery system. Additionally, payment methodologies will be consistent with those approved in the Medicaid State Plan.

Section V - Implementation of Demonstration

The State is aware of the CMS Implementation Plan requirements and is already planning activities that will support successful waiver implementation. The State has conducted a series of robust stakeholder engagement sessions that culminated in the formal public notice and comment process required for this waiver application described in Section VII. The stakeholder engagement process will continue throughout the waiver negotiation period, which DMS anticipates will facilitate further discussion of waiver details and inform Department planning for any necessary:

- State regulation changes.
- Provider standards and billing updates.
- Provider engagement and training needs; and
- Contract policy and payment rate changes.

Once the key elements of the waiver are agreed upon with CMS, the state will provide a full Implementation Plan according to CMS requirements within 90 days of approval of the application.

Section VI - Demonstration Financing and Budget Neutrality

Budget Neutrality Impact

Please refer to the attached documentation in **Appendix A** for a detailed analysis of the budget neutrality impact.

CHIP Allotment

This requirement is not applicable to this amendment request, as the amendment does not make any changes to the CHIP program.

Maintenance of Effort

In accordance with the November 13, 2018 CMS State Medicaid Director Letter, the state understands this waiver request is subject to a maintenance of effort (MOE) requirement to ensure the authority for more flexible inpatient treatment does not reduce the availability of outpatient treatment for these conditions. As demonstrated in **Section I,** *Overview of Kentucky Efforts to Improve Continuum of Care for the SMI Population*, the Commonwealth has many outpatient services, provider types, and initiatives to serve the SMI population which will continue to be available to beneficiaries despite increasing access to inpatient treatment services through this demonstration.

Section VII - List of Proposed Waiver and Expenditure Authorities

Kentucky requests waiver of Section 1902(a)(10)(B) to the extent necessary to allow the State to offer HRSN services, specifically recuperative care, for beneficiaries who meet the eligibility criteria specified in this waiver amendment application.

The State requests expenditure authority for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment for a SMI who are short-term in facilities that meet the definition of an IMD.

Section VIII - Tribal Notice & Public Notice

Tribal Notice

Kentucky does not have any tribal units.

Public Notice

In accordance with 42 CFR 431.408, the Cabinet for Health and Family Services (CHFS), Department for Medicaid Services (DMS) announces its intention to file an 1115 Amendment Application with the Centers for Medicare and Medicaid Services (CMS), requesting Medicaid coverage to (1) reimburse medically necessary short-term, defined as a state-wide average length of stay no longer than 30 days, inpatient treatment services within settings that qualify as institutions for mental diseases (IMDs) for Medicaid-eligible adults with serious mental illness; (2) implement a pilot program to provide Health-Related Social Needs (HRSN) services, specifically recuperative care services, also known as medical respite care, to adult beneficiaries, who are homeless or at risk of homelessness, and who need additional medical support and care coordination.

Copies of this notice are available on the DMS Website

In addition, DMS will hold 3 virtual town hall meetings on the following dates:

April 12, 2023, 3:00 EST
April 19, 2023, 10:00 EST
April 26, 2023, 12:00 EST
Join by Microsoft Teams Meeting: Click here to join the meeting

Meeting ID: 279 612 657 461
Passcode: 6wTdNE

Join by Phone:
502-632-6289
Phone Conference ID: 791 546 355#

Additional information regarding these proposed actions is available upon request at the address cited below:

A copy of this notice is available for public review at the Department for Medicaid Services at the Department for Medicaid Services at the address listed below.

Comments or inquiries should be submitted via email received on or before May 5, 2023, to: DMS.ISSUES@ky.gov. Written comments must be postmarked by May 5, 2023, and sent to the address below:

SMI 1115 Amendment Comment
c/o DMS Commissioner's Office
275 E. Main St. 2E
Frankfort, KY 40601

For Kentucky's 1115 Demonstration historical information refer to:
KY HEALTH 1115 Demonstration

Prior to submitting KY's Section 1115 Demonstration extension request to CMS DMS will follow all guidelines and procedures according to 42 CFR § 431.408 regarding collection, review of and response to public comments.

Section IV- Demonstration Administration

Name: Leslie Hoffmann
Title: Deputy Commissioner
Agency: Department for Medicaid Services
Address: 275 East Main Street 2E
Frankfort, KY 40601
Phone number: 502-229-5829
Leslie.Hoffmann@ky.gov

Appendix A: Demonstration Financing and Budget Neutrality

Pursuant to Section 1115(a) of the Social Security Act ("the Act"), states must demonstrate budget neutrality to receive approval of a demonstration waiver and to receive federal financial participation (FFP) for state expenditures that would not qualify for FPP under section 1093 of the Act.

Kentucky currently authorizes coverage for short-term, no more than fifteen (15) days, mental health stays in IMDs for beneficiaries from 21 to 64 years of age under the Managed Care In Lieu of Service authority according to 42 C.F.R. 438.6(e)(2). Under KY's Section 1115 Project Nos. 11-W-00306/4 and 21-W-00067/4, the Commonwealth requests to extend short-term mental health stays in IMDs for individuals with SMI to a statewide average length of stay of thirty (30) days with authorization to receive FFP for expenditures for otherwise covered services furnished to eligible individuals who are primarily receiving treatment for SMI in facilities that meet the definition of an IMD.[1] In accordance with CMS budget neutrality guidance, the amendment only seeks to extend the permissible length of stay, therefore is to be treated as hypothetical expenditures for purposes of calculating budget neutrality.

In addition, the proposed demonstration waiver amendment seeks to implement a pilot program to provide Health Related Social Needs (HRSN) services, specifically recuperative care services, also known as medical respite care, to adult beneficiaries aged 18-64 who are homeless or at risk of homelessness and need additional medical support and care coordination. In accordance with CMS guidance, these services can also be classified as hypothetical expenditures through a combination of state plan covered services provided. Behavioral health services that will be provided to individuals are authorized under State Plan Amendment (SPA) #19-002, while 24/7 care and residential stays are authorized under various SPAs including #22-007 and #22-008.

Demonstration Population 1: Medicaid Inpatient Stays of Members enrolled in Managed Care with Severe Mental Illness

The Commonwealth utilized historic enrollment and claims expenditures of inpatient hospital admissions to develop the with and without waiver (WW and WOW) projections.

- Historic data used was from the most recent complete five calendar years (January 1, 2017 – December 31, 2021).
- Data selected includes all inpatient hospital admissions of beneficiaries aged 21-64.
- Member months and claims expenditures were chosen for evaluation for the month(s) in which the inpatient claim occurred.
    - Claims include capitation payments made along with any FFS claims for that member that occurred in the same month.

Trend Factor and Projection

The historical five-year without waiver data reflected an average annual PMPM trend of 9.2%, which exceeds the estimated President's budget trend factor of 6.1%. Therefore, the estimated President's trend factor was applied to trend the base period forward to each demonstration year. Trends from historic to base year include the 6.1% estimated as the President's budget trend factor. Additionally, the percentage change incorporated into the factor trending historic costs to the base year PMPM includes the actual and estimated rate changes that would occur for the managed care population, from 2021 to demonstration effective date, above and beyond normal inflation.

Demonstration Population 2: Medicaid Inpatient Stays of Members enrolled in FFS with Severe Mental Illness

The Commonwealth utilized historic enrollment and claims expenditures of inpatient hospital admissions to develop the with and without waiver projections.

- Historic data used was from the most recent complete five calendar years (January 1, 2017 – December 31, 2021).
- Data selected includes all inpatient hospital admissions of beneficiaries aged 18-64.
- Member months and claims expenditures were chosen for evaluation for the month(s) in which the inpatient claim occurred.
    - Claims include all FFS expenditures made that occurred in the month of service.

Trend Factor and Projection

The historical five-year without waiver data reflected an average annual PMPM trend of 1.4%. However, to align the demonstration trend rate with federal budgeting principles, the Commonwealth proposes to utilize the President's Budget trend rate, the estimated President's Budget trend rate of 6.1% was applied.

Demonstration Population 3: Recuperative Care Population

The Commonwealth examined historic costs and utilization data of similar state plan covered services from the most recent complete five calendar years (January 1, 2017 – December 31, 2021). However, since the combination of services included in this program are new, the Commonwealth proposes to estimate the costs of providing the HRSN service based on some historic data, and also the expected reimbursement rate.

The Commonwealth estimated the allocation between FFS and Managed Care Medicaid claims based on historic facility stays incurred by the homeless population.

After applying the noted allocation, the FFS expenditures, unique members, and member months were calculated based on expected utilization, bed availability, and the expected reimbursement rate. Member months are counted as any month(s) which a member utilizes a recuperative care service.

To determine managed care costs and utilization statistics, the Commonwealth first examined the historic capitation categories of members who were homeless and had a facility stay. A weighted capitation rate average of eligible and estimated members likely to receive the service was calculated based on the historic data. Additionally, the cap rate determined was then increased based on the estimated effect of implementing the recuperative care program on existing capitation rates for affected cohorts.

The FFS and Managed Care expected member months and expenditures were then incorporated into one PMPM.

Only expected expenditures that occur due to the service were included in the budget neutrality calculation. Therefore, expenditures and member months for this MEG should be reported as follows:

- Member month(s) should be counted in a month where a recuperative care service occurred.
- For managed care members who receive a service, the expenditures reported should equal **only** the capitation payments made for that member in the month.
- For FFS members who receive a qualifying recuperative care service, the expenditures reported should report **only** the payments made for recuperative care services, not any expenditures paid for additional services received in the month.

Trends Factor and Projection

Since the historic costs were determined using a combination of historic data, expected utilization, and reimbursement rates, the use of five historic years to set budget neutrality limits is not applicable. Therefore, no trend rate exists for this service. The Commonwealth proposes to utilize the expected President's Budget trend rate of 6.1% for the budget neutrality demonstration. Additionally, the percentage change incorporated into the factor trending historic costs to the base year PMPM includes actual and estimated rate changes that would occur for the managed care population, from 2021 to demonstration effective date, above and beyond normal inflation.

Calculation of Reimbursement Rate

Reimbursement for the proposed IMD waiver will be the same as established through state plan services and will not be altered for the additional days. KY established the recuperative care daily per diem utilizing a "rate build-up" methodology applying market information, supplemented with cost information from similar provider types in the state.

Budget Neutrality and Fiscal Summary

The Commonwealth proposes to utilize a per capita budget limit for all 3 MEGs.

	Mental Health IMD		Recuperative Care	Annual Trend Factor
	Managed Care	Fee-For-Service		
Base Year PMPM	$1,594.70	$19,905.98	$2,031.80	6.1%

WW and WOW Demonstration Years					
	DY1	DY2	DY3	DY4	DY5
MH IMD MC					
Eligible Member Months	4,780	4,828	4,877	4,925	4,975
PMPM Cost	$1,691.98	$1,795.19	$1,904.70	$2,020.89	$2,144.16
Expenditures Subtotal	*$8,088,428*	*$8,667,636*	*$9,288,342*	*$9,953,497*	*$10,666,24 5*
MH IMD FFS					
Eligible Member Months	207	209	211	213	215
PMPM Cost	$21,120.24	$22,408.57	$23,775.49	$25,225.79	$26,764.56
Expenditures Subtotal	*$4,373,799*	*$4,687,006*	*$5,022,642*	*$5,382,312*	*$5,767,739*
MH IMD Total Expenditures	*$12,462,22 7*	*$13,354,64 2*	*$14,310,98 4*	*$15,335,80 9*	*$16,433,98 4*
Recuperative Care					
Eligible Member Months	1,248	1,260	1,273	1,285	1,298
PMPM Cost	$2,155.74	$2,287.24	$2,426.76	$2,574.79	$2,731.85
Recuperative Care Subtotal	*$2,689,615*	*$2,882,219*	*$3,088,612*	*$3,309,785*	*$3,546,796*

[1] Note, the Commonwealth is currently authorized to receive FFP for expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental disease (IMD) (Project Nos. 11-W-00306/4 and 21-W-00067/4). In this context, "short-term" is defined as a statewide average length of stay (ALOS) of thirty (30) days.