Kentucky Department of Medicaid Services
1115 SUD Demonstration Proposed Amendment
Continuity of Care for Incarcerated Members
Public Comments

1. Clear language that treatment in jails and prisons should not replace community treatment and more Kentuckians should receive access to these community resources.
   Response: **This waiver cannot change the way laws are enforced or prosecuted, or who has releasing authority. DOC is not the releasing authority. The waiver does not prolong or encourage incarceration in order to receive treatment. The waiver will utilize current programs to increase treatment to charged or convicted incarcerated individuals within DOC. It will explicitly transition more individuals out of the incarcerated setting and into community-based treatment. It will also provide continuity and coordination of care as well as other supports to improve health outcomes and ensure a successful re-entry into the community. While this waiver covers services as part of the DOC SAP or PSAP programs, nothing in this waiver precludes an agreement for community-based treatment for a person released by a court. However, court-ordered SUD treatment does not mean it is medically necessary. SUD treatment, including residential treatment, is only Medicaid reimbursable if it is medically necessary as determined by a behavioral health professional according to ASAM criteria.**

2. A revision that does not arbitrarily exclude Kentuckians based on the point in time or otherwise ranking of diagnoses. If an individual had a substance use disorder, they should be eligible to participate in the recovery paths provided by this demonstration project.
   Response: This waiver focuses on the incarcerated population with a substance use disorder (SUD) diagnosis. **Anyone within DOC with an SUD diagnosis who meets admission criteria is eligible to participate in SUD treatment.**

3. Outline the providers, services and treatment options available more clearly for those individuals who have co-occurring SUD and SMI.
   Response: **Currently, DOC Addiction Services and DOC Mental Health have an integrated program for individuals with SUD and SMI. While incarcerated, Medicaid will only cover SUD services but DOC will continue to cover mental health services and medications. Upon release, Medicaid will cover medically necessary SUD and SMI services and medications through managed care. As this program is further negotiated with CMS, covered services, operational considerations, and enrolled provider types will be fully described according to the federal 1115 waiver process.**

4. We advocate for the collection of data and transparency pertaining to individuals who receive SUD treatment while incarcerated and individuals who are awarded the opportunity to receive treatment the community.
   Response: **The University of Kentucky's Center for Drug and Alcohol Research already collects this data and prepares reports. The Criminal Justice Kentucky Treatment Outcome Study reports are available to the public on the DOC website at: https://corrections.ky.gov/Divisions/ask/Pages/SAMAT.aspx. In addition to the DOC reports, there will also be an evaluation of the 1115 Continuity of Care for Incarcerated Members demonstration.**

5. Modification to the amendment would be to strike the words "jail based" on page 12 to reflect that a community based 6 month treatment program may serve as an alternate to a felony conviction. If the intent of this portion of the demonstration was residential 6 month treatment program, adding the word "residential" would still allow for a community based treatment and not the clear preference for incarceration.
   Response: **This waiver cannot change the way laws are enforced or prosecuted, or who has releasing authority. DOC is not the releasing authority. The waiver does not prolong or encourage incarceration in order to receive treatment. The waiver will utilize current programs to increase treatment to charged or convicted incarcerated individuals within DOC. It will explicitly transition more individuals out of the incarcerated setting and into community-based treatment. It will also provide continuity and coordination of care as well as other supports to improve health outcomes and ensure a successful re-entry into the community. While this waiver covers services as part of the DOC SAP or PSAP programs, nothing in this waiver precludes an agreement for community-based treatment for a person released by a court. However, court-ordered SUD treatment does not mean it is medically necessary. SUD treatment, including residential treatment, is only Medicaid reimbursable if it is medically necessary as determined by a behavioral health professional according to ASAM criteria. We will clarify the language.**

6. To further prevent that unintended consequence, DOC and AOC should provide regular reports on lengths of incarceration for our fellow Kentuckians participating in this project, as well as the number of individuals who are incarcerated with a self-reported or diagnosed SUD.
   Response: **The University of Kentucky's Center for Drug and Alcohol Research already collects this data and prepares reports. The reports, the Criminal Justice Kentucky Treatment Outcome Study, are available to the public on the DOC website at: https://corrections.ky.gov/Divisions/ask/Pages/SAMAT.aspx. In addition to the DOC reports, there will also be an evaluation of the 1115 Continuity of Care for Incarcerated Members demonstration.**

7. We ask that clear guidance that Medicaid can be a payer for medically appropriate and billable healthcare that also fulfills court orders.
   Response: **SUD treatment, including residential treatment, is only Medicaid reimbursable if it is medically necessary as determined by a behavioral health professional according to ASAM criteria. We will clarify the language.**

8. We suggest clear communication and requirements from all appropriate state agencies (DMS, DOI, MCOs) and ongoing education from our MCOs. We also suggest ongoing communication with judicial training to educate judges about requiring evaluations and medically appropriate treatment only to further prevent the conflict.
   Response: **CHFS has and will continue to partner to provide training to all stakeholders, including those in Medicaid and the judicial system.**

9. Recommendation: DMS work with AOC to adjust diversion and sentencing forms to include acknowledgment of the availability of community based treatment for SUD.
   Response: **CHFS has and will continue to partner to provide information to all stakeholders, including those in Medicaid and the judicial system.**

10. Remove the requirement for a primary diagnosis of SUD.
    Response: **This proposal is a modification of the existing 1115 SUD waiver that specifically expands access to SUD treatment services. Co-occurring SUD and mental health conditions are eligible.**

11. Comment: Strongly supports the inclusion of coordinated enrollment pre-release. Pre-release Medicaid and MCO enrollment are a necessary foundation for successful case management and care delivery. Research is clear that poor health and healthcare needs make it harder for formerly incarcerated people to successfully reintegrate into their communities.
    Response: **Thank you for your comment.**

12. Suggestion: We suggest clarifying that same patient centered commitment and improved likelihood by replacing the word allow with the word required.
    Response: **Clarifying language has been added to the waiver.**

13. Kentucky's increased SUD treatment in jails should not increase pretrial detention. Kentucky should not detain people pretrial for the purposes of treatment. Instead, it should consider alternatives at the time of arrest, including, for example, law enforcement to provider referrals for community based treatment instead of charging people with a crime. In addition, decision making on the setting of bail should be limited to only those instances where prosecutors have affirmatively demonstrated a risk to public safety or willful flight.
    Response: **This waiver cannot change the way laws are enforced or prosecuted, or who has releasing authority. DOC is not the releasing authority. The waiver does not prolong or encourage incarceration in order to receive treatment. The waiver will utilize current programs to increase treatment to charged or convicted incarcerated individuals within DOC. It will explicitly transition more individuals out of the incarcerated setting and into community-based treatment. It will also provide continuity and coordination of care as well as other supports to improve health outcomes and ensure a successful re-entry into the community. While this waiver covers services as part of the DOC SAP or PSAP programs, nothing in this waiver precludes an agreement for community-based treatment for a person released by a court. However, court-ordered SUD treatment does not mean it is medically necessary. SUD treatment, including residential treatment, is only Medicaid reimbursable if it is medically necessary as determined by a behavioral health professional according to ASAM criteria.**

14. Comment: Medicaid plays an important role for beneficiaries who are justice involved.
    Response: **Thank you for your comment.**

15. Comment: We urge DMS to specifically include the provision of targeted case management without prior authorization requirements, which have been a serious barrier to people with SUD/SMI diagnoses in the past. We recommend that this policy be continued and be integrated into this demonstration program.
    Response: **Thank you for your comment.**

16. Please clarify how and when MCOs will be notified of individuals' MCO selection.
    Response: **DOC and/or DMS will notify the MCOs. The exact process has not been determined and will be created when the waiver amendment is approved. The process will be similar to how the Reentry Program is currently working. As this program is further**

negotiated with CMS, covered services, operational considerations, and enrolled provider types will be fully described according to the federal 1115 waiver process.

17. Must all meetings between the incarcerated individual and the MCO staff occur on-site or will there be an option for MCO staff to interact with individuals virtually, including telephonically?
    Response: **Virtual communication may occur between MCO staff and the incarcerated individual. In most instances, DOC reentry staff will be present as well.**

18. Can DMS provide reassurances regarding the planned testing of APPRISS with the Medicaid eligibility system so that we can in turn share with providers to reassure them during our efforts to solicit provider participation in this initiative?
    Response: **The implementation of APPRISS is occurring outside of this demonstration.**

19. Comment: We recommend a seamless, current and accurate eligibility process, with advance notification of MCO choice to avoid any provider participation barriers.
    Response: **Thank you for the comment.**

20. To safeguard against members running out of MAT medication after release, we emphasize that they be dispensed an ample supply of MAT medication upon release.
    Response: **DOC uses long acting injectable MAT as close to the time of release as possible (within the last few days) to allow close to a month before additional medication is needed. A key feature of this waiver is continuity and coordination of care by the MCOs to ensure that adequate follow-up and access to medications is in place post release.**

21. We ask DMS to confirm that methadone will not be used as a MAT medication for incarcerated individuals.
    Response: **As this demonstration is currently proposed, Methadone is not an available MAT medication.**

22. We ask DMS to confirm if NEMT to SUD treatment, including to pharmacies to pick up MAT medication prescriptions, will be covered for individuals post release. If transportation will not be covered, we fear this will create a substantial barrier to treatment and to the program's success.
    Response: **NEMT is available to any Medicaid recipient who meets all of the qualifications for the service**. **A key feature of this waiver is continuity and coordination of care by the MCOs including a case management function to ensure access to medications post release.**

23. Recommendation: the waiver amendment should never be used to justify incarceration, initial or ongoing.
    Response: **This waiver cannot change the way laws are enforced or prosecuted, or who has releasing authority. DOC is not the releasing authority. The waiver does not prolong or encourage incarceration in order to receive treatment. The waiver will utilize current programs to increase treatment to charged or convicted incarcerated individuals within DOC. It will explicitly transition more individuals out of the incarcerated setting and into community-based treatment. It will also provide continuity and coordination of care as well as other supports to improve health outcomes and ensure a successful re-entry into the community. While this waiver covers services as part of the DOC SAP or PSAP programs, nothing in this waiver precludes an agreement for community-based treatment for a person**

released by a court. However, court-ordered SUD treatment does not mean it is medically necessary. SUD treatment, including residential treatment, is only Medicaid reimbursable if it is medically necessary as determined by a behavioral health professional according to ASAM criteria.

24. It is not clear in the waiver whether enough Peer Support Specialists are currently employed or will be hired, if there is adequate oversight of their well-being and recovery while serving in this intense role, and if they will have lived experience with incarceration. We are also concerned about the relatively low percentage of families who are expected to be engaged in the recovery of their loved one. We'd like to see additional information on these aspects included in the waiver, or made available to advocates like ourselves who are charged with ensuring improvement, and not sent back, with all stakeholders in the mental health system in Kentucky.
    Response: **Peer Support Specialists would be an additional service to existing treatment services. The specifics would be determined if this waiver is approved. DOC Addiction Services is committed to family and community involvement in the treatment process and offer family and community engagement as well as a user-friendly website that offers several sub-pages with useful information under the Addiction Services Division at: https://corrections.ky.gov/Divisions/ask/pages/default.aspx**

25. We are concerned that all medication options are not being made available in this current version of the amendment. Long-acting injectable medications for SMI, long-acting MAT options, and medication other than Vivitrol should be widely available for use in treatment of these incarcerated individuals as medically necessary.
    Response: **The waiver is specific to SUD treatment services. Currently all SUD programs offer Vivitrol to individuals who meet clinical and medical criteria. Suboxone and Subloclade are currently offered in some programs. Medicaid reimbursement will assist with the funding necessary to expand MAT options to the incarcerated population. In addition, any other medically necessary medications and services will be covered post release.**

26. Section II & III. It is suggested that language be added to these 2 sections which permits DOC to either provide identified services directly or contract with a community based provider to provide the services within either a DOC facility or a local jail.
    Response: **The waiver does not change how DOC provides and contracts services.**

27. Section II. It is recommended that the community based provider which will be supporting the individuals served as they return to the community be permitted to assist with and be reimbursed for any transition services provided. Specific services may include assisting with housing, employment and scheduling necessary physical and behavioral health appointments. This will result in a warm hand-off from DOC services and supports to community services and supports resulting in a greater likelihood of a successful return to the community. This strategy has been used effectively in some DOC facilities in partnership with the appropriate regional CMHC. The sooner the linkage is established between the individuals and a local provider in the community to which the individual is returning the better outcome.
    Response: **The DOC Division of Addiction Services has clinicians located in all P&P offices across the state who are responsible for assisting individuals with SUD treatment and recovery services upon release of custody and providing case management of those services. The DOC also has a reentry division that works with individuals to provide resources and remove barriers. They assist with education, job training, employment, housing, Medicaid**

enrollment, and referral to other community-based agencies as needed. DOC will work with MCOs on a transition of care.

28. It will be imperative to increase the screening time for a person who enters incarceration until they are able to be diverted to treatment; hopefully outside the walls of incarceration. Faster screening times can relieve the jails of the difficult task of keeping a close eye on one person, when they have many others to watch.
    Response: **This waiver cannot change the way laws are enforced or prosecuted, or who has releasing authority. DOC is not the releasing authority. The waiver does not prolong or encourage incarceration in order to receive treatment. The waiver will utilize current programs to increase treatment to charged or convicted incarcerated individuals within DOC. It will explicitly transition more individuals out of the incarcerated setting and into community-based treatment. It will also provide continuity and coordination of care as well as other supports to improve health outcomes and ensure a successful re-entry into the community. While this waiver covers services as part of the DOC SAP or PSAP programs, nothing in this waiver precludes an agreement for community-based treatment for a person released by a court. However, court-ordered SUD treatment does not mean it is medically necessary. SUD treatment, including residential treatment, is only Medicaid reimbursable if it is medically necessary as determined by a behavioral health professional according to ASAM criteria.**

29. SAP programs have waiting lists inside KY jails and prisons; these lists can take months and because they are inside a jail and everyone incarcerated is dealing with legal issues, you can't predict how long you will be on the list. This is because many persons in SAP programs inside jails are there pre-trial and waiting on the outcome of their legal case.
    Response: **If approved, the waiver amendment will allow DOC to increase existing treatment opportunities and reduce the wait for SUD treatment for the incarcerated population.**

30. Will the Parole Board as well as Circuit Court Judges rationalize that if Medicaid is paying for "in-prison" and "in- jail" SAP programs, the risk is too great to refer these same individuals to community-based programs (as they are now). Their thinking may be that if residents are incarcerated and in a substance abuse treatment program paid for Medicaid then why they would send those residents to a community-based program where they may be more likely to reoffend.
    Response: **This waiver cannot change the way laws are enforced or prosecuted, or who has releasing authority. DOC is not the releasing authority. The waiver does not prolong or encourage incarceration in order to receive treatment. The waiver will utilize current programs to increase treatment to charged or convicted incarcerated individuals within DOC. It will explicitly transition more individuals out of the incarcerated setting and into community-based treatment. It will also provide continuity and coordination of care as well as other supports to improve health outcomes and ensure a successful re-entry into the community. While this waiver covers services as part of the DOC SAP or PSAP programs, nothing in this waiver precludes an agreement for community-based treatment for a person released by a court. However, court-ordered SUD treatment does not mean it is medically necessary. SUD treatment, including residential treatment, is only Medicaid reimbursable if it is medically necessary as determined by a behavioral health professional according to ASAM criteria.**

31. Individuals with substance use disorder who would normally be eligible for pretrial diversion (community-based treatment programs) may instead be sent to incarcerated programs that are paid for by Medicaid. This could result in more incarceration and longer stays since Medicaid would be paying for these programs as opposed to DOC.
    Response: **This waiver cannot change the way laws are enforced or prosecuted, or who has releasing authority. DOC is not the releasing authority. The waiver does not prolong or encourage incarceration in order to receive treatment. The waiver will utilize current programs to increase treatment to charged or convicted incarcerated individuals within DOC. It will explicitly transition more individuals out of the incarcerated setting and into community-based treatment. It will also provide continuity and coordination of care as well as other supports to improve health outcomes and ensure a successful re-entry into the community. While this waiver covers services as part of the DOC SAP or PSAP programs, nothing in this waiver precludes an agreement for community-based treatment for a person released by a court. However, court-ordered SUD treatment does not mean it is medically necessary. SUD treatment, including residential treatment, is only Medicaid reimbursable if it is medically necessary as determined by a behavioral health professional according to ASAM criteria.**

32. An in-prison or in-jail substance abuse program funded by Medicaid should be for those inmates who are at the greatest risk for reoffending. The Parole Board or the Circuit Courts determine that the offender can benefit from substance abuse treatment in prison- but because of their perceived risk to the community, they should remain incarcerated.
    Response: **This waiver cannot change the way laws are enforced or prosecuted, or who has releasing authority. DOC is not the releasing authority. The waiver does not prolong or encourage incarceration in order to receive treatment. The waiver will utilize current programs to increase treatment to charged or convicted incarcerated individuals within DOC. It will explicitly transition more individuals out of the incarcerated setting and into community-based treatment. It will also provide continuity and coordination of care as well as other supports to improve health outcomes and ensure a successful re-entry into the community. While this waiver covers services as part of the DOC SAP or PSAP programs, nothing in this waiver precludes an agreement for community-based treatment for a person released by a court. However, court-ordered SUD treatment does not mean it is medically necessary. SUD treatment, including residential treatment, is only Medicaid reimbursable if it is medically necessary as determined by a behavioral health professional according to ASAM criteria.**

33. According to the proposal MCOs will be responsible for determining the next level of care and services 30 days prior to incarceration. Are MCOs prepared to provide these services and how will they assure that clients are not given inappropriate levels of care or referrals as a cost saving mechanism to the MCO?
    Response: **DOC and/or DMS will notify the MCOs. The exact process has not been determined and will be created when the waiver amendment is approved. The process will be similar to how the Reentry Program is currently working. MCOs will adhere to ASAM criteria to determine the appropriate level of care.**

34. Why create a new system to build out community supports when it already exists in the community? If the perceived goal of Kentucky Department of Corrections and the Governor is

to move state inmates out of institutions and into community-based treatment would it not be more cost efficient to build a more effective system to network with already existing services?
Response: **The waiver will utilize current programs to increase treatment to charged or convicted incarcerated individuals within DOC. It will explicitly transition more individuals out of the incarcerated setting and into community-based treatment. It will also provide continuity and coordination of care as well as other supports to improve health outcomes and ensure a successful re-entry into the community. The waiver proposes a complement to the existing system to decrease gaps in coverage.**

35. This proposal asserts that clinical treatment services will be expanded within institutions. There is a current scarcity of certified and licensed alcohol and drug counselors in Kentucky. How will these SUD programs within institutions be staffed? Will the institutional programs have the same requirements and criteria for the professionals who provide the services? Will Medicaid requirements qualifications be waived in these programs? If the requirements are the same, how will this impact community-based treatment programs? If Medicaid has different requirements for institutional staffing how this will affect the quality of those services?
Response: **All of the DOC incarcerated treatment program hold an active AODE license and meet staffing requirements. The waiver will not change the way DOC provides or contracts services.**

36. Does this proposal open the door for Medicaid to pay costs (cancer treatment, surgeries, treatment of other chronic illnesses) that Kentucky Department of Corrections are currently required to pay for?
Response: **This waiver is specific to SUD treatment.**

37. Is there a reason that successful completion of a 6 month program in the community couldn't count as an alternative to a felony conviction?
Response: **This waiver cannot change the way laws are enforced or prosecuted, or who has releasing authority. DOC is not the releasing authority. The waiver does not prolong or encourage incarceration in order to receive treatment. The waiver will utilize current programs to increase treatment to charged or convicted incarcerated individuals within DOC. It will explicitly transition more individuals out of the incarcerated setting and into community-based treatment. It will also provide continuity and coordination of care as well as other supports to improve health outcomes and ensure a successful re-entry into the community. While this waiver covers services as part of the DOC SAP or PSAP programs, nothing in this waiver precludes an agreement for community-based treatment for a person released by a court. However, court-ordered SUD treatment does not mean it is medically necessary. SUD treatment, including residential treatment, is only Medicaid reimbursable if it is medically necessary as determined by a behavioral health professional according to ASAM criteria.**

38. It is unclear what BH treatment will be provided to individuals with dual diagnosis. What Medicaid billable BH providers, services and medications will be covered under this demonstration?

Response: **Currently, DOC Addiction Services and DOC Mental Health have an integrated program for individuals with SUD and SMI. While incarcerated, Medicaid will only cover SUD services but DOC will continue to cover mental health services and medications. Upon release, Medicaid will cover medically necessary SUD and SMI services and medications through managed care.**

39. We recognize that there aren't even evidence based SUD treatment programs with available beds in the community for all of the justice involved individuals who need treatment. What is DMS doing to ensure MCOs are meeting network adequacy and parity rules?
    Response: **DMS has been assured that there are ample amounts of treatment beds available. MCOs are required to provide network adequacy and parity pursuant to their contracts and state and federal law. In addition, the waiver affords an opportunity for a better transition of care from incarceration to the community by involving the MCOs before release.**

40. We are especially concerned that requiring the judge and attorney to agree that receiving SUD treatment during pre-trail can serve as an alternative to a felony conviction could create an unintended incentive for people to remain incarcerated, rather than treated in the community.
    Response: **Pretrial Substance Abuse Program (PSAP) is authorized by SB4 from the 2009 Session. The statutory language requires an agreement from the judge, attorneys and client. This law would need to be amended to create that change. DOC is operating as required by statute. The ultimate goal is to provide community based treatment to individuals. This waiver cannot change the way laws are enforced or prosecuted, or who has releasing authority. DOC is not the releasing authority. The waiver does not prolong or encourage incarceration in order to receive treatment. The waiver will utilize current programs to increase treatment to charged or convicted incarcerated individuals within DOC. It will explicitly transition more individuals out of the incarcerated setting and into community-based treatment. It will also provide continuity and coordination of care as well as other supports to improve health outcomes and ensure a successful re-entry into the community. While this waiver covers services as part of the DOC SAP or PSAP programs, nothing in this waiver precludes an agreement for community-based treatment for a person released by a court. However, court-ordered SUD treatment does not mean it is medically necessary. SUD treatment, including residential treatment, is only Medicaid reimbursable if it is medically necessary as determined by a behavioral health professional according to ASAM criteria.**

41. We are concerned that the current proposal could lead to an increase in incarceration by incentivizing the criminal legal system to incarcerate. All Kentuckians who are incarcerated need quality medical care including SUD treatment. Being connected to a MCO 30 days pre-release would be a major benefit because it would enable a warm handoff to health care providers, community services and family and friend support networks, which can reduce the likelihood of recidivism.
    Response: **This waiver cannot change the way laws are enforced or prosecuted, or who has releasing authority. DOC is not the releasing authority. The waiver does not prolong or encourage incarceration in order to receive treatment. The waiver will utilize current programs to increase treatment to charged or convicted incarcerated individuals within DOC.**

It will explicitly transition more individuals out of the incarcerated setting and into community-based treatment. It will also provide continuity and coordination of care as well as other supports to improve health outcomes and ensure a successful re-entry into the community. While this waiver covers services as part of the DOC SAP or PSAP programs, nothing in this waiver precludes an agreement for community-based treatment for a person released by a court. However, court-ordered SUD treatment does not mean it is medically necessary. SUD treatment, including residential treatment, is only Medicaid reimbursable if it is medically necessary as determined by a behavioral health professional according to ASAM criteria.

42. Reforms should emphasize broader access to treatment and community based alternatives that don't involve incarceration.
    Response: **This waiver cannot change the way laws are enforced or prosecuted, or who has releasing authority. DOC is not the releasing authority. The waiver does not prolong or encourage incarceration in order to receive treatment. The waiver will utilize current programs to increase treatment to charged or convicted incarcerated individuals within DOC. It will explicitly transition more individuals out of the incarcerated setting and into community-based treatment. It will also provide continuity and coordination of care as well as other supports to improve health outcomes and ensure a successful re-entry into the community. While this waiver covers services as part of the DOC SAP or PSAP programs, nothing in this waiver precludes an agreement for community-based treatment for a person released by a court. However, court-ordered SUD treatment does not mean it is medically necessary. SUD treatment, including residential treatment, is only Medicaid reimbursable if it is medically necessary as determined by a behavioral health professional according to ASAM criteria.**

43. Without significant guardrails, emphasizing SUD treatment in jails and prisons could increase incarceration, especially pretrial. If we want to increase the number of pretrial defendants with SUD who receive treatment, we should be connecting them to services in the community. Example: Bexar County, Texas where individuals can receive Personal Recognizance (PR) bonds for mental health and other reasons. After a person is arrested, a judge, nurse or detention officer can make a mental health screening request to determine eligibility for Mental Health PR bond. The person in question can then be scheduled for a screening with a RN or referred immediately to a crisis care center or psychiatric hospital. If the person is eligible for MH PR bond, they are released without financial conditions and transported to the least restrictive ad most clinically appropriate treatment setting.
    Response: **This waiver cannot change the way laws are enforced or prosecuted, or who has releasing authority. DOC is not the releasing authority. The waiver does not prolong or encourage incarceration in order to receive treatment. The waiver will utilize current programs to increase treatment to charged or convicted incarcerated individuals within DOC. It will explicitly transition more individuals out of the incarcerated setting and into community-based treatment. It will also provide continuity and coordination of care as well as other supports to improve health outcomes and ensure a successful re-entry into the community. While this waiver covers services as part of the DOC SAP or PSAP programs,**

nothing in this waiver precludes an agreement for community-based treatment for a person released by a court. However, court-ordered SUD treatment does not mean it is medically necessary. SUD treatment, including residential treatment, is only Medicaid reimbursable if it is medically necessary as determined by a behavioral health professional according to ASAM criteria.

44. What is the rationale for requiring treatment be completed in jail rather than in a community setting whenever possible?
    Response: **This waiver cannot change the way laws are enforced or prosecuted, or who has releasing authority. DOC is not the releasing authority. The waiver does not prolong or encourage incarceration in order to receive treatment. The waiver will utilize current programs to increase treatment to charged or convicted incarcerated individuals within DOC. It will explicitly transition more individuals out of the incarcerated setting and into community-based treatment. It will also provide continuity and coordination of care as well as other supports to improve health outcomes and ensure a successful re-entry into the community. While this waiver covers services as part of the DOC SAP or PSAP programs, nothing in this waiver precludes an agreement for community-based treatment for a person released by a court. However, court-ordered SUD treatment does not mean it is medically necessary. SUD treatment, including residential treatment, is only Medicaid reimbursable if it is medically necessary as determined by a behavioral health professional according to ASAM criteria.**

45. Could an individual with a primary diagnosis of mental illness and a secondary diagnosis of SUD be eligible to participate?
    Response: **This waiver is requesting an amendment to the existing SUD waiver. In order to qualify for the existing SUD waiver there must be a primary diagnosis of SUD. Individuals may also have a co-occurring diagnosis. DOC does offer treatment options for individuals with a primary diagnosis of mental illness and secondary diagnosis of SUD that is not covered in this waiver.**

46. Thank you for this opportunity to submit comments with regard to the proposed 1115 Waiver Amendment providing Substance Use Disorder (SUD) Services to Incarcerated Kentuckians. First, we want to congratulate the KY Department for Medicaid Services (DMS) for taking the legislative requirement in HB 352 and, through its working relationships and collaboration with the KY Department of Corrections and the KY Department for Behavioral Health, Developmental & Intellectual Disabilities, putting forward an expansive vision for assuring that Kentuckians in incarceration or in danger of incarceration be afforded the opportunity to receive evidence-based treatment for their substance use disorder under the coverage provided by Medicaid.
    Response: Thank you for your comment.

47. Instead of focusing solely on the period just prior to discharge – which has been the focus of similar waivers submitted by other states – DMS has chosen to address the individual's SUD across the entire timeframe from pre-trial through the incarceration period to discharge into the community and attempts to provide comprehensive, evidence-based SUD services through the entirety of this period. In that sense, Kentucky's proposed 1115 Waiver would appear to be the

most comprehensive and far-reaching of any similar waivers developed in other areas of the country.
Response: Thank you for your comment.

48. During the time when this waiver was being developed, we had inquired whether it would also cover services for treatment of severe mental illness (SMI) as well. We expressed our concern that, given the high percentage of individuals with co-occurring SUD and SMI, not providing SMI services would be a failure in addressing the needs of the Medicaid incarcerated recipients. Initially, we were told that the SMI services were already available through the Department of Corrections and would not be a part of the waiver. We were very pleasantly surprised, then, to see that SMI services are now included (p. 5) in the waiver, an addition which we strongly support. We have some questions about exactly what those services are and how individuals with SMI will qualify for the program which will be addressed later.
Response: Currently, DOC Addiction Services and DOC Mental Health have an integrated program for individuals with SUD and SMI. While incarcerated, Medicaid will only cover SUD services but DOC will continue to cover mental health services and medications. Upon release, Medicaid will cover medically necessary SUD and SMI services and medications through managed care. As this program is further negotiated with CMS, covered services, operational considerations, and enrolled provider types will be fully described according to the federal 1115 waiver process.

49. With its emphasis on a six-month SUD treatment program as being the evidence-based approach to be taken, we are concerned that meeting the requirement of completing a six-month program might result in an individual being required to stay in jail or prison beyond the time when they would be eligible for probation, parole or discharge. We feel strongly that this would be counterproductive for the individual caught in this situation, as it lengthens the time away from family and community based on treatment needs that can be addressed in the community and not based on the sentence for the crime committed. We recommend that wording in the waiver be revised to make clear that individuals would not be required to stay in jail or prison in order to complete the SUD treatment program. In the same vein, we strongly urge the inclusion of training programs and education for judges, prison officials and jailers, probation and parole officers, as well as relevant members of the bar about the intent of the waiver, the SUD and SMI services available, the timeframes during which they can be accessed and the process for preparing the individual to be connected to the appropriate community treatment programs. We feel strongly that this program will only be successful if all of the stakeholders are educated about its appropriate use and are working together to bring about its effective and ongoing implementation. We recommend that the Administrative Office of the Courts (AOC) be included in the group working to put forward this proposal and, upon final approval of CMS, to implement the program. Their inclusion would make it easier to educate judges and court workers about this program and to involve them in its implementation.
Response: This waiver cannot change the way laws are enforced or prosecuted, or who has releasing authority. DOC is not the releasing authority. The waiver does not prolong or encourage incarceration in order to receive treatment. The waiver will utilize current programs to increase treatment to charged or convicted incarcerated individuals within DOC. It will explicitly transition more individuals out of the incarcerated setting and into community-based treatment. It will also provide continuity and coordination of care as well as other supports to improve health outcomes and ensure a successful re-entry into the community. While this waiver covers services as part of the DOC SAP or PSAP programs,

nothing in this waiver precludes an agreement for community-based treatment for a person released by a court. However, court-ordered SUD treatment does not mean it is medically necessary. SUD treatment, including residential treatment, is only Medicaid reimbursable if it is medically necessary as determined by a behavioral health professional according to ASAM criteria. CHFS has and will continue to partner to provide information to all stakeholders, including those in Medicaid and the judicial system. Additional stakeholder meetings will occur after approval is received from CMS.

50. The success of this proposed program is also strongly dependent on coordination with the Medicaid Managed Care Organizations (MCOs) in putting the individual into their coverage in sufficient time prior to discharge to have the necessary information about treatment needs so as to provide the appropriate community treatment program for the individual, This will require each of the MCOs to have an appropriate, adequate network in the community of the full spectrum of SUD treatment and recovery programs, ranging from fully residential to partial residential programs to intensive outpatient to outpatient therapy to 12-step programs, and including peer support, targeted case management or care coordination and also including Medication-Assisted Treatment programs.
Response: DMS has been assured that there are ample amounts of treatment beds available. MCOs are required to provide network adequacy and parity pursuant to their contracts and state and federal law. In addition, the waiver affords an opportunity for a better transition of care from incarceration to the community by involving the MCOs before release.

51. Connections with community programs need to begin before release, with evidence-based, high quality programs immediately accessible to individuals as soon as they exit incarceration. To strengthen the connection with community programs, we recommend that personnel from the community mental health centers or other program providers be able to contact incarcerated individuals before their release. Reimbursement for these community services must be at parity with similar physical health services, and the prior authorization rules, if necessary, need to be at parity with those utilized by the MCOs for physical health services.
Response: The DOC Division of Addiction Services has clinicians located in all P&P offices across the state who are responsible for assisting individuals with SUD treatment and recovery services upon release of custody and providing case management of those services. The DOC also has a reentry division that works with individuals to provide resources and remove barriers. They assist with education, job training, employment, housing, Medicaid enrollment, and referral to other community-based agencies as needed. DOC will work with MCOs on a transition of care. In addition, the waiver affords an opportunity for a better transition of care from incarceration to the community by involving the MCOs before release. The exact process has not been determined and will be created when the waiver amendment is approved. The process will be similar to how the Reentry Program is currently working. As this program is further negotiated with CMS, covered services, operational considerations, and enrolled provider types will be fully described according to the federal 1115 waiver process.

52. While we applaud the inclusion of SMI services in the proposed waiver, we are very concerned that the waiver will apparently only cover those Kentuckians for whom SUD is the primary diagnosis (p. 11). While we understand that this program is being developed as an amendment to Kentucky's current SUD waiver, we see no reason why the criteria for eligibility should not be solely a diagnosis of SUD, whether that diagnosis is primary or secondary. Therefore, we urge

that the scope of the waiver be revised to clearly include those incarcerated Kentuckians whose primary diagnosis is SMI, with a secondary diagnosis of SUD. The focus and reason for this waiver is to address SUD in the incarcerated population of Kentuckians. It should not matter whether the SUD diagnosis at the given point in time is primary or secondary. The fact that an SUD diagnosis has been made should be sufficient to make the individual eligible for these waiver services, whether SMI is present or not, and whether the SUD diagnosis is primary or secondary. With this change, SUD issues will be addressed across the entire population of incarcerated Kentuckians.

Response: This waiver is requesting an amendment to the existing SUD waiver. In order to qualify for the existing SUD waiver there must be a primary diagnosis of SUD. Individuals may also have a co-occurring diagnosis. DOC does offer treatment options for individuals with a primary diagnosis of mental illness and secondary diagnosis of SUD that is not covered in this waiver.

53. In the table of program benefits on Page 13, we do not see any listing or description of the SMI services being offered in the coverage being developed under this waiver. The table should list the SMI services as it does for the proposed list of SUD services. We respectfully request that this benefits table be modified to include the SMI benefits.

    Response: This waiver is requesting an amendment to the existing SUD waiver. In order to qualify for the existing SUD waiver there must be a primary diagnosis of SUD. Individuals may also have a co-occurring diagnosis. DOC does offer treatment options for individuals with a primary diagnosis of mental illness and secondary diagnosis of SUD that is not covered in this waiver.

54. Successful transition of the incarcerated individual to community services in order to complete treatment and to engage in recovery is dependent on getting the individual in communication and collaboration with the chosen MCO which is charged to matching the individual's needs to community programs. The proposal reports significant and alarming data (p. 4), including a mean of 77 days between release from incarceration and resumption of Medicaid benefits, with resulting negative effects for the individuals involved. Because of the need to avoid these negative consequences, we recommend that the process for connecting the incarcerated individual with the chosen MCO begin no later than 30 days prior to their release date. The current language throughout the proposal is "an average of 30 days prior to transition…" which implies that in some cases, that timeframe will be less than 30 days. We do not feel that a timeframe less than 30 days allows sufficient time for all necessary preparations to be made for an effective transition to take place.

    Response: The date of release is fluid, therefore we stated within 30 days of release. The intent is for the MCO to begin working with the individual 30 days before release.

55. We were pleased to see that the project has already begun the necessary background work with the relevant technology and tracking entities to assure that there are no technology barriers to immediate access to Medicaid coverage and no lapses in the ability to track the individual's recovery outcome measures.

    Response: Thank you for your comment.

56. The proposal mentions "care navigation" as an integral service element. We wonder if this is the same as "targeted case management" as it is currently a service provided under Medicaid benefits and it has its approved regulations as to provider types and definition and goals are

already in place. This point should be clarified in the proposal; if "care navigation" is something different than "targeted case management", then it should be defined as such.
Response: The care navigation mentioned in the amendment is not targeted case management, but rather care coordination and discharge planning with the MCO.

57. The behavioral health community (mental health and SUD) has, for years, expressed concerned about the mechanism that MCOs employ to deny services – namely, prior authorization. This is particularly acute at the present time with regard to targeted case management requested by providers for Kentuckians with SMI, SUD or co-occurring disorders. Because the MCOs are allowed to choose their own medical necessity criteria – Milliman, Interqual and/or ASAM – it is extremely difficult for providers to make the case that Medicaid recipients need these services on an ongoing basis and then to have the services approved by the MCOs. Before the current pandemic emergency when DMS has suspended Prior Authorizations (PAs), it was more common than not for MCOs to apply "medical necessity" criteria to deny services or to delay them through an arduous PA process. This proposal (p. 6) refers to prior authorizations being "managed". How is this to be done? What recourse do providers have when they feel that a particular service in the benefit array (e.g., targeted case management) is necessary? If the program's services are to be effective, then prior authorization requirements are a hindrance to their being effectively provided. We urge that prior authorization (PA) continue to be suspended during the life of this waiver.
Response: As a part of care coordination, the MCO will make sure all PA's, which may be required, are obtained before release. Providers can appeal any decision that may involve an MCO denying or reducing services.

58. We agree that telehealth in Kentucky has been very effectively expanded during the COVID-19 pandemic state of emergency and, while it is not appropriate for all consumers and all behavioral health diagnoses and intervention services, there is no doubt that telehealth as a service delivery mechanism is "here to stay". Telehealth allows services available in one community to be offered to consumers who live in another community where that particular service is not available. While that may be appealing on the surface, we feel that caution must be exercised in substituting a service via telehealth, rather than assuring that there is network adequacy of the full range of SMI and SUD services in the individual's home community. Taking part in treatment and recovery services located geographically away from the individual's home makes it very difficult for family members and other important persons in the consumer's network to take part in the treatment/ recovery process, and thus, they are less able to provide support to the individual to help him/her to stay in recovery or to seek more intense treatment services when needed. The importance of family involvement is described as a key ingredient in the SAP (p. 9), and there are plans to extend it to other incarceration locations. One of the important outflows of this waiver project is to assure that community services and support programming is available all across the Commonwealth.
Response: Thank you for your comment.

59. The grant proposal outlines diversion programs already established in Kentucky (p. 10), some of which have been in place for years and have a track record of success. We are unclear how this proposed waiver would intersect with these diversion programs. Would they still be available at the pretrial level for individuals who are able to leave confinement by posting cash bail or meeting other requirements (p. 11)? The waiver suggested that the Pretrial Substance Abuse Program (PSAP) be expanded, but we are not clear where the treatment services are provided to

individuals who qualify and whether those services are included in the benefits being proposed in this waiver application. If that is the case, then PSAP should be included in the benefits table on page 13.

Response: Pretrial Substance Abuse Program (PSAP) is authorized by SB4 from the 2009 Session. The statutory language requires an agreement from the judge, attorneys and client. This law would need to be amended to create that change. DOC is operating as required by statute. The ultimate goal is to provide community based treatment to individuals. This waiver cannot change the way laws are enforced or prosecuted, or who has releasing authority. DOC is not the releasing authority. The waiver does not prolong or encourage incarceration in order to receive treatment. The waiver will utilize current programs to increase treatment to charged or convicted incarcerated individuals within DOC. It will explicitly transition more individuals out of the incarcerated setting and into community-based treatment. It will also provide continuity and coordination of care as well as other supports to improve health outcomes and ensure a successful re-entry into the community. While this waiver covers services as part of the DOC SAP or PSAP programs, nothing in this waiver precludes an agreement for community-based treatment for a person released by a court. However, court-ordered SUD treatment does not mean it is medically necessary. SUD treatment, including residential treatment, is only Medicaid reimbursable if it is medically necessary as determined by a behavioral health professional according to ASAM criteria.

60. On the Benefits Chart (p. 13), we have already noted that SMI services have been omitted and have recommended that they be included. Also, if PSAP is to be included in the waiver program, then it should be included in the Benefits Chart. We also recommend the following revisions in the Benefits Chart: In the first box under the Description of Amount, Duration and Value, the wording "substance abuse services" should be replaced with "substance use disorder services". In that same box, second sentence, the "ten hours of clinical treatment services" should be followed with an insert of "per week". In the third box in that same column, the language "prescribed by a qualified physician" should be replaced with "prescribed by a qualified provider" or "prescribed by a qualified physician or nurse practitioner". There are more than 400 APRNs who have the DEA waiver to prescribe medications for MAT and the language needs to be inclusive of them. The language on page 14 refers to "a medical provider" which would also be a suitable substitute in the Benefits Chart when referring to the MAT prescriber. On that same page, under "The following services are being requested" we are unclear in #1 what "service planning" refers to. Is this "targeted case management" which is an already-approved Medicaid service? How does "care navigation" differ from targeted case management and from service planning? [On page 14, there is reference to members being "involved with service planning and case management". What is the difference between the two and is service planning a Medicaid defined and reimbursable service? We also recommend adding to this list the treatment, medication, peer support and case management services that should be included for treatment of SMI.

Response: This waiver is specific to SUD treatment. At this time we are not changing the language as requested but will keep this in mind as we negotiate the waiver with CMS. With regard to service planning, it is a Medicaid reimbursable service. All care coordination will be completed by the MCO 30 days prior to release. DOC and/or DMS will notify the MCOs. The exact process has not been determined and will be created when the waiver amendment is approved. The process will be similar to how the Reentry Program is currently working. As this program is further negotiated with CMS, covered services, operational considerations,

and enrolled provider types will be fully described according to the federal 1115 waiver process.

61. With regard to a detailed discharge plan (pp. 14-15), we recommend that the language make clear that planning needs to take place before discharge with Medicaid coverage and access to needed services available immediately upon leaving the facility. The plan should identify "physical and behavioral health and social services needs to support the member's successful return to the community." We see a significant difference between "making a referral" and "scheduling appointments" and recommend that actually scheduling the appointment be the appropriate level of discharge implementation.
Response: The waiver indicates that care coordination and discharge planning will occur 30 days prior to release.

62. In the Rate Development section (p. 15), it appears that the assumption is that the same practitioner or the same level of practitioner will be providing all of the services included in the bundle. Since the services range from individual, group or family therapy to peer support to medication to case management (or service planning or care navigation), that assumption would not appear to be well-founded. Is the bundled rate premised on a mixture of the appropriate level of practitioner for each of the services in the bundle? It is unclear to us in the Medication section (pp 15-16), whether the incarcerated members receiving services under this waiver will be utilizing the single Medicaid formulary required by SB 50 (enacted in the 2020 KY General Assembly session) and being readied to be operational by January 1, 2021. If that is the case, then that formulary will need to include all medications utilized for MAT, as well as all medications for the treatment of SMI, including the full range of long acting injectables.
Response: Currently, DOC Addiction Services and DOC Mental Health have an integrated program for individuals with SUD and SMI. While incarcerated, Medicaid will only cover SUD services but DOC will continue to cover mental health services and medications. Upon release, Medicaid will cover medically necessary SUD and SMI services and medications through managed care. As this program is further negotiated with CMS, covered services, operational considerations, and enrolled provider types will be fully described according to the federal 1115 waiver process. The bundled rate will cover all treatment services, exclusive of medication management, regardless of practitioner level.

63. On p. 16 in the section on Implementation, there is a reference to "peer supports" which we assume would include both SUD and SMI peer support specialists, since individuals with co-occurring disorders are being included in the waiver program. The statement that there will be no cost-sharing for SUD treatment needs to also include SMI treatment.
Response: This waiver covers SUD treatment. Peer Support Specialists would be an additional service to existing treatment services. The specifics would be determined if this waiver is approved. DOC Addiction Services is committed to family and community involvement in the treatment process and offer family and community engagement as well as a user-friendly website that offers several sub-pages with useful information under the Addiction Services Division at: https://corrections.ky.gov/Divisions/ask/pages/default.aspx

64. Under Evaluation – Hypothesis 1: The Question is being asked in the past tense – "Was there a decrease in re-incarceration rates among those who received Medicaid SUD treatment?" We suggest that the Example of a Measure be – "Number and percent of members who received

Medicaid treatment and had a re-incarceration vs. number and percent of members who did not receive Medicaid treatment and had a re-incarceration."
Response: Thank you for the comment. At this time we are not changing the language as requested but will keep this in mind as we negotiate the waiver with CMS.

65. Hypothesis 2: We suggest that the second Question might be asked in a more straightforward manner as – "What is the median length of time between release and Medicaid activation?" We wonder if the Example of Measures might be broadened to include use of other Medicaid services such as treatment for SMI, physical health services, etc. which would also indicate that the individual stayed enrolled in Medicaid after release.
Response: Thank you for the comment. At this time we are not changing the language as requested but will keep this in mind as we negotiate the waiver with CMS.

66. Hypothesis 3: This hypothesis speaks to "health outcomes" which should certainly include utilization of SMI treatment services, as well as other physical and behavioral health services provided in the community.
Response: Thank you for the comment. At this time we are not changing the language as requested but will keep this in mind as we negotiate the waiver with CMS.

67. Finally, on p. 19, where the objectives of the amendment are described, we suggest – "First, to provide SUD treatment and SMI treatment to those with co-occurring disorders to ensure….while incarcerated; and to allow require the recipient's chosen MCO to coordinate aftercare with a Medicaid community provider no less than 30 days before release."
Response: The date of release is fluid, therefore we stated within 30 days of release. The intent is for the MCO to begin working with the individual 30 days before release.

68. Thank you for the opportunity to provide comments on this 1115 SUD Waiver. Again, we are appreciative of the ambitiously broad scope of the waiver and agree in principle with that goal, as long as individuals are not penalized by being incarcerated instead of accessing diversion program or Drug Court or are held in incarceration for completion of treatment programs that are available in the community. The integration of services for co-occurring disorders and with physical health services is promising, but care needs to be taken that all those individuals who have co-occurring SUD and SMI are included in the proposed program.
Response: Thank you for your comment.

69. Ongoing problems that currently exist in Kentucky's behavioral health community vis-à-vis MCOs with regard to network adequacy, prior authorizations, and definitions and applications of medical necessity criteria are issues that should be addressed in this waiver proposal so that they do not become barriers to successful implementation. Access to a full and robust continuum of community-based SUD and SMI treatment and recovery programs is critical to enable formerly incarcerated Kentuckians to achieve and maintain recovery. I hope that these comments provide helpful input and recommendations for revisions. Best wishes on a successful submission of the revised 1115 SUD Waiver!
Response: Thank you for your comment.

70. Comment: Supports the 1115 Demonstration Waiver regarding the SUD treatment and care coordination for incarcerated individuals.
Response: Thank you for your comment.

71. Comment: support for DMS' proposal to expand access to SUD services for Medicaid beneficiaries in Kentucky state prisons and county jails. Thank you for your efforts to increase access to SUD treatment in Kentucky.
    Response: Thank you for your comment.

72. Comment: wrote opinion-editorial applauding this proposal and highlighting the need to connect those in our criminal justice system with the treatment and support services they need to return to meaningful, productive lives.
    Response: Thank you for your comment.

73. Comments:
    • 96.3% support allowing Kentucky Medicaid to pay for Substance Use Disorder treatment and Behavioral Health services provided to eligible individuals during incarceration.
    • 100% support making sure individuals are actively enrolled with an MCO when they are released from incarceration to ensure they can continue to receive care in the community
    • 96.3% support offering family engagements sessions to individual during incarceration • 100% support requiring an individual's MCO to provide access to an SUD treatment program in the community as an alternative option for the judge's consideration.
    Response: Thank you for your comments.
    a. B.C. Has made considerable strides in diversion and re-entry programs. The support of Medicaid can greatly enhance those efforts.
    b. If it weren't for Medicaid I wouldn't be sober for 5.5 years. The counseling I received after I stopped drinking was critical. Stop treating addiction like a crime and start treating it like a disease!!
    c. The community would benefit. Because those that aren't working or have insurance.
    d. If we can deal with an individual's substance abuse while incarcerated, their likelihood of using when released could be diminished. Their need for money to support their habit is eliminated, and crime can be reduced. This seems like a no-brainer to me.
    e. Absolutely supportive of these proposed changes! They are critical to the public health of our vulnerable citizens experiencing incarceration as it relates both to treatment within prison and preventative resources for re-entry into society.
    f. The proposed changes have the opportunity to continue to solidify what we already know access to healthcare reduces incarceration, increases recovery, and saves lives. The ability for a person to walk out of incarceration into the first or tenth stages of recovery with the ability to walk into a doctor's office is the one major way that we can help that person re-enter their community with dignity and respect.
    g. Expedite this implementation.
    h. I'm glad this initiative is being considered. Too many Kentuckians are being incarcerated, and jails are NOT designed to help people improve their lives. It's time to make some changes.
    i. This would be a waste of tax dollars. The only clear way to combat the opiate crisis is to love these people back to life, outside of incarceration.
    Response: Thank you for your comments.

74. KY Medicaid is to be commended for this innovative amendment to the Medicaid KY Health 1115 Demonstration to authorize federal Medicaid matching funds for the provision of SUD treatment to eligible incarcerated members. We appreciate the DOCs commitment to reducing incarcerations. We believe this waiver will be an effective approach to reducing recidivism and incarceration through PSAP. In addition, due to the robust array of SUD services and supports available at the CMHCs individuals will not need to remain incarcerated solely to complete their SUD services and supports. The waiver amendment will increase collaboration between DOC and CMHCs which allows for earlier release dates with established linkages in the community to continue treatment and recovery.
    Response: Thank you for your comment.

75. There are elements of this application that are truly ground breaking , especially the inclusion of Medicaid Fee-For-Service care provision before the end of the incarcerated person's sentence. Thank you for recognizing the need for substance use disorder and mental health treatment of incarcerated individuals. We have been heartened to see Peer Support Specialists and family engagement programs included in the service provisions. We've come a long way as a state and it shows in this regard. Ultimately, we support the intent of this 1115 SUD Medicaid Waiver Amendment.
    Response: Thank you for your comment.

76. We applaud DMS for its work to address the SUD treatment needs of people who are incarcerated.
    Response: Thank you for your comment.

77. We support the waiver amendment seeking to provide Medicaid coverage for SUD services for certain justice involved individuals and urge Kentucky to submit it to the federal CMS.
    Response: Thank you for your comment.