



DHS Secretary Kristi Putnam  
Office of the Secretary

P.O. Box 1437, Slot S201, Little Rock, AR 72203-1437  
P: 501.682.8650 F: 501.682.6836 TDD: 501.682.8820

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Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Blvd.  
Baltimore, Maryland 21244

Dear Administrator Brooks-LaSure:

On behalf of the state of Arkansas and Governor Sarah Huckabee Sanders, I am pleased to submit a proposed Section 1115 Demonstration Project, "Opportunities to Test Transition-Related Strategies to Support Community Reentry from Incarceration and Institutions for Mental Disease" (Reentry Waiver).

The Arkansas Department of Human Services (DHS) designed this Reentry Waiver based on guidance in recent years from the Centers for Medicare & Medicaid Services (CMS), as well as waivers CMS already has approved. It combines different CMS initiatives on the Opioid Epidemic, reentry from carceral facilities, and treatment in an Institution for Mental Disease (IMD) into a single application. It will also enable Arkansas to meet the requirements of Section 5121 of the Consolidated Appropriations Act (CAA) to provide certain health screenings or diagnostic services to eligible youths in the juvenile justice system beginning January 1, 2025. Moreover, it will enhance the state's ability to support the CMS Behavioral Health Strategy and is aligned with priorities in the Substance Abuse and Mental Health Services Administration (SAMHSA) Strategic Plan.

Most importantly, this Reentry Waiver, if approved, will help empower thousands of low-income Arkansans to break the cycle of incarceration and poverty. It will fill gaps in the mental health services continuum of care, and provide upstream services to formerly incarcerated individuals that help prevent recidivism and promote better health, independence, and self-sufficiency.

We look forward to meeting with CMS in late February on several waiver matters, and hope to work with you for approval by July 1, 2024 and an effective date of January 1, 2025. If you have any questions, please do not hesitate to contact me.

Very Respectfully,



Kristi Putnam  
Secretary  
Arkansas Department of Human Services

Opportunities to Test Transition-Related Strategies  
to Support Community Reentry from Incarceration  
and Institutions for Mental Disease  
Section 1115 Demonstration Project

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State of Arkansas  
Department of Human Services



February 21, 2024

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## Section I: Executive Summary

The connection between incarceration and poor health is strong. First, prisons and jails often amass individuals who are most at risk for health disparities, such as those experiencing violence, substance abuse, mental health issues, and infectious and chronic diseases.<sup>1</sup> Many individuals enter incarceration with pre-existing health conditions or other health risk factors. Second, time spent incarcerated has a significant detrimental impact on physical and mental health. One study found a two-year decline in life expectancy for each year served in prison.<sup>2</sup> The compounding effects of incarceration on individuals already experiencing health challenges can lead to a host of negative outcomes. According to the Centers for Medicare & Medicaid Services (CMS):

A 2021 county-level analysis identified a strong association between jail incarceration and increases in premature death rates from infectious diseases, chronic lower respiratory disease, drug use, and suicide.<sup>3</sup>

Individuals experiencing incarceration are particularly likely to suffer from mental illness or substance use disorder (SUD). As CMS notes:

It is also noteworthy that from 2011 to 2012, approximately 37 percent of people in state and federal prisons and 44 percent of people incarcerated in jails had a history of mental illness.

Further, according to a 2020 report, although the exact rate of [SUD] in individuals who are incarcerated is difficult to determine, it may be as high as 65 percent in prisons nationally.<sup>4</sup>

Access to vital medical services for Medical-eligible individuals who are inmates of a public institution or who are adults who receive medically necessary services in an Institution for Mental Disease (IMD) is limited by federal law.<sup>5</sup> Federal Medicaid funds are not allowed to pay for the cost of medical treatment for an “inmate of a public institution,” with the exception of inpatient hospital services. The prohibition on coverage for inmates of a public institution is not restricted by age. Therefore, Medicaid funding is not available to pay for medically necessary services to a youth with Serious Emotional Disturbance (SED) detained in a juvenile facility, despite the federal Medicaid requirement to provide all medically necessary services to Medicaid-enrolled children under the Early Periodic Screening Diagnosis and Treatment (EPSDT) program. The extant restrictions also suspend Medicaid coverage during incarceration, despite the well-established link between health and incarceration. Importantly, most justice-involved individuals will qualify for Medicaid upon release.<sup>6</sup>

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<sup>1</sup> <https://healthandjusticejournal.biomedcentral.com/articles/10.1186/2194-7899-1-3>

<sup>2</sup> <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2012.301148>

<sup>3</sup> SMD#23-003 p. 3

<sup>4</sup> *Id.*

<sup>5</sup> See Section 1905(a) in subdivision A after paragraph 29 and 1905(a) in subdivision B after paragraph 30 respectively.

<sup>6</sup> <https://www.macpac.gov/wp-content/uploads/2018/07/Medicaid-and-the-Criminal-Justice-System.pdf>

The healthcare infrastructure in correctional facilities is ill-equipped to treat individuals with complex medical needs.<sup>7</sup> Being able to access care while incarcerated would help fill this treatment void. Moreover, the incarceration period is a crucial time to keep individuals connected to their Medicaid coverage to support effective transitions of care upon release.

Similarly, federal funds are also not allowed to pay for the cost of treatment of an adult in an Institution for Mental Disease (IMD). Prohibitions on the use of federal funds under certain circumstances create gaps in the continuum of care for Medicaid-eligible individuals, especially for adults with a serious mental illness (SMI) and Opioid Use Disorder (OUD) and other SUDs. The combination of these two federal exclusions create significant health disparities based largely upon the existence and diagnosis of a disease. Discriminating against where treatment is provided based on age is inconsistent with Medicare and private insurance as well as federal and state laws against pre-existing conditions. These federal exclusions exacerbate health disparities between justice-involved individuals and the general population.

The federal IMD exclusion presents a barrier to care faced only by Medicaid patients, not those covered by Medicare or private insurance. Medicare, for example, reimburses for medically necessary treatment in an inpatient psychiatric hospital although it does place a lifetime limit of 190 days.<sup>8</sup> Federal rules permit reimbursement for medically necessary treatment for 19- and 20-year-olds, and under certain circumstances for a 21-year old in an IMD due to the requirements of EPSDT for Medicaid eligible children.<sup>9</sup> However, Federal Financial Participation (FFP) must end when the individual turns age 22. These exclusions create breaks in the continuum of care for these individuals which in turn lower the effectiveness of treatment and thus increase the total cost of care.

As applied, the federal IMD exclusion creates serious gaps among Medicaid enrollees and the non-Medicaid population in access to all treatment options. Even among Medicaid enrollees there are differences in access. While federal law restricts payment for services in IMD settings, 42 CFR 438.6(e) permits payments under managed care contracts for short-term stays not to exceed 15 days per month. These payments are allowable as “in lieu of” an inpatient hospital stay.<sup>10</sup> However, for Arkansas, this managed care option divides the small number of individuals from the majority of Medicaid enrolled adults, as only a fraction of adults are enrolled in a managed care plan in the state and thus have limited access to IMD treatment services.

### **Waiver Seeks to Define Temporary Period for a Carceral Facility and IMD Stay**

Under 42 CFR 435.1010(b), an individual is not considered an inmate if “he is in a public institution *for a temporary period* pending other arrangements appropriate to his needs (emphasis added).” Through this waiver request, Arkansas seeks to define “temporary” as a period not to exceed 90-days. Because of the uncertainty of how long an individual may be incarcerated or admitted, there will be two 90-day periods under the waiver, the first at the beginning of incarceration or admission to an IMD and a second period up to 90-days prior to release or discharge. If approved, the waiver will strengthen the continuum of care by closing these arbitrary gaps in coverage and ensuring treatment is available in all settings that are most

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<sup>7</sup> <https://healthandjusticejournal.biomedcentral.com/articles/10.1186/2194-7899-1-3>

<sup>8</sup> <https://www.medicare.gov/coverage/mental-health-care-inpatient>

<sup>9</sup> <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441#441.151>

<sup>10</sup> <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438>

appropriate to meet the medical needs of the individual, regardless of whether they temporarily reside in a carceral or an IMD facility. Because Arkansas faces severe statewide shortages in mental health professionals, the 90-day periods are necessary to ensure access to treatment. Shorter periods of coverage could be illusory for many Medicaid beneficiaries.

The gaps in coverage due to the archaic federal prohibitions have been partially addressed by Congress and CMS through a number of recent initiatives:

- On November 1, 2017, CMS released “Strategies to Address the Opioid Epidemic” (SMD # 17-003) which permits states to “receive federal matching funds for Medicaid-coverable services provided to individuals residing in residential treatment facilities that are not ordinarily matchable because these facilities qualify as IMDs ...”.<sup>11</sup>
- The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) (P.L. 115-271), which added a new state plan option to allow states to provide Medicaid coverage in an IMD for adults with SUD for up to 30 days.<sup>12</sup>
- CMS issued guidance to states on “Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated” (SMD#23-003) on April 17, 2023, which provides an 1115 waiver opportunity for states to provide Medicaid transition services to incarcerated individuals prior to their release.<sup>13</sup>
- Section 12003 of the 21<sup>st</sup> Century Cures Act (Cures Act) required CMS to provide opportunities to states to improve care for adults with SMI or children with SED. Accordingly, on November 13, 2018, CMS released SMD #18-011, “Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance.”<sup>14</sup>
- Section 5121 of the Consolidated Appropriations Act (CAA) requires states to provide certain behavioral health screenings or diagnostic services in the 30 days prior to release and, targeted case management services, including referrals to appropriate care for at least 30 days after release to Medicaid and Children’s Health Insurance Program (CHIP) eligible youths in the juvenile justice system beginning January 1, 2025.
- Section 5122 provides states with the option to provide Medicaid and CHIP coverage to juvenile youth in public institutions during the initial period pending disposition of charges.<sup>15</sup>
- Using broad Section 1115 waiver authority, the Secretary of the U.S. Department of Health and Human Services (HHS) has approved Demonstration projects that waive the IMD exclusion for up to 60 days.

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<sup>11</sup> <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd17003.pdf>

<sup>12</sup> <https://www.congress.gov/115/plaws/publ271/PLAW-115publ271.pdf>

<sup>13</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf>

<sup>14</sup> <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf>

<sup>15</sup> <https://www.govinfo.gov/content/pkg/BILLS-117hr2617enr/pdf/BILLS-117hr2617enr.pdf> p.1483 and p. 1494.

Building off these important federal initiatives, the Arkansas Department of Human Services (DHS) proposes to combine the various federal opportunities into this single waiver application to improve care and transitions for vulnerable beneficiaries on a broad scale. Arkansas views the waiver of both federal exclusions (IMD and inmate) as an opportunity to greatly impact care for individuals temporarily residing in facilities, whether that facility is a prison, jail, or IMD.

### **Waiver Promotes the Objectives of Medicaid**

For the Secretary of the Department of Health and Human Services to approve a Section 1115 Demonstration Project, he must determine that the project is likely to promote the objectives of the Medicaid Act. Based on CMS guidance, this waiver application, “Opportunities to Test Transition-Related Strategies to Support Community Reentry from Incarceration and Institutions for Mental Disease,” meets this test. It combines the CMS guidance on the opioid epidemic, the SUPPORT Act and the Cures Act into a single Demonstration Project (“Reentry Waiver”). The purpose of the Reentry Waiver is to provide Medicaid funding for medical treatment for individuals who are inmates of a public institution on a temporary basis and to bridge the gap in coverage for adults receiving treatment in an IMD in order to facilitate access to care and successful community reentry.

This Reentry Waiver will improve the health outcomes of thousands of children and adults in Arkansas in need of treatment for SED, SMI, or SUD by streamlining the various federal exclusions to reduce gaps in services. By testing consistent transition strategies for both carceral and IMD settings, regardless of factors such as the enrollee’s delivery system or specific diagnosis that have previously impacted IMD authorizations, Arkansas seeks to create greater access for individuals in need of Medicaid services.

Further, this Reentry Waiver will enable Arkansas to comply with the requirements under Section 5121 of the CAA and adopt the optional coverage under Section 1522 of the CAA to expand critical Medicaid services for Medicaid and CHIP eligible youths in public institutions.

This Reentry Waiver would permit the use of federal funds for temporary coverage of Medicaid-funded services while an individual resides in either an IMD or carceral setting to support post-release transition planning appropriate to each individual’s needs. Such coverage during the temporary but crucial transition periods will increase the likelihood of successful transitions back into our communities.

In sum, Arkansas requests authority for the following:

1. To cover all Medicaid services for incarcerated adults and juveniles who have been determined to be eligible for Medicaid for up to 90 days beginning on the first day of incarceration in which benefits have been restarted and for another period of up to 90 days prior to release; and
2. To waive the IMD exclusion in order to cover Medicaid services provided to Medicaid eligible adults ages 19-64 receiving treatment in qualifying IMD institutions for up to 90



days beginning on the first day of admission and for another period of up to 90 days prior to the individuals transition back to community-based treatment.<sup>16</sup>

This Reentry Waiver holds great promise to:

- Alleviate impacts of the severe shortage of mental health providers by opening the doors of IMDs on a temporary basis;
- Reduce recidivism back into the justice system for both adults and juveniles;
- Promote efficiency and effectiveness of the Medicaid program through care coordination and new models of care delivery that include HCBS services that are bundled with care coordination; and
- Improve health outcomes for individuals with SUD and SMI/SED by addressing individuals' Health-Related Social Needs (HRSN).

This Reentry Waiver is consistent with the CMS guidance to States provided by SMD# 23-003. If approved, it also will enhance Arkansas Medicaid's ability to support key parts of the CMS Behavioral Health Strategy including:

- Enhancing Access to Telehealth Services
- Strengthening Crisis Services
- Encouraging Interprofessional Access
- Supporting Re-Entry and Care Transitions for Justice-Involved Individuals
- Supporting a Full Continuum of Care

Further, the Reentry Waiver is critical to supporting a full continuum of care and is consistent with the CMS priority as, "CMS has used the Section 1115 demonstration authority in Medicaid to help states to **ensure access to a full array of levels of care** for beneficiaries with mental health (MH) and SUD, including **inpatient** and residential treatment settings, as well as intensive outpatient and community based recovery supports ... (emphasis added)."<sup>17</sup>

The Reentry Waiver also would align with the priorities developed in the Substance Abuse and Mental Health Services Administration (SAMSHA) *Strategic Plan 2023-2026* which describes the lack of adequate access to treatment:

People with behavioral health conditions often experience challenges getting the care they need. Forty-four million people ages 12 and older in the United States needed substance use treatment in the past year; however, only 6.3 percent reported receiving any. Close to 58 million adults ages 18 or older had any mental illness during the same time period, but less than half (47.2 percent or 26.5 million) reported receiving mental health services in the past year.<sup>18</sup>

The five SAMSHA Strategic Plan priorities are:

- Preventing Substance Use and Overdose
- Enhancing Access to Suicide Prevention and Mental Health Services

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<sup>16</sup> As previously noted, the EPSDT requirements permit coverage for individual ages 19-21 in Medicaid ("ARKids A"). Arkansas administers a separate Children's Health Insurance Program (CHIP) ("ARKids B") for children at higher income levels that does not include EPSDT benefits.

<sup>17</sup> <https://www.cms.gov/files/document/cms-behavioral-health-strategy.pdf> p.2

- Promoting Resilience and Emotional Health for Children, Youth, and Families
- Integrating Behavioral and Physical Health Care
- Strengthening the Behavioral Health Workforce

The state also has reviewed the SAMHSA guide, *Best Practices for Successful Reentry From Criminal Justice Settings for People Living With Mental Health Conditions and/or Substance Use Disorders*. The Guide states, “[i]mplementing new programs and practices requires a comprehensive, multi-pronged strategy.”<sup>19</sup> DHS recently created the new Office of Substance Abuse and Mental Health (OSAMH) to lead its comprehensive, multi-pronged strategy.

Providing coverage for the full array of Medicaid services is consistent with the SAMHSA guide:

“Co-occurring disorders are prevalent among incarcerated individuals as well, and programs should provide comprehensive screening, assessment, and treatment to support individuals with these conditions.”<sup>20</sup>

Addressing these two critical periods of transition, specifically the transition into and the transition out of the IMD or carceral setting, will have a positive impact on the health of these at-risk populations. However, the Reentry Waiver also is designed to emphasize that services provided in an institutional setting should be only temporary and transitional. Arkansas remains committed to serving individuals who need medical treatment first and foremost in their communities, with a focus on prevention to reduce the need for higher intensity and more expensive institutional and residential services as well as to reduce the likelihood of future criminal behavior that could lead to incarceration.

Arkansas also is strengthening and expanding its mobile crisis system to serve individuals with mental illness and divert people in crisis from hospital emergency rooms and local jails. This Reentry Waiver therefore is a critical component of a multi-faceted strategy to improve the timely delivery of mental health services in the most appropriate setting.

## **Section II: Background & Historical Narrative**

Across Arkansas, many individuals, families, and communities struggle with the effects of poverty, as demonstrated by the demographic statistics below. Research conclusively shows that experiencing poverty leads to poor physical and behavioral health and poor overall health outcomes. Poverty also is interconnected with a host of negative social outcomes, including risk of incarceration. Incarceration itself then presents its own independent risk of negatively impacting an individual’s mental and physical health and contributes to the continuation of a cycle of poverty that many individuals and families struggle to escape. The loss of a parent’s income due to poor health and incarceration in turn also often results in children becoming confined into intergenerational poverty.

Due to high poverty rates, many Arkansans qualify for Medicaid, which is a critical tool to providing access to necessary care that could be one step in the process of ending the cycle of poverty and improving health outcomes for parents and, subsequently, for their children. Based on federal restrictions, current policy in Arkansas suspends an individual’s Medicaid coverage

when they are incarcerated or seeking behavioral health treatment in an IMD, disconnecting them from these critical services when they are needed most.

Arkansans receiving Medicaid experience a host of chronic and disabling conditions, but treatment for mental illness is an especially critical issue due to the workforce shortage of mental health professionals in the state.

### **Arkansas Demographics**

Arkansans experience poverty at a rate far higher than the national average. According to the U.S. Census Bureau estimates for July 1, 2022, Arkansas has a population of 3,045,637 or 57.9 people per square mile. The median family income (in 2021 dollars) was \$52,123 and the per capita income was \$29,210. 16.3% of Arkansans live at or below the poverty level. 78.5% of the population was White; 15.6% was Black; 8.6% was Hispanic or Latino; 2.4% were two or more races 1.8% was Asian; 1.1% was American Indian and Alaska Native; and 0.5% was Native Hawaiian or Other Pacific Islander. 89.8% of households had a computer and 79.7% had a broadband internet subscription. 87.7% of persons aged 25 or greater were high school graduates and 24.3% had obtained a bachelor's degree or higher.<sup>21</sup>

The three-year average (2019, 2020, and 2021) of the percentage of people in poverty was 15.1%. Only Mississippi (18.1%), Louisiana (17.2%), and New Mexico (16.7%) had higher percentages of people in poverty.<sup>22</sup> The percentage of people in poverty varies dramatically among the 75 counties in Arkansas. The percentage of those in poverty ranged from 8.1% in Benton County to 33.3% in Phillips County.<sup>23</sup>

High rates of poverty across the state have likely led to poorer health outcomes, as the clear linkage between poverty and poor health is well documented by research.<sup>24</sup> Arkansas ranks as the 48<sup>th</sup> healthiest state.<sup>25</sup>

### **Incarceration and Poverty**

Relative to other states, Arkansas has a high rate of incarceration.<sup>26</sup> This means that, each year, large numbers of incarcerated Arkansans are being released and expected to transition back into the community. In 2022, the Arkansas Department of Corrections (DOC) released approximately 5,000 individuals. Prior to that, approximately DOC released about 10,000 individuals per year. About half will return to prison. As DOC bluntly warns, “[p]revious incarceration predicts future incarceration.”<sup>27</sup> Young adults (ages 18-24) are 1.5 times more

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<sup>21</sup> <https://www.census.gov/quickfacts/AR>

<sup>22</sup> <https://www.census.gov/content/dam/Census/library/publications/2022/demo/p60-277.pdf> Table B-5, p. 69.

<sup>23</sup> <https://fred.stlouisfed.org/release/tables?rid=416&eid=339639>

<sup>24</sup> E.g., <https://www.aafp.org/about/policies/all/poverty-health.html#:~:text=Poverty%20affects%20health%20by%20limiting,an%20individual's%20standard%20of%20living>.

<sup>25</sup> <https://achi.net/newsroom/arkansas-ranks-48th-in-annual-americas-health-rankings-report/>

<sup>26</sup> <https://www.axios.com/local/nw-arkansas/2022/02/17/arkansas-incarceration-rate-up-as-other-states-decline>

<sup>27</sup> [https://doc.arkansas.gov/wp-content/uploads/2022/04/Recidivism-in-Arkansas-A-Roadmap-to-Reform-April29\\_2022-single\\_BOC\\_FINAL.pdf](https://doc.arkansas.gov/wp-content/uploads/2022/04/Recidivism-in-Arkansas-A-Roadmap-to-Reform-April29_2022-single_BOC_FINAL.pdf) p.2.

likely to return to prison than older adults. Access to healthcare or other supportive services is critical to reducing the likelihood that formerly incarcerated individuals will return to prison or jail.

Experiencing poverty also raises the risk of an individual becoming incarcerated. Many incarcerated individuals struggled with poverty prior to going to prison or jail and continue to struggle after release. In a March 2018 study, “Work and Opportunity Before and After Incarceration,” the Brookings Institution reported that poverty preceded incarceration as well as followed it:

The data show that ex-prisoners struggle in the labor market after their period of incarceration. In the first full calendar year after their release, only 55 percent have any reported earnings. Among those with jobs, their median annual earnings is \$10,090 and only 20 percent earn more than \$15,000 that year—an amount roughly equivalent to the earnings of a full-time worker at the federal minimum wage.

The struggles of ex-prisoners after leaving prison are mirrored by their struggles prior to being incarcerated. Three years prior to incarceration, only 49 percent of prime-age men are employed, and when employed, their median earnings were only \$6,250. Only 13 percent earned more than \$15,000. Tracking prisoners over time and comparing employment and earnings before and after incarceration, we find surprisingly little difference in labor market outcomes like employment and earnings.<sup>28</sup>

Incarceration presents an even higher risk of poor health. According to Healthy People 2030:

When compared to the general population, men and women with a history of incarceration are in worse mental and physical health. Data from the Bureau of Justice found that, in 2011, 44 percent of people who were incarcerated had a mental health disorder. Studies have shown that when compared to the general population, people of both sexes who are incarcerated are more likely to have high blood pressure, asthma, cancer, arthritis, and infectious diseases, such as tuberculosis, hepatitis C, and HIV.<sup>29</sup>

Within 3 years of their release, 2 out of 3 people are rearrested and more than 50 percent are incarcerated again. Many people face obstacles reintegrating into society following their release, such as problems with family, employment, housing, and health, as well as difficulty adjusting to their new circumstances. People who were formerly incarcerated often have difficulty securing employment and housing because of their criminal history.<sup>30</sup>

Furthermore, people who were formerly incarcerated are at an increased risk for experiencing health issues. For example, a North Carolina-based study found that within 2 weeks following their release, people who were formerly incarcerated were 40 times more likely to die of an opioid overdose than someone in the general population. People who were formerly incarcerated are also at a higher risk for committing suicide soon after their release.<sup>31</sup>

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<sup>28</sup> [https://www.brookings.edu/wp-content/uploads/2018/03/es\\_20180314\\_looneyincarceration\\_final.pdf](https://www.brookings.edu/wp-content/uploads/2018/03/es_20180314_looneyincarceration_final.pdf)

p.1

<sup>29</sup> <https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/incarceration> accessed online July 5, 2023, p 3

<sup>30</sup> Ibid.

<sup>31</sup> Ibid.p.5

## 2.1 Arkansas Medicaid Background

Due to high rates of poverty, Arkansas enrolls more people in Medicaid as a percentage of total population than most states.<sup>32</sup> Arkansas Medicaid provides coverage to more than 1 million individuals with income at or near the federal poverty level over the course of year. Children account for 37% of the total Medicaid population; adults represent 41% of the total Medicaid population; individuals with disabilities are 15% of the Medicaid population and 8% are seniors. Approximately two-thirds of the population receives coverage through the Fee-For-Service (FFS) delivery system.

Medicaid purchases coverage through Qualified Health Plans (QHPs) for about 240,000 adults each calendar year under a Section 1115 waiver, the Arkansas Health and Opportunity for Me (ARHOME) program. ARHOME also provides authority and funding for three types of community bridge organizations called Life360 HOMEs. These are designed to serve target populations—individuals with mental illness who live in rural areas (Rural Life360); women with high-risk pregnancies (Maternal Life360) and young adults most at risk of long-term poverty (Success Life360). Individuals served in a Life360 HOME will receive “intensive care coordination” which may include daily support to meet the individualized “action plan.” An amendment to expand Life360 HOMEs is pending CMS approval to provide “focused care coordination” from a Success Coach for an expanded group of people.

About 50,000 people with serious mental illness or a developmental disability who meet an institutional level of care are enrolled in the PASSE program. PASSE is a comprehensive benefit program that includes all state plan services and a full array of home and community-based services (HCBS). PASSE is administered under Medicaid managed care rules. Each individual in a PASSE has a care coordinator and a Person-Centered Service Plan (PCSP).

## 2.2 Overview of Justice System in Arkansas

Federal Medicaid funds may not be used to pay for services for individuals who are incarcerated, excluding when that individual is receiving inpatient care in a medical institution. To address this prohibition, states have been required to suspend an incarcerated individual’s Medicaid coverage and reinstate it upon their release.

Currently, DHS, through the Division of County Operations (DCO), which administers the Arkansas Medicaid eligibility and enrollment system, suspends Medicaid eligibility for up to 12 months once an individual enters a correctional facility. DCO receives an electronic file to suspend status. If a Medicaid-eligible inmate is admitted to a hospital, for which federal funds are available, coverage is allowed and the claim is paid. These claims are coordinated through Wellpath, a national vendor with experience in working with correctional facilities.

DCO has a contract with an external entity to monitor inmate releases and apply for Medicaid coverage once they are released. DCO is currently in the process of upgrading the eligibility system to accept and process applications 45 days prior to release.

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<sup>32</sup> <https://www.medicaid.gov/state-overviews/scorecard/percentage-of-population-enrolled-medicaid-or-chip-state/index.html>

## **Profile of Arkansas Department of Corrections Inmates**

According to the Arkansas Department of Corrections, the average 2022 monthly custody count was 14,733. The number of inmates admitted to the Department of Corrections increased from 5,182 to 5,429 in State Fiscal Year 2022, an increase of 4.8%.<sup>33</sup> The 2022 Annual Report shows that:

### **Admissions**

- New Commits: 61.2%
- Parole Violator New Time: 25.2%
- Technical Violator: 13.6%
- Admissions by Gender: Males--4,468 (82.3%); Females—961 (17.7%)
- Average age at admission: Males—37; Females--36
- Race of Inmates Admitted:
  - Caucasian: 66.3%
  - Black: 29.7%
  - Hispanic: 2.8%
  - Other: 1.2%

### **Releases**

- 5,028 released
- Average Time Served Releases: 5 years, 1 month, 3 days

### **Recidivism**

Over half of those released will return to prison within 36 months. Young adults (18-24) have the highest recidivism rate and are 1.5 times more likely to return to prison than older adults.<sup>34</sup>

## **Overview of the Arkansas Juvenile Justice System**

The prohibition on federal funding for medical treatment for inmates of a public institution applies to all ages. While most juvenile offenders remain in the communities, many are court-ordered into state-operated juvenile treatment centers or are retained in local jails. The Division of Youth Services (DYS) oversees five treatment centers for serious offenders:

- Arkansas Juvenile Assessment & Treatment Center
- Dermott Juvenile Treatment Center
- Harrisburg Juvenile Treatment Center
- Mansfield Juvenile Treatment Center
- Lewisville Juvenile Treatment Center

DYS also operates the Civilian Student Training Program (CSTP) which is a residential program at Camp Robinson and contracts with various community providers including out-of-home placements.

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<sup>33</sup>[https://doc.arkansas.gov/wp-content/uploads/ADC-FY22-Annual-Report\\_12-20-2022\\_FINAL\\_spread.pdf](https://doc.arkansas.gov/wp-content/uploads/ADC-FY22-Annual-Report_12-20-2022_FINAL_spread.pdf)

<sup>34</sup>[https://doc.arkansas.gov/wp-content/uploads/2022/04/Recidivism-in-Arkansas-A-Roadmap-to-Reform-April29\\_2022-single\\_BOC\\_FINAL.pdf](https://doc.arkansas.gov/wp-content/uploads/2022/04/Recidivism-in-Arkansas-A-Roadmap-to-Reform-April29_2022-single_BOC_FINAL.pdf) p.2.

In SFY 2021, there were 256 commitments to DYS of which 210 were males and 46 were females. Residential facilities costs were \$25.1 million and community-based programs and services were \$19.8 million. DYS also contracts for specialized services programs including therapeutic group homes, residential treatment services and in psychiatric facilities at the Arkansas State Hospital and Methodist Behavior Hospital.

The average length of stay in different settings were:

- Juvenile Correctional Facilities: 122 days
- Juvenile Treatment Centers: 166 days
- Specialized placements: 197 days
- Juvenile Detention Centers: 12 days

There were 2,250 community-based intakes among 12 contracted providers.

Local jurisdictions across the state also operate county and regional Juvenile Justice Centers and Juvenile Detention Centers for juveniles charged with delinquency or criminal offenses. DHS will collaborate with the Administrative Office of the Courts Juvenile Division and local county governments which are responsible for these types of facilities.

Arkansas also operates more than 100 specialty courts that include Adult Drug Court, Juvenile Drug Court, Veterans Treatment Court, Mental Health Court, and DWI Court that served an average of 2,396 participants each month in 2021:

To be eligible for a specialty court, an individual must be charged with a criminal offense, have an untreated substance use or behavioral health disorder, and be at substantial risk for reoffending or failing to complete a less intensive disposition, such as general probation or parole. These individuals are commonly referred to as “high risk, high-need.” In other words, they are the most challenging individuals within the criminal justice system.

Individuals entering specialty courts are often unemployed, homeless, engaged in severe drug use, and facing long-term incarceration. Rather than incarceration, specialty courts provide an opportunity to enter long-term treatment with intensive court supervision. Specialty courts address the root causes of criminal behavior such as substance abuse and behavioral health disorders, poverty, physical health conditions, and unemployment. Through a combination of accountability and treatment, special court participants are able to maintain recovery from drugs and alcohol, gain employment, reunite with family, pursue educational advancements, and act as valued members of the community.<sup>35</sup>

## 2.3 Overview of Behavioral Health System in Arkansas

Adults in Arkansas experience symptoms of anxiety and/or depressive disorder at a rate higher than the national average and the suicide rate is almost four percentage points higher than the national average.<sup>36</sup> Arkansans enrolled in Medicaid experience behavioral health needs at

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<sup>35</sup><https://www.arcourts.gov/sites/default/files/2021-ANNUAL-REPORT.pdf> p.13.

<sup>36</sup><https://www.arkansasbluecross.com/docs/librariesprovider9/default-document-library/behavioral-health-background-blue-and-you-foundation.pdf>

higher rates than individuals with commercial coverage. There is a lack of mental health professionals across the state, with only 34.4% of the need for practitioners met.<sup>37</sup>

### **Overview of the Arkansas Behavioral Health System**

The largest source of funding for mental health services in Arkansas is the Medicaid program. In 2020, Medicaid paid out \$825.3 million for behavioral health medical services and prescriptions for patients with a behavioral health primary diagnosis.

In FY 2021, Arkansas received \$110.9 million in federal grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) through a combination of Formula Funding and Discretionary Funding. Total mental health funds were \$61.1 million and total substance abuse funds were \$49.9 million.<sup>38</sup> The Division of Aging, Adult, and Behavioral Health Services (DAABHS) administers the federal grants received by the state.

Of the 75 counties in Arkansas, only three, Faulkner, Pulaski, and Saline, are not designated as workforce shortage areas for mental health professionals.<sup>39</sup> In a recent *Health Affairs* article, researchers found that although Arkansas Medicaid is one of the highest paying states for selected mental health services, it is well below the national average ratio of 6.7 psychiatrists participating in Arkansas Medicaid per 10,000 Medicaid enrollees.<sup>40</sup>

The impact of the mental health professional workforce shortage in Arkansas is acutely reflected in the Medicaid Adult Core Set Report on key measures according to an analysis by Mathematica of the Quality Measure Reporting system report for Federal Fiscal Year 2022. In Arkansas, only 34.9% of adults ages 18 to 64 who experienced an emergency department visit and had a principal diagnosis of mental illness or intentional self-harm had a follow-up visit with a mental health professional within 30 days. Of the 48 states that reported on this measure, only Georgia (34.0%), Louisiana (27.8%), and West Virginia (12.4%) reported lower percentages. The state mean was 53.5% and the state median for this measure was 52.5%.<sup>41</sup>

Arkansas also reported one of the lowest percentages for follow-up visit with a mental health practitioner within 30 days of a hospital discharge. Arkansas reported a 36.4% rate compared to the state mean of 54.7% and the state median of 54.5%. Of the 46 states reporting on this measure, only Florida (34.4%), Louisiana (31.9%), North Carolina (35.4%), and West Virginia (22.8%) reported lower rates. Relief from the IMD exclusion is critical to lifting Arkansas from the bottom tier of states on behavioral health quality measures.<sup>42</sup>

In 2022, DHS and the Arkansas Center for Health Improvement (ACHI) collaborated on the “Behavioral Health Landscape Project” to analyze the use of behavioral health services covered by Medicaid, Medicare, commercial insurance plans, and state self-insured plans for the period 2018-2020. According to the Landscape Report, nearly 400,000 individuals had a behavioral

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<sup>37</sup> *Id.*

<sup>38</sup> <https://www.samhsa.gov/grants-awards-by-state/AR/2021#>

<sup>39</sup> <https://www.ruralhealthinfo.org/charts/7?state=AR>

<sup>40</sup> Jane M. Zhu, Stephanie Renfro, Kelsey Watson, Ashmira Deshmukha, and K. John McConnell, Medicaid Reimbursement For Psychiatric Services: Comparisons Across States and With Medicare. *Health Affairs*, April 2023. 42:4.

<sup>41</sup> <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html> Table FUM-AD.

<sup>42</sup> *Ibid.* Table FUH-AD.



health primary diagnosis in 2019. Of these individuals, 55.1% were covered through Medicaid, 22.8% were covered by commercial insurance, and 22.1% were covered by Medicare. Claims for medical services and prescriptions totaled \$1.2 billion in 2019. Medicaid made \$787 million (64.4%) in payments to providers, Medicare spent \$290 million (23.7%) and commercial insurance paid out \$145 million (11.9%). In addition to claims-based expenditures, DHS made \$67.1 million in direct payments for services through a variety of grant programs. Arkansas State Hospital (ASH) expenditures were approximately \$55.4 million.

In 2020, Arkansas Medicaid spent \$825.3 million for behavioral health medical services and prescription drugs for patients with a behavioral health primary diagnosis. Of this total amount, the PASSE program accounted for \$337.6 million (40.9%), Medicaid FFS accounted for \$312.3 million (37.8%) and QHPs expenditures in the ARHOME program were \$175.4 million (21.3%).

### **Community Mental Health Centers and Specialty Clinics**

Arkansas has designated 12 geographic catchment areas across the 75 counties in the state which are served by Community Mental Health Centers (CMHCs). Each CMHC is nationally accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC) or Council on Accreditation (COA).

The CMHCs are:

- Centers for Youth and Families
- Community Counseling Services, Inc.
- Counseling Associates, Inc.
- Delta Counseling Associates, Inc.
- Arisa Health, Inc.
- Ozark Guidance Center, Inc.
- Professional Counseling Associates
- South Arkansas Regional Health Center
- Southeast Arkansas Behavioral Healthcare System, Inc.
- Southwest Arkansas Counseling & Mental Health Center, Inc.
- The Counseling Clinic, Inc.
- Western Arkansas Counseling and Guidance Center

In SFY 2021, the CMHCs and Specialty Clinics served more than 77,000 clients at 115 sites:

CMHCs provide screenings for all persons referred for publicly supported inpatient care, including at Arkansas State Hospital and in local psychiatric hospital beds paid for through SAMSHA grant funds provided to the CMHCs.

Additionally, CMHCs provide a comprehensive array of clinical and rehabilitative mental health services including: crisis intervention and stabilization; mental health, psychiatric, psychological and forensic assessment, treatment planning; individual, family, multi-family, and group therapy; medication management; case management; day treatment/partial hospitalization programs, psychiatric rehabilitation day programs; and

other supportive services such as housing, vocational, and therapeutic foster care services.<sup>43</sup>

### **Outpatient Behavioral Health Agencies and Independently Licensed Practitioners**

The CMHCs are also enrolled in the state Medicaid program as Outpatient Behavioral Health Agencies (OBHAs). In addition to these entities, dozens of other OBHAs and Independently Licensed Practitioners (ILPs) are Medicaid enrolled providers. In SFY 2022, Medicaid FFS paid more than \$42 million to OBHA and ILPs for services delivered by professionals.

### **Alcohol and Drug Prevention and Treatment Services**

DAABHS is also “responsible for the funding of alcohol and drug prevention and treatment services, providing court ordered treatment, licensing of alcohol and drug treatment programs, overseeing the State Methadone Authority, administering the Drug and Alcohol Safety Educational Programs, providing treatment order by juvenile drug court, and assisting with providing training in the field of substance abuse.”<sup>44</sup>

During SFY 2021, nearly 14,000 individuals received substance abuse treatment services through a variety of grants and contracts authorized by DAABHS. Because of the IMD exclusion, the primary use of grant funding is for adult SUD residential treatment. Arkansas has the second highest rate of opioid dispensing in the country with 75.8 per 100 people compare to 43.3 per 100 people nationwide.<sup>45</sup>

The state intends to build out the continuum of care of services by adding residential SUD treatment providers and expand provider capacity. However, the state recognizes that additional time and efforts will be necessary to adequately provide treatment in SUD facilities. Accordingly, coverage of SUD residential services will not be effective until January 1, 2026 in order to allow sufficient time for the state to set program standards and qualifications and for providers to obtain American Society of Addiction Medicine (ASAM) certification for the level of care to be offered.

### **Arkansas State Hospital**

The Arkansas State Hospital (ASH) is the sole public psychiatric hospital in Arkansas and has 222 patient beds. In SFY 2021, there were 710 individuals who received services at ASH. The average daily census for all patients (acute, forensic adult, and adolescent) was 203. For those who were served at ASH at any point during SFY 2023, the average length-of-stay at ASH was 605 days. There were no stays of less than 60 days. DHS understands that CMS has typically limited its approval of IMD coverage to 30-days or 60-days. Clearly, such limitations represent only a small fraction of Arkansas’s actual experience with its sole state hospital.

A disproportionate percentage of ASH patients are Black. While 17.7% of clients who received substance abuse treatment were Black, 18.3% of CMHC clients were Black, 44.2% of ASH patients were Black.

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<sup>43</sup> [https://humanservices.arkansas.gov/wp-content/uploads/Annual\\_Statistical\\_Report\\_2021\\_010222.pdf](https://humanservices.arkansas.gov/wp-content/uploads/Annual_Statistical_Report_2021_010222.pdf)  
p. DAABHS-11.

<sup>44</sup> Ibid.

<sup>45</sup> <https://www.cdc.gov/drugoverdose/rxrate-maps/state2020.html>

ASH meets the definition of a public institution. Many individuals receiving treatment at ASH are disadvantaged relative to individuals receiving psychiatric services elsewhere in the state because they are involved with the judicial system. Individuals may experience longer lengths of stay for several reasons including delays in discharge planning. Many community providers may lack experience in interacting with the judicial system. Individuals may also experience a loss in their support system because they have been removed from their communities for lengthy periods. This waiver will address such disparities at least in part by better discharge planning and support through care coordination provided through the PASSE program.

In SFY 2023, ASH costs were \$55.9 million with patient revenue of \$4.1 million. The excess costs are covered through state general revenue funds.

### **Private Institution for Mental Disease and Acute Crisis Units/Crisis Stabilization Units**

There are currently 11 private IMDs that are Medicaid enrolled providers and have active Medicaid IDs:

- Valley Behavioral Health System
- Rivendell Behavioral Health Services of Arkansas
- Conway Behavioral Health
- Springwoods Behavioral Health Services
- Vantage Point of Northwest Arkansas
- Freedom Behavioral Hospital of Central Arkansas
- Pinnacle Pointe Behavioral Healthcare System
- United Methodist Behavioral Hospital
- The BridgeWay
- Riverview Behavioral Health
- Perimeter Behavioral Hospital of West Memphis

In 2022, Arkansas Medicaid FFS paid \$17.2 million in claims for more than 5,000 unique children/youth beneficiaries to these private IMDs. Although FFS expenditures have declined since the PASSE organizations assumed full-risk in March 2019, these figures demonstrate there remains a significant number of low-income Arkansans with mental health treatment needs outside the PASSE. In 2022, more than 2,000 individuals treated in a psychiatric hospital experienced multiple hospitalizations.

Arkansas has been seeking to build capacity to serve individuals experiencing a mental health crisis by expanding the number of acute crisis units (ACU)/crisis stabilization units (CSU). Currently, ACUs/CSUs are freestanding or located in general hospitals and an individual must have a minimum stay of 24 hours.

DHS believes that ACUs are a critical link in the continuum of care for people with mental illness and, with the support and cooperation of local law enforcement agencies, can divert individuals from jail, emergency departments, and ASH. Studies have shown that "Crisis Stabilization Centers are effective at providing suicide prevention services, addressing behavioral health treatment, diverting individuals from entering a higher level of care and addressing the distress experienced by individuals in a behavioral health crisis. Studies also show that the cost of

Crisis Stabilization Centers is considerably less than psychiatric inpatient units and satisfaction among clients is greater.”<sup>46</sup>

There is still a lack of ACU capacity across the state. DHS is working to build greater understanding and acceptance of delivering services in this type of setting as an alternative to emergency rooms and local jails by strengthening the state’s mobile crisis system. DHS also intends to require IMDs to open ACUs in order to participate in the waiver.

Arkansas also provides coverage to children in foster care through Qualified Residential Treatment Programs (QRTPs). These facilities are 16 beds or less and thus are not excluded from federal financial participation.

### **General Hospitals with Psychiatric Stays**

In SFY 2023, Medicaid paid \$29.1 million in FFS claims from general hospitals in which the attending provider had a specialty of psychiatry.

## **Section III: Demonstration Description and Objectives**

Arkansas intends to align this Reentry Waiver with the goals, milestones, and objectives stated by CMS in its guidance regarding the reentry and IMD opportunities.<sup>47</sup> In addition to seeking to achieve those outcomes identified for each unique waiver component, Arkansas intends for both requests to demonstrate progress toward the overarching state policy goals for the Reentry Waiver:

1. Strengthen the care continuum for individuals residing on a temporary basis in an IMD, jail, or prison to support better health outcomes among this highly vulnerable population; and
2. Support smoother care transitions from IMD and carceral settings to increase the likelihood that these individuals will maintain coverage and receive the healthcare they need to thrive in a community setting.

It has been well documented that the correlation between incarceration and poor health is strong. Individuals entering prisons and jails are already at a higher risk for chronic health conditions than the general population, including SMI and SUD. Once in a facility, the impact of incarceration can exacerbate these conditions. Individuals at risk of incarceration and those with a prior history of incarceration also experience poverty at high rates, and thus often obtain health coverage from Medicaid. Because Medicaid coverage must be suspended when an individual is incarcerated, individuals in prisons and jails are disconnected from critical health services during a time of heightened need.

The same is true of individuals in other facility settings such as IMDs. Individuals receiving services in an IMD for SED, SMI, or SUD are often experiencing a behavioral health crisis that requires an enhanced level of care that cannot be provided in an outpatient setting. When this level of care is not covered by Medicaid, beneficiaries may be forced to receive less intensive

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<sup>46</sup> <https://www.mentalhealthjournal.org/articles/behavioral-health-crisis-stabilization-centers-a-new-normal.pdf>

<sup>47</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf>

services than they need, forgo services entirely, or seek care through emergency departments that are not equipped to provide the specialty behavioral health care needed. A substantial number of Medicaid beneficiaries report an unmet need for drug or alcohol treatment (80%) and many report a lack of needed mental health treatment (36%).<sup>48</sup> The prohibition on payment for services in certain treatment settings only serves to keep beneficiaries from receiving necessary services in the most appropriate setting.

Arkansas requests this combined waiver of both the inmate and IMD exclusions to better serve individuals experiencing physical and behavioral health needs across a variety of carceral and inpatient settings. Arkansas envisions a connected system of care for Medicaid beneficiaries, in which a limited time served in a prison or jail or a stay in an IMD does not derail a beneficiary's progress toward improved health outcomes and where their community-based care team can remain involved in their care. Arkansas seeks these waivers to support beneficiaries through critical transition periods by paying for medically necessary services to support continuity of care, connecting individuals to more consistent coverage, and coordinating care before and after release or transition to or from the community.

Arkansas recognizes that reentry and transitions are part of a lengthy process, not a single event. As such it requires careful planning and collaboration. Through this Reentry Waiver, Arkansas proposes to define the "temporary period" not subject to the federal exclusions as up to 90 days after placement in a public institution, including an IMD, jail or prison, and for 90 days prior to discharge from a public institution, including an IMD, jail or prison. The period of time begins when an individual has been determined to be eligible for Medicaid and benefits have (re)started. This will allow adequate transition planning for all individuals transitioning to and from the community in an equitable manner.

### 3.1 Reentry Services

To facilitate continuity of care for individuals transitioning to carceral settings as well as to facilitate the equitable provision of reentry services for individuals transitioning out of carceral settings, this Reentry Waiver proposes to:

1. Provide Medicaid services (including via telemedicine, as applicable), including case management, medication assisted treatment (MAT) services, and prescription drugs, for individuals who were enrolled in Arkansas Medicaid prior to incarceration, for 90 days beginning on the day benefits have restarted during incarceration and 90 days prior to release.
2. Begin the Medicaid application process for incarcerated individuals not enrolled in Medicaid 135 days prior to release in order to determine eligibility and if found to be eligible. DHS is required to determine eligibility within 45 days. The Division of County Operations will coordinate with the Department of Corrections to process applications. For those determined to be eligible, Medicaid will begin paying for medically necessary services for up to 90-days prior to release and to obtain authorizations for services, including a 30-day supply of prescription drugs per CMS guidance, upon release.

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<sup>48</sup> <https://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

3. Inmates who are determined to be Medicaid eligible will be enrolled in the PASSE program. The PASSE will assign a care coordinator to the individual, develop the Person-Centered Service Plan (PCSP), and provide medical services from network providers, including via telemedicine as applicable, for up to up to 90-days during an individual's pre-release period. The individual will remain enrolled in the PASSE for 12 months after release if the individual continues to be eligible for Arkansas Medicaid.
4. If, after 12 months, the individual continues to need treatment for a mental illness or SUD or needs Home and Community Based Services (HCBS) under the state plan or via 1915(i) authority, the individual will remain in the PASSE and continue to receive all covered services including care coordination through the PASSE. Adults who do not need treatment for a mental illness or SUD or HCBS services after 12 months will be transitioned out of the PASSE. Adults will be enrolled in a Qualified Health Plan (QHP) or FFS depending upon a person's category of eligibility, while children will continue to be served by the PASSE.
5. After the first 12-month period from reentry, care coordination still will be provided to these individuals through either a PASSE, a Life360 HOME, or a Success Coach (pending CMS approval of the Opportunities for Success Amendment). Among other things, the care coordinator will assess the individual's Health-Related Social Needs (HRSN) and assist the individual in obtaining local resources and community supports.

This Reentry Waiver application includes a "front door" approach as well as reentry focused strategy to divert children and adolescents from the out-of-home residential placement juvenile justice system and adults from the correctional system and the Arkansas State Hospital (ASH). By providing transition services on both ends, Arkansas will have the flexibility to provide more equitable services by reaching individuals with unknown release dates and who reside in a jail or prison for less than 90 days. Further permitting these individuals to maintain Medicaid coverage during these temporary periods will facilitate stronger collaboration between the correctional facilities and the Medicaid service providers to improve health outcomes.

In addition to seeking federal match for transition services provided to individuals in carceral settings, this Reentry Waiver also requests training and IT network funding. Specifically, DHS seeks funding to enable coordination with Department of Corrections and local correctional facilities to prepare individuals for release back into their communities. It also requests funding to expand the number of small, independent behavioral health providers with interoperable electronic health records (EHR) and participation in the State Health Alliance for Records Exchange (SHARE), the state's Health Information Exchange (HIE) system. The state also requests funding to reconfigure existing EHR systems for interoperability and to link communities together using common case management systems that can track the use of medical and nonmedical services and supports. By linking community-based care management systems across the state, providers and health plans will be able to meet health improvement goals, milestones, and performance measure targets including those reported to CMS on the Medicaid Adult Core Set measures related to behavioral health as well as those required under the CMS guidelines for the three waiver opportunities.

While the operational details of the proposed reentry services will be established via detailed implementation and reinvestment plans developed post-approval, the Reentry Waiver will be designed in a manner to address all elements described in Appendix 1 of SMD #23-003 as outlined in more detail below.

1. *Quality.* The Demonstration will best address quality through care coordination, expanding access to care and providing continuity of care. During the 90-day transition period, adults with SMI and children with SED will receive an Independent Assessment (IA) to coincide with enrollment into a PASSE. The PASSE program provides the most comprehensive coverage package available in Arkansas Medicaid and includes intensive care coordination and 1915(i) HCBS-like services as well as all state plan services.
2. *Carceral Settings.* Settings for reentry services will include state prisons and local jails. In addition, these services also will be made available to justice-involved juveniles.
3. *Eligible Individuals.* Individuals regardless of age and eligibility category who are enrolled in the Arkansas Medicaid program who are incarcerated will be eligible for the reentry services through this Reentry Waiver.
4. *Medicaid Eligibility and Enrollment.* The state confirms that eligibility of an individual enrolled in Arkansas Medicaid is suspended during periods of incarceration. DHS will coordinate eligibility reinstatement 90 days prior to release with DOC and local jurisdictions.
5. *Scope of Health Care Services.* As required by SMD# 23-003, the state will provide case management and care coordination services (as described in more detail below in *Section 3.1.1*), MAT services, and a 30-day supply of prescription drugs. In addition, all medically necessary Medicaid covered services will be available to an individual during the pre-release period, including via telehealth services provided through community-based providers.
6. *Pre-Release Timeframe.* Individuals enrolled in Medicaid will be eligible for a temporary period not to exceed 90 days beginning on the first day of when Medicaid benefits have (re)started during incarceration in an Arkansas correctional facility. In addition, individuals enrolled in Medicaid will be eligible for a temporary period not to exceed 90 days prior to their release date from a correctional facility, as described in more detail below in *Section 3.1.2*.
7. *Administrative Information Technology (IT) System Costs.* The state is not requesting funding at this time for IT System costs.
8. *Transitional Non-Service Expenditures.* The State is requesting limited expenditure authority to provide funding for independent, non-affiliated mental health professionals to obtain EHRs and join SHARE.
9. *Reinvestment Plan.* The State will submit a Reinvestment Plan with the Implementation Plan in accordance with the Special Terms and Conditions (STCs).

### **3.1.1 Care Coordination**

Arkansas Medicaid provides coverage to Medicaid enrollees through three separate delivery system models: (i) the Provider-led Arkansas Shared Savings Entity (PASSE) program; (ii) Qualified Health Plans (QHPs); and (iii) Fee-for-Service (FFS). Every individual under the Reentry Waiver will be provided care coordination services through one of three service delivery models based on their Medicaid delivery system enrollment:

- *PASSE Enrolled Individuals.* The PASSE model is a comprehensive managed care model that includes the entire array of state plan services and home and community-based services (HCBS) including care coordination for individuals with SMI, SED, or

SUD. The care coordination provided by PASSEs meets and exceeds the expanded definition of case management provided by the CMS SMD #23-003. All individuals exiting a carceral setting will be enrolled in a PASSE for 12 months and receive care coordination services from the PASSE.

- *QHP or FFS Enrolled Individuals.* After 12 months in the PASSE, adults who do not need HCBS services or treatment for a mental illness or SUD will be transitioned to receive coverage through either a QHP if eligible under the new adult group or FFS, eligible under different eligibility category. These individuals may continue to receive intensive care coordination services through a Life360 HOME or focused care coordination services through a Success Coach provided through DHS. Note, the availability of Success Coaches is pending approval of the *ARHOME waiver amendment which seeks to expand focused care coordination services through Success Coaches*. A child will remain enrolled in a PASSE.

### **3.1.2 Reentry Coverage Timeframe**

The Reentry Waiver is focused on the importance of smooth transitions of care. Arkansas is requesting to define the temporary period as both 90 days after entering a carceral setting and benefits have started and a period not to exceed 90 days prior to release to support the individual during both of the transition periods they will experience while incarcerated.

By providing services at the beginning of the incarceration period, Arkansas hopes to connect the individual to critical services to support continuity of care. For many incarcerated individuals, an SUD or SMI may play a role in their incarceration. Addressing these needs at the beginning and the end of the individual's jail or prison term may better support short- and long-term rehabilitation.

Further, although the aim of CMS' Reentry Demonstration Opportunity described in the April 17, 2023 SMDL is to address the needs of beneficiaries at the end of their incarcerated period, for many individuals in local county jails, this period aligns with the first 90 days as many individuals only have short-term interactions with the correctional system. It can be difficult to determine an exact release date for many incarcerated individuals, especially those who are in a county jail setting. In addition, because jails generally hold individuals who are awaiting trial, jail stays are often shorter in duration than 90 days. The unpredictable nature of the length of a jail stay may lead to challenges in activating reentry benefits in a timely manner and contribute to disparities in care coordination and access to available services among jail and prison populations. By defining the temporary period as both 90 days after entry and up to 90 days prior to reentry, Arkansas seeks to proactively ensure equitable access to these critical transition services.

As part of the reentry services, a care coordinator will develop a reentry person-centered care plan with the client and facility that includes the individual's medical records and release plans related to mental health, physical health, substance use, and Health-Related Social Needs (HSRN). Arkansas proposes to provide these transitional services to individuals for up to 90 days after entering prison or jail and up to 90 days prior to their release from prison or jail with the intention of alleviating the many operational challenges of predicting release dates to ensure that all eligible individuals receive the important transitional benefits available to them during their incarceration, regardless of facility setting or length of stay.



The state sees this request as an opportunity to support necessary healthcare interventions for jail populations who otherwise may transition into and out of a facility too quickly to receive services, at a time that these interventions are most critical.

### **3.1.3 Reentry Goals, Implementation, & Key Milestones**

The Reentry waiver will address the milestones described in the Reentry Section 1115 Demonstration Opportunity waiver guidance and support the following goals related to the new reentry services:

Goal 1: Increase coverage, continuity of coverage, and appropriate service uptake;

Goal 2: Improve access to services prior to release and improve transitions;

Goal 3: Improve coordination and communication between correctional systems and Medicaid;

Goal 4: Increase additional investments in health care and related services;

Goal 5: Improve connections between carceral settings and community services upon release;

Goal 6: Reduce all-cause deaths in the near-term post-release; and

Goal 7: Reduce number of emergency department (ED) visits and inpatient hospitalizations.

These goals will be met through strengthening and expanding the relationships and partnerships between DHS and:

- The Department of Corrections;
- Local jails and sheriffs
- Carceral health care providers
- PASSE organizations;
- Life360 HOMEs;
- Community Mental Health Centers; and
- Qualified Health Plans.

In conformance with the CMS Reentry guidelines, Arkansas shall submit an implementation plan, a reinvestment plan, monitoring protocol, and quarterly/annual monitoring reports after the Demonstration is approved. The monitoring and evaluation plans will align with the goals and objectives described in this Section.

If approved, the Reentry Waiver will be administered as a collaboration between the Division of Medical Services (DMS) and the Office of Substance Abuse and Mental Health (OSAMH) within the Division of Aging, Adult, and Behavioral Health Services. In conjunction with the waiver, OSAMH is developing a five-year strategic plan for calendar years 2024 through 2029. The strategic plan will incorporate the seven Demonstration goals. This will include reinvestment of savings to address Goals 1-5, which in turn, will achieve Goal 6 and Goal 7.

Preliminary strategies to support the overall system goals include:

- Increase the number of mental health professionals;
- Increase the number of direct care workers;
- Increase the use of peers, particularly as members of team-based service delivery models;
- Upgrade mobile equipment to support crisis mobilization;
- Train first responders for crisis intervention;

- Increase the number of mental health providers with interoperable Electronic Health Records (EHR) and participation in the State Health Alliance for Records Exchange (SHARE), the state’s Health Information Exchange (HIE);
- Expand the use of telemedicine, especially among rural hospitals;
- Expand the use of Acute Crisis Units (ACUs) as diversions from EDs, jails, and ASH as Behavioral Health Urgent Care Centers;
- Expand availability of partial hospitalization programs; and
- Ensure that individuals in residential facilities have appropriate access to services and supports to increase integration into community living.

In a January 2023 Report to Congress, the Office of the Assistant Secretary for Planning and Evaluation at the US Department of Health and Human Services describes many of the challenges states will face in communicating and coordinating among state and local jurisdictions.<sup>49</sup> Limited data sharing, limited community resources particularly in rural areas, the health care professional shortage, and inadequate discharge planning will all need to be addressed. The state will describe how each of these key milestones will be met in its implementation plan to be submitted after CMS approval.

Prior to 2022, the Arkansas DOC released approximately 10,000 individuals per year or more than 800 individuals per month. Releases from DYS custody and local jails will add to these numbers. Much of the 90-day pre-release transition period will be taken up with administrative functions of determining eligibility, conducting Independent Assessments, assessing HRSN, enrolling individuals into PASSE coverage, preparing person-centered service plans, obtaining prior authorizations for services, and connecting individuals to their community-based case manager. These actions will be coordinated between DHS, the PASSEs, and Department of Corrections. The key milestones for this Reentry Waiver as described in SMD #23-003 will include the following:<sup>50</sup>

- *Milestone 1.* Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated.
- *Milestone 2.* Covering and ensuring access to the minimum set of pre-release services for individuals who are incarcerated to improve care transitions upon return to the community.
- *Milestone 3.* Promoting continuity of care.
- *Milestone 4.* Connecting to services available post-release to meet the needs of the reentering population.
- *Milestone 5.* Ensuring cross-system collaboration

### 3.2 Waiver of the IMD Exclusion

Similar to the federal Medicaid exclusion for incarcerated populations, federal funds are also not permitted for adults residing in an IMD. To support continuity of care for individuals seeking

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<sup>49</sup> <https://aspe.hhs.gov/sites/default/files/documents/d48e8a9fdd499029542f0a30aa78bfd1/health-care-reentry-transitions.pdf>

<sup>50</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf>

treatment in an IMD, Arkansas also requests a waiver of the IMD exclusion for services provided to adults ages 19-64 who have been diagnosed with SUD and/or SMI. To align with the Reentry Waiver, Arkansas seeks to cover all Medicaid covered services provided to this population while being treated in an IMD for up to 90 days upon admission and up to 90 days prior to discharge. Arkansas seeks this IMD portion of the Reentry Waiver in hopes of filling gaps in the provision of behavioral health services and enhancing the complete care continuum for individuals with mental health and substance use challenges.

Currently in Arkansas, inpatient services provided to this population in settings that meet the definition of an IMD are not Medicaid reimbursable, except for adults enrolled in the PASSE program who are eligible to receive up to 15 days as a managed care “in lieu of” service.

This perpetuates disparities for individuals based on their Medicaid delivery system, but also exacerbates differences in behavioral health service delivery more broadly that discourage beneficiaries from receiving services in the most appropriate setting. Individuals who require residential services in a facility are likely experiencing a mental health or substance use crisis and hence require an elevated level of care that can only be provided in an IMD. Without access to IMDs, Medicaid enrolled individuals typically either receive less intensive services in the community than they need or do not access services at all until their condition requires them to seek care through costly emergency departments that are often not equipped to handle their complex behavioral health needs. The IMD exclusion serves to disincentivize the provision of services that are most likely to help a beneficiary during this time of crisis and put them on a path toward recovery. By waiving the IMD exclusion, Arkansas hopes to remove barriers to increase equitable access to the full continuum of care to enable Medicaid beneficiaries to receive services in whatever the setting that is most appropriate for their current care needs.

Arkansas is experiencing an acute shortage of behavioral health providers that has impacted access to care across the state, especially in rural areas. Waiving the IMD exclusion will help expand access to critical behavioral health and SUD treatment options across the state and bolster Arkansas’s care continuum by increasing the number of treatment facilities that will become available to the Medicaid population.

### **3.2.1 IMD Coverage Timeframe**

Arkansas is requesting to cover services provided in an IMD for adults aged 19-64 for up to 90 days upon admission into an IMD facility and for an additional 90 days prior to scheduled discharge from an IMD facility. The state is requesting this timeframe to align the IMD request with the Reentry Waiver request, which allows for up to 90 days of Medicaid services to be provided to individuals who would be otherwise eligible for Medicaid but for the federal exclusion. DHS anticipates these two requests as key to aligning services provided to all individuals, including forensic patients, with behavioral health and substance use needs regardless of the type of facility in which they are incarcerated or receiving services. By linking these requests, Arkansas hopes to create a more administratively streamlined approach to authorizing services for individuals in jails, prisons, or other facilities typically excluded from Medicaid.

Although Medicaid currently reimburses for an inpatient level of care for individuals with SMI and/or SUD, lacking the ability to reimburse in an IMD setting outside of the limited “in lieu of services” exception for PASSE enrollees, most Medicaid enrolled adults with intensive behavioral health needs end up seeking treatment in emergency department or acute care

settings. By expanding reimbursement for up to 90 days for all medically necessary services provided in an IMD for individuals with SMI and/or SUD, Arkansas seeks to build out the behavioral health continuum, increase access to behavioral health services across the state, reduce utilization of emergency department services, and improve health outcomes.

While most individuals will reside in an IMD for significantly less than 90 days, there are some individuals who must remain in an IMD for substantially longer. These individuals are primarily residents of the ASH, which has an average length of stay (LOS) of 605 days, as they treat the most acute behavioral health patients in the state as well as all forensic patients. The average number of monthly admissions and discharges are summarized in the table below.

**Average Monthly Number of Admissions and Discharges at Arkansas State Hospital (ASH) by State Fiscal Year**

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Adolescents Admitted	1	2	3	2	3
Adolescents Discharged	1	2	3	1	2
Adults Admitted	28	24	23	17	17
Adults Discharged	28	24	21	17	17

By providing coverage at the first 90-day period, the state expects that individuals will receive quality psychiatric and neurological evaluations on a more timely basis that will permit diversions from ASH.

Similar to the Reentry Waiver, individuals transitioning back to the community from ASH, including the justice-involved forensic patients of ASH, will be enrolled in a PASSE and will benefit from the same services provided to individuals transitioning to the community from jails and prisons. Such coverage should reduce the average LOS at ASH. Thus, Arkansas requests authority to provide coverage for all medically necessary Medicaid services to individuals up to 90 days prior to their discharge from an IMD, which shall include the provision of case management, medication assisted treatment (MAT) services, and a 30-day supply of prescription drugs upon release to provide equitable support to all enrollees transitioning back to a community setting.

**3.2.2 IMD Goals, Implementation, & Key Milestones**

The following goals and milestones are adopted and incorporated from SMD #18-011:

- Goal 1: Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;
- Goal 2: Reduced preventable readmissions to acute care hospitals and residential settings;
- Goal 3: Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as

services provided during acute-short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;

Goal 4: Improved access to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and

Goal 5: Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Arkansas continues to make progress on these goals through the PASSE program which is specifically designed to provide comprehensive coverage for providing physical, mental health, and HCBS services with the support of care coordinators. Currently, there are four (4) organizations that participate in the PASSE program. As these organizations are at full-risk for all of the covered services, they have inherent incentives to achieve Goals 1, 2, 3, and 4.

The state is also developing the building blocks for a statewide mobile crisis system that will link local providers together to provide more timely access to the most appropriate level of care to achieve Goal 5.

Arkansas assures that it will comply with the following milestones set forth in CMS guidance to ensure a robust behavioral health continuum and quality of care:

#### Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

- Participating hospitals and residential settings are licensed or otherwise authorized by the state to primarily provide treatment for mental illnesses and are accredited by a nationally recognized accreditation entity including the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) prior to receiving Federal Financial Participation (FFP known as “federal match”) for services provided to beneficiaries;
- Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity’s accreditation requirements;
- Use of a utilization review entity (e.g., a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;
- Participating psychiatric hospitals and residential treatment settings meet federal program integrity requirements, and the state has a process for conducting risk-based screening of all newly enrolling providers, as well as revalidating existing providers (specifically, under existing regulations, states must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);

- Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen enrollees for co-morbid physical health conditions and SUDs and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in these treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

#### Improving Care Coordination and Transitions to Community-Based Care

- Implementation of a process to ensure that psychiatric hospitals and residential treatment settings provide intensive pre-discharge, care coordination services to help transition beneficiaries out of these settings and into appropriate community-based outpatient services – as well as requirements that community-based providers participate in these transition efforts (e.g., by allowing initial services with a community-based provider while a beneficiary is still residing in these settings and/or by hiring support specialists, including peers, to help beneficiaries make connections with available community-based providers, including, where applicable, plans for employment);
- Implementation of a process to assess the housing situation of individuals transitioning to the community from psychiatric hospitals and residential treatment settings and connect those who are homeless or have unsuitable or unstable housing with community providers that coordinate housing services where available;
- Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and by contacting the community-based provider to whom the person was referred;
- Implementation of strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers); and
- Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers with the goal of enhancing care coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI.

#### Increasing Access to Continuum of Care Including Crisis Stabilization Services

- Annual assessments of the availability of mental health services throughout the state, particularly crisis stabilization services and updates on steps taken to increase availability;
- Commitment to a financing plan approved by CMS to be implemented by the end of the demonstration to increase availability of non-hospital, non-residential crisis stabilization services, including services made through crisis call centers, mobile crisis units, coordinated community response that involves law enforcement and other first responders, and observation/assessment centers as well as on-going community-based services, e.g., intensive outpatient services, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model described in Part I of this letter as well as consideration of a self-direction option for beneficiaries;

- Implementation of strategies to improve the state’s capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible; and
- Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association, e.g., LOCUS or CASII, to help determine appropriate level of care and length of stay.

Earlier Identification and Engagement in Treatment Including Through Increased Integration

- Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with serious mental health conditions, in treatment sooner including through supported employment and supported education programs;
- Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of serious mental health conditions sooner and improve awareness of and linkages to specialty treatment providers; and
- Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

**3.2.3 Strategies to Address the Opioid Epidemic: Goals, Implementation, & Key Milestones**

The Reentry Waiver will also include the “Milestones for 1115 Demonstrations Addressing Opioids and Other Substances” described in SMD# 17-003 which are<sup>51</sup>:

- *Milestone 1:* Access to critical levels of care for OUD and other SUDs
- *Milestone 2:* Use of evidence-based SUD-specific patient placement criteria
- *Milestone 3:* Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities
- *Milestone 4:* Sufficient provider capacity at critical levels of care including for Medication Assisted Treatment for OUD
- *Milestone 5:* Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD
- *Milestone 6:* Improved care coordination and transitions between Levels of Care (LOC)

The Reentry Waiver will include the Demonstration Goals and Performance Measures for SMD #17-003 which are:<sup>52</sup>

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<sup>51</sup> SMD #17-003. Table 1.

<sup>52</sup> SMD #17-003. Table 2.

Demonstration/SUD Goals	Performance Measures
Increased rates of identification, initiation, and engagement in treatment	Initiation and engagement of alcohol and other drug dependence treatment (National Committee for Quality Assurance; #0004)
Improved adherence to treatment	<ol style="list-style-type: none"> <li>1. Continuity of pharmacotherapy for OUD (NQF #3175)</li> <li>2. Follow-up after discharge from Emergency Department for mental health or alcohol or other drug dependence (NQF #2605)</li> <li>3. Percentage of beneficiaries with a SUD diagnosis including those with OUD who used the following services per month (multiple rates reported): <ul style="list-style-type: none"> <li>• Outpatient;</li> <li>• Intensive outpatient services;</li> <li>• Medication assisted treatment;</li> <li>• Residential treatment (including average lengths of stays in residential treatment aiming for statewide average LOS of 30 days; and</li> <li>• Medically supervised withdrawal management</li> </ul> </li> </ol>
Reduction in overdose deaths particularly those due to opioids	<ol style="list-style-type: none"> <li>1. Use of opioids at high dosage in persons without cancer (NQF #2940)</li> <li>2. No. of overdose deaths/1,000 Medicaid beneficiaries/month and specifically deaths due to any opioid</li> <li>3. No. of overdose deaths, and specifically deaths due to overdose of any opioid, among Medicaid beneficiaries in the reporting year</li> </ol>
Reduced utilization of emergency departments and inpatient hospital settings	<ol style="list-style-type: none"> <li>1. ED visits for SUD-related diagnoses and specifically for OUD/1,000 member months</li> <li>2. Inpatient admissions for SUD and specifically OUD among Medicaid beneficiaries/1,000 member months</li> <li>3. Baseline and periodic updates on spending on beneficiaries in residential treatment and on inpatient and ED services for beneficiaries with SUD diagnoses including spending on</li> </ol>



	physical health conditions commonly associated with SUDs
Fewer readmissions to the same or higher level of care	30-day readmission rate following hospitalization for a SUD-related diagnosis and specifically for OUD
Improved access to care for co-morbid physical health conditions among beneficiaries	Percentage of beneficiaries with a SUD diagnosis, and specifically with those with OUD, who access physical health care

In reviewing the Key Milestones and Elements of the Opportunities to Support Community Reentry and the Goals and Milestones of the Opportunities to Design Innovative Service Delivery Systems and those for the Strategies to Address the Opioid Epidemic, it is clear to the state that submitting a single application is the best way to achieve all of these goals, milestones, and performance measures. As a rural state with severe workforce shortages in both mental health professionals and physical health professionals, it would be exceedingly difficult to succeed in one waiver without the other two.

## **Section IV: Impact on Enrollment, Benefits, Cost Sharing and Delivery System**

### **4.1 Impact to Enrollment**

Prior to 2022, about 10,000 individuals were released each year from the Arkansas correctional system. Nearly all are or will become Medicaid eligible under the new adult group upon their release from jail or prison. Approximately 1,000 youths who are or will become Medicaid eligible transition through the juvenile justice system each year. Some individuals in these two groups have already been determined eligible for Medicaid but have had their coverage suspended due to their incarceration status. Others have not as yet applied for Medicaid at the time of their incarceration. Most of these individuals will likely be determined eligible for and enrolled in Medicaid as a result of the enrollment activities during the pre-release period.

In addition, a small group of adults are enrolled in Medicaid but are being treated in an IMD, meaning that no services provided to the person are reimbursed by Medicaid. This waiver will impact enrollment by permitting Medicaid enrolled individuals temporarily residing in an IMD or carceral setting to maintain their full Medicaid coverage during their first 90 days in a previously excluded facility and to allow Medicaid coverage to begin for Medicaid eligible individuals in the 90 days prior to their transition back to the community from an excluded facility.

### **4.2 Impact to Covered Benefits/Cost Sharing**

In general, the Reentry Waiver seeks to increase access to existing Medicaid covered benefits to individuals temporarily residing in a jail, prison, youth correctional facility, or IMD. All state plan services will be available to the Demonstration populations. In conformance with the requirements of the Reentry Section 1115 Demonstration Opportunity, Arkansas will add case management services as not all individuals currently receive case management as a state plan benefit.

The waiver request does not make any changes to cost sharing. Under the Arkansas State Plan, there is no cost sharing for:

- Individuals who are enrolled in a PASSE
- Adults with income at or below 20% FPL
- Children in Arkids A

Under the Arkansas State Plan, cost sharing conforms to federal regulations which limits cost sharing per type of service and by a 5% cap on out-of-pocket (OOP) payments per quarter. Cost sharing applies to:

- Adults with income above 20% FPL
- Children in Arkids B

### 4.3 Impact to Delivery System

Through the Reentry Waiver, individuals transitioning from jail, prison, or youth correctional facilities will be enrolled in the PASSE program rather than fee-for-service Medicaid or the Qualified Health Plans. The PASSE program currently provides comprehensive coverage, including specialty services for individuals with complex behavioral health needs, to more than 50,000 Medicaid enrollees. There is sufficient capacity among the four PASSE organizations to absorb additional members from the enrollment of individuals released from jails, prisons, and youth correctional facilities each year.

More broadly, approval of this waiver will strengthen the overall delivery system and improve the financial status of Arkansas mental health providers resulting in an increase in provider capacity. Specifically, DHS expects the following delivery system improvements:

- Access to treatment for SMI and SUD will be expanded by permitting treatment through an IMD, including at the Arkansas State Hospital (ASH).
- There are 11 private IMDs enrolled in Arkansas Medicaid. DHS intends to expand access to acute crisis units, which serve as Behavioral Health Urgent Care Centers, by requiring the IMDs to open an ACU as a condition of participation in this waiver initiative. ACUs are opportunities to work more closely with law enforcement agencies and serve as diversions from jails and ASH.
- Through the increased use of telemedicine, Arkansas intends to expand services to individuals in crisis through creating additional crisis mobilization units across the state.
- Additionally, this work will support the improvement of health services and care coordination for individuals within the justice system, including improvement in jail health services and those services that support and coordinate with jail health.

## Section V: Requested Waivers and Expenditure Authority

DHS requests all necessary additional waiver authority to implement the waiver request, including at minimum, the following:

**Amount, Duration, and Scope of Services and Comparability**

**Section 1902(a)(10)(B)  
and 1902(a)(17)**

To the extent necessary to enable DHS to offer focused care coordination services and LIFE360 HOME services to the populations as described in this Application which may vary and not otherwise be available to all beneficiaries in the same eligibility group.

**Statewideness**

**Section 1902(a)(1)**

To the extent necessary to enable DHS to provide care coordination services and LIFE360 HOME services on a less than statewide basis.

To enable the state to provide pre-release services to qualifying beneficiaries on a geographically limited basis.

**Freedom of Choice**

**Section 1902(a)(23)(A)**

To the extent necessary to enable DHS to restrict individuals' choice of providers to the network of providers under the PASSE program and LIFE360 HOME services on a less than statewide basis.

DHS requests all necessary additional waiver expenditure authority to implement the waiver request, including the following:

**Expenditures for Treatment During a Period of Incarceration**

**Section 1905(a)**

The state requests expenditure authority under Section 1115 to the extent necessary to enable DHS to pay for Medicaid covered services during an initial 90-day period upon a Medicaid enrolled individual entering a state prison, county or city jail, or youth correctional facility, and for an additional period of up to 90 days immediately prior to the expected date of release from a participating state prison, county or city jail, or youth correctional facility.

**Expenditures for Treatment in an Institution for Mental Disease**

**Section 1905(a)**

The state requests expenditure authority under Section 1115 to the extent necessary to enable DHS to reimburse for Medicaid covered services for up to 90 days from the date of admission in an IMD furnished to otherwise eligible individuals who are primarily receiving treatment for SMI, SED, and/or SUD (including withdrawal management services) at a facility that meets the definition of an institution for mental disease (IMD).

In addition, the state requests expenditure authority under Section 1115 to the extent necessary to enable DHS to reimburse for Medicaid covered services for an additional 90-day period prior to the discharge of a Medicaid enrolled individual from a facility that meets the definition of an IMD, including an IMD that is a public institution.

**Expenditures for Building Capacity of Pre-Release Supports Through an Approved Reinvestment Plan**

**Section 1905(a)**

The state requests expenditure authority under Section 1115 for costs not otherwise matchable related to a variety of activities necessary to support successful transitions from a carceral facility into the community. The activities will include pre-release readiness assessments, improving the eligibility process, education and training, linking Electronic Health Records, and other activities to be submitted in the Implementation Plan and Reinvestment Plan.

**Expenditures to Incentivize Community Mental Health Providers to Adopt Electronic Health Records and Participate in SHARE** **Section 1905(a)**

The state requests expenditure authority under Section 1115 for costs not otherwise matchable related to grants to small, independent community mental health providers as incentive payments to adopt interoperable electronic health records and to participate in the State Health Alliance for Records Exchange (SHARE).

**Expenditures to Incentivize Community Providers to Link Interoperable Electronic Health Records and Case Management IT Platform** **Section 1905(a)**

The state requests expenditure authority under Section 1115 for costs not otherwise matchable related to grants to providers and community agencies to adopt interoperable EHR systems and IT platforms to support the linkage of common case management systems across the state for various purposes including use in crisis assessments, evaluations, including forensic evaluations, use of community resources related to individuals' HRSN, and track follow-up visits post-hospitalization.

**Section VI: Hypotheses and Evaluation Plan**

Arkansas proposes the following evaluation plan, which has been developed in alignment with CMS evaluation design guidance for Reentry and SMI 1115 demonstrations. The state intends to contract with an independent evaluator to conduct this review.

## 6.1 Transition-Related Strategies to Support Community Reentry Goals and Objectives

Goal/Objective #1	Hypothesis #1	Evaluation Parameters/Methodology
<p><b>Evaluation Questions:</b></p> <ul style="list-style-type: none"> <li>• What percentage of the Demonstration population had any type of health insurance coverage prior to incarceration. Of these, what percentage had been enrolled in Medicaid?</li> <li>• What is the impact of incarceration on health status (physical, mental)?</li> <li>• Does the Demonstration result in increased Medicaid enrollment rates among individuals leaving incarceration?</li> <li>• Does the Demonstration increase the percentage of individuals leaving incarceration that have a primary care provider within one/three/and six months from release?</li> <li>• Does the Demonstration increase the percentage of individuals leaving incarceration that have continuity in their prescription drugs filled within one/three/and six months from release?</li> </ul>		
<p><b>GOAL 1. Increase coverage, continuity of coverage, and appropriate service uptake</b></p>	<p><b>Hypothesis 1.</b> The demonstration will result in increases in Medicaid enrollment and service utilization among individuals who re-enter the community after a period of incarceration</p>	<p><b>Data Sources:</b></p> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Medical records or administrative records</li> <li>• Interviews or focus groups</li> </ul> <p><b>Analytic Approach:</b></p> <ul style="list-style-type: none"> <li>• Difference-in-differences model</li> <li>• Subgroup analyses</li> <li>• Descriptive quantitative analysis</li> <li>• Qualitative analysis</li> </ul>

Goal/Objective #2	Hypothesis #2.	Evaluation Parameters/Methodology
<p><b>Evaluation Questions:</b></p> <ul style="list-style-type: none"> <li>• Does the demonstration result in reductions in preventable readmissions to acute care hospitals and residential settings?</li> <li>• How do the demonstration effects on reducing preventable readmissions to acute care hospitals and residential settings vary by geographic area or beneficiary characteristics?</li> <li>• How do demonstration activities contribute to reductions in preventable readmissions to acute care hospitals and residential settings?</li> <li>• Does the demonstration result in increased screening and intervention for comorbid SUD and physical health conditions during acute care psychiatric inpatient and residential stays and increased treatment for such conditions after discharge?</li> </ul>		
<p><b>GOAL 2. Improve access to services prior to release and improve transitions and continuity of care</b></p>	<p><b>Hypothesis 2.</b> The demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.</p>	<p><b>Data Sources:</b></p> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Medical records</li> <li>• Beneficiary survey</li> </ul> <p><b>Analytic Approach:</b></p> <ul style="list-style-type: none"> <li>• Difference-in-difference models</li> <li>• Qualitative analysis</li> <li>• Descriptive quantitative analysis</li> </ul>
<p><b>Evaluation Questions:</b></p> <ul style="list-style-type: none"> <li>• To what extent does the demonstration result in improved availability of crisis outreach and response services throughout the state?</li> <li>• To what extent does the demonstration result in improved availability of intensive outpatient services and partial hospitalization?</li> <li>• To what extent does the demonstration improve the availability of crisis stabilization services provided during acute short-term stays in each of the following: public and private psychiatric hospitals, residential treatment facilities, general hospital psychiatric units, and community-based settings?</li> </ul>		

Goal/Objective #3	Hypothesis #3	Evaluation Parameters/Methodology
<p><b>Evaluation Questions:</b></p> <ul style="list-style-type: none"> <li>• Does the demonstration divert individuals in crisis from local jails?</li> <li>• Does the demonstration reduce the use of ASH?</li> <li>• Does the demonstration decrease gaps between determination of eligibility and onset of treatment?</li> <li>• Does the demonstration reduce recidivism rates?</li> </ul>		
<p><b>GOAL 3. Improve coordination and communication between correctional systems, Medicaid systems, managed care plans, and community providers</b></p>	<p><b>Hypothesis 3.</b> The demonstration will result in improved availability of crisis stabilization services throughout the state and thereby reduce delays in receiving necessary treatment in the community and reduce recidivism rates</p>	<p><b>Data Sources:</b></p> <ul style="list-style-type: none"> <li>• Annual assessments of availability of mental health services</li> <li>• Administrative data</li> <li>• Provider survey</li> </ul> <p><b>Analytic Approach:</b></p> <ul style="list-style-type: none"> <li>• Descriptive quantitative analysis</li> </ul>

Goal/Objective #4	Hypothesis #4	Evaluation Parameters/Methodology
<p><b>Evaluation Questions:</b></p> <ul style="list-style-type: none"> <li>• Does the demonstration result in reductions in utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings?</li> <li>• How do the demonstration effects on reducing utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI/SED vary by geographic area or beneficiary characteristics?</li> <li>• How do demonstration activities contribute to reductions in utilization and lengths of stays in emergency departments among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings?</li> </ul>		
<p><b>GOAL 4. Increase additional investments in health care and related services</b></p>	<p><b>Hypothesis 4.</b> The demonstration will result in increases in Medicaid providers of mental health and SUD services and expansion of service delivery models including ACUs and Life360 HOMEs, thereby reducing the use of Emergency Departments, reduce inpatient hospitalizations, and reduce length-of-stays (LOS)</p>	<p><b>Data Sources:</b></p> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Medical records or administrative records</li> <li>• Interviews or focus groups</li> </ul> <p><b>Analytic Approach:</b></p> <ul style="list-style-type: none"> <li>• Difference-in-differences model</li> <li>• Subgroup analyses</li> <li>• Descriptive quantitative analysis</li> <li>• Qualitative analysis</li> </ul>



Goal/Objective #5	Hypothesis #5	Evaluation Parameters/Methodology
<p><b>Evaluation Questions:</b></p> <ul style="list-style-type: none"> <li>• Does the Demonstration result in reductions in measured days of homelessness?</li> <li>• Does the Demonstration result in reductions measured days of food insecurity?</li> <li>• Does the Demonstration increase the use of employment, education, and training services among those formerly incarcerated?</li> <li>• Does the Demonstration reduce the rate of incarceration recidivism?</li> </ul>		
<p><b>GOAL 5. Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs (HRSN)</b></p>	<p><b>Hypothesis 5.</b> The demonstration will result in increases in Medicaid enrollment among individuals who re-enter the community after a period of incarceration and divert individuals from the judicial system.</p>	<p><b>Data Sources:</b></p> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Medical records or administrative records</li> <li>• Interviews or focus groups</li> </ul> <p><b>Analytic Approach:</b></p> <ul style="list-style-type: none"> <li>• Difference-in-differences model</li> <li>• Subgroup analyses</li> <li>• Descriptive quantitative analysis</li> <li>• Qualitative analysis</li> </ul>

Goal/Objective #6	Hypothesis #6	Evaluation Parameters/Methodology
<p><b>Evaluation Questions:</b></p> <ul style="list-style-type: none"> <li>• Does the Demonstration result in reductions in the rate of overdoses among those released from incarceration at 6-month, 12-month, and 18-month intervals?</li> <li>• Does the Demonstration result in reductions of suicides among those released from incarceration at 6-month, 12-month, and 18-month intervals?</li> <li>• Does the Demonstration reduce the mortality rate among those released from incarceration at 6-month, 12-month, and 18-month intervals?</li> </ul>		
<p><b>GOAL 6. Reduce all-cause death</b></p>	<p><b>Hypothesis 6.</b> The demonstration will result in increases in Medicaid enrollment among individuals who re-enter the community after a period of incarceration who have access to treatment services and reduce the rate of overdoses, suicides, and all causes of deaths among those released from incarceration at 12-month, 24-month, and 36-month intervals</p>	<p><b>Data Sources:</b></p> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Medical records or administrative records</li> <li>• Interviews or focus groups</li> </ul> <p><b>Analytic Approach:</b></p> <ul style="list-style-type: none"> <li>• Difference-in-differences model</li> <li>• Subgroup analyses</li> <li>• Descriptive quantitative analysis</li> <li>• Qualitative analysis</li> </ul>

Goal/Objective #7	Hypothesis #7	Evaluation Parameters/Methodology
<p><b>Evaluation Questions:</b></p> <ul style="list-style-type: none"> <li>• Does the Demonstration result in reductions in utilization and lengths of stay in emergency departments among Medicaid beneficiaries while awaiting mental health/SUD treatment in specialized settings?</li> <li>• Does the Demonstration result in reducing utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI/SED/SUD vary by geographic area or beneficiary characteristics?</li> <li>• Does the Demonstration increase the use of community-based services to treat SED/SMI/SUD?</li> <li>• Does the Demonstration divert individuals from the judicial system?</li> </ul>		
<p><b>GOAL 7. Reduce number of ED visits and inpatient hospitalizations</b></p>	<p><b>Hypothesis 7.</b> The demonstration will result in fewer ED visits, fewer inpatient hospitalizations, and shorter-lengths of stay</p>	<p><b>Data Sources:</b></p> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Medical records or administrative records</li> </ul> <p><b>Analytic Approach:</b></p> <ul style="list-style-type: none"> <li>• Difference-in-differences model</li> <li>• Subgroup analyses</li> <li>• Descriptive quantitative analysis</li> <li>• Qualitative analysis</li> </ul>

## 6.2 Goals, Objectives, and Hypotheses for IMD Provisions

Goal/Objective/Goal #1	Hypothesis #1	Evaluation Parameters/Methodology
<p><b>Evaluation Questions:</b></p> <ul style="list-style-type: none"> <li>• Does the demonstration result in reductions in utilization and lengths of stay in emergency departments among Medicaid beneficiaries while awaiting mental health/SUD treatment in specialized settings?</li> <li>• How do the demonstration effects on reducing utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI/SED vary by geographic area or beneficiary characteristics?</li> <li>• How do demonstration activities contribute to reductions in utilization and lengths of stays in emergency departments among Medicaid beneficiaries with SMI/SED/SUD while awaiting mental health treatment in specialized settings?</li> </ul>		
<p><b>GOAL 1.</b> Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries while awaiting mental health/SUD treatment in specialized settings.</p>	<p><b>Hypothesis 1.</b> The demonstration will result in reductions in utilization of stays in emergency department among Medicaid beneficiaries while awaiting mental health/SUD treatment.</p>	<p><b>Data Sources:</b></p> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Medical records or administrative records</li> <li>• Interviews or focus groups</li> </ul> <p><b>Analytic Approach:</b></p> <ul style="list-style-type: none"> <li>• Difference-in-differences model</li> <li>• Subgroup analyses</li> <li>• Descriptive quantitative analysis</li> <li>• Qualitative analysis</li> </ul>

Goal/Objective #2	Hypothesis #2	Evaluation Parameters/Methodology
<p><b>Evaluation Questions:</b></p> <ul style="list-style-type: none"> <li>• Does the demonstration result in reductions in preventable readmissions to acute care hospitals and residential settings?</li> <li>• How do the demonstration effects on reducing preventable readmissions to acute care hospitals and residential settings vary by geographic area or beneficiary characteristics?</li> <li>• How do demonstration activities contribute to reductions in preventable readmissions to acute care hospitals and residential settings?</li> <li>• Does the demonstration result in increased screening and intervention for comorbid SUD and physical health conditions during acute care psychiatric inpatient and residential stays and increased treatment for such conditions after discharge?</li> </ul>		
<p><b>GOAL 2.</b> Reduced preventable readmissions to acute care hospitals and residential settings.</p>	<p><b>Hypothesis 2.</b> The demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.</p>	<p><b>Data Sources:</b></p> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Medical records</li> <li>• Beneficiary survey</li> </ul> <p><b>Analytic Approach:</b></p> <ul style="list-style-type: none"> <li>• Difference-in-difference models</li> <li>• Qualitative analysis</li> <li>• Descriptive quantitative analysis</li> </ul>

Goal/Objective #3	Hypothesis #3	Evaluation Parameters/Methodology
<p><b>Evaluation Questions:</b></p> <ul style="list-style-type: none"> <li>• To what extent does the demonstration result in improved availability of crisis outreach and response services throughout the state?</li> <li>• To what extent does the demonstration result in improved availability of intensive outpatient services and partial hospitalization?</li> <li>• To what extent does the demonstration improve the availability of crisis stabilization services provided during acute short-term stays in each of the following: public and private psychiatric hospitals, residential treatment facilities, general hospital psychiatric units, and community based settings?</li> </ul>		
<p><b>GOAL 3.</b> Improved availability of crisis stabilization services, including services made available through care coordination and mobile crisis units; intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs; psychiatric hospitals; and residential treatment settings throughout the state</p>	<p><b>Hypothesis 3.</b> The demonstration will result in increased availability of crisis stabilization services throughout the state that reduces inpatient hospitalization at ASH</p>	<p><b>Data Sources:</b></p> <ul style="list-style-type: none"> <li>• Annual assessments of availability of mental health services</li> <li>• Administrative data</li> <li>• Provider survey</li> </ul> <p><b>Analytic Approach:</b></p> <ul style="list-style-type: none"> <li>• Descriptive quantitative analysis</li> </ul>

Objective/Goal #4	Hypothesis #4	Evaluation Parameters/Methodology
<p><b>Evaluation Questions:</b></p> <ul style="list-style-type: none"> <li>• Does the demonstration result in improved access of beneficiaries with SMI/SED/SUD to community based services to address their chronic mental health needs?</li> <li>• To what extent does the demonstration result in improved availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI/SED/SUD?</li> <li>• To what extent does the demonstration result in improved access of SMI/SED/SUD beneficiaries to specific types of community-based services?</li> <li>• How do the demonstration effects on access to community-based services vary by geographic area or beneficiary characteristics?</li> <li>• Does the integration of primary and behavioral health care to address the chronic mental health care needs of beneficiaries with SMI/SED/SUD improve under the demonstration?</li> </ul>		
<p><b>GOAL 4.</b> Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI/SED/SUD, including through increased integration of primary and behavioral health care</p>	<p><b>Hypothesis 4.</b> Access of beneficiaries with SMI/SED/SUD to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and behavioral health care.</p>	<p><b>Data Sources:</b></p> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Annual assessments of availability of mental health services</li> <li>• Administrative data</li> <li>• Medical records</li> </ul> <p><b>Analytic Approach:</b></p> <ul style="list-style-type: none"> <li>• Descriptive quantitative analysis</li> <li>• Difference-in-differences model</li> </ul>

Objective/Goal #5	Hypothesis #5	Evaluation Parameters/Methodology
<p><b>Evaluation Questions:</b></p> <ul style="list-style-type: none"> <li>• Does the demonstration result in improved care coordination for beneficiaries with SMI/SED/SUD?</li> <li>• Does the demonstration result in improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?</li> <li>• Does the demonstration result in improved discharge planning and outcomes regarding housing for beneficiaries transitioning out of acute psychiatric care in hospitals and residential treatment facilities?</li> <li>• How do demonstration activities contribute to improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?</li> </ul>		
<p><b>GOAL 5.</b> Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.</p>	<p><b>Hypothesis 5.</b> The demonstration will result in a reduction in out-home-home placements and a reduction in LOS in institutional and residential settings</p>	<p><b>Data Sources:</b></p> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Medical records</li> <li>• Interviews or focus groups</li> <li>• Facility records</li> </ul> <p><b>Analytic Approach:</b></p> <ul style="list-style-type: none"> <li>• Difference-in-differences model</li> <li>• Descriptive quantitative analysis</li> <li>• Qualitative analysis</li> </ul>

The Evaluation will also specifically address the efficacy of defining “temporary period” as up to 90-days. As a rural state and a state that faces a significant workforce shortage, a lesser time period is likely not realistic to affect a successful transition to the community with immediate access to care. In addition, since many individuals have shorter stays in excluded settings with unknown release or discharge dates, providing Medicaid services during the enrollee’s transition to the facility will support improved outcomes and more equitable provision of pre-release services. In the January 2023 Report to Congress, “Health Care Transitions for Individuals Returning to the Community from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group,” the Report concluded:

Based on stakeholder discussion, key considerations for demonstration design include the scope of benefits provided pre-release, who would be eligible, **the length of time for pre-release coverage for services**, and strategies for addressing social supports (emphasis added).<sup>53</sup>

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<sup>53</sup> <https://aspe.hhs.gov/sites/default/files/documents/d48e8a9fdd499029542f0a30aa78bfd1/health-care-reentry-transitions.pdf> p.35



Thus, this Reentry Waiver will provide opportunities for comparing the length of time among states with reentry waivers, including recidivism rates among the states based on both length of time of the intervention as well as the timing of the intervention. Department of Corrections data shows that recidivism rates are highest among the young adult group ages 18-24 who are 1.5 times more likely to return to prison. “Previous incarceration predicts future incarceration.”<sup>54</sup>

The state is committed to a robust Evaluation and a well-designed Implementation Plan that will meet the milestones described in each of the two Opportunities waiver guidance letters. The state has reviewed the Potential Standard Measures and Measure Concepts in Appendix B of SMD # 18-011 and affirms its commitment to report on the standard set of measures and data points.

## **Section VII: Financing and Budget Neutrality**

The Budget Neutrality (BN) limits are determined on a per member per month (PMPM) basis. The BN limits were calculated separately for the IMD population and the Reentry population. The financing summary, including expected changes in Medicaid expenditures, and the detailed budget neutrality member month and expenditure tables are available in Attachment 1, attached hereto.

The state will be at risk for the PMPM cost. It will not be at risk for the number of people who will be covered by the Reentry Waiver.

It is important to bear in mind that once Medicaid eligible individuals are released from incarceration, they will be eligible to receive all Medicaid covered benefits. The purpose of providing coverage during the first 90-day period of incarceration is to prevent an individual’s health condition from deteriorating which would increase medical expenditures. The purpose of the second 90-day period is to make an individual’s transition back into the community successful.

The state’s request for expenditure authority for costs not otherwise matchable (CNOM) each Demonstration Year (DY) and the corresponding Calendar Year (CY) for the five-year period is summarized in the table below.

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<sup>54</sup> <https://doc.arkansas.gov/wp-content/uploads/2022/04/Recidivism-in-Arkansas-A-Roadmap-to-Reform-April29-2022-single-BOC-FINAL.pdf> p. 2.

### Expenditure Authority

(in millions)

Activity	DY1 CY 2025	DY2 CY 2026	DY3 CY 2027	DY4 CY 2028	DY5 CY 2029	Total Request
Education and Training of Community Partners	\$3	\$3	\$3	\$0	\$0	\$9
Incentives to Adopt EHR and SHARE	\$5	\$5	\$5	\$0	\$0	\$15
Link EHR and Case Management to Statewide IT Platform	\$20	\$15	\$10	\$5	\$5	\$55

Unexpended funds can be rolled over and can be reallocated between activities.

The traditional and historical approach to calculating “with waiver” and “without waiver” is particularly challenging in the case of providing SED, SMI, and SUD services because there is significant under-utilization of appropriate services provided in the community. For example, the April 2023 DRAFT Strategic Plan from the Substance Abuse and Mental Health Services Administration (SAMSHA) describes both the challenge and opportunity:

Unfortunately, many young people do not receive the treatment supports they need. According to the 2021 National Survey on Drug Use and Health, over half of children/youth with mental health needs did not receive services and over 98 percent of young adults with a SUD did not receive appropriate treatment. Furthermore, those seeking treatment experienced longer days, including days long stays in the emergency department for those needing an inpatient hospital bed.<sup>55</sup>

In a March 2021 Report to Congress, *Trends in the Utilization of Emergency Department Services, 2009-2018*, the Office of the Assistant Secretary for Planning and Evaluation (ASPE), reported that 15.3% of ED visits in 2018 with Medicaid as the primary expected payer had a diagnosis of mental illness or SUD compared to 11.1% in 2009.<sup>56</sup>

Studies show that chronic disease is undertreated in jails and prisons. For example, in an April 2023 JAMA Health Forum, researchers found that:

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<sup>55</sup> <https://www.samhsa.gov/sites/default/files/draft-strategic-plan-2023.pdf> p. 20.

<sup>56</sup> <https://aspe.hhs.gov/sites/default/files/private/pdf/265086/ED-report-to-Congress.pdf> Table 1, p.26.

In this cross-sectional descriptive study of incarcerated and nonincarcerated populations in the US from 2018 to 2020, use of prescription medications for chronic conditions was consistently lower in jails and state prisons compared with community settings. After adjusting for disease prevalence, the relative disparity was 2.9-fold for diabetes, 5.5-fold for asthma, 2.4-fold for hypertension, 1.9-fold for hepatitis B or C, 3.0-fold for human immunodeficiency virus, 4.1-fold for depression, and 4.1-fold for severe mental illness.

This analysis suggests that prescription medications for chronic conditions may be substantially underused in jails and state prisons in the US relative to the nonincarcerated population, after accounting for the differential burden of disease in these settings.<sup>57</sup>

Expanding access to treatment increases spending. However, reducing the use of emergency departments and hospital length-of-stays reduces the total cost of care. The data from California shows that connecting those released from incarceration to treatment will save lives and reduces higher costs associated with recidivism and inpatient utilization:

According to a report on the impact of the ISUDT (Integrated Substance Use Disorder Treatment) program released by the department and CCHCS (California Correctional Health Care Services) in April 2022, an overall decrease in overdose deaths by 58 percent was observed in the first year of the program, from 2019 to 2020. In addition, the overdose hospitalization rate among MAT recipients was 42 percent lower compared with participants on the MAT waitlist. Overdose hospitalizations among ISUDT participants decreased by 18 percent from late 2019 to the middle of 2021 (from 92 to 75 per 100,000 residents) and the number of bacterial and viral infections associated with substance abuse also decreased.”<sup>58</sup>

Residents with mental illness/SUD in rural areas are more likely to use the ED than those in large metropolitan areas.<sup>59</sup> Over half the 19-64 adults enrolled in the ARHOME program live in rural counties.

## **Section VIII: Public Notice & Comment Process**

### **8.1 Overview of Compliance with Public Notice Process**

In accordance with 42 CFR §431.408, DHS will provide the public the opportunity to review and provide input on the waiver request through a formal thirty-day public notice and comment process was held from **December 31, 2023, through January 29, 2024**. During this time, the state held two dedicated public hearings.

#### **Public Notice**

The abbreviated public notice of the waiver application will be published on **December 31, 2023**, to the Arkansas Democrat-Gazette, the newspaper with widest circulation in each city

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<sup>57</sup> Curran J. et. Al. *JAMA Health Forum*.2023;4(4):e230482. “Estimated Use of Prescription Medications Among Individuals Incarcerated in Jails and State Prisons in the US.” April 14, 2023.

<sup>58</sup> California Rehabilitation Oversight Board. P.56.

<sup>59</sup> ASPE. Table 2, p. 21

with a population of 100,000 or more in accordance with 42 CFR §431.408(a)(2)(ii). In addition, DHS will use its standard electronic mailing list of interested parties, comprised of 144 individuals and organizations, to notify the public of the waiver request, the public hearings, and the opportunity to comment on the waiver request draft.

A copy of the formal public notice is attached as Attachment 2 and a copy of the abbreviated public notice document is attached as Attachment 3. Both documents, along with a copy of the complete waiver draft, are also made available for viewing in hard copy format as well as on the state’s website: <https://humanservices.arkansas.gov/rules/arhome/>.

**Public Hearings**

DHS will hold two public hearings during the notice and comment period- The hearings will be available for interested persons to attend and provide verbal comment on the Reentry Waiver both in person and via the Zoom platform. One of the meetings will occur during the **Medicaid Client Voice Council** meeting, an existing commission where meetings are open to the public.

The state will hold the two public hearings on the following dates and locations, as scheduled and as publicized in the formal notice:

Public Hearing #1	Public Hearing #2
<p><b>Public Hearing #1: Department of Human Services Virtual Public Forum</b></p> <p>January 10, 2024, 10:30 a.m. CST,</p> <p>Location: Department of Human Services (DHS) via Zoom, Little Rock, Arkansas.</p> <p>Zoom Link: <a href="https://us02web.zoom.us/j/88981640420">https://us02web.zoom.us/j/88981640420</a></p> <p>Zoom Dial-In: +1 346 248 7799 US (Houston)</p> <p>Meeting ID: 889 8164 0420</p>	<p><b>Public Hearing #2: Medicaid Client Voice Council (In-Person and Virtual)</b></p> <p>January 23, 2023, 11:00 a.m. to 2:00 p.m. CST</p> <p>Locations: In-Person at AFMC Campus, 1020 W. 4<sup>th</sup> St., Little Rock, AR 72201</p> <p>Virtual participation information will be announced at <a href="https://ar.gov/clientvoice">https://ar.gov/clientvoice</a> and at <a href="https://ar.gov/dhs-proposed-rules">ar.gov/dhs-proposed-rules</a> once the information becomes available</p>

**8.2 Summary of Public Comments & State Responses**

Throughout the development of the proposed waiver, DHS made a number of presentations to interested parties. In total, DHS received 12 timely comments from the public during the public comment period. Nine of the commenters conveyed overall support for the proposed waiver. Although supportive of the waiver, two of the commenters expressed opposition to the proposed use of Success Coaches as care coordinators. DHS received comments from three groups which did not clearly express their support or opposition to the proposed waiver.

This section consolidates and summarizes the comments to specific provisions in the Reentry Waiver. DHS identified each unique item of feedback contained within an individual

commenter's formal submission and thoughtfully analyzed and carefully considered each comment individually.

All comments are summarized by relevant topic areas and themes. Ultimately, while the state is not proposing to make any changes to the Reentry Waiver based on public comment, DHS provides a response to clarify various aspects of the proposal.

### **Support for the Waiver**

One commenter described the proposal as follows: "As an economically disadvantaged state with high rates of incarceration and mental health and substance abuse challenges, the proposed Reentry Waiver is an innovative and much-needed solution to historic barriers."

"The proposed Reentry Waiver would not only eliminate systemic barriers in place due to federal policy but also offer support to other at-risk individuals in the juvenile justice system for which the long-term benefits are likely immeasurable. Additionally, the ability to expand support for services to inpatient mental health and substance abuse facilities will help alleviate the inability to access critical services needed for Arkansans across the state."

### **Detainees in County Jail**

Local law enforcement and administrative officers in support of the proposed waiver provided an important reminder about the diversity of the population who are detained. "County jail detainees include pre-conviction arrestees and post-conviction inmates serving misdemeanor sentences, as well as post-conviction felony inmates serving state prison sentences, held by counties for the state due to insufficient state prison bedspace."

### **DHS Response**

The comments reinforce the importance of the first 90-day period. Under 42 CFR 435.1010(b), an individual is not considered an inmate if "he is in a public institution *for a temporary period* pending other arrangements appropriate to his needs (emphasis added)." The first 90-day period is critical to prevent individuals with chronic conditions to decompensate.

### **Role of Private IMDs**

One commenter in strong support of the proposed waiver provided some important statistics on private psychiatric hospitals that are IMDs. Three IMDs received over 2,500 referrals of adult Medicaid beneficiaries. These hospitals work to place many of them with other med-surg hospitals with psychiatric units that do not qualify as IMDs. The commenter noted that delays in placement due to lack of capacity result in crowded emergency rooms. The private IMDs provide a significant amount of uncompensated care. Some individuals refuse treatment because hospitals cannot bill Medicaid.

### **Opposition to First 90-day Period**

One commenter expressed opposition to the inclusion of the first 90-day period based on a concern that, "...the state may create an incentive to incarcerate individuals in order to provide federally financed health care."

### **DHS Response**

DHS respectfully disagrees that the waiver will create an incentive to increase the number of individuals in carceral facilities. By providing access to medical care during this period, DHS anticipates that individuals who are detained will be released sooner than under current practices. Providing the necessary medical treatment that will improve or stabilize an individual's

health condition will also likely divert individuals from ASH. The comment does highlight the likelihood that for some detainees, especially those in the custody of the Division of Youth Services, the first 90-day period may also be within the 90-day prerelease period.

### **Opposition to Use of a Success Coach to Provide Care Coordination**

Three commenters expressed opposition to the use of a Success Coach as proposed in the pending Opportunities for Success Amendment to the Arkansas Health and Opportunity for Me (ARHOME) Section 1115 Demonstration Project to provide care coordination to the reentry population. The commenters raised concerns that the pending Opportunities for Success Amendment would threaten access to and continuity of care and create additional barriers and implementation challenges.

#### DHS Response

DHS respectfully disagrees that the role of a Success Coach as proposed in the pending Amendment would threaten access to services and continuity of care. A Success Coach will be trained to provide enhanced care coordination to address individuals' HRSN.

Many individuals in the reentry population will need access to education, training, and employment as well as to medical services. Such nonmedical services are key to reducing recidivism.

### **Stateness**

Some commenters referenced the request to waive stateness and questioned the purpose of waiving this requirement and whether the waiver would be limited to certain geographic areas.

#### DHS Response

DHS appreciates the opportunity to clarify the purpose of this provision. DHS intends and expects that Medicaid enrollees will have access to all services throughout the state. However, as noted by the Arkansas Sheriffs' Association, Sheriffs operate 72 county jails which collectively house over 10,000 detainees throughout the state. Given the operational challenges of establishing Medicaid eligibility and building workforce capacity, a phased-in approach likely will be necessary. DHS also acknowledges that it will take time to build capacity to provide SUD treatment across the state. Although addressing the IMD exclusion is central to the waiver itself, the vast majority of Medicaid expenditures will continue to go to community-based care.

### **Operational Considerations**

A number of commenters raised questions that are operational in nature.

One commenter requested that existing acute crisis units in IMDs be permitted to qualify as ACUs.

#### DHS Response

DHS agrees that IMDs with existing ACUs should qualify as ACUs under the waiver. DHS will review program manuals to ensure their participation.

One commenter advocated that the waiver take effect earlier than January 1, 2025.

#### DHS Response

DHS anticipates that January 1, 2025 is an aggressive timetable for implementing the waiver. DHS will consider whether the IMD provision can be implemented sooner based on how quickly final approval is secured.

One commenter recommended that DHS adopt new criteria for assigning the reentry population into a single PASSE or a combination of PASSEs.

#### DHS Response

DHS anticipates close cooperation with the PASSEs in addressing such critical operational issues. Additional language to the waiver regarding attribution is not necessary.

One commenter recommended additional language be added to clarify responsibilities for MAT and prescription drugs.

#### DHS Response

DHS anticipates close cooperation with the PASSEs, the Department of Corrections, and other carceral facilities in addressing such critical operational issues. Additional language to the waiver regarding MAT and prescribing is not necessary.

One commenter recommended additional language to the care coordination ratios that PASSEs are required to meet.

#### DHS Response

DHS anticipates close cooperation with the PASSEs in addressing such critical operational issues. Additional language to the waiver regarding care coordination ratios is not necessary.

One commenter recommended additional language regarding Assertive Community Treatment and increased training and awareness on the Community Employment Services (CES) waiver.

#### DHS Response

DHS anticipates close cooperation with the PASSEs and providers in addressing such critical operational issues. Additional language to the waiver regarding service delivery and training is not necessary.

Several commenters requested additional details including a “robust plan” as to how DHS will address the shortage of community-based services and requests for details about how reinvestment funds will be used.

#### DHS Response

DHS will submit a detailed Implementation Plan, a detailed Reinvestment Plan, and a detailed plan for the activities to be funded under the Expenditure Waiver. These plans will be due to CMS within a timeframe specified under the Special Terms and Conditions (STCs). In developing the plans, DHS will include consultation with a variety of interested parties including the Commenters.

### **Issues Unrelated to the Waiver Request**

One commenter raised a number of issues that are unrelated to the Waiver. These included comments about 1915(i) services, the role of the Independent Assessment (IA), different types of waivers, and Medicaid reimbursement rates.

#### DHS Response

DHS remains committed to working closely and collaboratively with its partners who provide direct services and supports to vulnerable populations who are served with Medicaid funds as non-Medicaid funds such as Mental Health Block Grant funds. Approximately 90% of all Arkansans below age 65 and 94% of children under age 19 have health care coverage through private insurance sources or through Medicaid/CHIP. Yet coverage alone will not solve all of the challenges Arkansans face due to poverty, workforce shortages, and lack of access especially in rural areas. This waiver is critical to completing the continuum of care for vulnerable populations.

## **Section IX: Conclusion**

In reviewing the Key Milestones and Elements of the “Opportunities to Support Community Reentry and Improve Care Transitions for Individuals Who are Incarcerated” and the Goals and Milestones of the “Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance” and those in “Strategies to Address the Opioid Epidemic,” it is clear to the state that submitting a single application is the best way to achieve them all of these. As a rural state with severe workforce shortages in both mental health professionals and physical health professionals, it would be exceedingly difficult to succeed in one waiver without the other.

By combining all three federal opportunities into a single waiver application, this Reentry Waiver will improve the health outcomes of thousands of children and adults in Arkansas, especially those in need of treatment for SED, SMI, or SUD. It will address the severe shortage of mental health providers by opening the doors of IMDs on a temporary basis. It will reduce recidivism back into the justice system. It will promote efficiency and effectiveness of the Medicaid program through care coordination and new models of care delivery that include HCBS services that are bundled with care coordination. Recidivism rates and hospitalization rates will be reduced by addressing individuals’ HRSN. This waiver will also address the gaps in services faced by individuals with SMI or SUD. By removing the barriers associated with the both the federal IMD and inmate exclusions, DHS will be able to reach Medicaid enrollees where they are at critical points in their lives to provide crucial healthcare services to facilitate successful community reentry and improved health outcomes.

## **Section X: State Contact**

Name and Title: Janet Mann, Deputy Director of Health and State Medicaid Director, Arkansas Department of Human Services

Telephone Number: (501) 682-8999



## [Attachment 1: Budget Neutrality](#)

See Milliman Letter to Paula Stone.

## [Attachment 2: Public Notice](#)

### Public Notice

#### For Proposed Medicaid Section 1115 Demonstration Project

#### Opportunities to Test Transition-Related Strategies to Support Community Reentry from Incarceration and Institutions for Mental Disease

**The Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) is providing public notice of its intent to submit to the Centers for Medicare & Medicaid Services (CMS) a written request to submit a 1115 Demonstration Project and to hold public hearings to receive comments on the demonstration.**

In accordance with 42 §CFR 431.408, this notice provides a summary of the waiver request and serves to formally open the 30-day public comment period, which will begin on **December 31, 2023** and conclude on **January 29, 2024**

DHS proposes to seek a new Section 1115 demonstration waiver, which combines two federal waiver opportunities related to the inmate and IMD exclusions. This waiver application, “Opportunities to Test Transition-Related Strategies to Support Community Reentry from Incarceration and Institutions for Mental Disease,” combines the CMS guidance on the SUPPORT Act and Cures Act into a single Demonstration Project (“Reentry Waiver”). The purpose of the Reentry Waiver is to provide Medicaid funding for treatment for individuals who are inmates on a temporary basis in a public institution and to bridge the gap in coverage for adults receiving treatment in an IMD. Arkansas views both waivers as an opportunity to greatly impact care for individuals in facilities, whether that facility is a correctional facility or an IMD.

Specifically, DHS seeks public comment on the Reentry Waiver, which proposes to:

3. *Improve Reentry Services for Justice Involved Populations.* Arkansas is seeking to cover all Medicaid services for all justice involved populations for up to 90 days beginning on the first day of incarceration and for another period of up to 90 days prior to release. The aim of this component is to support smoother care transitions into and from carceral settings to increase the likelihood that individuals who are transitioning out of incarceration can maintain coverage and receive the care they need.
4. *Address IMD (Institute for Mental Disease) Exclusion to Increase Access to Behavioral Health Services.* Arkansas is seeking to waive the IMD exclusion in order to cover Medicaid services provided to individuals receiving treatment within qualifying IMD institutions. Similar to the reentry services for justice involved populations, these services would be provided for up to 90 days beginning on the first day of admission to an IMD facility, and also for an addition period of up to 90 days prior to the individuals discharge back to community-based treatment for those that were in an IMD facility for greater than 90 days. This component will increase equitable access to services for

Arkansas' Medicaid population within IMD settings and support improved care transitions and overall health outcomes.

### **Program Description & Detailed Summary of Proposed Changes**

Through this waiver, Arkansas aims to:

- 1) Strengthen the care continuum for individuals residing on a temporary basis in an IMD or carceral setting (jail, prison, or youth correctional facility) to support better health outcomes among this vulnerable populations; and
- 2) Support smoother care transitions from IMD and carceral settings to increase the likelihood that these individuals will maintain coverage and receive the health care they need upon reentry to a community setting.

Arkansas would like to address existing health disparities and inequitable access to services that exist for individuals who are either incarcerated or are receiving care within an IMD setting, due to the current federal inmate and IMD Medicaid exclusions. This Reentry Waiver will improve the health outcomes of thousands of children and adults in Arkansas in need of treatment for SED, SMI, or SUD by streamlining the various federal exclusions to fill gaps in treatment and reduce disparities in health outcomes. By testing consistent transition strategies for both carceral and IMD settings, regardless of factors such as the enrollee's delivery system or specific diagnoses that have previously impacted IMD authorizations and Medicaid coverage status, Arkansas seeks to create greater equity for individuals in need of Medicaid services.

By permitting the use of federal funds for temporary coverage of Medicaid services while an individual resides in either an IMD or carceral setting, Arkansas will be able to provide post-release transition planning, supports, and services appropriate to each individual's needs. Such coverage during the crucial temporary transition periods will increase the likelihood of successful transitions back into our communities, reducing recidivism and improving health outcomes.

In sum, Arkansas requests authority for the following:

3. To cover all Medicaid services for incarcerated adults and juveniles for up to 90 days beginning on the first day of incarceration and for another period of up to 90 days prior to release; and
4. To waive the IMD exclusion in order to cover Medicaid services provided to individuals receiving treatment in qualifying IMD institutions for up to 90 days beginning on the first day of admission and for another period of up to 90 days prior to discharge back to community-based treatment.

This Waiver holds great promise for Arkansans to accomplish the following goals:

- Alleviate impacts of the severe shortage of mental health providers by allowing equitable access to services through payment for services at IMD facilities;
- Reduce recidivism back into the justice system;
- Promote efficiency and effectiveness of the Medicaid program through care coordination and new models of care delivery that include HCBS services that are bundled with care coordination; and

- Improve health outcomes for individuals with SUD and SMI/SED by addressing individuals' Health-Related Social Needs (HRSN).

### **Eligibility, Cost Sharing, Delivery Systems, and Benefits**

Eligibility. While the Reentry Waiver does not change underlining Medicaid eligibility, it will waive the inmate and IMD exclusions that currently prohibit Medicaid services from being provided to otherwise Medicaid eligible individuals temporarily residing in an excluded facility. Specifically, the Waiver would impact eligibility as follows:

- Individuals regardless of age and eligibility category who are enrolled in the Arkansas Medicaid program who are incarcerated will retain eligibility and enrollment during the specific 90-day transition time frames noted above.
- Individuals regardless of age and eligibility category who are enrolled in the Arkansas Medicaid program and receiving medically necessary services within an IMD will retain eligibility for all covered Medicaid services, including services provided by the IMD, during the specific 90-day transition time frames noted above.

Benefits. In general, the Reentry Waiver seeks to increase access to existing Medicaid covered benefits by extending them to individuals temporarily residing in a jail, prison, youth correctional facility, or IMD. All state plan services will be available to the Demonstration populations. In conformance with the requirements of the Reentry Section 1115 Demonstration Opportunity, Arkansas will add case management services as not all individuals currently receive case management as a state plan benefit.

Cost Sharing. The Reentry Waiver will not impact cost sharing. The current benefit packages will remain the same.

Delivery Systems: Through the Reentry Waiver, individuals transitioning from jail, prison, or youth correctional facilities will be enrolled in the PASSE program rather than fee-for-service Medicaid or the Qualified Health Plans. The PASSE program currently provides comprehensive coverage, including specialty services for individuals with complex behavioral health needs, to more than 50,000 Medicaid enrollees. There is sufficient capacity among the four PASSE organizations to absorb additional members resulting from this waiver.

More broadly, approval of this waiver will strengthen the overall delivery system and improve the financial status of Arkansas mental health providers resulting in an increase in provider capacity. Specifically, DHS expects the following delivery system improvements:

- Access to treatment for SED, SMI and SUD will be expanded by permitting treatment through an IMD, including at the Arkansas State Hospital (ASH).
- There are 11 private IMDs enrolled in Arkansas Medicaid. DHS intends to expand access to acute crisis units by requiring the IMDs to open an ACU (Acute Crisis Unit) as a condition of participation in this waiver initiative. ACUs are opportunities to work more closely with law enforcement agencies and serve as diversions from jails and ASH.
- Through the increased use of telemedicine, Arkansas intends to expand services to individuals in crisis through creating additional crisis mobilization units across the state.

- Additionally, this work will support the improvement of health services and care coordination for individuals within the justice system, including improvement in jail health services and those services that support and coordinate with jail health.

**Enrollment and Expenditures**

See attachment 1 for budget neutrality estimates.

**Hypotheses and Evaluation Parameters**

Arkansas proposes the following evaluation plan, which has been developed in alignment with CMS evaluation design guidance for Reentry and SMI 1115 demonstrations. The state intends to contract with an independent evaluator to conduct this review. Below find the proposed hypotheses for the two components of the proposed components of the 1115 waiver:

<b>Goals, Objectives and Hypotheses Transition-Related Strategies to Support Community Reentry</b>		
<b>Goal/Objective</b>	<b>Hypothesis</b>	<b>Evaluation Parameters/Methodology</b>
<b>GOAL 1. Increase coverage, continuity of coverage, and appropriate service uptake</b>	<b>Hypothesis 1.</b> The demonstration will result in increases in Medicaid enrollment and service utilization among individuals who re-enter the community after a period of incarceration	<b>Data Sources:</b> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Medical records or administrative records</li> <li>• Interviews or focus groups</li> </ul> <b>Analytic Approach:</b> <ul style="list-style-type: none"> <li>• Difference-in-differences model</li> <li>• Subgroup analyses</li> <li>• Descriptive quantitative analysis</li> <li>• Qualitative analysis</li> </ul>
<b>GOAL 2. Improve access to services prior to release and improve transitions and continuity of care</b>	<b>Hypothesis 2.</b> The demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.	<b>Data Sources:</b> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Medical records</li> <li>• Beneficiary survey</li> </ul> <b>Analytic Approach:</b> <ul style="list-style-type: none"> <li>• Difference-in-difference models</li> <li>• Qualitative analysis</li> <li>• Descriptive quantitative analysis</li> </ul>
<b>GOAL 3. Improve coordination and communication between correctional systems, Medicaid systems,</b>	<b>Hypothesis #3.</b> The demonstration will result in improved availability of crisis stabilization services throughout the state and	<b>Data Sources:</b> <ul style="list-style-type: none"> <li>• Annual assessments of availability of mental health services</li> <li>• Administrative data</li> </ul>

<b>Goals, Objectives and Hypotheses Transition-Related Strategies to Support Community Reentry</b>		
<b>Goal/Objective</b>	<b>Hypothesis</b>	<b>Evaluation Parameters/Methodology</b>
<b>managed care plans, and community-based providers</b>	thereby reduce delays in receiving necessary treatment in the community and reduce, recidivism rates.	<ul style="list-style-type: none"> <li>• Provider survey</li> </ul> <b>Analytic Approach:</b> <ul style="list-style-type: none"> <li>• Descriptive quantitative analysis</li> </ul>
<b>GOAL 4. Increase additional investments in health care and related services</b>	<b>Hypothesis 4.</b> The demonstration will result in increases in Medicaid providers of mental health and SUD services and expansion of service delivery models: ACUs, Life360 HOMEs, PACTs, and FITTs thereby reducing the use of Emergency Departments, reduce inpatient hospitalizations, and reduce length-of-stays (LOS)	<b>Data Sources:</b> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Medical records or administrative records</li> <li>• Interviews or focus groups</li> </ul> <b>Analytic Approach:</b> <ul style="list-style-type: none"> <li>• Difference-in-differences model</li> <li>• Subgroup analyses</li> <li>• Descriptive quantitative analysis</li> <li>• Qualitative analysis</li> </ul>
<b>GOAL 5. Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and health-related social needs (HRSN)</b>	<b>Hypothesis 5.</b> The demonstration will result in increases in Medicaid enrollment among individuals who re-enter the community after a period of incarceration and divert individuals from the judicial system.	<b>Data Sources:</b> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Medical records or administrative records</li> <li>• Interviews or focus groups</li> </ul> <b>Analytic Approach:</b> <ul style="list-style-type: none"> <li>• Difference-in-differences model</li> <li>• Subgroup analyses</li> <li>• Descriptive quantitative analysis</li> <li>• Qualitative analysis</li> </ul>
<b>GOAL 6. Reduce all-cause death</b>	<b>Hypothesis 6.</b> The demonstration will result in increases in Medicaid enrollment among individuals who re-enter	<b>Data Sources:</b> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Medical records or administrative records</li> <li>• Interviews or focus groups</li> </ul>

<b>Goals, Objectives and Hypotheses Transition-Related Strategies to Support Community Reentry</b>		
<b>Goal/Objective</b>	<b>Hypothesis</b>	<b>Evaluation Parameters/Methodology</b>
	the community after a period of incarceration who have access to treatment services and reduce the rate of overdoses, suicides, and all causes of deaths among those released from incarceration at 12-month, 24-month, and 36-month intervals	<b>Analytic Approach:</b> <ul style="list-style-type: none"> <li>• Difference-in-differences model</li> <li>• Subgroup analyses</li> <li>• Descriptive quantitative analysis</li> <li>• Qualitative analysis</li> </ul>
<b>GOAL 7. Reduce number of ED visits and inpatient hospitalizations</b>	<b>Hypothesis 7.</b> The demonstration will result in fewer ED visits, fewer inpatient hospitalizations, and shorter-lengths of stay	<b>Data Sources:</b> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Medical records or administrative records</li> </ul> <b>Analytic Approach:</b> <ul style="list-style-type: none"> <li>• Difference-in-differences model</li> <li>• Subgroup analyses</li> <li>• Descriptive quantitative analysis</li> <li>• Qualitative analysis</li> </ul>
<b>Goals, Objectives, and Hypotheses for IMD Provisions</b>		
<b>GOAL 1.</b> Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries while awaiting mental health/SUD treatment in specialized settings.	<b>Hypothesis 1.</b> The demonstration will result in reductions in utilization of stays in emergency department among Medicaid beneficiaries with while awaiting mental health/SUD treatment.	<b>Data Sources:</b> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Medical records or administrative records</li> <li>• Interviews or focus groups</li> </ul> <b>Analytic Approach:</b> <ul style="list-style-type: none"> <li>• Difference-in-differences model</li> <li>• Subgroup analyses</li> <li>• Descriptive quantitative analysis</li> <li>• Qualitative analysis</li> </ul>
<b>GOAL 2.</b> Reduced preventable readmissions to acute care hospitals and residential settings.	<b>Hypothesis 2.</b> The demonstration will result in reductions in preventable readmissions to acute	<b>Data Sources:</b> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Medical records</li> <li>• Beneficiary survey</li> </ul>

<b>Goals, Objectives and Hypotheses Transition-Related Strategies to Support Community Reentry</b>		
<b>Goal/Objective</b>	<b>Hypothesis</b>	<b>Evaluation Parameters/Methodology</b>
	care hospitals and residential settings.	<b>Analytic Approach:</b> <ul style="list-style-type: none"> <li>• Difference-in-difference models</li> <li>• Qualitative analysis</li> <li>• Descriptive quantitative analysis</li> </ul>
<b>GOAL 3.</b> Improved availability of crisis stabilization services, including services made available through care coordination and mobile crisis units; intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs; psychiatric hospitals; and residential treatment settings throughout the state.	<b>Hypothesis 3.</b> The demonstration will result in increased availability of crisis stabilization services throughout the state that reduces inpatient hospitalization at ASH	<b>Data Sources:</b> <ul style="list-style-type: none"> <li>• Annual assessments of availability of mental health services</li> <li>• Administrative data</li> <li>• Provider survey</li> </ul> <b>Analytic Approach:</b> <ul style="list-style-type: none"> <li>• Descriptive quantitative analysis</li> </ul>
<b>GOAL 4.</b> Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI, including through increased integration of primary and behavioral health care	<b>Hypothesis 4.</b> Access of beneficiaries with SMI/SED to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and behavioral health care.	<b>Data Sources:</b> <ul style="list-style-type: none"> <li>• Claims data</li> <li>• Annual assessments of availability of mental health services</li> <li>• Administrative data</li> <li>• Medical records</li> </ul> <b>Analytic Approach:</b> <ul style="list-style-type: none"> <li>• Descriptive quantitative analysis</li> <li>• Difference-in-differences model</li> </ul>
<b>GOAL 5.</b> Improved care coordination, especially	<b>Hypothesis 5.</b> The demonstration will result in	<b>Data Sources:</b> <ul style="list-style-type: none"> <li>• Claims data</li> </ul>

<b>Goals, Objectives and Hypotheses Transition-Related Strategies to Support Community Reentry</b>		
<b>Goal/Objective</b>	<b>Hypothesis</b>	<b>Evaluation Parameters/Methodology</b>
continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	a reduction in out-home-home placements and a reduction in LOS in institutional and residential settings	<ul style="list-style-type: none"> <li>• Medical records</li> <li>• Interviews or focus groups</li> <li>• Facility records</li> </ul> <p><b>Analytic Approach:</b></p> <ul style="list-style-type: none"> <li>• Difference-in-differences model</li> <li>• Descriptive quantitative analysis</li> <li>• Qualitative analysis</li> </ul>

The Evaluation will also specifically address the efficacy of defining “temporary period” as up to 90-days. As a rural state and a state that faces a significant workforce shortage, a lesser time period is likely not realistic to affect a successful transition to the community with immediate access to care. In addition, since many individuals have shorter stays in excluded settings with unknown release dates, providing Medicaid services during the enrollee’s transition to the facility will support improved outcomes and more equitable provision of pre-release services. Thus, this Reentry Waiver will provide opportunities for comparing the length of time among states with reentry waivers, including recidivism rates among the states based on both length of time of the intervention as well as the timing of the intervention.

### **Waiver and Expenditure Authorities**

DHS requests all necessary additional waiver authority to implement the waiver request, including at minimum, the following:

<b>Amount Duration, and Scope of Services and Comparability</b>	<b>Section 1902(a)(10)(B) and 1902(a)(17)</b>
To the extent necessary to enable DHS to offer focused care coordination services and LIFE360 HOME services to the populations as described in this Application which may vary and not otherwise be available to all beneficiaries in the same eligibility group.	
<b>Stateness</b>	<b>Section 1902 (a)(1)</b>
To the extent necessary to enable DHS to provide care coordination services, and LIFE360 HOME services on a less than statewide basis. To enable the state to provide pre-release services to qualifying beneficiaries on a geographically limited basis.	
<b>Freedom of Choice</b>	<b>Section 1902(a)(23)(A)</b>
To the extent necessary to enable DHS to restrict individuals’ choice of providers to the network of providers under the PASSE program, and LIFE360 HOME services on a less than statewide basis.	



DHS requests all necessary additional waiver expenditure authority to implement the waiver request, including the following:

<b>Expenditures for Treatment During a Period of Incarceration</b>	<b>Section 1905(a)</b>
The state requests expenditure authority under Section 1115 to the extent necessary to enable DHS to pay for Medicaid covered services during an initial 90-day period upon a Medicaid enrolled individual entering a state prison, county or city jail, or youth correctional facility, and for an additional 90-day period immediately prior to the expected date of release from a participating state prison, county or city jail, or youth correctional facility.	
<b>Expenditures for Treatment in an Institution for Mental Disease</b>	<b>Section 1905(a)</b>
The state requests expenditure authority under Section 1115 to the extent necessary to enable DHS to reimburse for Medicaid covered services for up to 90 days from the date of admission in an IMD furnished to otherwise eligible individuals who are primarily receiving treatment for SMI, SED, and/or SUD (including withdrawal management services) at a facility that meets the definition of an institution for mental disease (IMD). In addition, the State requests expenditure authority under Section 1115 to the extent necessary to enable DHS to reimburse for Medicaid covered services for an additional 90-day period prior to the discharge of a Medicaid enrolled individual from a facility that meets the definition of an IMD, including an IMD that is a public institution.	
<b>Expenditures for Building Capacity of Pre-Release Supports Through an Approved Reinvestment Plan</b>	<b>Section 1905(a)</b>
The state requests expenditure authority under Section 1115 for costs not otherwise matchable related to a variety of activities necessary to support successful transitions from a carceral facility into the community. The activities will include pre-release readiness assessments, improving the eligibility process, education and training, linking Electronic Health Records, and other activities to be submitted in the Implementation Plan and Reinvestment Plan.	
<b>Expenditures to Incentivize Community Mental Health Providers to Adopt Electronic Health Records and Participate in SHARE</b>	<b>Section 1905(a)</b>
The state requests expenditure authority under Section 1115 for costs not otherwise matchable related to grants to small, independent community mental health providers as incentive payments to adopt interoperable electronic health records and to participate in the State Health Alliance for Records Exchange (SHARE).	

### Public Notice and Comment Process

The proposed 1115 waiver and full public notice are available for public review on the DHS website at [ar.gov/dhs-proposed-rules](http://ar.gov/dhs-proposed-rules).

In addition, the draft documents are also available for hard copy review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P.O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437.

During the 30-day public comment period which runs from **December 31, 2023 to January 29, 2024**, the public is invited to provide written comments to DHS via US postal service or electronic mail as well as make comments verbally during the two public hearings.

DHS will hold two public hearings on the following dates, times, and locations:

Public Hearing #1	Public Hearing #2
<p><b>Public Hearing #1: Department of Human Services Virtual Public Forum</b></p> <p>January 10, 2024, 10:30 a.m. CST,</p> <p>Location: Department of Human Services (DHS) via Zoom, Little Rock, Arkansas.</p> <p>Zoom Link:  <a href="https://us02web.zoom.us/j/88981640420">https://us02web.zoom.us/j/88981640420</a></p> <p>Zoom Dial-In: +1 346 248 7799 US (Houston)</p> <p>Meeting ID: 889 8164 0420</p>	<p><b>Public Hearing #2: Medicaid Client Voice Council (In-Person and Virtual)</b></p> <p>January 23, 2023, 11:00 a.m. to 2:00 p.m. CST</p> <p>Locations: In-Person at AFMC Campus, 1020 W. 4<sup>th</sup> St., Little Rock, AR 72201</p> <p>Virtual participation information will be announced at <a href="https://ar.gov/clientvoice">https://ar.gov/clientvoice</a> and at <a href="https://ar.gov/dhs-proposed-rules">ar.gov/dhs-proposed-rules</a> once the information becomes available</p>

Interested persons should submit all comments to DHS on the proposed waiver on or before **January 29, 2024**.

Comments can be submitted via email to [ORP@dhs.arkansas.gov](mailto:ORP@dhs.arkansas.gov) or by mail to Department of Human Services (DHS) Office of Rules Promulgation, 2nd Floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437.

Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter’s name and any personal information contained within the public comment, will be made publicly available.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated and managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin.

If you need a copy of the draft waiver or public notice documents in a different format, such as large print or in hard copy, contact the Office of Rules Promulgation at 501-320-6428.

## Attachment 3: Abbreviated Public Notice

### **Abbreviated Public Notice For Proposed Medicaid Section 1115 Demonstration Project**

#### **Opportunities to Test Transition-Related Strategies to Support Community Reentry from Incarceration and Institutions for Mental Disease**

**The Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) is providing public notice of its intent to submit to the Centers for Medicare & Medicaid Services (CMS) a written request to submit a 1115 Demonstration Project and to hold public hearings to receive comments on the demonstration.**

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DHS proposes to seek a new Section 1115 demonstration waiver, which combines two federal waiver opportunities related to the inmate and IMD exclusions. This waiver application, “Opportunities to Test Transition-Related Strategies to Support Community Reentry from Incarceration and Institutions for Mental Disease,” combines the CMS guidance on the SUPPORT Act and Cures Act into a single Demonstration Project (“Reentry Waiver”). The purpose of the Reentry Waiver is to provide Medicaid funding for treatment for individuals who are inmates on a temporary basis in a public institution and to bridge the gap in coverage for adults receiving treatment in an IMD. Arkansas views both waivers as an opportunity to greatly impact care for individuals in facilities, whether that facility is a correctional facility or an IMD.

Specifically, DHS seeks public comment on the Reentry Waiver, which proposes to:

1. *Improve Reentry Services for Justice Involved Populations*. Arkansas is seeking to cover all Medicaid services for all justice involved populations for up to 90 days beginning on the first day of incarceration and for another period of up to 90 days prior to release. The aim of this component is to support smoother care transitions into and from carceral settings to increase the likelihood that individuals who are transitioning out of incarceration can maintain coverage and receive the care they need.
2. *Address IMD (Institute for Mental Disease) Exclusion to Increase Access to Behavioral Health Services*. Arkansas is seeking to waive the IMD exclusion in order to cover Medicaid services provided to individuals receiving treatment in qualifying IMD institutions. Similar to the reentry services for justice involved populations, these services would be provided for up to 90 days beginning on the first day of admission to an IMD facility, and also for another period of up to 90 days prior to the individuals discharge back to community-based treatment for those that were in an IMD facility for greater than 90 days. This component will increase equitable access to services for Arkansas’ Medicaid population within IMD settings and support improved care transitions and overall health outcomes.

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The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated and managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin.

If you need a copy of the draft waiver or public notice documents in a different format, such as large print or in hard copy, contact the Office of Rules Promulgation at 501-320-6428.

Elizabeth Pitman, Director  
 Division of Medical Services

## Attachment 4: Public Comments Received

**Hobe Runion, Sheriff**

**Sebastian County, Arkansas**

**Comment:**

Please accept this letter from me in reference to the possibility of Medicaid being made available to inmates while incarcerated in county jail.



Medicaid.pdf

**Phillip Miller, Sheriff**

**White County, Arkansas**

**Comment:**



Medicaid  
Eligibility.pdf

**Colin Jorgensen, Litigation Counsel**

**Association of Arkansas Counties**

**For Scott Bradley and Dale Cook**

**On behalf of Arkansas Sheriff's Association**

**Comment:**

Attached please find a signed letter of public comment by the President and Executive Director of the Arkansas Sheriffs Association. The body of the comment is also pasted below for your convenience. Please confirm receipt of this public comment and let us know if the ASA can assist further with the proposed waiver.



ASA final LTR to  
DHS re Medicaid Re

Dear DHS-ORP:

We write as the Executive Director of the Arkansas Sheriffs Association (ASA) and the President of the ASA (and Mississippi County Sheriff) to express the ASA's strong support for DHS' proposed Section 1115 Demonstration Project, Opportunities to Test Transition-Related Strategies to Support Community Reentry from Incarceration and Institutions for Mental Disease (December 31, 2023).

The ASA includes and represents the 75 Sheriffs of Arkansas, who proudly serve and protect the citizens of Arkansas. Arkansas Sheriffs operate 72 county jails in Arkansas, which collectively house over 10,000 detainees across the state. County jail detainees include pre-conviction arrestees and post-conviction inmates serving misdemeanor sentences, as well as post-conviction felony inmates serving state prison sentences, held by counties for the state due to insufficient state prison bedspace.

Arkansas Sheriffs are charged with providing access to necessary medical care to the detainees in their physical custody in the county jails. Access to necessary medical care for county-jail inmates is an important duty of the Arkansas Sheriffs, and it represents a significant cost to the counties of Arkansas. Arkansas Sheriffs have a strong interest in ensuring that detainees in their custody receive quality medical care, which necessarily requires Sheriffs to manage the costs of detainee care to ensure that limited funds are sufficient to provide adequate medical care to all detainees.

Arkansas Sheriffs strongly support DHS' proposed Medicaid reentry waiver because it will both improve the quality of medical care for detainees in county jails in Arkansas, and decrease the cost of that medical care for Arkansas counties. Sheriffs are also well-positioned to assist with continuing and expanding care for detainees in IMDs (ultimately including facilities providing SUD treatment)—both as a diversion/alternative to incarceration and upon reentry.

Arkansas Sheriffs not only support the proposed waiver—their experience indicates that the benefits of the proposed waiver will be realized as asserted in the proposed waiver. The Sheriffs are hopeful that the proposed waiver will increase access to medical care, increase the quality of medical care, close gaps in the continuum of care, and improve the health outcomes of county-jail detainees in Arkansas—the only question is the degree to which these benefits will be realized. Arkansas Sheriffs are committed to doing their part to ensure that the waiver promotes these objectives that are shared by Medicaid, DHS, and the Sheriffs themselves.

Thank you for your excellent work preparing the waiver request, and your commitment to work with correctional officials to successfully implement the waiver if approved. We look forward to working with you in this pursuit.

**Laura Turner**

**American Lung Association**

**Comment:**

Please see the attached comments on the Arkansas 1115 Demonstration Project.



American Lung  
Association Comment

**David Donohue**

**Care Source**

**Comment:**

Please accept the attached comments for review related to the 1115 Waiver Demonstration Project:  
“Opportunities to Test Transition-Related Strategies to Support Community Reentry from Incarceration  
and Institutions for Mental Disease.”



1115 Prison Reentry  
Waiver Comments CS.

**Juanita Tolbert**

**Mitchell and Blackstock**

**For Robert Wright**

**On behalf of United Health Services, Inc.**

**Comment:**

Please see attachment for a letter from Robert Wright.



2024.01.29 Ltr to  
DHS.pdf

**Diana Marin**

**Leukemia & Lymphoma Society**

**Comment:**

Attached are LLS comments on Arkansas 1115 Medicaid demonstration project. If you have any questions or concerns, please contact Diana Marin at [diana.marin@lls.org](mailto:diana.marin@lls.org).



LLS comments on  
Arkansas 1115 Medic

**J. Craig Wilson, JD, MPA**

**Arkansas Center for Health Improvement**

**Comment:**

Attached please find public comment on the Reentry Waiver on behalf of the Arkansas Center for Health Improvement.



240129 ACHI Public  
Comment Reentry Wa

**Camille Richoux, MPH**

**Arkansas Advocates for Children and Families**

**Comment:**

Please see the attached document for Arkansas Advocates for Children and Families' submitted comments on the Opportunities to Test Transition-Related Strategies to Support Community Reentry from Incarceration and Institutions for Mental Disease Section 1115 Demonstration Project proposal.



1115 Opportunities  
to Test Transition-Rel



**Joel P. Landreneau, Esq.**

**Arkansas Council for Behavioral Health, Inc.**

**Comment:**

Please find attached the public comment submitted by the Arkansas Council for Behavioral Health regarding the published 1115 demonstration waiver application entitled “Opportunities to Test Transition-Related Strategies to Support Community Reentry from Incarceration and Institutions for Mental Disease,” made public on 12/31/2023.

Please include these in the public record for this publication.



1115 Demonstration  
Waiver comments from

**Trevor Hawkins, Attorney**

**Legal Aid of Arkansas – Jonesboro**

**Comment:**

Please accept the attached as public comments on the Opportunities to Test Transition-Related Strategies to Support Community Reentry from Incarceration and Institutions for Mental Disease proposal.



1115 Reentry Waiver  
Comments - TH.pdf

**Jared Sparks**

**Arisa Health**

**Comment:**

Thank you for the opportunity to provide feedback about the proposed 1115 waiver. Arisa Health, Inc.'s comments are attached.



Arisa Health  
Comments on propos



17335 Golf Parkway  
 Suite 100  
 Brookfield, WI 53045  
 USA  
 Tel +1 262 784 2250

milliman.com

Greg J. Herrle, FSA, MAAA  
 Principal and Consulting Actuary

greg.herrle@milliman.com

December 15, 2023

Paula Stone  
 Arkansas Department of Human Services  
 Division of Medical Services  
 700 Main Street  
 Little Rock, AR 72203  
 Sent via email: paula.stone@dhs.arkansas.gov

**Re: 1115 Budget Neutrality Estimates – IMD and Justice Involved Populations**

Dear Paula:

The Arkansas Department of Human Services’ (DHS) Division of Medical Services engaged Milliman, Inc. (Milliman) to develop budget neutrality limits for the proposed 1115 IMD demonstration waiver for Institute of Mental Disease (IMD) stays and community reentry services targeted for those incarcerated in state custody. This demonstration targets two distinct temporary populations:

- **IMD Population:** Individuals with serious mental illness (SMI) and substance use disorders (SUD) temporarily residing in an IMD who are in their first 90 days of residence or who are within 90 days of discharge from the IMD.
- **Justice Involved Population:** Individuals temporarily incarcerated in state prison, county or city jail, or youth correctional facility who are in their first 90 days of custody or who are within 90 days of release from incarceration.

This letter provides a preliminary analysis of budget neutrality limits separately for the IMD population and the justice involved population. We note, that very few individuals with historical IMD stays have an SUD diagnosis. Additionally, it is unclear which population groupings CMS will ultimately require under the 1115 demonstration waiver. We separated the PASSE population into Children and Adults for this preliminary analysis, but we included all ages in a single FFS population. CMS may require different population identification, including potentially developing costs separately for mental health and SUD diagnoses.

**Please note, the per member per month budget neutrality estimates included in this letter are preliminary in nature and based on information / direction provided by DHS. It is likely that further discussions with DHS and / or CMS will result in updated budget neutrality estimates. All budget neutrality limits are subject to CMS review and approval.**

**RESULTS**

Table 1 shows the projected per member per month (PMPM) budget neutrality limits by Medicaid Eligibility Group (MEG) for the state fiscal year (SFY) 2025 (July 2024 to June 2025) through SFY 2029 initial demonstration period.

<b>Table 1</b> <b>Arkansas Department of Human Services</b> <b>1115 IMD Demonstration Waiver</b> <b>SFY 2025 to SFY 2029 Budget Neutrality Limits</b> <b>Per Member Per Month</b>					
<b>MEG</b>	<b>SFY 2025</b>	<b>SFY 2026</b>	<b>SFY 2027</b>	<b>SFY 2028</b>	<b>SFY 2029</b>
IMD – FFS	\$12,219	\$12,817	\$13,445	\$14,104	\$14,795
IMD – PASSE Children	2,439	2,558	2,684	2,815	2,953
IMD – PASSE Adults	3,211	3,369	3,534	3,707	3,888
IMD – Expansion Adults	5,667	5,945	6,236	6,542	6,862
Justice Involved	2,205	2,313	2,427	2,545	2,670

In the remainder of this letter, we demonstrate how we developed the SFY 2025 budget neutrality limits. We then applied a 4.9% trend to calculate the limits for SFY 2026 to SFY 2029. The 4.9% annual trend is consistent with President’s Budget trend rates developed from the 2018 Actuarial Report on the Financial Outlook for Medicaid prepared by CMS’ Office of the Actuary (OACT). No more recent such report has been developed as of the date of this letter.

### IMD Population Cost Development

We developed an estimated projected cost for the IMD population separately by program type: traditional fee-for-service (FFS) eligibles, PASSE children, PASSE adults, and Expansion Adults covered under FFS. We summarized CY 2022 claims experience for each population to estimate their expected costs under the proposed demonstration. Table 2 below shows the historical expenditures and the projection to SFY 2025.

Table 2 Arkansas Department of Human Services 1115 Demonstration Waiver Development of Estimated IMD SFY 2025 Monthly Costs				
	FFS	PASSE Children	PASSE Adults	Expansion Adults
Total IMD Costs	\$45,255,209	n/a	\$11,879,144	\$190,430
Applicable Member Months	4,651	n/a	97,400	54
Per Member Per Month (PMPM) Costs				
IMD Costs	\$9,730.14	n/a	\$121.96	\$3,526.48
Other FFS Costs	895.30	n/a	n/a	1,305.95
Pre-Release Services	185.34	185.34	185.34	185.34
PASSE Capitation		1,887.34	2,505.55	
Dental Capitation	24.13	26.80	11.59	6.63
NET Capitation	3.09	3.28	3.45	3.09
PCCM Fee	3.37	n/a	n/a	0.78
Total CY 2022 Cost PMPM	10,841	1,917	2,828	5,028
Annual Trend to SFY 2025	4.9%	10.1%	5.2%	4.9%
<b>Total SFY 2025 Cost PMPM</b>	<b>\$12,219</b>	<b>\$2,439</b>	<b>\$3,211</b>	<b>\$5,667</b>

\*Represents total PASSE Adults enrollment. Historical IMD usage months are 1,290.

The estimates in the table above include the following components:

- IMD Costs:** We summarized the CY 2022 costs incurred at IMDs for each population. The IMD costs for the FFS population include 90 days associated with each admission and each discharge. Nearly all IMDs had no stays longer than 90 days, so we included their data without adjustment. Only Arkansas State Hospital had stays in excess of 90 days, and we manually calculated the costs associated with the first and last 90 days of each stay. Based on information provided by DHS, there are roughly 218 unique admissions and 229 discharges per year for the FFS population, which results in 1,324 member months and \$30,799,180 of costs based on a per diem rate of \$765. These costs and member months are included in the “total IMD costs” and “applicable member months” lines of Table 2 along with non-Arkansas State Hospital experience.

We calculated the IMD costs to include in the demonstration as total IMD costs divided by the *applicable* member months. Since IMD costs for the PASSE adults (currently paid outside of managed care) will be added to the PASSE capitation rates, these costs will be spread over the entire adult BH population in PASSE rather than only the members with IMD stays. The PASSE Children show “n/a” since psychiatric stays are already included in the PASSE capitation rate development.

- Other FFS Costs:** For the populations not in managed care (i.e., FFS and Expansion Adult), we capture the “other FFS costs” that these individuals incur during the same month as an IMD stay. For example, if an individual has an inpatient stay at the beginning of a month and then separately has an IMD stay later in the month, the inpatient costs would be included as other FFS costs.

In addition to the FFS costs present in the historical data, we include \$556.01 in pre-release services (applicable to each 90-day period), comprising a one-hour new patient telehealth appointment with a community provider (\$148.71) and a 30-day fill of their prescriptions prior to release (\$407.30).

- **Capitation Costs:** We also include any capitation amounts DHS pays for members with an IMD stay. These include the PASSE, Dental, NET, and Primary Care Case Management (PCCM) programs. The PASSE capitation rates are only applicable for PASSE Children and PASSE Adults, while the PCCM costs are only applicable for the FFS and Expansion Adult populations.

We trend the aggregate CY 2022 costs to SFY 2025 by applying the actual capitation rate changes (11% for Adults and 13% for Children) to the PASSE capitation costs and the president's annual budget trend of 4.9% to all remaining costs.

### Justice Involved Population Cost Development

We developed an estimated projected cost for the justice involved population. Each component of this development represents SFY 2025 costs and is discussed in more detail below. Since the inclusion of an incarcerated population in an 1115 demonstration waiver is a relatively new option from CMS through the State Medicaid Director Letter (SMD) #23-003, we highlight a few key assumptions related to the justice involved population below. Many of these assumptions are based on discussions with DHS.

- Incarcerated individuals may enter the demonstration waiver for 90 days upon incarceration, as well as 90 days prior to their community release.
- The cost associated with existing acute medical services received while incarcerated (e.g., inpatient, pharmacy, physician, etc.), are currently not paid by Medicaid, but DHS intends to include these services in the demonstration waiver when received during each 90-day transitional period. CMS expects states "to reinvest the total amount of new federal matching funds received for such services under the demonstration into activities and / or initiatives that increase access to or improve the quality of health care services for individuals who are incarcerated (including individuals who are soon-to-be released) or were recently released from incarceration, or for health-related social services that may help divert individuals from criminal justice involvement." (SMD #23-003)
- Based on discussions with DHS, we understand the incarcerated population in this waiver may reasonably have cost profiles consistent with the Behavioral Health Tier 2 adults in the existing PASSE program.
- DHS may decide to develop a capitation payment for the re-release population, potentially structured as a 90-day kick payment, to transfer risk to the PASSEs for this population. As such, we included an assumption for non-benefit expenses consistent with the existing PASSE program.

Table 3 below shows the detailed assumptions used in developing projected costs under this new program.

**Table 3**  
**Arkansas Department of Human Services**  
**1115 Demonstration Waiver**  
**Justice Involved Population – SFY 2025 Costs Development**

<b>Rate Development Component</b>	
Number of Eligible Participants	10,000
Participation Rate	75%
Program Duration (Days)	90
Estimated Member Months	22,500
Pre-Release Community-Based Provider Appointments per Participant	1.00
MAT (Counseling and Prescription Drug) Services per Participant	0.30
Prescription Drugs Provided Upon Release Services per Participant	1.00
All Other Service Costs	1.00
Pre-Release Community-Based Provider Appointments Fee (one time)	\$149
MAT (Counseling and Prescription Drug) Services Fee (90 days) per MAT patient	1,827
Prescription Drugs Provided Upon Release Services Fee (one time)	407
All Other Service Costs (90-days)	4,865
Administrative Cost Load	6.28%
Risk / Margin Load	1.00%
Premium Tax	2.50%
Total Estimated Annual Spend	\$49,615,178
<b>Total Estimated PMPM Cost</b>	<b>\$2,205</b>

From conversations with DHS, we included the following assumptions to estimate the cost per participant:

- All participants will get a one-hour new patient telehealth appointment with a community provider (99205) before being released from the facility. The current Arkansas fee schedule indicates a per-visit rate of \$149.
- All substance use disorder program participants, estimated to be roughly 30% of total participants, will receive MAT counseling and prescription drug-related services before being released from the facility.
  - The counseling service costs include one psychiatric session (CPT 90791), two psychotherapy sessions (CPT 90834), and one group session (CPT 90853), based on the current fee schedule.
  - The prescription drug cost is based on the CY 2022 average monthly cost per MAT patient of \$505 as reported in PASSE encounter data, trended to SFY 2025 at an annual trend rate of 4.0% and shown in Table 3 on a 90-day basis.
- All participants will receive a 30-day fill of their prescriptions prior to release from the facility to ensure continued access to medication following release. We estimate an average cost of \$407 for 30-day prescription fills based on the prescription drug costs included for Behavioral Health Tier 2 Adults in the PASSE program, trended to SFY 2025.
- Participants will have expected overall costs consistent with the Behavioral Health Tier 2 Adult population in the PASSE program. As such, we estimated the costs of all other services (i.e., those not captured in the preceding three bullets) as the projected SFY 2025 PASSE costs, reduced for MAT services and care coordination since those costs are separately included above. Table 3 shows this cost on a 90-day basis.

We also included an allowance for managed care organizations (i.e., PASSEs) to administer the claims payment and provide other administrative functions for the demonstration in the event DHS chooses to create a new eligibility category within PASSE. As such, we applied an administrative cost load of 6.3% of revenue, which is based on the administrative cost assumptions currently used for the SFY 2025 PASSE program capitation rates.

We applied a risk and margin load of 1.0% of revenue for both populations; this is consistent with the assumption used in the PASSE rate setting process. Finally, we adjusted the total projected costs to reflect the Arkansas 2.5% premium tax.

#### CAVEATS AND LIMITATIONS ON USE

Milliman developed certain models to estimate the values included in this report. The intent of the models was to evaluate historical costs for individuals with an IMD stay and estimate future costs for these individuals as well as the justice involved population. We reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We used detailed claims and eligibility data provided by DHS, as well as supplemental information provided in conversations with DHS. We did not audit this data or other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and did not find material defects in the data.

Future alignment of the estimated costs and the actual experience will depend on the extent to which future experience conforms to the assumptions reflected in the calculations. It is certain that actual experience will not conform exactly to the historical data and assumptions used in this deliverable due to population differences, economic conditions, policy initiatives, and many other factors. Actual amounts will differ from historical and projected amounts to the extent that actual experience is higher or lower than expected.

Milliman prepared this letter for the specific purpose of developing budget neutrality limits for the demonstration waiver related to the IMD and justice involved populations. This letter should not be used for any other purpose. This letter has been prepared solely for the internal business use of, and is only to be relied upon by, the management of DHS. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work. This letter should only be reviewed in its entirety.

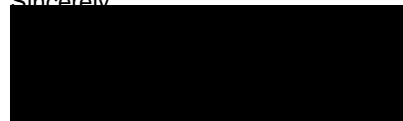
The results of this letter are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

I, Greg Herrle, am an actuary for Milliman, a member of the American Academy of Actuaries, and I meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of my knowledge and belief, this letter is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.



Paula, we look forward to discussing these results with you and your team. Please let us know if you require any changes to this letter or the underlying calculations.

Sincerely,



Greg J. Herrle, FSA, MAAA  
Principal and Consulting Actuary

GJH/db