New York State Department of Health
Medicaid Redesign 1115 Demonstration Amendment Application:
Continuity of Coverage for Justice-involved Populations
August 9, 2019

Section I – Historical Narrative Summary of the Demonstration

Introduction

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

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

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

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

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

disorders; delivery system reform efforts to reduce avoidable hospitalizations and integrate primary care and behavioral health services; and Health Homes to provide intensive care coordination to individuals with multiple chronic conditions, including, importantly, five State-funded criminal justice health home pilots to identify and engage justice-involved individuals in order to reduce their health care costs and improve the quality of care for this population. Medicaid is the core financing stream for each of these efforts.

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

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

Background

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

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

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

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

In New York, a staggering 83 percent of New York's incarcerated individuals are in need of substance use disorder treatment upon release, according to the New York Department of Corrections and Community Supervision (DOCCS).[3] Meanwhile, the share of individuals in New York City's jails who have mental illnesses has reached nearly 40 percent in recent years, even as the total number of incarcerated individuals has decreased.[4] Of the 29,391 individuals who were discharged from jail in New York City during the 2018 calendar year, 26 percent had mental health problems; 11 percent suffered a severe mental illness; and 63 percent struggled with substance use.[5] Nearly a quarter of former justice-involved individuals had an emergency department visit within 1 month of release,[6] while approximately 20 percent were hospitalized within 8-10 months of release.[7] These issues are not confined to New York City -- in the 19 counties participating in the New York State County Re-Entry Task Force Program, 26 percent of eligible individuals required mental health treatment, 79 percent required substance use disorder treatment, while 82 percent required social services.[8]

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

- 1 in 70 individuals are hospitalized within a week of release from prison or jail (2.5 times higher than those never incarcerated), and 1 in 12 are hospitalized within 90 days (nearly twice as high as those never incarcerated).[9]
- Nearly a quarter of justice-involved individuals had a first emergency department visit within one month of release and were more likely than the general population to visit the emergency

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

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

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

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

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

[7] Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration (Feb. 2008). Available from http://www.urban.org/sites/default/files/alfresco/publication-pdfs/411617-Health-and-Prisoner-Reentry.PDF

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

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

department due to a mental health condition, substance use disorder, or ambulatory sensitive condition.[10]

These findings are consistent with New York-specific data, which also highlights that there is a major gap in continuity of care for people cycling in and out of jail and that stronger outreach and engagement efforts could improve outcomes and prevent unnecessary utilization of expensive services. For example, in a study of 1,427 Medicaid recipients residing in Brooklyn, New York, with an SMI who had also been released from prison within the past five years, 1,009 (71 percent) met criteria (based on Medicaid claims) suggesting inadequate behavioral health care in the prior year. The project team attempted to contact behavioral health providers who had served these individuals and were able to complete detailed treatment histories for 556 individuals. Of these 556 completed case reviews, 406 (73 percent) were confirmed to be disengaged from care and considered at high-risk for adverse events or poor outcomes. Among these 406 disengaged individuals, 176 (43 percent) were found to be re-incarcerated (prison or jail) at the time of review and another 161 (40 percent) were completely lost to care with no provider able to initiate outreach. Outreach was successfully initiated for only 64 (16 percent) of these individuals. This very high-risk population has very high rates of *inadequate* care. [11] A follow-up study to the one above analyzed the population of individuals identified as disengaged from care. The study showed that if a provider was able to initiate outreach, approximately 65 percent of the group of disengaged individuals successfully re-engaged in care within 12 months. However, if no provider connected, or if the individual was incarcerated when reviewed, re-engagement rates remained very low (30 percent re-engaged within one year).[12]

State and local correctional facilities (i.e., prisons and jails, respectively) provide medical services, including medications for medical and mental health conditions. Individuals also re-enter the community with a limited supply of medications. However, medication management for substance use disorders is generally not provided with an eye on release back into the community. The provision of medication for specific conditions occurs within the controlled setting run by the facility. This stability disappears when a person is released into the community. Even under the best of circumstances, when a person is discharged without prior contact with a future care manager/provider or without long-acting depot medications or other addiction/mental health medications as indicated, there is a high risk he/she will establish other priorities and will not engage with critical service providers when they re-enter the community. Contact between service providers and the incarcerated individual needs to occur prior to release to facilitate the continuity of care after discharge and the use of medications appropriate for community-based (rather than jail or prison) settings. The use of depot/long acting and other addiction/mental health medications for treatment of schizophrenia and opioid addiction can support a smoother transition into the community and facilitate the successful linkage to other services that in turn, further maintain stability[13]. The ability to begin the use of depot/long-acting medications prior to release will ensure these medications are clinically appropriate, well tolerated and more likely to remain

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

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

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

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

in use when the individual re-enters the community. For patients for which longer acting medications are less appropriate, other mental health and addiction medications would be indicated.

New York is seeking to build and strengthen the relationship between the care provided inside its jails and prisons and the care offered by Medicaid providers upon release. To facilitate the arrangement of critical services prior to release, the NYS Council on Community Re-Entry and Reintegration was formed to address obstacles faced by individuals transitioning to the community and recommended that NYS reinstate Medicaid benefits 30 days prior to release, without allowing the billing of services, and issue a Medicaid benefit card prior to release. In 2017, the DOH Office of Health Insurance Programs began reinstating Medicaid benefits prior to release across all systems. Further, as part of the Fiscal Year 2016/17 Budget, enacted state legislation directs the state to "seek federal authority to provide medical assistance for transitional services including but not limited to medical, prescription, and care coordination services for high needs inmates in state and local correctional facilities thirty days prior to release."[14]

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

Section II. Changes Requested to the Demonstration

Covered Services

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

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

The three components above, specifically care management, consultation with medical and/or behavioral health providers, and medications (including long-acting depot medications and other

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

addiction/mental health medications as indicated) are covered Medicaid benefits. When a community provider cannot meet directly with the individual and/or discharge planner due to distance from a specific State prison, the majority of State prisons have videoconferencing that should allow services consistent with New York State Medicaid telehealth requirements.

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

Eligibility

Individuals eligible for this program are those Medicaid enrolled members who have two or more qualifying chronic diseases (such as HCV and diabetes), or one single qualifying condition of either HIV, a serious mental illness, or an opioid use disorder, and who are scheduled to be discharged from a jail or prison within 30 days. The State also suggests that providers be allowed to engage individuals in County jails within the first 15 days of incarceration, as the average length of stay is often brief, less than two weeks. It was found that between March and September 2018, two-thirds of Health Home members identified spent less than 72 hours in jail. Allowing care managers to provide service in the first 15 days would encourage community-based providers to collaborate with County jails and support the best practice of including discharge planning as part of jails' medical intake sessions.

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

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

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

Table 1: Incarcerated Population in New York State

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

Enrollment

The State is in the process of implementing a workflow to identify eligible individuals using a memorandum of understanding between DOCCS and DOH. In order to operationalize this demonstration, the State will need to first identify individuals who are currently in a Medicaid suspension status and who meet the high-risk criteria and then connect them to a Health Home or managed care plan care manager to commence the in-reach 30 days prior to release. Currently, reinstating Medicaid 30 days prior to release is more easily accomplished in the State prison system where there is more certainty around release dates and there are systems in place for data exchanges and high-risk identification. The State is now working to create data exchange processes between county jails, State criminal justice agencies and DOH. During the development of those processes, the State will phase in the demonstration by beginning the program in the State prisons, followed by an expansion to county jails.

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

Network Adequacy and Provider Readiness Analysis

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

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

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

IV. Requested Waivers and Expenditure Authorities

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

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

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

VII. Financial Data

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

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

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

VIII. Evaluation

While this programming has not been previously implemented with this population in New York State and with this service coordination approach, we have expectations based on studies conducted in other states that the detailed benefits are attainable and that New York will experience similar, if not more improved outcomes because of the proposed pre-release interventions. For example, New Mexico establish an in-reach pilot project with the Albuquerque jail where managed care plan coordinators met with incarcerated individuals twice to prepare them for discharge. The initiative resulted in reducing emergency department use after release by 64 percent.[15] This amendment will allow CMS and New York to accumulate the data needed to evaluate the improvements in health outcomes for providing critical discharge planning services to incarcerated individuals pre-release.

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

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

IX. Compliance with the Tribal and Public Notice Process

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

Tribal Notice

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

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

Public Notice and Processing

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

X. Public Notice

Public comments and responses:

1. Copy of proposed amendment requested by Office of the NYS Comptroller. Response: The State will provide a copy when the draft amendment is completed.

2. Copy of proposed amendment requested by Stateside Associates. Response: The State will provide a copy when the draft amendment is completed.

3. Copy of proposed amendment requested by Mallinckrodt Pharmaceuticals. Response: The State will provide a copy when the draft amendment is completed.

4. Comments from the New York City Department of Health and Mental Hygiene: The Department expressed its support of the waiver, and submitted several suggestions including:
   - Expanding the waiver to cover all Medicaid-eligible incarcerated persons (not just those persons eligible for the Health Home program).
   - Expand the waiver to include pre-trial detainees in county jails.
   - If the waiver is not expanded to cover all Medicaid-eligible incarcerated persons, expand the waiver to additional high-risk patient populations.
   - Include the New York City jail system in the first phase of waiver implementation.
   - Encourage in-person service delivery and use of Community Health Workers within program design.
   - Amend indicators to approve the ability to measure patient outcomes and program impact.

   Response: The State has indicated in the amendment that it will request changes in the State Plan Amendment to seek re-imbursement for peer services for justice-involved populations prior to release. In addition, the State has also suggested that providers be allowed to engage individuals in County jails within the first 15 days of incarceration, as the average length of stay is often brief, less than two weeks.

5. Comments from the Legal Action Center: LAC expressed its support of the waiver, and submitted several suggestions, including:
   - Expand the waiver target population beyond Health Home eligible to include those at increased risk of opioid overdose and/or homelessness upon release;
   - Prioritize jail populations, particularly sentenced inmates with known discharge dates and those receiving opioid replacement therapy in need of robust care continuity planning; and broaden the types of in-reach services to include targeted case management and wrap-around services shown to improve health outcomes and reduce costs.

Response: The State has incorporated relevant opioid epidemic points throughout the demonstration application, and has also suggested that providers be allowed to engage individuals in County jails within the first 15 days of incarceration.

6. Comments from the Coalition of NYS Health Homes: The Coalition has expressed its support of the waiver, and submitted several suggestions, including:
   - Maximize Medicaid Managed Care enrollment and active status to ensure billable services 30 days prior to release
   - Develop appropriate billing rates for jail-in reach work
   - Consider requesting waiver inclusion of all FDA approved medications
   - Consider amending waiver to permit billable jail in-reach services during initial 30-day period of incarceration for all pre-trial individuals

   Response: The State has indicated that Health Homes will work with Medicaid managed care plans to enroll individuals in a plan prior to release, and has also suggested that providers be allowed to engage individuals in County jails within the first 15 days of incarceration.

7. Comments from New York City Health & Hospitals/Correctional Health Services: NYC H&H/CHS has expressed its support of the waiver, and submitted several suggestions, including:
   - That the amendment not be limited to persons in custody and sentenced in county and state facilities, since the majority of detainees in local facilities are not sentenced
   - That eligibility be open to persons who are Medicaid eligible, and not just those who are eligible for New York's Health Home program. Alternatively, DOH should consider making individuals with substance use disorders, including opioid use, Health Home eligible
   - The inclusion of all medication assisted treatment and not just long acting medications; and curative and not just preventive medications for conditions such as HCV infection
   - CHS understands the DOH rationale for delaying local implementation of the program until Phase Two. Nonetheless, CHS urges that New York City be included in Phase One, since New York City accounts for fully 36% of the locally detained population statewide

   Response: The State has suggested that providers be allowed to engage individuals in jail within the first 15 days of incarceration. The State will also request changes in the State Plan Amendment to add opioid use disorder (OUD) as single-qualifying condition for Health Home enrollment.