DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, MD 21244-1850

State Demonstrations Group

February 27, 2026

Lisa Lee
Commissioner, Department for Medicaid Services
Cabinet for Health and Family Services
275 East Main Street,
Frankfort, KY 40601

Dear Commissioner Lee:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the Health Related Social Needs (HRSN) Implementation Plan for Kentucky's section 1115(a) demonstration, "TEAMKY" (Project Numbers11-W-00306/4 and 21-W-00067/4). We have determined that the HRSN Implementation Plan is consistent with the requirements outlined in the special terms and conditions (STCs). CMS has incorporated the finalized HRSN Implementation Plan into the STCs as Attachment P.

CMS rescinded the November 2023 and December 2024 Center for Medicaid and CHIP Services (CMCS) Center Information Bulletins (CIB) related to coverage of certain services and supports to address "health-related social needs" while CMS evaluates policy options consistent with Medicaid and CHIP program requirements and objectives. Additional information is available on Medicaid.gov.

States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid and CHIP funds and must fully comply with all applicable Medicaid and CHIP statutes and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in Title XIX and Title XXI of the Social Security Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid and CHIP services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and

conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

We look forward to our continued partnership on the TEAMKY section 1115(a) demonstration. If you have any questions, please contact your CMS project officer, Valisha Andrus, at Valisha.Andrus@cms.hhs.gov.

Sincerely,

Andrea J. Casart
Director
Division of Eligibility and Coverage Demonstrations

Enclosure

cc: Christine Davidson, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBERS: **11-W-00306/4**
21-W-00067/4

TITLE: **TEAMKY Section 1115 Demonstration**

AWARDEE: **Kentucky Cabinet for Health and Family Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the Commonwealth of Kentucky for the services described below, which are not otherwise included as expenditures under section 1903 of the Act, must be regarded as matchable expenditures under the state's Title XIX plan, unless otherwise specified, provided however that these expenditures are further limited by the special terms and conditions (STCs) for the TEAMKY (formerly KY Helping to Engage and Achieve Long Term Health (HEALTH)) section 1115 demonstration. Expenditures associated with the TEAMKY section 1115 demonstration are approved from January 1, 2025 through December 31, 2029.

As described further in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the Secretary of Health and Human Services has determined that the TEAMKY Section 1115 demonstration, including the granting of the waiver and expenditure authorities described below, is likely to assist in promoting the objectives of title XIX of the Social Security Act.

The following expenditure authorities shall enable Kentucky to implement the TEAMKY demonstration:

1. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an institution for mental disease (IMD), as describe in section XIV of the STCs.

2. **Residential and Inpatient Treatment for Individuals with Serious Mental Illness (SMI).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment for serious mental illness (SMI) who are short-term residents in facilities that meet the definition of an IMD, and who meet the eligibility criteria described in section XV of the STCs.

3. **Recovery Residence Support Services (RRSS)**. Expenditures for RRSS for up to 90 days, for individuals diagnosed with a SUD and meet the eligibility criteria, as described in section XIV of the STCs.

4. **Health-Related Social Needs (HRSN) Services**. Expenditures for allowable HRSN services not otherwise covered that are furnished to individuals who meet the qualifying

criteria as described in Section VII of the STCs. This expenditure authority is contingent upon compliance with Section VII of the STCs, as well as all other applicable STCs.

5. **HRSN Services Infrastructure**. Expenditures for allowable HRSN administrative and infrastructure costs not otherwise covered under section 1903 of the Act, as described in section VII of the STCs.

6. **Pre-Release Services.** Expenditures for pre-release services, as described in section VIII of the STCs, furnished to individuals who meet qualifying criteria in STC 42 for up to 60 days immediately prior to the expected date of release from a correctional facility that is participating in the reentry demonstration initiative under this demonstration.

7. **Pre-Release Administrative Costs.** Expenditures for allowable administrative costs, supports, transitional non-service expenditures, infrastructure and interventions, as described in STC 51. These expenditures may not be recognized as medical assistance under section 1905(a) and may not otherwise qualify for federal matching funds under section 1903, to the extent such activities are authorized as part of the Reentry Demonstration Initiative.

Title XIX Requirements Not Applicable to the Medicaid Expenditure Authority for Pre-Release Services:

Amount, Duration, and Scope of Services and Comparability **Section 1902(a)(10)(B)**

To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups authorized under the state plan or demonstration authority.

Freedom of Choice **Section 1902(a)(23)(A)**

To enable the state to require qualifying individuals to receive pre-release services, as authorized under this demonstration, through only certain providers.

Comparability; Amount, Duration and Scope; Provision of Medical Assistance **Section 1902(a)(10)(b) and Section 1902(a)(17)**

To the extent necessary to allow the state to offer HRSN services and to vary the amount, duration, and scope of HRSN services covered for a subset of beneficiaries, depending on beneficiary needs as determined by the application of qualifying criteria, as specified in Section VII of the STCs.

Title XXI Expenditure Authority:

Under the authority of section 1115(a)(2) of the Act as incorporated into Title XXI by section 2107(e)(2)(A), state expenditures described below, shall, for the period of this demonstration, through December 31, 2029, and to the extent of the state's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the state's Title XXI plan. All requirements of Title XXI will be applicable to such expenditures for demonstration populations.

Expenditures for Pre-Release Services. Expenditures for pre-release services, as described in these STCs, provided to qualifying Children's Health Insurance Program (CHIP) individuals who are or would be eligible for CHIP if not for their incarceration status, for up to 60 days immediately prior to the expected date of release from a correctional facility that is participating in the Reentry Demonstration Initiative.

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBERS: **11-W-00306/4**
21-W-00067/4

TITLE: **TEAMKY Section 1115 Demonstration**

AWARDEE: **Kentucky Cabinet for Health and Family Services**

Title XIX Waiver Authority

Under the authority of Section 1115(a)(1) of the Social Security Act ("the Act"), the following waivers are granted to enable Kentucky (referred to herein as the state or the State) to operate the TEAMKY (formerly KY HEALTH) Demonstration. These waivers are effective January 1, 2025 through December 31, 2029 and are limited to the extent necessary to achieve the objectives below. These waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs) as set forth in the accompanying document.

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted for the TEAMKY section 1115 demonstration, subject to these STCs.

1. Provision of Medical Assistance **Section 1902(a)(8) and 1902(a)(10)**

To the extent necessary to permit Kentucky to limit the provision of medical assistance (and treatment as eligible) for individuals described in the eligibility group under section 1902(a)(10)(A)(ii)(XX) of the Act and the state plan to only former foster care youth who are under 26 years of age, who turned 18 on or before December 31, 2022, were in foster care under the responsibility of another state or tribe on the date of attaining 18 years of age (or such higher age as the state has elected), and who were enrolled in Medicaid on that date.

2. Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release **Section 1902(a)(84)(D)**

To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.

Title XXI Waiver Authority

All requirements of the CHIP program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in accompanying expenditure authorities and/or these STCs, shall apply to the demonstration project through December 31, 2029. In addition, these waivers may only be implemented consistent with the approved STCs.

Under the authority of section 1115(a)(1) of the Act, the following waiver of state plan requirements contained in section 2102 of the Act are granted for the TEAMKY section 1115 demonstration, subject to these STCs.

1. **Coverage of Certain Screening, Diagnostic, Referral, and Case Management Services for Targeted Low-Income Children in the 30 Days Prior to Release Section 2102(d)(2)**

   To enable the state not to provide coverage of the screening, diagnostic, referral, and case management services identified in section 2102(d)(2) of the Act for a targeted low-income child as a state plan benefit in the 30 days prior to the release of such targeted low-income child from a public institution, to the extent and for the period that the state instead provides such coverage to such targeted low-income children under the approved expenditure authorities under this demonstration. The state will provide coverage to targeted low-income children in alignment with section 2102(d)(2) of the Act at a level equal to or greater than would be required under the state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBERS: **11-W-00306/4**
21-W-00067/4

TITLE: **TEAMKY 1115 Demonstration**

AWARDEE: **Kentucky Cabinet for Health and Family Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the "TEAMKY" (formerly KY Helping to Engage and Achieve Long Term Health (KY HEALTH)) section 1115(a) Medicaid and CHIP demonstration (hereinafter "demonstration") to enable Kentucky (referred to herein as the state) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted the state waivers of requirements under sections 1902(a) and section 2107 of the Social Security Act (the Act), and expenditure authorities authorizing federal matching of demonstration costs that are not otherwise matchable, and which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration, and the state's obligations to CMS related to this demonstration. The TEAMKY demonstration will be statewide and is approved from January 1, 2025 through December 31, 2029.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility and Enrollment
V. Benefits
VII. Health-Related Social Needs
VIII. Reentry Demonstration Initiative
IX. Delivery System
IX. Monitoring and Reporting Requirements
X. General Financial Requirements
XI. Budget Neutrality
XII. CHIP Monitoring Allotment Neutrality
XIIV. Evaluation of the Demonstration
XIV. Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) Program and Benefits
XV. Serious Mental Illness (SMI) Program and Benefits
XVI. Schedule of Deliverables for the Demonstration Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

- Attachment A: Developing the Evaluation Design
- Attachment B: Preparing the Evaluation Report
- Attachment C: SMI Implementation Plan
- Attachment D: SUD/SMI Monitoring Protocol
- Attachment E: SUD Implementation Plan
- Attachment F: Evaluation Design
- Attachment G: Reentry Demonstration Initiative Implementation Plan
- Attachment H: Reentry Demonstration Initiative Reinvestment Plan
- Attachment I: Monitoring Protocol
- Attachment J: RRSS Service Description
- Attachment K: Protocol for Assessment of Beneficiary Eligibility and Needs, and Provider Qualification for HRSN Services
- Attachment L: Interim Evaluation Report
- Attachment M: Summative Evaluation Report
- Attachment N: HRSN Service Matrix
- Attachment O: HRSN Infrastructure Protocol
- Attachment P: HRSN Implementation Plan

II. PROGRAM DESCRIPTION AND OBJECTIVES

The TEAMKY (formerly KY HEALTH) section 1115 demonstration is authorized under section 1115 of the Social Security Act (the Act), and is funded through titles XIX and XXI of the Act. The demonstration began on January 12, 2018, and includes a substance use disorder (SUD) treatment program available to all Kentucky Medicaid beneficiaries. Additionally, the demonstration enables the state to provide Medicaid coverage to former foster care youth (FFCY) under age 26, who turned 18 on or before December 31, 2022, who were in foster care under the responsibility of another state or tribe when they turned 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Social Security Act), and were enrolled in Medicaid at that time, and are now applying for Medicaid.

In July 2024, CMS approved the reentry demonstration initiative, which provides expenditure authority for limited coverage for certain services furnished to certain incarcerated individuals for up to 60 days immediately prior to the individual's expected date of release.

In December 2024, the TEAMKY demonstration was extended to continue the SUD treatment program, coverage for FFCY, and the reentry demonstration initiative. The extension approval also amended the demonstration to provide medically necessary short-term inpatient treatment services within settings that qualify as institutions for mental diseases (IMDs) for Medicaid eligible adults with serious mental illness (SMI), and authority for an HRSN initiative to provide a recuperative care pilot program. Lastly, the demonstration extension provided expenditure authority for Kentucky to provide RRSS under the SUD program, which are non-clinical activities necessary to support beneficiaries recovering with SUD.

III. GENERAL PROGRAM REQUIREMENTS

1. Compliance with Federal Non-Discrimination Statues. The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

2. Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy. All requirements of the Medicaid and CHIP programs, expressed in federal law, regulation, and written policy, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. Changes in Medicaid and CHIP Law, Regulation, and Policy. The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid and/or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state thirty (30) business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit reports required in the approved STCs and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

   a. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

   b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

   c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary ; and,

e. The state must identify how it will modify its evaluation design to incorporate the amendment provisions.

8. Extension of the Demonstration. States that intend to request an extension of the demonstration must submit an application to CMS at least 12 months in advance from the Governor of the state in accordance with the requirements of 42 CFR 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 9.

9. Demonstration Phase Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a thirty (30) day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the thirty (30) day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as

required under 42 CFR 435.916(d)(1), consistent with 42 CFR 435.911. For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

12. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to

submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

13. **Federal Financial Participation (FFP).** No federal matching for state expenditures under this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration

15. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(d)(5).

IV. ELIGIBILITY AND ENROLLMENT

16. **Eligibility Groups Affected by the Demonstration.** There is no change to Medicaid state plan eligibility. All affected groups derive their eligibility through the Medicaid state plan. Standards and methodologies for eligibility remain set forth under the state plan and are subject to all applicable Medicaid laws and regulations.

17. **Former Foster Care Youth.** Beneficiaries made eligible under the demonstration are former foster care youth who are under 26 years of age, who turned 18 on or before

December 31, 2022, who were in foster care under the responsibility of another state or tribe on the date of attaining 18 years of age (or such higher age as the state has elected), who were enrolled in Medicaid at the time of aging out, are now applying for Medicaid in Kentucky, and are not otherwise eligible for Medicaid.

V. BENEFITS

18. Former Foster Care Youth Benefits. Out-of-state former foster care youth will receive the same Medicaid State Plan benefits and may be subject to the same cost-sharing requirements effectuated by the state for the mandatory title IV-E foster care youth eligibility category enacted by the Adoption Assistance and Child Welfare Act of 1980 (Pub. L. 96-272).

VI. HEALTH-RELATED SOCIAL NEEDS

19. Health Related Social Needs (HRSN) Service. The state may claim FFP for expenditures for certain qualifying HRSN services identified in STC 20 and Attachment K, subject to the restrictions described below. Expenditures are limited to expenditures for items and services not otherwise covered under Title XIX, but consistent with Medicaid demonstration objectives that enable the state to continue to increase the efficiency and quality of care. All HRSN interventions must be evidence-based and medically appropriate for the population of focus based on clinical and social risk factors. The state is required to align clinical and health-related social risk criteria across services and with other relevant, non-Medicaid social support agencies, to the extent possible and appropriate. The HRSN services may not supplant any other available funding sources such as housing or nutrition supports available to the beneficiary through other local, state, or federal programs. The HRSN services will be the choice of the beneficiary; a beneficiary can opt out of HRSN services anytime; and the HRSN services do not absolve the state or its managed care plans, as applicable, of their responsibilities to make payment for other covered services. Under no circumstances will the state be permitted to condition Medicaid coverage, or coverage of any benefit or service, on a beneficiary's receipt of HRSN services. The state must submit additional details on covered services as outlined in STC 28 (Service Delivery) and Attachment K.

20. Allowable HRSN Service. The state may cover the following HRSN services:

a. Housing interventions, including:

a) Episodic housing interventions with clinical services with room and board, limited to a clinically appropriate amount of time, including:

1) Short-term pre-procedure housing, where a provider has determined that preparatory steps are required for an upcoming procedure or

treatment and integrated, clinically oriented recuperative or rehabilitative services and supports are provided.

2) Short-term post-transition housing (e.g., post-hospitalization), where integrated, clinically oriented rehabilitative services and supports are provided, but ongoing monitoring of the individual's condition by clinicians is not required.

21. HRSN Intervention Duration and Frequency.

a. Housing interventions with room and board.

i. Housing interventions that are classified as episodic interventions, as described in in STC 20.a., with clinical services with room and board may be covered for a qualifying beneficiary, as medically appropriate, up to a combined 6 months per rolling year. For purposes of this demonstration, rolling year is defined as a continuous 12-month period with the start date beginning when the beneficiary begins receiving the service.

ii. For the 6-month cap, coverage will be permitted in one or more spans or episodes, as long as the total duration remains under the cap for the rolling year or demonstration period. CMS will also apply a total combined cap of 6 months of all types of HRSN housing interventions with room and board (including episodic interventions and room and board-only supports), per beneficiary, in any 12-month period.

22. Excluded HRSN Service. Excluded items services, and activities that are not covered as HRSN services include, but are not limited to:

a. Construction (bricks and mortar) except as needed for approved medically necessary home modifications;

b. Capital investments;

c. Room and board, outside of specifically enumerated care or housing transitions or beyond 6 months, except as described in STC 20;

d. Research grants or expenditures not related to monitoring and evaluation;

e. Services furnished to beneficiaries for which payment is not available under the inmate payment exclusion in the matter following the last numbered paragraph of section 1905(a) of the Act except those HRSN-related case management services provided as part of an approved reentry demonstration initiative;

f. Services provided to individuals who are not lawfully present in the United States;

g. Expenditures that supplant services and activities funded by other state and federal governmental entities;

h. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and

i. Any other projects or activities not specifically approved by CMS as qualifying for demonstration coverage as a HRSN item or services under this demonstration.

    i. For all HRSN housing interventions with room and board, the following setting exclusions apply: Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space.

23. HRSN Infrastructure.

a. The state may claim FFP for expenditures for infrastructure investments to support the development and implementation of the HRSN service, subject to STC 21. This FFP will be available for the following activities:

    i. Technology – e.g., electronic referral systems, shared data platforms, electronic health record (EHR) modifications or integrations, screening tool and/or case management systems, licensing, databases/data warehouses, data analytics and reporting, data protections and privacy, accounting and billing systems.

    ii. Development of business or operational practices – e.g., developing policies, procedures and workflows, training and technical assistance, and administrative activities to support or expand HRSN operations.

    iii. Workforce development – e.g., recruiting and hiring, salary and fringe benefits for staff, necessary certifications, cultural competency training, trauma-informed training, developing and training staff on new policies, procedures, and training materials.

    iv. Outreach, education, and interested parties convening – e.g., design and production of outreach and education materials, translation, obtaining community input, investments in interested parties convening and community engagement activities.

b. The state may claim FFP in HRSN infrastructure expenditures for no more than the annual amounts outlined in Table 1. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to

one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 1. Annual Limits in Total Computable Expenditures for HRSN Infrastructure

	DY 9	DY 10	DY 11	DY 12	DY 13	DY 14	TOTAL
Total Computable Expenditures	$ 2,000,000	$ 184,575	$ 184,575	$ 184,575	$184,575	$0	$2,738,299

c. Infrastructure expenditures will receive the FFP match for applicable administrative costs for the expenditure.

d. This infrastructure funding is separate and distinct from payments for delivery of HRSN services. The state must ensure that HRSN infrastructure expenditures described in STC 23 are not included in HRSN service payments (including capitation payments, as applicable) and that there is no duplication of payments to entities providing or administering HRSN service benefits.

e. The state may not claim any FFP in HRSN infrastructure expenditures until Attachment O: HRSN Infrastructure Protocol is approved, as described in STC 27. Once approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the beginning of when the demonstration expenditure authority for HRSN infrastructure was approved.

f. To the extent the state requests any additional infrastructure funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS's consideration.

24. Covered Populations. Expenditures for HRSN services may be made for the targeted populations specified in Attachment K, consistent with this STC. To qualify to receive coverage for HRSN services, individuals must be Medicaid (or Medicaid demonstration)-eligible and have a documented medical/clinical need for the services and the services must be determined medically/clinically appropriate, as described STC 19, to address the documented need. Medical appropriateness must be based on clinical and health-related social risk factors. This determination must be documented in the beneficiary's care plan or medical record. Additional detail, including the clinical and other health related-social needs criteria, is outlined in Attachment K. Attachment N, the HRSN Service Matrix, describes the full list of clinical and social risk factors the state anticipates incorporating into Attachment K over the course of the demonstration at the time of the demonstration approval of the expenditure authority for HRSN services. While Attachment K reflects the full list of clinical and social risk factors the state is authorized to implement, the state is not required to implement all of the clinical and social risk factors outlined in Attachment

N. Additionally, the state can later include additional clinical and social risk factors in compliance with STC 25 and 26.

25. Protocol for Assessment of Beneficiary Eligibility and Needs, and Provider Qualifications for HRSN Services. The state must submit, for CMS approval, a Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications to CMS no later than 90 days after approval of the HRSN expenditure authority. The protocol must include, as appropriate, a list of the HRSN services and service descriptions, the criteria for defining a medically appropriate population of focus for each service, the process by which those criteria will be applied including care plan requirements and/or other documented processes, and provider qualification criteria for each service. Any changes to the initial scope of clinical and social risk factors reflected in Attachment N must be effectuated through the process indicated in STC 26. The state must resubmit a revised protocol if required by CMS feedback on the initial submission. The state may not claim FFP for HRSN services until CMS approves the initial protocol. Once the initial protocol is approved, the state can claim FFP in expenditures for HRSN services retrospectively to the date of approval of the expenditure authority for HRSN services. The approved protocol will be appended to the STCs as Attachment K.

If the state adds new HRSN services beyond those specified in STC 20 through a demonstration amendment, the state must also submit revisions to the Protocol to CMS no later than 90 days after the approval of the amendment to the demonstration. The Protocol revisions must include a list of the new services and service descriptions provided through all delivery systems applicable, the criteria for defining a medically appropriate population of focus for each new service, the process by which those criteria will be applied including service plan requirements and/or other documented processes, and provider qualification criteria for each new service. This revised protocol must comply with applicable STCs.

Specifically, the protocol must include the following information:

a. A list of the covered HRSN services (not to exceed those allowed under STC 20), with associated service descriptions and service-specific provider qualification requirements.

b. A description of the process for identifying beneficiaries with health-related social needs, including outlining beneficiary qualifications, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable.

c. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may determine the service to be medically appropriate.

    i. Plan to identify medical appropriateness based on clinical and social risk factors.

    ii. Plan to publicly maintain these clinical and social risk criteria to ensure transparency for beneficiaries and other interested parties.

d. A description of the process for developing care plans based on assessment of need.

i. Plan to initiate care plans and closed-loop referrals to social services and community providers based on the outcomes of screening.

ii. Description of how the state will ensure that HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma informed, as appropriate.

26. Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services.

a. The state may choose to cover a subset of the HRSN services and/or beneficiary qualifying criteria specified in Attachments K and N. Certain changes to the state's service offerings and eligibility criteria, within what CMS has approved in Attachment K and N, do not require additional CMS approval. The state must follow the following process to notify CMS of any such HRSN service or qualifying criteria change.

i. The state must follow the same beneficiary notification procedures as apply in the case of changes to coverage and/or beneficiary service qualification criteria for state plan services, including with respect to beneficiaries who currently qualify for and/or are receiving services who may receive a lesser amount, duration, or scope of coverage as a result of the changes.

ii. The state must provide public notice.

iii. The state must submit a letter to CMS no less than 30 days prior to implementation describing the changes, which will be incorporated in the demonstration's administrative record.

b. In addition to the requirements in a. above, if the state seeks to implement additional clinical and social risk factors than what were included in approved Attachment N, the state must follow the process below to update the protocol:

i. The state must provide a budget neutrality analysis demonstrating the state's expected cost for the additional population(s). The state may only add additional clinical and social risk factors through the protocol process described in this STC if CMS determines the criteria are allowable and doing so would not require an increase to the amount of the state's HRSN expenditure authority in Table 10.

ii. The state must receive CMS approval for the updated protocol prior to implementation of changes under this STC 26.b.

iii. The state is limited to submitting to CMS one update to its protocol per demonstration year as part of this process outlined in this STC. 26.

27. **HRSN Infrastructure Protocol**. The state must submit, for CMS approval, an HRSN Infrastructure Protocol to CMS no later than 90 days after approval of the expenditure authority for HRSN infrastructure expenditures. The protocol must include the state's proposed uses of HRSN infrastructure funds. The state must resubmit the revised protocol as may be required by CMS feedback on the initial submission. The protocol may be updated as details are changed or added. The state may not claim FFP for HRSN infrastructure expenditures until CMS approves the protocol. Once the protocol is approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the date of approval of the expenditure authority for HRSN infrastructure. The approved protocol will be appended to the STCs as Attachment O: HRSN Infrastructure Protocol. If the state adds new HRSN services through a demonstration amendment, the state must submit revisions to the Protocol to CMS no later than 90 days after approval, if required based on changes to expenditures for HRSN infrastructure to support the newly added HRSN services. The revisions must include a list of proposed uses of HRSN infrastructure funds, if different than previously submitted.

Specifically, the protocol(s) must include the following information: Proposed uses of HRSN infrastructure expenditures, including the type of entities to receive funding, the intended purpose of the funding, the projected expenditure amounts, and an implementation timeline.

28. **Service Delivery**. HRSN services will be provided in the managed care delivery system, and through FFS, and will be delivered by HRSN service providers. Terms applicable to all HRSN Services:

a. **FFS**. HRSN services will be paid on a FFS basis when those HRSN services are provided to beneficiaries through the Medicaid FFS.

i. In accordance with STC 29, CMS expects the state to have appropriate claims data associated with each HRSN service. This is necessary to ensure appropriate fiscal oversight for HRSN services as well as monitoring and evaluation. This is also critical to ensure appropriate documentation for claims payment. Therefore, CMS requires that, for HRSN services delivered in a FFS delivery system, the state must clearly document the name and definition of each HRSN service as well as the coding used on claims data. For example, the state must note specific Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology codes that identify each HRSN service. CMS will also consider this documentation necessary for approval of any rate methodologies per STC 36. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports on the delivery of HRSN services through FFS.

b. **Managed Care**. When HRSN services are provided to beneficiaries enrolled in Medicaid managed care, the following terms will apply:

i. HRSN services can be provided by managed care plans and paid on a non-risk basis and must be appropriately included in contracts. This can be accomplished by either a separate non-risk contract with a prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP) (see the definition of "non-risk contract" at 42 CFR § 438.2) or as an amendment to a state's existing risk-based managed care plan contract to include a non-risk payment. The state must take measures to ensure there is no duplication of payments for either the delivery of such service or the administrative costs of delivering such services.

ii. For a non-risk contract or a non-risk payment, the managed care plan is not at financial risk for changes in utilization or for costs incurred under the contract or payment that do not exceed the upper payment limits specified in 42 CFR 447.362 and may be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits. For the purposes of this demonstration, fee-for-service as defined in 42 CFR 447.362 is the fee-for-service authorized in this demonstration for HRSN services paid on a fee-for-service basis by the state. The managed care plan contracts must clearly document the process and methodology for non-risk payments.

iii. When the state includes non-risk payments in a risk-based contract, the state must ensure all non-risk payments are separate and apart from risk-based payments and clearly define what services/populations are covered under non-risk payments versus included in risk-based capitation rates. All of the costs of delivering services under a non-risk payment must be excluded from the development of the risk-based capitation rates for the risk-based contracts. Specifically, the costs of delivery the services as well as any costs of administering the non-risk payment must be excluded from the development of the risk-based capitation rates.

iv. Prior written CMS approval pursuant to STC 29 is required before the state moves to incorporate the HRSN services into the risk-based capitation rates in Medicaid managed care. When the state incorporates the HRSN services into the risk-based capitation rates in Medicaid managed care, the state must comply with all applicable federal requirements, including but not limited to 42 CFR 438.4, 438.5, 438.6, and 438.7, and may no longer utilize non-risk payments for the services included in risk-based capitation rates.

v. Any applicable HRSN services that are delivered by managed care plans in a risk arrangement, must be included in the risk-based managed care contracts and rate certifications submitted to CMS for review and approval in accordance with 42 CFR 438.3(a) and 438.7(a).

vi. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports on the inclusion of HRSN services in managed care programs.

vii. All expenditures for HRSN services delivered under non-risk contracts must be excluded from MLR reporting. When HRSN services (i.e., HRSN services defined in STC 20 for the covered populations defined in STC 24 are included in capitation rates paid to managed care plans under risk-based contracts, and only then, should HRSN services be reported in the medical loss ratio (MLR) reporting as incurred claims.

viii. The state must develop an MLR monitoring and oversight process specific to HRSN services. This process must be submitted to CMS, for review and approval, no later than 6 months prior to the implementation of HRSN services in risk-based managed care contracts and capitation rates. The state should submit this process to CMS at DMCPMLR@cms.hhs.gov. This process must specify how HRSN services will be identified for inclusion in capitation rate setting and in the MLR numerator. The state's plan must indicate how expenditures for HRSN administrative costs and infrastructure will be identified and reported in the MLR as non-claims costs.

c. CMS expects the state to have appropriate encounter data associated with each HRSN service. This is necessary to ensure appropriate fiscal oversight for HRSN services as well as monitoring and evaluation. This is also critical to ensure appropriate base data for Medicaid managed care rate development purposes as well as appropriate documentation for claims payment in managed care. Therefore, CMS requires that for HRSN services provided in a managed care delivery system, the state must include the name and definition of each HRSN service as well as the coding to be used on claims and encounter data in the managed care plan contracts. For example, the state must note specific Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology costs that identify each HRSN service. CMS will also consider this documentation necessary for approval of any rate methodologies per STC 36.

29. Requirements for Services Prior to Being Delivered in Risk-Based Managed Care. The state's plan to incorporate HRSN into risk-based managed care contracts must be submitted to CMS, for review and approval, no later than 6 months prior to the implementation of HRSN services in risk-based managed care contracts and capitation rates. At least 6 months prior to moving HRSN services approved under these STCs into risk-based Medicaid managed care contracts, the state must submit to CMS, for review and written prior approval, documentation that details the following information:

a. Each HRSN service defined in STC 20 and each covered population that will receive each HRSN service defined in STC 24 where the state is seeking CMS written approval to deliver services to populations through one or more risk-based managed care program(s). The applicable managed care program(s) for each service and population should also be specified.

b. If the HRSN service will be offered in all regions under each risk-based managed care program or if the offerings will be limited geographically.

c. The first rating period the state is seeking to start offering the HRSN service(s) through risk-based managed care. If the HRSN services will be delivered through risk-based managed care on a rolling basis, provide the timeline for each service and/or population.

d. The state's timeline to complete a readiness review pursuant to 438.66(d). Implementation may only begin when each managed care plan has been determined by the state to meet certain readiness and network requirements, including providing any documentation specified by CMS.

e. A transition of care plan that provides continuity of care for beneficiaries transitioning from another delivery system (e.g. FFS) or non-risk contracts into risk-based contracts.

f. A description of base data that the state and its actuary plan to use for capitation rate setting process to develop both the benefit and non-benefit costs, including the types of data used (FFS claims data, managed care encounter data, managed care plan financial data, etc.), and the data source(s) that will be used for capitation rate development. Consistent with Medicaid managed care rate development requirements under 42 CFR 438, CMS requires at least 3 years of encounter data or similar data (e.g. cost reports, claims data) for the HRSN services defined in STC 20 for the covered populations defined in STC 24 that will be incorporated into risk-based managed care. CMS will consider exceptions to the requirement for 3 years of base data for periods impacted by COVID-19.

g. The methodology the state's actuary will use in the capitation rate setting process. This includes, but is not limited to, any trend factors and adjustments to the data the state and its actuary will apply to the base data in the capitation rate setting process. The methodology should also include information on the approach the actuary will take to incorporating the HRSN service(s) into capitation rate development (for example, if the actuary will create an add-on that will be applied to some or all existing rates cells, creating a separate rate cell, or some other method) and any changes to or new risk adjustments or acuity adjustments applied due to the inclusion of the HRSN services defined in STC 20 for the covered populations defined in STC 24.

h. If the state is planning to delegate risk for the delivery of HRSN services to clinical providers, community organizations, and/or subcontractors for specific HRSN services, the capitation rate setting plan should include a description of these proposed delegated arrangements and/or sub-capitated payment arrangements that the state intends to use in the delivery of any HRSN services defined in STC 20 for covered populations defined in STC 24.

i. Identification of any in-lieu of services (ILOS) the state currently offers through its managed care programs and if there will be changes to those ILOS as a result of the state moving these HRSN service(s) into risk-based managed care contracts.

j. Because of the uncertainty associated with HRSN services and in alignment with past guidance about situations with high levels of uncertainty, CMS is requiring the state to implement a 2-sided risk mitigation strategy (such as a 2-sided risk corridor) to provide protection for state and federal governments, as well as managed care plans. The HRSN capitation rate setting plan should provide a description of the risk mitigation mechanism(s) that will be used in the transition of HRSN services to risk-based managed care. As part of plan to incorporate HRSN into risk-based managed care, the state will also need to develop an MLR monitoring and oversight process specific to HRSN services. This process must specify how HRSN services will be identified for inclusion in the MLR numerator. The state's plan must indicate how expenditures for HRSN administrative costs and infrastructure, as applicable, will be identified and reported by managed care plans as non-claims costs.

k. All state directed payments the state plans to implement for any HRSN services defined in STC 20 for the covered populations defined in STC 24 that will be provided under risk-based contracts must comply with all applicable federal requirements, including but not limited to 438.6(c). The state should submit this information to establish compliance for any state-directed payments for HRSN services to CMS at statedirectedpayment@cms.hhs.gov.

30. Contracted Providers. Managed care plan contracts must provide, applicable to all HRSN services:

a. Managed care plans will contract with providers to deliver the elected HRSN services authorized under the demonstration and included in the managed care contract.

b. Managed care plans must establish a network of providers and ensure the HRSN service providers have sufficient experience and training in the provision of the HRSN services being offered. HRSN service providers do not need to be licensed, however, staff offering services through HRSN service providers must be licensed when applicable (i.e., when the staff member is performing activities for which a licensure requirement applies in the state).

c. The managed care plan and contracted providers will use rates set by the state for the provision of applicable HRSN services, consistent with state guidance for these services, and in compliance with all related federal requirements. Any state direction of managed care plan expenditures under risk-based contract(s) and risk-based payments would be considered a state directed payment subject to the requirements in 42 CFR 438.6(c).

31. **Provider Network Capacity**. Managed care plans must ensure the HRSN services authorized under the demonstration are provided to qualifying beneficiaries in a timely manner and shall develop policies and procedures outlining the managed care plan's approach to managing provider shortages or other barriers to timely provision of the HRSN services, in accordance with the managed care plan contracts and other state Medicaid/operating agency guidance.

32. **Compliance with Federal Requirements**. The state shall ensure HRSN services are delivered in accordance with all applicable federal statutes and regulations.

33. **Person Centered Service Plan**. The state shall ensure there is a person-centered service plan for each beneficiary receiving HRSN services that is person-centered, identifies the beneficiary's needs and individualized strategies and interventions for meeting those needs, and developed in consultation with the beneficiary and the beneficiary's chosen support network, as appropriate. The service plan is reviewed and revised at least every 12 months, when the beneficiary's circumstances or needs change significantly, or at the beneficiary's request.

34. **Conflict of Interest**. The state shall ensure appropriate protections against conflicts of interest in HRSN service planning and delivery, including by ensuring that appropriate separation of service planning and service provision functions is incorporated into the state's conflict of interest policies.

35. **CMS Approval of Managed Care Contracts**. As part of the state's submission of associated Medicaid managed care plan contracts to implement HRSN service through managed care, the state must include contract requirements including, but not limited to :

a. Beneficiary and plan protections, including but not limited to:

i. HRSN services must not be used to reduce, discourage, or jeopardize beneficiaries' access to covered services.

ii. Beneficiaries always retain their right to receive covered service on the same terms as would apply if HRSN services were not an option.

iii. Beneficiaries who are offered or utilized an HRSN service retain all rights and protections afforded under 42 CFR 438.

iv. Managed care plans are not permitted to deny a beneficiary a covered service on the basis that the beneficiary is currently receiving HRSN services, has requested those services, has previously qualified for or received those services, or currently qualifies or may qualify in the future for those services.

v. Managed care plans are prohibited from requiring a beneficiary to receive HRSN services.

b. Managed care plans must timely submit data when requested by the state or CMS, including, but not limited to:

   i. Data to evaluate the utilization and effectiveness of the HRSN services.

   ii. Any data necessary to monitor health outcomes and quality of care metrics at the individual and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status, and language spoken to inform health quality improvement efforts, which may thereby mitigate health disparities.

   iii. Any data necessary to monitor appeals and grievances for beneficiaries.

   iv. Documentation to ensure appropriate clinical support for the medical appropriateness of HRSN services.

   v. Any data determined necessary by the state or CMS to monitor and oversee the HRSN initiatives.

c. All data and related documentation necessary to monitor and evaluate the HRSN services initiatives, including cost assessment, to include but not limited to:

   i. The managed care plans must submit timely and accurate encounter data to the state for beneficiaries eligible for HRSN services. When possible, this encounter data must include data necessary for the state to stratify analyses by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts and subsequent efforts to mitigate health disparities undertaken by the state.

   ii. Any additional information requested by CMS, the state, or another legally authorized oversight body to aid in ongoing evaluation of HRSN services initiative or any independent assessment or analysis conducted by the state, CMS, or a legally authorized independent entity.

   iii. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports its progress in building and sustaining its partnership with existing housing agencies and nutrition agencies to utilize their expertise and existing housing and nutrition resources to avoid duplication of efforts.

   iv. Any additional information determined reasonable, appropriate and necessary by CMS.

36. **HRSN Rate Methodologies**. For FFS payment methodologies and/or rates, the state must comply with the payment rate-setting requirements in 42 CFR Part 447, as though a state plan amendment were required, to establish any payment rate and/or methodology for HRSN services as approved under demonstration expenditure authority 4. The state must conduct state-level public notice under 42 CFR 447.205 prior to the implementation of the applicable FFS payment rates or methodologies for HRSN and maintain documentation of these FFP payment rates or methodologies on its website described in 42 CFR 447.203. The state may receive FFP for HRSN service expenditures authorized under this demonstration upon implementation of the FFS payment rates and/or methodologies for which it has conducted prior public notice and may begin claiming for this FFP (for dates of service no earlier than the effective date of approval for the relevant expenditure authority) no earlier than the date of submission of the payment rates and/or methodology to CMS for approval. However, any FFS payments to providers or claims for FFP prior to CMS approval of the payment rate or methodology must be reconciled to the ultimately approved FFS payment rate and/or methodology within one year of CMS's approval. All requirements for timely filing of claims for FFP continue to apply.

For managed care payments and rates (including capitation rates, non-risk payments, and state directed payments), the state must comply with all federal requirements, including those in 42 CFR Part 438 and these STCs. As applicable, the state must also notify CMS at least 60 days prior to intended implementation if it intends to direct its managed care plans on how to pay for HRSN services (i.e., state directed payments).

All rates/payment methodologies for HRSN services, for both FFS and managed care delivery systems, must be submitted to CMS for review and approval, including but not limited to fee-for-service payments as well as managed care capitation rates, any state directed payments that require prior written approval, and non-risk payments, as outlined in the STCs. For all payment methodologies and/or rates, for both FFS and managed care delivery systems, in addition to submitting the payment rates and/or methodology, the state must also submit all supporting documentation requested by CMS, including but not limited to how the rates and/or methodology were developed, state responses to any public comments on the rates and/or methodology (when applicable), and information about Medicaid non-federal share financing.

37. **Maintenance of Effort (MOE)**. The state must maintain a baseline level of state funding for ongoing social services related to housing transition supports for the duration of the demonstration, not including one time or non-recurring funding. Within 90 days of demonstration approval, the state will submit a plan to CMS as part of the HRSN Implementation Plan required by STC 39 that specifies how the state will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 58, with any justifications, including declines in available state resources, necessary to describe the findings, if the level of state funding is less than the comparable amount of the pre-demonstration baseline.

38. Partnership with State and Local Entities. To ensure that expenditures for HRSN services under this demonstration do not supplant any other available funding sources available to the beneficiary through other local, state, or federal programs, the state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authorities) to assist beneficiaries in obtaining non-Medicaid funded housing supports, if available, upon the conclusion of temporary demonstration payment for such supports, in alignment with beneficiary needs identified in the beneficiary's care plan, as appropriate. The state will submit a plan to CMS as part of the HRSN Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing and/or nutrition supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Monitoring Reports described in STC 58, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Monitoring Reports.

39. HRSN Implementation Plan.

a. The state is required to submit a HRSN Implementation Plan that will elaborate upon and further specify requirements for the provision of HRSN services and will be expected to provide additional details not captured in the STCs regarding implementation of demonstration policies that are outlined in the STCs. The state must submit the MOE information required by STC 37 no later than 90 calendar days after approval of demonstration expenditure authority for HRSN services. All other Implementation Plan requirements outlined in this STC must be submitted no later than 9 months after the approval of demonstration expenditure authority for HRSN services. The Implementation Plan shall be submitted to CMS but does not require CMS approval. CMS will ensure it is complete and contains sufficient detail for purposes of on-going monitoring. The state may update the implementation plan as initiatives are changed or added, with notification to CMS. The Implementation Plan will be appended as Attachment P.

b. At a minimum, the Implementation Plan must provide a description of the state's strategic approach to implementing the policy, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The Implementation Plan does not need to repeat any information submitted to CMS under the Protocol for Assessment of Beneficiary Eligibility and Needs, and Provider Qualifications for HRSN services; however, as applicable, the information provided in the two deliverables must be aligned and consistent.

c. The Implementation Plan must include information on, but not limited to, the following:

    i. A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services stakeholders interested parties to the

extent those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation.

ii. Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries);

iii. Plans for changes to IT infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, qualification and consent to receive HRSN services, screening, referrals, and service provision;

iv. A plan for tracking and improving the share of Medicaid demonstration beneficiaries in the state who are eligible and enrolled in SNAP, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Temporary Assistance for Needy Families (TANF), and/or federal, state, and local housing and/or other nutrition assistance programs, relative to the number of total eligible demonstration beneficiaries in the state (including those who are eligible but unenrolled);

v. An implementation timeline and considerations for demonstration evaluation that may be impacted by the timeline (e.g., in the case of a phased rollout of HRSN services), to facilitate robust evaluation designs;

vi. Information as required per STC 37 (MOE); and

vii. Information as required per STC 38 (Partnerships with State and Local Entities).

VII. REENTRY DEMONSTRATION INITIATIVE

40. Overview of Pre-Release Services and Program Objectives. This component of the demonstration will provide coverage for pre-release services up to 60 days immediately prior to the expected date of release to certain individuals as specified in STC 42 who are inmates residing in state prisons or youth correctional facilities (hereinafter "correctional facilities"). To qualify for services covered under this demonstration, individuals residing in correctional facilities must be eligible for Medicaid or CHIP (or be eligible for CHIP if not for their incarceration status) as determined pursuant to an application filed before or during incarceration, and must have an expected release date no later than 60 days as further specified in the STCs below.

41. The objective of this component of the demonstration is to facilitate individuals' access to certain healthcare services and case management, provided by Medicaid and CHIP participating providers, while individuals are incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to their communities. This bridge to coverage begins within a short time prior to release and is expected to promote continuity of coverage and care and improve health outcomes for justice-involved individuals. The Reentry Demonstration Initiative provides short-term Medicaid and CHIP enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other SUD and behavioral health treatments, as appropriate for the individual.

During the demonstration, the state seeks to achieve the following goals:

a. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release;

b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;

c. Improve coordination and communication between correctional systems, Medicaid and CHIP systems, managed care plans (as applicable), and community-based providers;

d. Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release;

e. Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs, and health-related social needs;

f. Reduce all-cause deaths in the near-term post-release;

g. Reduce the number of emergency department visits, behavioral health crisis services, and inpatient hospitalizations among recently incarcerated Medicaid and CHIP individuals through increased receipt of preventive and routine physical and behavioral health care;

h. Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release.

42. Qualifying Criteria for Pre-Release Services. To qualify to receive services under this component of the demonstration, an individual must meet the following qualifying criteria:

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a correctional facility specified in STC 40;

b. Have been determined eligible for Medicaid or CHIP or be otherwise eligible for CHIP if not for their incarceration status;

c. Have an expected release date within 60 days.

43. Scope of Pre-Release Services. The pre-release services authorized under the Reentry Demonstration Initiative include the following services to be detailed in the implementation Plan required under STC 49.

a) The covered pre-release services are:

i. Case management to assess and address physical and behavioral health needs, and health-related social needs;

ii. MAT for all types of SUDs as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies; and

iii. A 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid or CHIP state plan coverage authority and policy.

b) The expenditure authority for pre-release services through this initiative constitutes a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Similarly, for CHIP, the expenditure authority for pre-release services constitutes a limited exception to the general exclusion of children who are inmates of a public institution from the definition of a targeted low-income child under section 2110(b)(2)(A) of the Act ("child exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the Reentry Demonstration Initiative as described in these STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule or an exception in section 2110(b)(7) of the Act to the child exclusion rule, effective January 1, 2025, remain subject to the inmate exclusion rule or the child exclusion rule, as applicable. Accordingly, other benefits and services covered under the Kentucky Medicaid or CHIP State Plan(s), as relevant, that are not included in the above-described pre-release services (e.g., EPSDT treatment services) benefit for qualifying Medicaid or CHIP individuals are not available to qualifying individuals through the reentry demonstration initiative.

44. Participating Correctional Facilities. The pre-release services will be provided at correctional facilities or outside of the correctional facilities, with appropriate transportation and security oversight provided by the correctional facility, subject to the Kentucky Cabinet for Health and Family Services' approval of a facility's readiness, according to the implementation timeline described in STC 48/49. States must be mindful of and ensure the policies, procedures, and processes developed to support implementation of these provisions do not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems. Correctional facilities that are also institutions for mental diseases (IMDs) are not allowed to participate in the reentry demonstration initiative.

45. Participating Providers.

a) Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under Kentucky's scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws and must be enrolled as Medicaid or CHIP providers.

b) Participating providers eligible to deliver services under the reentry demonstration initiative may be either community-based or correctional facility-based providers.

c) All participating providers and provider staff, including correctional providers, shall have necessary experience and receive appropriate training, as applicable to a given correctional facility, prior to furnishing demonstration-covered pre-release services under the reentry demonstration initiative.

d) Participating providers of reentry case management services may be community-based or correctional providers who have expertise working with justice-involved individuals.

46. Suspension of Coverage. Upon entry of a Medicaid or CHIP enrolled individual into a correctional facility, the Kentucky Cabinet for Health and Family Services must not terminate and generally shall suspend their Medicaid coverage or CHIP eligibility.

a) If an individual is not enrolled in Medicaid or CHIP when entering a correctional facility, the state must ensure that such an individual receives assistance with completing an application for Medicaid or CHIP and with submitting an application, unless the individual declines such assistance or wants to decline enrollment.

47. Interaction with Mandatory State Plan Benefits for Eligible Juveniles and Targeted Low-Income Children. To the extent Kentucky's reentry demonstration includes coverage otherwise required to be provided under section 1902(a)(84)(D) and section 2102(d)(2) of the Act, and because this coverage is included in the base expenditures used to determine the budget neutrality or allotment neutrality expenditure limit, the state will claim for these expenditures and related transitional non-service expenditures under this demonstration as well as include this coverage in the monitoring and evaluation of this demonstration.

48. Reentry Demonstration Initiative Implementation Timeline. Delivery of pre-release services under this demonstration will be implemented as described below. All participating correctional facilities must demonstrate readiness, as specified below, prior to participating in this initiative (FFP will not be available in expenditures for services furnished to qualifying individuals who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). The Kentucky Cabinet for Health and Family Services will determine that each applicable facility is ready to participate in the reentry demonstration initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

a) Pre-release Medicaid and CHIP application and enrollment processes for individuals who are not enrolled in Medicaid or CHIP prior to incarceration and who do not otherwise become enrolled during incarceration;

b) The screening process to determine an individual's qualification for pre-release services, per the eligibility requirements described in STC 42;

c) The provision or facilitation of pre-release services for a period of up to 60 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth, as applicable.

d) Coordination amongst partners with a role in furnishing health care services to individuals who qualify for pre-release services, including, but not limited to, physical and behavioral health community-based providers, social service departments, and managed care plans.

e) Appropriate reentry planning, pre-release case management, and assistance with care transitions to the community, including connecting individuals to physical and behavioral health providers and their managed care plan (as applicable), and making referrals to case management and community supports providers that take place throughout the 60-day pre-release period, and providing individuals with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate) upon release, consistent with approved Medicaid or CHIP state plan coverage authority and policy;

f) Operational approaches related to implementing certain Medicaid and CHIP requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the reentry demonstration initiative;

g) A data exchange process to support the care coordination and transition activities described in (d), (e), and (f) of this subsection subject to compliance with applicable

federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

h) Reporting of data requested by the Kentucky Cabinet for Health and Family Services to support program monitoring, evaluation, and oversight; and

i) A staffing and project management approach for supporting all aspects of the facility's participation in the reentry demonstration initiative, including information on qualifications of the providers with whom the correctional facilities will partner for the provision of pre-release services.

49. Reentry Demonstration Initiative Implementation Plan. The state is required to submit a Reentry Demonstration Initiative Implementation Plan in alignment with the expectations outlined in the State Medicaid Director Letter (#23-003 Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals who are Incarcerated). As such, the implementation plan will identify for each milestone, as well as each associated action, what the state anticipates to be the key implementation challenges and the state's specific plans to address these challenges. This will include any plans to phase in demonstration components over the lifecycle of the demonstration.

The state must submit the draft Implementation Plan to CMS no later than 120 calendar days after approval of the reentry demonstration initiative. The state must submit any required clarifications or revisions to its draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. Once approved, the finalized Implementation Plan will be incorporated into the STCs as Attachment G titled "Reentry Demonstration Initiative Implementation Plan," and may be revised only with CMS approval.

CMS will provide the state with a template to support development of the Implementation Plan..

50. Reentry Demonstration Initiative Reinvestment Plan. To the extent that the reentry demonstration initiative covers services that are the responsibility of and were previously provided or paid by the correctional facility with custody of qualifying individuals, the state must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services, as further defined in the Reentry Demonstration Initiative Reinvestment Plan (Attachment H). The Reinvestment Plan will define the amount of reinvestment required over the term of the demonstration, based on an assessment of the amount of projected expenditures for which reinvestment is required pursuant to this STC. FFP projected to be expended for new services covered under the reentry demonstration initiative, defined as services not previously provided or paid by the correctional facility with custody of qualifying individuals prior to the facility's implementation of the reentry demonstration initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the reentry demonstration initiative, with respect to the relevant increase in expenditures, as described in Attachment H the Reentry Demonstration Initiative Reinvestment Plan), is not required to be reinvested pursuant to this STC.

a) Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the demonstration period. Allowable reinvestments include, but are not limited to:

   i. The state share of funding associated with new services covered under the reentry demonstration initiative, as specified in this STC;

   ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the needs of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

   iii. Improved access to or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the reentry demonstration initiative opportunity;

   iv. Improved health information technology (IT) and data sharing subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

   v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;

   vi. Expanded or enhanced community-based services and supports, including services and supports to meet the needs of the justice-involved population; and

   vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

b) The reinvestment plan will describe whether privately-owned or -operated carceral facilities would receive any of the reinvested funds and, if so, the safeguards the state proposes to ensure that such funds are used for the intended purpose and do not have the effect of increasing profit or operating margins for privately-owned or -operated carceral facilities.

c) Within six months of approval, the state will submit a Reentry Demonstration Initiative Reinvestment Plan (Attachment H) for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan will also identify the types of expected reinvestments that will be made over the demonstration period. Actual reinvestments will be reported to CMS in Attachment H titled "Reentry Demonstration Initiative Reinvestment Plan."

51. Reentry Demonstration Initiative Planning and Implementation.

a. The Reentry Demonstration Initiative Planning and Implementation Program will provide expenditure authority to fund supports needed for Medicaid and CHIP pre-release application and suspension/unsuspension planning and purchase of certified electronic health record (EHR) technology to support Medicaid and CHIP pre-release applications In addition, reentry demonstration initiative planning and implementation funds will provide funding over the course of the demonstration to support planning and IT investments that will enable implementation of the reentry demonstration initiative services covered in a period for up to 60 days immediately prior to the expected date of release, and for care coordination to support reentry. These investments will support collaboration and planning among the Kentucky Cabinet for Health and Family Services and Qualified Applicants listed in STC 51(d) below. The specific use of this funding will be proposed by the qualified applicant submitting the application, as the extent of approved funding will be determined according to the needs of the entity. Allowable expenditures are limited to only those that support Medicaid-related expenditures and/or demonstration-related expenditures (and not other activities or staff in the correctional facility) and must be properly cost-allocated to Medicaid and CHIP. These allowable expenditures may include the following:

   i. **Technology and IT Services.** Expenditures for the purchase of technology for Qualified Applicants which are to be used for assisting the reentry demonstration initiative population with Medicaid and CHIP application and enrollment for demonstration coverage (e.g., for inmates who would be eligible for CHIP but for their incarceration status and coordinating pre-release and post-release services for enrollees). This includes the development of electronic interfaces for Qualified Applicants listed in STC 30(d). to communicate with Medicaid and CHIP IT systems to support Medicaid and CHIP enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with Qualified Applicants listed in STC 30(d), in order to support the provision of pre-release services delivered in the period up to 60 days immediately prior to the expected date of release and reentry planning.

   ii. **Hiring of Staff and Training.** Expenditures for Qualified Applicants listed in STC 51(d). to recruit, hire, onboard, and train additional and newly assigned staff to assist with the coordination of Medicaid and CHIP enrollment and suspension/unsuspension, as well as the provision of pre-release services in a period for up to 60 days immediately prior to the expected date of release and for care coordination to support reentry for justice-involved individuals. Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.

   iii. **Adoption of Certified Electronic Health Record Technology.** Expenditures for providers' purchase or necessary upgrades of certified electronic health record (EHR) technology and training for the staff that will use the EHR.

iv. **Purchase of Billing Systems**. Expenditures for the purchase of billing systems for Qualified Applicants.

v. **Development of Protocols and Procedures**. Expenditures to support the specification of steps to be taken in preparation for and execution of the Medicaid and CHIP enrollment process, suspension/unsuspension process for eligible individuals, and provision of care coordination and reentry planning for a period for up to 60 days immediately prior to the expected date of release for individuals qualifying for reentry demonstration initiative services.

vi. **Additional Activities to Promote Collaboration**. Expenditures for additional activities that will advance collaboration among Kentucky's Qualified Applicants in STC 30(d). This may include conferences and meetings convened with the agencies, organizations, and other stakeholders involved in the initiative.

vii. **Planning**. Expenditures for planning to focus on developing processes and information sharing protocols to: (1) identifying individuals who are potentially eligible for Medicaid and CHIP; (2) assisting with the completion of a Medicaid or CHIP application; (3) submitting the Medicaid or CHIP application to the county social services department or coordinating suspension/unsuspension; (4) screening for eligibility for pre-release services and reentry planning in a period for up to 60 days immediately prior to the expected date of release; (5) delivering necessary services to eligible individuals in a period for up to 60 days immediately prior to the expected date of release and care coordination to support reentry; and (6) establishing on-going oversight and monitoring process upon implementation.

viii. **Other activities to support a milieu appropriate for provision of pre-release services.** Expenditures to provide a milieu appropriate for pre-release services in a period for up to 60 days immediately prior to the expected date of release, including accommodations for private space such as movable screen walls, desks, and chairs, to conduct assessments and interviews within correctional institutions, and support for installation of audio-visual equipment or other technology to support provision of pre-release services delivered via telehealth in a period for up to 60 days immediately prior to the expected date of release and care coordination to support reentry. Expenditures may not include building, construction, or refurbishment of correctional facilities.

b. The state may claim FFP in Reentry Demonstration Initiative Planning and Implementation Program expenditures for no more than the annual amounts outlined in Table 1. In the event that the state does not claim the full amount of FFP for a given demonstration year as defined in STC 89, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 2. Annual Limits of Total Computable Expenditures for Reentry Demonstration Initiative Planning and Implementation Program

	DY 9	DY10	DY11	DY12	DY13	DY14
Total Computable Expenditures	$2,328,750	$1,293,750	$258,750	$258,750	$258,750	$0

c. Reentry Demonstration Initiative Planning and Implementation funding will receive the applicable administrative match for the expenditure.

d. Qualified Applicants for the Reentry Demonstration Initiative Planning and Implementation Program will include the state Medicaid/CHIP Agency, correctional facilities, other state agencies supporting carceral health, Probation Offices, and other entities as relevant to the needs of justice-involved individuals, including health care providers, as approved by the state Medicaid/CHIP agency.

VIII. DELIVERY SYSTEM

52. Overview. TEAMKY will utilize FFS, and the current statewide mandatory managed care delivery system for all covered populations under the authority of the Kentucky Managed Care Organization Program 1915(b) waiver.

IX. MONITORING AND REPORTING REQUIREMENTS

53. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singularly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable(s) were due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable(s) into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay, the steps the state has taken to address such issue(s), and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b) above, and the state fails to comply with the corrective action plan or despite the corrective action plan, still fails to submit the overdue deliverable(s) that meet the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

54. Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Plan and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

55. Submission of Post-Approval Deliverables. The state must submit deliverables as stipulated by CMS and within the timeframes outlined within these STCs, unless CMS and the state mutually agree to another timeline.

56. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all section 1115 demonstration, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

57. Monitoring Protocol. The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after the approval of the demonstration. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated in the STCs as Attachment I.

At a minimum, the Monitoring Protocol must affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, as applicable and relevant for different policies. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., those described under the performance metrics section in STC 58.b. the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS, as applicable. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography) and demonstration component.

The Monitoring Protocol requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Disparities Sensitive Measure Set, and outlining the corresponding data sources and reporting timelines, as applicable to the demonstration initiatives and populations. If needed, the state may submit an amendment to the Monitoring Protocol within 150 days after the receipt of the final Disparities Sensitive Measure Set from CMS. This set of measures consists of metrics known to be important for addressing disparities in Medicaid/CHIP (e.g. the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e. social) drivers. The Monitoring Protocol must also outline the state's planned approaches and parameters to track implementation progress and performance relative to the goals and milestones including relevant transitional, non-service expenditures investments, as captured in these STCs, or other applicable implementation and operations protocols.

In addition, the state must describe in the Monitoring Protocol methods and the timeline to collect and analyze relevant non-Medicaid administrative data to help calculate applicable

monitoring metrics. These sources may include but are not limited to data related to carceral status, Medicaid eligibility, and the health care needs of individuals who are incarcerated and returning to the community. Across data sources, the state must make efforts to consult with relevant non-Medicaid agencies to collect and use data in ways that support analyses of data on demonstration beneficiaries and subgroups of beneficiaries, in accordance with all applicable requirements concerning privacy and the protection of personal information.

For the qualitative elements (e.g., operational updates as described in STC 58.a), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Quarterly and Annual Monitoring Reports.

58. Monitoring Reports. The state must submit three Quarterly Monitoring Reports and one Annual Report each demonstration year (DY). The fourth-quarter information that would ordinarily be provided in a separate Quarterly Monitoring Report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than ninety (90) calendar days following the end of the DY. The state must submit a revised monitoring report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Quarterly and Annual Monitoring Reports must follow the framework to be provided by CMS, which is subject to change as monitoring systems are developed/evolve, and will be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed. The discussion should also include any issues or complaints identified by individuals; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, monitoring reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The demonstration's monitoring activities through quantitative data and narrative information must support tracking the state's progress toward meeting the applicable program-specific goals and milestones—including relative to their projected timelines—of the demonstration's program and policy implementation and infrastructure investments and transitional non-service expenditures, as applicable.

Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to individuals and the uninsured population, as well as on individuals' outcomes as well as outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances, and appeals. Specifically, the state must undertake standardized reporting on categories of metrics including, but not limited to: beneficiary participation in demonstration components, primary and specialist provider participation, utilization of services, quality of care, and health outcomes. The reporting of metrics focused on quality of care and health outcomes must be aligned with the demonstration's policies' and objectives' populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography), and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

c. The state's selection and reporting of quality of care and health outcome metrics outlined above must also accommodate the Reentry Demonstration Initiative. In addition, the state is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones of the Reentry Demonstration Initiative. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services as defined in STC 43, provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating correctional facility settings. In addition, the state is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in its Monitoring Reports narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the state has addressed them or plans to address them. This information must also capture the transitional, nonservice expenditures, including enhancements in the data infrastructure and information technology.

d. For the HRSN component, in addition to reporting on the metrics described above, the state must track beneficiary participation, screening, receipt of referrals and social services over time under the HRSN program component, as well as adoption of information technology infrastructure to support data sharing between the state or partner entities administering the administration of the demonstration and social services organizations..

e. Common SUD metrics include, but are not limited to, those that measure alignment with assessment of need and qualification for SUD treatment services and the

demonstration's six milestones as outlined in the State Medicaid Director Letter (SMDL) dated November 1, 2017 (SMDL #17- 003).[1]

f. Common SMI metrics include, but are not limited to, screening of beneficiaries admitted to psychiatric hospitals or residential treatment facilities, mental health services utilization (inpatient and outpatient), and average length of stay in IMDs and the demonstration's four milestones as outlines in the SMDL dated November 13, 2018 (SMDL #18—011).[2]

g. Metrics for the RRSS component should include, but not be limited to rates of program enrollment among the SUD population, as well as measures pertaining to skills training, coaching, and overall case management furnished by the program.

h. In addition, and pertaining to all components under the extension, the state must include the results of member satisfaction surveys, if conducted, and grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports and must follow the framework provided by CMS to support federal tracking and analysis.

i. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the Form CMS-64.

j. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

k. SUD and SMI Health IT. The state will include a summary of progress made in regard to SUD and SMI Health IT requirements outlined in Attachment E and STC 118(d).

[1] SMDL #17-003, Strategies to Address the Opioid Epidemic. Available at: https://www medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

[2] SMDL #18—011, Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

59. Reentry Demonstration Initiative Mid-Point Assessment. The state must contract with an independent entity to conduct a mid-point assessment of the Reentry Demonstration Initiative and complete a Reentry Demonstration Initiative Mid-Point Assessment.

The Mid-Point Assessment must integrate all applicable implementation and performance data from the first 2.5 years of implementation of the Reentry Demonstration Initiative. The report must be submitted to CMS by the end of the third year of the demonstration. In the event that the Reentry Demonstration Initiative is implemented at a timeline within the demonstration approval period, the state and CMS will agree to an alternative timeline for submission of the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment within 60 calendar days after receipt of CMS's comments, if any. If requested, the state must brief CMS on the report.

The state must require the independent assessor to provide a draft of the Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies used, the findings on demonstration progress and performance, including identifying any risks of not meeting milestones and other operational vulnerabilities, and recommendations for overcoming those challenges and vulnerabilities. In the design, planning, and execution of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: provider participation in the state's Reentry Demonstration Initiative, eligible individuals, and other key partners in correctional facility and community settings.

For milestones and measure targets at medium to high risk of not being achieved, the state and CMS will collaborate to determine whether modifications to the Reentry Demonstration Initiative Implementation Plan and the Monitoring Protocol are necessary for ameliorating these risks, with any modifications subject to CMS approval. Elements of the Mid-Point Assessment must include, but not be limited to:

a. An examination of progress toward meeting each milestone and timeframe approved in the Reentry Demonstration Initiative Implementation Plan and toward meeting the targets for performance metrics as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and progress toward performance metrics targets to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets; and

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Reentry Demonstration Initiative Implementation Plan or to pertinent factors that the state can influence that will support improvement.

CMS will provide additional guidance for developing the state's Reentry Initiative Mid-Point Assessment.

60. SUD and SMI Mid-Point Assessment. For the SUD and SMI components, the state must contract with an independent entity to conduct an independent Mid-Point Assessment. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In addition, if applicable, the state should use the prior approval period experiences as context and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning and conduct of the Mid- Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of MCOs, health care providers (including treatment providers), beneficiaries, community groups, and other key partners.

a. The state must require that the assessor provide a Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than 60 calendar days after December 12, 2027. If requested, the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.

b. For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the relevant Implementation Plan and Monitoring Protocol for ameliorating these risks. Modifications to the Implementation, Financing Plan, and Monitoring Protocol are subject to CMS approval.

c. Elements of the Mid-Point Assessment must include:

i. An examination of progress toward meeting each milestone and timeframe approved in the Implementation Plans and toward meeting the targets for performance measures as approved in the Monitoring Protocol;

ii. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

iii. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

iv. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Implementation Plan, or to pertinent factors that the state can influence that will support improvement; and

v. An assessment of whether the state is on track to meet the budget neutrality requirements in these STCs.

61. Corrective Action Plan Related to Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS will withdraw an authority, as described in STC 10, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

62. Close Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

a. The draft Close Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 106 and 107, respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out report.

d. The state must take into consideration CMS's comments for incorporation into the final Close Out Report.

e. A revised Close Out Report is due to CMS no later than thirty (30) calendar days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 53.

63. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operations, to include (but not limited to), any significant actual or anticipated developments affecting the

demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, enrollment and access, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

64. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its Medicaid website. The state must also post the most recent Annual Monitoring Report on its Medicaid website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

X. GENERAL FINANCIAL REQUIREMENTS

65. Allowable Expenditures. This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

66. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

67. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

68. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met.

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

69. Financial Integrity for Managed Care Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

70. Requirements for Health Care-Related Taxes and Provider Donations. As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

71. State Monitoring Federal Share. If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 53. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

72. Extent of Federal Financial Participation (FFP) for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section XI:

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan, and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

73. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

74. Medicaid Expenditure Groups. Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table #3: Master MEG Chart

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
SUD	Hypo 1	X		X	All expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment, described in Section XIV.
RRSS	Hypo 2	X		X	All expenditures for RRSS services, described in Section XIV.
SMI MCO	Hypo 3	X		X	All managed care expenditures for services provided to an individual while they are a patient in an IMD for SMI treatment described in of Section XV.
SMI FFS	Hypo 3	X		X	All FFS expenditures for services provided to an individual while they are a patient in an IMD for SMI treatment described in of Section XV
Reentry	Hypo 4	X		X	Expenditures for targeted services that are otherwise

Table #3: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
					covered under Medicaid provided to qualifying beneficiaries for up to 60 days immediately prior to release from participating facilities.
Reentry Non-Service	Hypo 4		X		Expenditures for allowable planning and non-services for the reentry demonstration initiative.
HRSN	SHAC		X		Expenditures for HRSN services described in Section VII.
HRSN Infrastructure	SHAC		X		Expenditures for planning and supporting the HRSN initiative, as described in Section VII.
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.

75. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W--00306/4). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements**. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be

reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates.** Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise in the STCs in section XI, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in section IX, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications

Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 4: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
SUD	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/5/18	12/31/29
RRSS	Report all medical assistance expenditures for RRSS services.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/25	12/31/29
SMI MCO	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SMI treatment under managed care.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/25	12/31/29
SMI FFS	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SMI treatment under FFS		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/25	12/31/29

Reentry Services	Report all expenditures for reentry services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 60 days immediately prior to release from participating facilities.		Follow standard CMS 64.9 Based Category of Service Definitions	Date of service	MAP	Y	7/2/24	12/31/29
Reentry Non-Services	Report all expenditures for allowable planning and non-services for the reentry demonstration initiative.		Follow CMS 64.9 Base Category of Service Definition	Date of payment	ADM	N	7/2/24	12/31/29
HRSN	Report all expenditures for HRSN Services		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/25	12/31/29
HRSN Infrastructure	Report all expenditures for HRSN infrastructure		Follow standard CMS 64.9 Category of Service Definitions	Date of payment	ADM	N	1/1/25	12/31/29
ADM	Report all additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject		Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	10/5/18	12/31/29

	to budget neutrality							

76. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the table below.

Table 5: Demonstration Years		
Demonstration Year 9	January 1, 2025 to September 30, 2025	9 months
Demonstration Year 10	October 1, 2025 to September 30, 2026	12 months
Demonstration Year 11	October 1, 2026 to September 30, 2027	12 months
Demonstration Year 12	October 1, 2027 to September 30, 2028	12 months
Demonstration Year 13	October 1, 2028 to September 30, 2029	12 months
Demonstration Year 14	October 1, 2029 to December 31, 2029	3 months

77. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in STC XI. CMS will provide technical assistance, upon request.[3]

78. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

[3] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

79. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

80. Budget Neutrality Mid-Course Correction Adjustment Request. No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process**. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 80c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant

to STC 7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

   i. Provider rate increases that are anticipated to further strengthen access to care;

   ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

   iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

   iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

   v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

   vi. High-cost innovative medical treatments that states are required to cover; or,

   vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

   i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and

   ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

81. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of Hypothetical Budget Neutrality Tests, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

82. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 3, Master MEG Chart and Table 4, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

83. Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

84. Main Budget Neutrality Test. This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests, including the "Supplemental HRSN Aggregate Ceiling." Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.

85. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to

variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

86. Hypothetical Budget Neutrality Test 1: SUD. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 6: Hypothetical Budget Neutrality Test 1

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 9	DY 10	DY 11	DY 12	DY 13	DY 14
SUD	PC	Both	6.2%	$1,136.09	$1,197.49	$1,271.73	$1,350.58	$1,434.32	$1,489.27

87. Hypothetical Budget Neutrality Test 2: RRSS. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality

expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 7: Hypothetical Budget Neutrality Test 2									
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 9**	**DY 10**	**DY 11**	**DY 12**	**DY 13**	**DY 14**
RRSS	PC	Both	5.0%	$18.18	$18.97	$19.92	$20.92	$21.97	$22.65

88. **Hypothetical Budget Neutrality Test 3: SMI**. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 8: Hypothetical Budget Neutrality Test 3									
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 9**	**DY 10**	**DY 11**	**DY 12**	**DY 13**	**DY 14**
SMI MCO	PC	Both	4.8%	$1,497.67	$1,560.39	$1,635.29	$1,713.78	$1,796.04	$1,849.45
SMI FFS	PC	Both	4.8%	$21,842.91	$22,757.61	$23,849.98	$24,994.78	$26,194.53	$26,973.44

89. **Hypothetical Budget Neutrality Test 4: Reentry**. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 4. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget

neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 4 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 9: Hypothetical Budget Neutrality Test 4

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 9	DY 10	DY 11	DY 12	DY 13	DY 14
Reentry Services	PC	Both	5.6%	$1,591.32	$1,669.03	$1,762.50	$1,861.20	$1,965.43	$2,033.52
Reentry Non-Services	PC	Both	N/A	$2,328,750	$1,293,750	$258,750	$258,750	$258,750	$0

90. Supplemental HRSN Aggregate Ceiling (SHAC) Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives. When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in section VII), CMS considers these expenditures to be "supplemental HRSN aggregate ceiling (SHAC)" expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state's expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, SHAC expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for SHAC expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent SHAC Budget Neutrality Test, which subjects SHAC expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the SHAC Budget Neutrality Test's expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state's SHAC spending exceeds the SHAC Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS

approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the SHAC.

91. **SHAC Budget Neutrality Test: HRSN.** The table below identifies the MEGs that are used for the SHAC Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the SHAC Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the SHAC Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table 10: SHAC Budget Neutrality Test

MEG	PC or Agg	WOW Only, WW Only, or Both	DY 9	DY 10	DY 11	DY 12	DY 13	DY 14
HRSN	Agg	Both	$6,326,698	$8,999,263	$9,539,219	$10,111,572	$10,718,266	$2,832,559
HRSN Infrastructure	Agg	Both	$2,000,000	$184,575	$184,575	$184,575	$184,575	$0

92. **Former Foster Care Youth (FFCY) Budget Neutrality**. CMS has determined that the FFCY demonstration population is budget neutral based on CMS' assessment that the waiver authorities granted for this demonstration population are unlikely to result in any increase in federal Medicaid expenditures, and that no expenditure authorities are associated with this demonstration population. The state will not be allowed to obtain budget neutrality "savings" from this demonstration population. The demonstration population will not include a budget neutrality expenditure limit. The state must report quarterly claims and report expenditures on the CMS-64 base form(s) for Medicaid State Plan populations in accordance with section 2500 of the State Medicaid Manual.

93. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be

known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

94. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from 1/1/2025 to 12/31/2029. The Main Budget Neutrality Test for this demonstration period may incorporate carry-forward savings, that is, net savings from up to 10 years of the immediately prior demonstration approval period(s) (1/1/2025 to 12/31/2029). If at the end of the demonstration approval period the Main Budget Neutrality Test or a SHAC Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

95. Corrective Action Plan. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 11: Budget Neutrality Test Corrective Action Plan Calculation		
DY 9	Cumulative budget neutrality limit plus:	**2.0%**
DY 9 through DY 10	Cumulative budget neutrality limit plus:	**1.5%**
DY 9 through DY 11	Cumulative budget neutrality limit plus:	**1.0%**
DY 9 through DY 12	Cumulative budget neutrality limit plus:	**0.5%**
DY 9 through DY 13	Cumulative budget neutrality limit plus:	**0%**
DY 9 through DY 14	Cumulative budget neutrality limit plus:	**0%**

XII. CHIP MONITORING ALLOTMENT NEUTRALITY

96. Reporting Expenditures Subject to the Title XXI Allotment Neutrality Agreement. The following describes the reporting of expenditures subject to the allotment neutrality agreement for this demonstration:

a) Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES),

following routine CMS-21 reporting instructions outlined in section 2115 of the State Medicaid Manual.

b) Use of Waiver Forms. Title XXI demonstration expenditures will be reported on the following separate forms designated for CHIP (i.e., Forms CMS-21 Waiver and/or CMS-21P Waiver), identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The state must submit separate CMS-21 waiver forms for each title XXI demonstration population.

c) Premiums. Any premium contributions collected under the demonstration shall be reported to CMS on the CMS-21 Waiver form (specifically lines 1A through 1D as applicable) for each title XXI demonstration population that is subject to premiums, in order to assure that the demonstration is properly credited with the premium collections.

d) Claiming Period. All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately, on the Form CMS-21 Waiver, net expenditures related to dates of service during the operation of the demonstration.

97. Standard CHIP Funding Process. The standard CHIP funding process will be used during the demonstration. The state will continue to estimate matchable CHIP expenditures on the quarterly Forms CMS-21B for CHIP. On these forms estimating expenditures for the title XXI funded demonstration populations, the state shall separately identify estimates of expenditures for each applicable title XXI demonstration population.

a) CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must report demonstration expenditures through Form CMS-21W and/or CMS-21P Waiver for the CHIP population. Expenditures reported on the waiver forms must be identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). CMS will reconcile expenditures reported on the CMS-21W/CMS-21P Waiver form with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

98. Title XXI Administrative Costs. All administrative costs (i.e., costs associated with the title XXI state plan and the title XXI funded demonstration populations identified in these STCs) are subject to the title XXI 10 percent administrative cap described in section 2105(c)(2)(A) of the Act.

99. Limit on Title XXI Funding. The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on eligible CHIP state plan populations and the CHIP demonstration populations described in STC XX during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and the demonstration populations identified in these STCs) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.

100. Exhaustion of Title XXI Funds for CHIP Population. If the state exhausts the available title XXI federal funds in a federal fiscal year during the period of the demonstration, the state must continue to provide coverage to the approved title XXI separate state plan population.

XIII. EVALUATION OF THE DEMONSTRATION

101. Cooperation with Federal Evaluators and Learning Collaborative. As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to: commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged; and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, a that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable – in a federal learning collaborative aimed at cross state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 54.

102. Independent Evaluator. The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

103. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than one hundred eighty (180) calendar days after approval of the demonstration.

The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

a. Attachment A (Developing the Evaluation Design) of these STCs, and

b. Any applicable CMS evaluation guidance and technical assistance specific to the demonstration's policy components.

c. The draft Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic), as these implementation strategies help create strong comparison groups and facilitate robust evaluation. The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 107 and 108.

d. For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amended Evaluation Design must also be reflected in the state's Interim (as applicable) and Summative Evaluation Reports, described below.

104. Evaluation Design Approval and Updates. The state must submit to CMS a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's Medicaid website within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Quarterly and Annual Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval. if the changes are substantial in scope;

otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.

a. Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals. The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP; Consumer Assessment of Health Care Providers and Systems (CAHPS); the Behavioral Risk Factor Surveillance System (BRFSS) survey; and/or measures endorsed by NQF.

   CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary individual understanding of and experience with and experience the various demonstration policy components, including but not limited to, beneficiary experiences with access to and quality of care. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration components in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

b. Evaluation of the Reentry Demonstration Initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the Reentry Demonstration Initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination; connections between correctional and community services; access to and quality of care

in correctional and community settings; preventive and routine physical and behavioral health care utilization; non-emergent emergency department visits and inpatient hospitalizations; and all-cause deaths.

The state must also provide a comprehensive analysis of the distribution of services rendered by type of service over the duration of up to 60-days coverage period before the individual's expected date of release—to the extent feasible—and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes, including utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient, and effective reentry planning; enabled pre-release management and stabilization of clinical, physical, and behavioral health conditions; and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage of pre-release services.

The demonstration's evaluation efforts will be expected to include the experiences of correctional and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

c. Evaluation hypotheses for the HRSN initiatives in the demonstration must focus on assessing the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on the prevalence and severity of beneficiaries' HRSNs and the provision of and beneficiary utilization of HRSN services. Furthermore, the HRSN evaluation must include an analysis of how the initiatives (e.g., short-term pre-procedure, and/or post-hospitalization housing (recuperative care) with room and board) affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high-acuity health care, and beneficiary physical and mental health outcomes. In alignment with the demonstration's objectives to improve outcomes for the state's overall beneficiary populations eligible for the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual, population, and/or community level.

The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing, nutrition and any other type of allowable HRSN services change over time in

concert with new Medicaid funding toward those services. In addition, in light of how demonstration HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiatives must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. It is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

In addition, in accordance with the approved Evaluation Design, the state must coordinate with its managed care plans to secure necessary data—for a representative beneficiary population eligible for the HRSN services—to conduct a robust evaluation of the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such an assessment will require setting up a data infrastructure and/or data sharing arrangement to collect data on beneficiary screening and rescreening and prevalence and severity of beneficiaries' HRSNs, among others. If the data system is not operational to capture necessary data for a quantitative evaluation by the time the state's evaluation activities must be conducted, the state must provide applicable qualitative assessment to this effect leveraging suitable primary data collections efforts (e.g., beneficiary surveys).

d. Evaluation hypotheses for the SUD component of the demonstration must support an assessment of the demonstration's success in achieving the core goals of the program through addressing, among other outcomes, initiation and compliance with treatment, utilization of health services in appropriate care settings, and reductions in key outcomes such as deaths due to overdose.

e. Hypotheses for the SMI component must map to the SMI goals of the demonstration including reducing utilization and lengths of stay in EDs, reducing preventable readmissions to acute care hospitals and residential settings, improving the availability of crisis stabilization services, improving access to community-based services, and improving care coordination.

f. Hypotheses for the RRSS program must align with the goals of the program to support SUD beneficiaries achieve independence in the community. Toward this end, the hypotheses should address whether the skills and coaching provided through the program result in greater community integration and better treatment outcomes for participants than would have occurred in the counterfactual scenario, i.e., no RRSS program.

g. Finally, the state must accommodate data collection and analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes and help inform how the demonstration's various policies might support reducing such disparities.

105. Evaluation Budget. A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

106. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension of the demonstration, the Interim Evaluation Report should be posted to the state's Medicaid website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority of any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for the extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses, and a description of how the design was adapted should be included. If the state is not requesting an extension for a demonstration, an Interim Evaluation Report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any,
e. Once approved by CMS, the state must post the document to the state's Medicaid website within 30 calendar days.

f. The Interim Evaluation Report must comply with Attachment L (Preparing the Interim and Summative Evaluation Report) of these STCs.

107. Summative Evaluation Report. The state must submit to CMS a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment M (Preparing the Interim and

Summative Evaluation Reports) of these STCs, and in alignment with the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state must submit the revised Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft, if any.

b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

108. Corrective Action Plan Related to Evaluation Data. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 54. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

109. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

110. Public Access. The state shall post the final documents (e.g., Implementation Plan, Monitoring Protocol, Monitoring Reports, Mid-Point Assessment, Close-Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

111. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

XIV. OPIOID USE DISORDER (OUD)/SUBSTANCE USE DISORDER (SUD)

112. SUD Program Benefits. Effective upon CMS's approval of the SUD Implementation Plan, in Attachment C, the demonstration benefit package for Medicaid beneficiaries will include SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Medicaid beneficiaries who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD services, that would otherwise be matchable if the beneficiary were not residing in an IMD once CMS approves the state's Implementation Plan. CMS approved the SUD Implementation Plan on July 10, 2018. The state will aim for a statewide average length of stay of 30 days or less in residential treatment settings, to be monitored pursuant to the Monitoring Protocol as outlined in STC 57, to ensure short-term residential stays.

Under this demonstration beneficiaries will have access to high quality, evidence-based OUD/SUD treatment services across a comprehensive continuum of care, ranging from residential and inpatient treatment to ongoing chronic care for these conditions in cost-effective community-based settings.

113. Recovery Residence Support Services. RRSS are non-clinical activities necessary to support beneficiaries recovering with SUD, which support their independence in the community through skills training and coaching. RRSS removes barriers to recovery of SUD and support continued engagement in the SUD recovery process.

a. **RRSS Eligibility**: Individuals eligible for RRSS must be individuals who are ages 18 or older, enrolled in Medicaid either through a Medicaid state plan eligibility group or through the FFCY demonstration population. Individuals must also meet the following eligibility criteria:

   i. Be participating in a Behavioral Health Conditional Dismissal Program (BHCDP) or have received pre-release services under the Reentry demonstration initiative;

   ii. Reside in an approved Recovery Residence;

   iii. Meet American Society of Addiction Medicine (ASAM) Level of Care 2.7 or less, and

   iv. Be experiencing homelessness, unemployment, or have a history of criminal justice involvement.

b. **RRSS Services**: Beneficiaries may receive RRSS for up to 90 days per rolling year. Activities and services included in RRSS are outlined in the RRSS Service Description Attachment J. Components of the RRSS Service Description include a list of the services covered under the RRSS program, and the associated service descriptions.

c. **RRSS Providers**: Providers participating in the RRSS program must be a certified National Association of Recovery Residences (NARR) Level 2 or 3 recovery residence in accordance with the Kentucky Recovery Housing Network (KRHN) standards. Providers must be contracted with a Kentucky Medicaid MCO. In addition, Kentucky will require that RRSS be provided by:

   i. Certified peer support specialists in accordance with 908 Kentucky Administrative Regulations (KAR) 2:220, with lived substance use experience and trained in recovery capital;

   ii. Registered alcohol and drug peer support specialist in accordance with Kentucky Revised Statutes 309.080(12), with lived substance use experience and training in recovery capital, and may include;

   iii. Targeted Case Managers certified in accordance with 908 KAR 2:260, with working experience in substance use disorder and training in recovery capital.

d. **Unallowable Expenditures Under the RRSS Expenditure Authority**: The state may not claim or receive FFP under the RRSS expenditure authority for room and board costs for RRSS providers.

114. SUD Evaluation. The SUD Evaluation will be subject to the same requirements as the overall demonstration evaluation, as described in Sections IX (Monitoring and Reporting Requirements) and XIII (Evaluation of the Demonstration) of these STCs.

115. Unallowable Expenditures Under the SUD Expenditure Authority. In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

XV. SERIOUS MENTAL ILLNESS (SMI) PROGRAM AND BENEFITS

116. SMI Program Benefits. Under this demonstration, beneficiaries will have access to, the full range of otherwise covered Medicaid services, including SMI treatment services. These SMI services will range in intensity from short-term acute care in inpatient settings for SMI, to ongoing chronic care for such conditions in cost-effective community-based settings. The state will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must achieve a statewide average length of stay of no more than 30 days for beneficiaries receiving treatment in an IMD treatment setting through this demonstration's SMI Program, to be monitored pursuant to the SMI Monitoring Protocol as outlined in STC 57.

117. SMI Program Eligibility. Beneficiaries eligible to receive benefits under the SMI Program are 21 to 64 years of age, receiving a full Medicaid state plan benefit package, either through a Medicaid state plan eligibility group or the demonstration, with income up to 213 percent of the FPL. The state will not impose an income limit for state plan eligible former foster care children, demonstration eligible FFCY, and individuals determined aged, blind, or disabled. Individuals that receive limited Medicaid benefits or who are receiving long-term care services and supports (LTSS) are not eligible for the SMI program.

118. SMI Implementation Plan.

a. The state must submit the SMI Implementation Plan within 90 calendar days after approval of the demonstration extension for CMS review and comment. If applicable, the state must submit a revised SMI Implementation Plan within 60 calendar days after receipt of CMS's comments. The state may not claim FFP for services provided to beneficiaries residing in IMDs primarily to receive treatment for SMI under expenditure authority until CMS has approved the SMI Implementation Plan and the SMI financing plan described in STC 118(e). After approval of the required Implementation Plan and Financing Plan, FFP will be available prospectively, but not retrospectively.

b. Once approved, the SMI Implementation Plan will be incorporated into the STCs as Attachment C, and once incorporated, may be altered only with CMS approval. Failure to submit an SMI Implementation Plan, within 90 calendar days after approval of the demonstration, will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 53.

c. At a minimum, the SMI Implementation Plan must describe the strategic approach, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

    i. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings:

        1. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and either: a) be certified by the state agency as being in

compliance with those conditions through a state agency survey, or b) have deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS

2. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD

3. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating hospitals and residential treatment settings in which beneficiaries receiving coverage pursuant to the demonstration are residing meet applicable state licensure or certification requirements as well as a national accrediting entity's accreditation requirements

4. Use of a utilization review entity (for example, 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

5. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements, and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure 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)

6. Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for co-morbid physical health conditions and SUDs and demonstrate the

capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

ii. Improving Care Coordination and Transitions to Community-Based Care:

1. Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment)

2. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who have been experiencing or are likely to experience homelessness or who would be returning to unsuitable or unstable housing with community providers that coordinate housing services, where available;

3. Implementation of a requirement that psychiatric hospitals and residential treatment settings that are discharging beneficiaries who have received coverage pursuant to this demonstration have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary and the community-based provider to which the beneficiary was referred within 72 hours of discharge to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider the person was were referred to;

4. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers);

5. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI.

iii. Increasing Access to Continuum of Care Including Crisis Stabilization Services:

1. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability (the state must provide updates on how it has increased the availability of mental health services in every Annual Monitoring Report)

2. Commitment to implementation of the SMI financing plan described in STC 118(e). The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI program under the demonstration. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC X;

3. 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;

4. 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., Level of Care Utilization System (LOCUS) or the Child and Adolescent Service Intensity Instrument (CASII)] to determine appropriate level of care and length of stay.

iv. Earlier Identification and Engagement in Treatment and Increased Integration:

1. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI in treatment sooner, including through supported employment and supported education programs;

2. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI conditions sooner and improve awareness of and linkages to specialty treatment providers;

3. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI.

d. SMI Health Information Technology (Health IT) Plan. The Health IT plan is intended to apply only to those State Health IT functionalities impacting beneficiaries within this demonstration and providers directly funded by this demonstration. The state will provide CMS with an assurance that it has a sufficient health IT infrastructure "ecosystem" at every appropriate level (i.e., state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If the state is unable to provide such an assurance, it will submit to CMS a Health IT Plan, to be included as a section of the applicable Implementation Plan (see STC 118(c)), to develop the infrastructure/capabilities of the state's health IT infrastructure.

i. The Health IT Plan will detail the necessary Health IT capabilities in place to support beneficiary health outcomes to address the SMI goals of the demonstration. The plan(s) will also be used to identify areas of health IT ecosystem improvement. The Protocol must include implementation milestones and projected dates for achieving them (see Attachment D) and must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan.

ii. The state will include in its Monitoring Protocol (see STC 57e) an approach to monitoring its SMI Health IT Plan which will include performance metrics to be approved in advance by CMS.

iii. The state will monitor progress, each DY, on the implementation of its SMI Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Monitoring Report (see STC 58).

iv. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SMI Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

v. Where there are opportunities at the state- and provider-level (up to and including usage in managed care organization (MCO) or Accountable Care

Organization (ACO) participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B "Standards and Implementation Specifications for HIT". If there is no relevant standard in 45 CFR 170 Subpart B, the state should review the Office of the National Coordinator for Health Information Technology's Interoperability Standards Advisory (https://www.healthit.gov/isa/) to locate other industry standards in the interest of efficient implementation of the state plan.

vi. Components of the Health IT Plan include:

1. The SMI Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SMI care delivery. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

2. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: (1) Referrals, (2) Electronic care plans and medical records, (3) Consent, (4) Interoperability, (5) Telehealth, (6) Alerting/analytics, and (7) Identity management.

3. In developing the Health IT Plan, states should use the following resources.
    - States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).
    - States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.
    - States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

e. SMI Financing Plan. As part of the SMI Implementation plan referred to in STC 118(d), the state must submit, within 90 calendar days after approval of the demonstration, a financing plan for approval by CMS. Once approved, the Financing Plan will be incorporated into the STCs as part of the Implementation Plan in Attachment C and, once incorporated, may only be altered with CMS approval. Failure to submit an SMI Financing Plan within 90 days of approval of the demonstration will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI program under this demonstration. Components of the financing plan must include:

    i. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and

    ii. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings.

119. Maintenance of Effort. The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI program under the demonstration. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 58.

120. Availability of FFP for the SMI Services Under Expenditure Authority #1. Federal Financial Participation is only available for services provided to beneficiaries who are residing in an IMD when the beneficiary is a short-term resident in the IMD primarily to receive treatment for mental illness. The state may claim FFP for services furnished to beneficiaries during IMD stays of up to 60 days, as long as the state shows at its Mid-Point Assessment that it is meeting the requirement of a 30-day average length of stay (ALOS) for beneficiaries residing in an IMD who are receiving covered services under the demonstration. Demonstration services furnished to beneficiaries whose stays in IMDs exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the Mid-Point Assessment, the state may only claim FFP for services furnished to beneficiaries during IMD stays of up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days or 45 days, as relevant.

121. Unallowable Expenditures Under the SMI Expenditure Authority. In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a) Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

b) Costs for services furnished to beneficiaries who are residents in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.

c) Costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.

d) Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

XVI. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Date	Deliverable	STC
30 calendar days after demonstration approval	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
90 calendar days after demonstration approval	SUD/SMI Implementation Plan (including Health IT Plan)	STC 118
60 calendar days after receipt of CMS comments	Revised SUD/SMI Implementation Plan (including Health IT Plan)	STC 118
150 calendar days after demonstration approval	Monitoring Protocol	STC 57
60 calendar days after receipt of CMS comments	Revised Monitoring Protocol	STC 57
180 calendar days after demonstration approval	Draft Evaluation Design	STC 103
60 days after receipt of CMS comments	Revised Evaluation Design	STC 103
No later than 60 calendar days after December 12, 2027	Reentry Mid-Point Assessment	STC 59
No later than 60 calendar days after December 12, 2027	SUD and SMI/SED Mid-Point Assessments	STC 60
60 calendar days after receipt of CMS comments	Revised Reentry Mid-Point Assessment	STC 59
60 calendar days after receipt of CMS comments	Revised SUD and SMI/SED Mid-Point Assessment	STC 60
December 31, 2028, or with renewal application	Draft Interim Evaluation Report	STC 106
60 calendar days after receipt of CMS comments	Revised Interim Evaluation Report	STC 106
Within 18 months after ***December 31, 2029***	Draft Summative Evaluation Report	STC 107
60 calendar days after receipt of CMS comments	Revised Summative Evaluation Report	STC 107
Monthly	Monitoring Calls	STC 63
Quarterly monitoring reports due 60 calendar days after end of each quarter, except 4th quarter.	Quarterly Monitoring Reports, including implementation updates	STC 58
	Quarterly Expenditure Reports	STC 58
Annual Deliverables - Due 90 calendar days after end of each 4th quarter	Annual Monitoring Reports	STC 58

Attachment A: Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

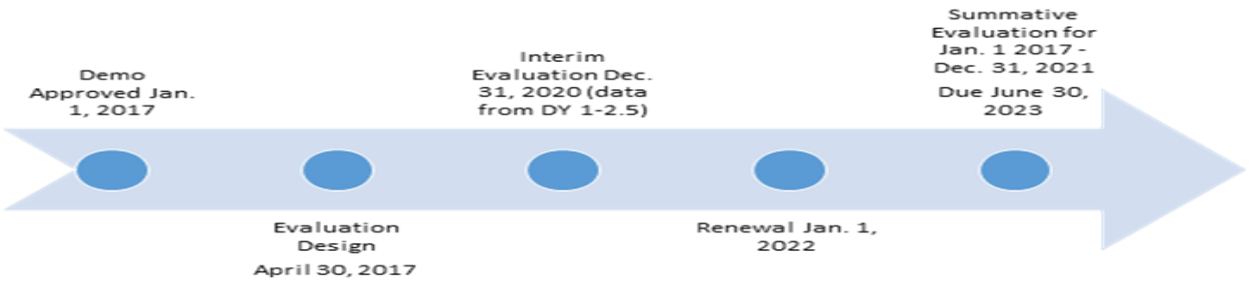
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

A. General Background Information;
B. Evaluation Questions and Hypotheses;
C. Methodology;
D. Methodological Limitations;
E. Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs
The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

3) Identify the state's hypotheses about the outcomes of the demonstration:
   i. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
   ii. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).
This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
b. Qualitative analysis methods may be used, and must be described in detail.
a. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
b. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
c. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
   a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
   b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
   c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
   d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

E. Special Methodological Considerations – CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include:

When the demonstration is considered successful without issues or concerns that would require more regular reporting, such as:

a. Operating smoothly without administrative changes; and
b. No or minimal appeals and grievances; and
c. No state issues with CMS 64 reporting or budget neutrality; and
d. No Corrective Action Plans (CAP) for the demonstration.

F. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.
3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

Attachment B: Preparing the Evaluation Report

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. With the following kind of information, states and CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Attachment

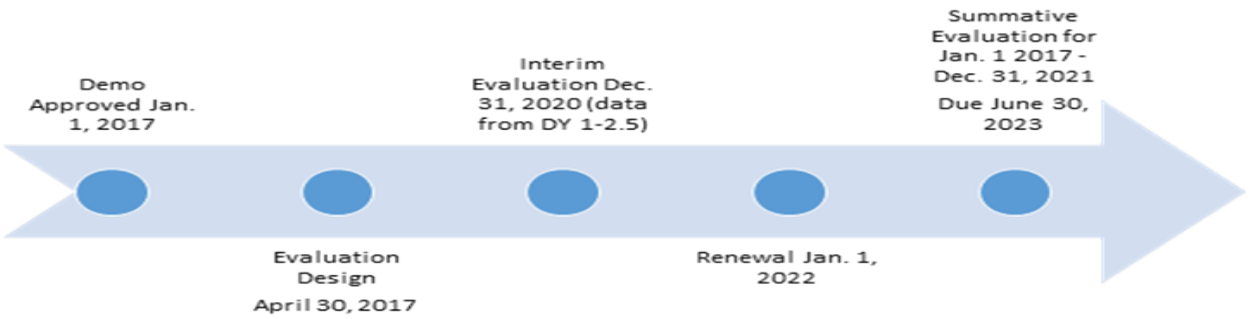
Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;

E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines
There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design Attachment) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.
B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2) Identify the state's hypotheses about the outcomes of the demonstration;
    a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
    b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
    c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1) *Evaluation Design*—Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc?
2) *Target and Comparison Populations*—Describe the target and comparison populations; include inclusion and exclusion criteria.
3) *Evaluation Period*—Describe the time periods for which data will be collected.
4) *Evaluation Measures*—What measures are used to evaluate the demonstration, and who are the measure stewards?
5) *Data Sources*—Explain where the data will be obtained, and efforts to validate and clean the data.
6) *Analytic Methods*—Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations
This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

Conclusions – In this section, the state will present the conclusions about the evaluation results.

1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
   a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1) What lessons were learned as a result of the demonstration?
2) What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment

1) Evaluation Design: Provide the CMS-approved Evaluation Design.

Attachment C: SMI Implementation Protocol

Section 1115 Serious Mental Illness (SMI) Demonstration Implementation Plan

Overview: The Implementation Plan documents the State's approach to implementing SMI/SED demonstrations. It also helps establish what information the State will report in its quarterly and annual monitoring reports. The Implementation Plan does not usurp or replace standard Centers for Medicare & Medicaid Services (CMS) approval processes, such as advance planning documents, verification plans, or state plan amendments (SPAs).

This template only covers SMI/SED demonstrations. The template has three sections: Section 1 is the uniform title page, Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care.
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services.
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration.
5. Financing Plan.
6. Health IT Plan.

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing State strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on "Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]" over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the State already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the State to meet all the expectations for each milestone, including the persons or entities responsible for completing these actions.
2. Describe the timelines and activities the State will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The State may not claim federal financial participation for services provided to Medicaid beneficiaries residing in institutions for mental diseases (IMDs), including residential treatment facilities, until CMS has approved a State's Implementation Plan.

Memorandum of Understanding (MOU): The state Medicaid agency should enter into an MOU or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

State Point of Contact: Please provide the contact information for the State's point of contact for the Implementation Plan.

Name and Title: Jodi Allen, Behavioral Health Supervisor
Telephone Number: 502-229-7339
Email Address: jodi.allen@ky.gov

1. Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration

The state should complete this transmittal title page as a cover page when submitting its implementation plan.

State	*Kentucky*
Demonstration name	*TEAMY KY*
Approval date	*December 12, 2024*
Approval period	*January 1, 2025-December 31, 2029*
Implementation date	*January 1, 2026*

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state's SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place "NA" in the summary cell if a prompt does not pertain to the state's demonstration. Answers are meant to provide details beyond the information provided in the state's special terms and conditions. Answers should be concise but provide enough information to fully answer the question. This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid.	*Current Status:* Kentucky has established a comprehensive regulatory framework to ensure the quality of care in psychiatric hospitals through licensure, accreditation, and oversight processes. These policies are designed to maintain high standards of care, patient safety, and regulatory compliance while ensuring facilities provide appropriate mental health treatment to individuals with SMI. Kentucky does not currently license residential treatment facilities for adults with SMI. **Licensure Requirements for Psychiatric Hospitals.** All Kentucky hospitals, including psychiatric hospitals, in Kentucky are required to obtain and maintain licensure from the Office of the Inspector General (OIG) within the Cabinet for Health and Family Services (CHFS), as mandated by 902 Kentucky Administrative Regulations (KAR) 20:016. This regulation establishes minimum licensure requirements to ensure the safe, adequate, and efficient operation of hospitals. Specific to psychiatric hospitals, 902 KAR 20:180 further outlines operational and service standards to regulate the provision of psychiatric care in Kentucky. These regulations require psychiatric hospitals to: • Conduct comprehensive patient assessments upon admission (Section 4, 902 KAR 20:180). • Develop individualized treatment plans for each patient.

Prompts	Summary
	• Implement special treatment procedures, as needed. • Comply with the staffing requirements in 902 KAR 20:180. • Adhere to specific discharge planning and transfer procedures to ensure continuity of care. • Maintain detailed administrative records and policies to ensure compliance with state and federal requirements. Additionally, Kentucky Revised Statutes Chapter 202A and 202B establish statutory provisions governing the care and treatment of individuals with SMI in psychiatric hospitals, including admission, treatment standards, and discharge protocols. **Certificate of Need (CON) and Application Process for Licensure.** To establish a new psychiatric hospital in Kentucky, providers must first obtain a CON from CHFS, which assesses whether there is a demonstrated need for additional psychiatric services in a specific area. Once a CON is granted, the provider must apply for licensure to the OIG, demonstrating compliance with all state licensing standards and operational requirements. **Accreditation Requirements for Psychiatric Hospitals.** While Kentucky state licensure is mandatory, psychiatric hospitals are also encouraged to seek national accreditation from recognized accrediting organizations such as: • The Joint Commission (TJC). • The Commission on Accreditation of Rehabilitation Facilities (CARF). • The Council on Accreditation (COA). Accreditation from these organizations serves as an additional assurance that facilities adhere to the highest clinical and operational standards for psychiatric care. Many Medicaid reimbursement requirements incentivize or mandate accreditation as a condition of participation.
	Future Status: Continued operation of current requirements.
	Summary of Actions Needed: • N/A - Milestone requirements already met.

Prompts	Summary

1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	*Current Status:* Kentucky ensures the quality of care in psychiatric hospitals and any future residential treatment settings through licensure, accreditation, and oversight processes. These mechanisms are designed to ensure facilities meet regulatory requirements and adhere to state and federal standards for Medicaid participation.
	
	Licensure Process for Psychiatric Inpatient Facilities. All psychiatric hospitals in Kentucky must obtain licensure through the OIG under CHFS, as mandated by 902 KAR 20:180 and 902 KAR 20:016. The licensing process includes:
	
	• **Application Submission.** Facilities must apply for a hospital license through OIG, demonstrating compliance with state health and safety regulations.
	• **CON Approval.** New psychiatric hospitals must secure a CON to verify that additional psychiatric services are needed in the region.
	• **Initial Inspection and Compliance Review.** Before issuing a license, OIG conducts on-site inspections to ensure compliance with:
	  o Physical facility standards.
	  o Clinical and administrative policies.
	  o Staffing and credentialing requirements.
	  o Patient rights and safety protocols.
	• **Issuance of License.** Once compliance is verified, OIG grants a license to operate as a psychiatric hospital in Kentucky.
	• **License Renewal.** To maintain licensure, psychiatric hospitals must renew their license annually and undergo periodic compliance inspections conducted by OIG. These inspections verify continued adherence to state licensing requirements and address any deficiencies found during prior audits.
	
	Accreditation Process for Psychiatric Hospitals. Many psychiatric hospitals in Kentucky voluntarily seek national accreditation from TJC, CARF, or COA. Accreditation ensures facilities meet higher standards of patient care, safety, and clinical quality.
	
	Enrollment and Compliance Policy for Medicaid Participation. To enroll in Kentucky Medicaid, psychiatric hospitals must:

Prompts	Summary

	• **Submit a Medicaid Provider Enrollment Application.** Facilities must provide documentation of:
	  o OIG licensure.
	  o Accreditation status (if applicable).
	  o Staffing and operational policies.
	• **Meet Medicaid Conditions of Participation.** Facilities must comply with federal Medicaid regulations regarding patient care standards, billing integrity, and program oversight.
	• **Renew Medicaid Enrollment Every Five Years.** Medicaid enrollment requires revalidation every five years, with compliance audits and on-site inspections conducted periodically.
	
	Oversight and Unannounced Compliance Reviews. Kentucky conducts routine and unannounced inspections to ensure psychiatric hospitals maintain licensure and accreditation standards. Key oversight mechanisms include:
	• **Annual License Renewal Inspections.** OIG conducts scheduled site visits to verify that hospitals comply with state regulations under 902 KAR 20:180.
	• **Unannounced Site Inspections.** When applicable, OIG conducts random, unannounced visits to:
	  o Investigate complaints or compliance violations.
	  o Assess patient safety and treatment conditions.
	  o Ensure hospitals adhere to state and federal quality-of-care standards.
	• **Medicaid Program Integrity Audits.** Medicaid auditors review billing practices, patient records, and treatment documentation to detect fraud, waste, or abuse.

	Future Status: Continued operation of current requirements.
	Summary of Actions Needed: N/A - Milestone requirements already met.
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	*Current Status:* Kentucky has established a utilization review (UR) process to ensure that Medicaid beneficiaries with SMI receive appropriate levels and types of care while maintaining oversight on lengths of stay (LOS) in psychiatric hospitals. The UR process is designed to ensure all psychiatric care is medically necessary, appropriate, and cost-effective. **Utilization Review (UR) Committee Requirement.** In accordance with 902 KAR 20:016 Section 3, all licensed hospitals, including psychiatric hospitals, must establish a UR Committee. The UR Committee is

Prompts	Summary
	responsible for: • Reviewing the necessity and appropriateness of inpatient psychiatric care. • Evaluating patient treatment plans and progress. • Ensuring that LOS are clinically justified based on medical necessity criteria. • Assessing whether patients should continue inpatient care or transition to lower levels of care (e.g., outpatient or community-based services). The UR Committee's oversight helps prevent unnecessary hospitalizations while ensuring patients receive the level of care (LOC) that best meets their treatment needs. **Prior Authorization (PA) and LOC Determination.** To ensure Medicaid coverage for psychiatric inpatient treatment, PA is required for both fee-for-service (FFS) Medicaid and managed care organization (MCO) beneficiaries. The PA process determines: • Whether the admission meets medical necessity criteria for psychiatric hospitalization. • The appropriate LOC based on clinical guidelines. • The initial authorized length of stay, with continued stay reviews conducted periodically. • The criteria used to determine LOC and continued authorization include: • InterQual Behavioral Health Criteria used by Medicaid FFS to determine medical necessity. • MCO-specific criteria. Each Kentucky MCO follows its own Medicaid-approved UR process. • American Society of Addiction Medicine (ASAM) criteria used for SUD treatment to assess LOC appropriateness. PA requirements ensure that psychiatric hospitalizations are reserved for patients who require intensive inpatient care, while those who can safely transition to less restrictive environments are provided with community-based alternatives. **Oversight of LOS in Psychiatric Hospitals.** The OIG, in collaboration with DMS and the Kentucky MCOs, monitors LOS in psychiatric hospitals to ensure appropriate utilization of services. Oversight responsibilities include: • A designated hospital oversight contact exists to ensure that psychiatric hospitals adhere to state licensing standards regarding LOS.

Prompts	Summary
	• Medicaid FFS and MCO UR teams conduct continued stay reviews to assess whether a patient still meets criteria for inpatient psychiatric care. • Hospitals must provide clinical documentation justifying extended stays beyond the initial authorization period. If a patient no longer meets inpatient criteria, discharge planning and referral to outpatient or step-down services are initiated to ensure continuity of care while managing costs and preventing unnecessary hospitalizations.
	Future Status: Continued operation of current requirements. Currently, Kentucky does not license residential treatment facilities for adults with SMI. However, DMS may consider residential treatment expansion, and if so, UR processes will be established to ensure appropriate oversight.
	Summary of Actions Needed: Kentucky currently meets milestone requirements.

1.d Compliance with program integrity requirements and state compliance assurance process	*Current Status:* Kentucky ensures compliance with program integrity requirements and state compliance assurance processes to protect Medicaid funds, prevent fraud and abuse, and maintain high-quality care in psychiatric hospitals. Program integrity efforts are enforced through provider enrollment requirements, MCO contracts, and routine compliance audits.
	
	Provider Enrollment Process for Psychiatric Hospitals. All psychiatric hospitals that wish to participate in Kentucky Medicaid must complete a comprehensive provider enrollment process to ensure they meet state and federal participation requirements. The provider enrollment process includes:
	• **Submission of an Enrollment Application.** Psychiatric hospitals must submit a formal application to Kentucky Medicaid, providing:
	  o Proof of licensure by the OIG under 902 KAR 20:016 and 902 KAR 20:180.
	  o Accreditation documentation from TJC, CARF, or COA, if applicable.
	  o Certification of compliance with federal and state Medicaid conditions of participation.
	• **Review of Provider Eligibility.** The Medicaid Program Integrity Division conducts a background check and risk assessment, ensuring the hospital has:
	  o No history of Medicaid fraud, waste, or abuse.
	  o No exclusions or terminations from Medicare or other Medicaid programs.

Prompts	Summary

	• **Site Inspection and Enrollment Approval.** Before approval, the OIG and Medicaid Enrollment Team may conduct an on-site inspection to verify compliance with state licensure and program integrity requirements.
	• **Revalidation and Recertification.** Psychiatric hospitals must renew Medicaid enrollment every five years and undergo routine compliance audits to maintain eligibility.
	
	This provider enrollment process ensures only qualified, high-performing facilities participate in Kentucky's Medicaid program, protecting patient safety and fiscal integrity.
	
	MCO Contractual Program Integrity Requirements. Kentucky MCOs are required to follow strict program integrity requirements outlined in their state contracts. Per the MCO contract, MCOs must:
	• Conduct pre- and post-payment audits to prevent improper billing and fraud.
	• Monitor psychiatric hospital claims to detect billing inconsistencies, duplicate payments, and excessive LOS.
	• Require provider credentialing and re-credentialing every three years to verify qualifications and compliance.
	• Implement fraud detection analytics to flag suspicious claims and report anomalies to Kentucky's Medicaid Fraud & Abuse Prevention Unit.
	
	Compliance Monitoring and Audits. Kentucky ensures compliance with Medicaid program integrity requirements through ongoing monitoring, audits, and investigations. Key mechanisms include:
	• **Medicaid Fraud and Abuse Prevention Audits.** The Kentucky Medicaid Fraud Control Unit and the OIG Program Integrity Division conduct randomized and targeted audits of psychiatric hospital billing practices.
	• **Annual Kentucky Compliance Reviews.** The OIG and Medicaid Program Integrity Division review:
	  o Provider licensure compliance with 902 KAR 20:016 and 902 KAR 20:180.
	  o Medical records and billing documentation to ensure alignment with state and federal requirements.
	• **Sanctions for Non-Compliance.** Psychiatric hospitals that fail to meet program integrity requirements may face:
	  o Recoupment of improper payments.
	  o Suspension or termination from Medicaid participation.

Prompts	Summary
	○ Civil monetary penalties or referrals for criminal investigation in cases of fraud. **Medicaid Compliance Hotline.** Patients, families, and providers will be able to report suspected fraud or program violations anonymously through an established 800 hotline.
	Future Status: Continued operation of current requirements.
	Summary of Actions Needed: N/A - Kentucky currently meets milestone requirements.
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	*Current Status:* Kentucky's psychiatric hospitals are required to assess patients upon admission and throughout their treatment to identify co-morbid physical health conditions, substance use disorders (SUDs), and psychiatric conditions. While 902 KAR 20:180 Section 4 outlines general patient assessment requirements, it does not explicitly mandate screenings for SUDs or SI, though these assessments may be integrated into broader psychiatric and medical evaluations. **Patient Assessment and Management in Psychiatric Hospitals.** Under 902 KAR 20:180 Section 4, psychiatric hospitals must conduct comprehensive assessments of each patient upon admission and throughout their stay. These assessments include: • A psychiatric evaluation to determine the individual's mental health diagnosis and treatment needs. • A physical health assessment to identify any co-morbid medical conditions that may impact mental health treatment. • A treatment plan that includes referrals to additional services as needed, such as specialty medical care, substance use treatment, or crisis intervention for suicidal patients. **Screening for Co-Morbid Physical Health Conditions.** Kentucky recognizes that individuals with SMI frequently experience co-occurring physical health conditions such as: • Hypertension. • Diabetes. • Cardiovascular disease. • Obesity and metabolic disorders. To ensure proper identification and management of these conditions, psychiatric hospitals:

Prompts	Summary
	• Conduct basic medical screenings upon admission to identify any immediate physical health concerns. • Consult with family medicine doctors to provide care for patients in psychiatric hospitals who have physical health concerns that need attention during their stay. • Refer patients to primary care providers (PCPs) or specialists if medical conditions require further management. • Coordinate with Medicaid MCOs to facilitate access to appropriate physical health treatments. **Screening for Substance Use Disorders (SUDs).** Many individuals with SMI also experience co-occurring SUDs, which can significantly impact their psychiatric treatment and recovery. Specifically, co-occurring SMI and SUD increases the likelihood of relapse for both conditions and creates medication treatment complexity. While 902 KAR 20:180 does not explicitly require SUD screenings, psychiatric hospitals generally assess for substance use history, severity of any diagnosed SUD, withdrawal symptoms, and the need for detoxification services. If a patient is identified as having a co-occurring SUD, they may be: • Provided with medication-assisted treatment (MAT), if appropriate. • Provided with tapering protocols to treat benzodiazepine use disorder and manage withdrawal symptoms. • Referred to specialized addiction treatment programs. • Connected with outpatient or residential SUD services upon discharge. **Screening for Suicidal Ideation (SI) and Crisis Intervention.** SI is a critical concern for individuals admitted to psychiatric hospitals as they may be at high risk for self-harm or suicide attempts. While Kentucky regulations may not explicitly mandate SI screenings, psychiatric hospitals typically follow best practices in suicide risk assessment. Many Kentucky hospitals use validated screening tools such as: • The Columbia-Suicide Severity Rating Scale. • The Beck Scale for Suicidal Ideation. • The Suicide Crisis Inventory. • The Patient Health Questionnaire (PHQ-9). • Other standardized risk assessment tools. If a patient is found to be at high risk for suicide, hospitals are required to:

Prompts	Summary
	• Implement suicide precautions (e.g., close observation, removal of harmful objects). • Regularly monitor the patient's safety risk through standardized screening tools and clinical judgement. • Develop a crisis intervention plan. • Refer the patient to ongoing outpatient treatment services upon discharge. **Facilitating Access to Treatment for Co-Occurring Conditions.** Psychiatric hospitals must ensure patients with co-occurring medical, substance use, or suicidal risks receive appropriate treatment as well as referrals. This is done through: • Referrals to MCOs which coordinate physical health care, SUD treatment, and follow-up psychiatric services for patients' post-discharge. • Directly providing outpatient behavioral health services and/or collaborating with Community Behavioral Health providers to deliver ongoing outpatient care, case management, and crisis intervention. **Integration of Behavioral and Physical Health Services.** Some hospitals have co-located primary care providers (PCPs) or partnerships with medical specialists to address physical health conditions during psychiatric hospitalization.
	Future Status: Continued operation of current requirements.
	Summary of Actions Needed: N/A - Kentucky currently meets milestone requirements.

Prompts	Summary
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	*Current Status:* See sections above.
	Future Status: Continued operation of compliance activities.
	Summary of Actions Needed: N/A - Kentucky currently meets milestone requirements.
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	

Prompts	Summary
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community-based providers in care transitions.	*Current Status:* Kentucky has established care coordination benefits and requirements to ensure individuals transitioning from psychiatric hospitals to community-based care receive adequate support, follow-up services, and care continuity. Pre-discharge planning, post-discharge follow-ups, and information-sharing mechanisms are essential components of these efforts. The following outlines Kentucky's current care coordination and pre-discharge planning in Kentucky's psychiatric hospitals. **Pre-Discharge Planning Requirements in Psychiatric Hospitals.** Kentucky mandates a formal discharge planning process for psychiatric hospitals to ensure the beneficiary transitions smoothly to community-based care. **Hospital Regulations and Discharge Planning (§ 42 Code of Federal Regulations [CFR] 482.43) (Section 6).** Psychiatric hospitals are required to develop a written discharge plan that includes: • Coordination with community-based providers before the patient is discharged. • Assessment of medical, behavioral health, and social needs to determine ongoing service requirements. • Scheduling of follow-up appointments with outpatient behavioral health providers, PCPs, or specialty providers. • Patient and caregiver education on medication adherence, crisis response planning, and warning signs of relapse. **MCO Contract Language on Continuity of Care (§ 42 CFR 438 [Section 33.10]).** Kentucky's MCO contracts require continuity of care provisions that mandate: • Timely communication between psychiatric hospitals and MCO care management teams. • Engagement of MCO case managers in discharge planning to ensure follow-through on referrals to community-based services. • Assistance with benefit coordination for Medicaid beneficiaries who require additional services upon discharge.

Prompts	Summary
	DBHDID Oversight of CMHCs. DBHDID oversees CMHCs, which provide community-based behavioral health services. CMHCs collaborate with psychiatric hospitals to: • Accept referrals for outpatient therapy, psychiatric medication management, and crisis intervention. • Facilitate warm hand-offs by ensuring community providers participate in discharge planning discussions before the patient leaves inpatient care. • DBHDID conducts annual assessments of the availability and capacity of CMHCs as part of the Substance Abuse and Mental Health Services Administration (SAMHSA) block grant reporting requirements. **Post-Discharge Follow-Up and Care Coordination.** Kentucky requires psychiatric hospitals to facilitate post-discharge follow-up services to ensure continued engagement in care. **Healthcare Effectiveness Data and Information Set (HEDIS) Measures.** Post-discharge follow-up rates are monitored using HEDIS quality measures to assess: • Percentage of individuals receiving outpatient visits within 7-30 days post-hospitalization. • Timeliness and effectiveness of community-based interventions after inpatient stays. • These metrics are used to evaluate MCO performance in maintaining continuity of care. **Current Information-Sharing Mechanisms.** Kentucky DMS and contracted MCOs use electronic health record (EHR) systems and the Kentucky health information exchange (KHIE) to facilitate data-sharing between inpatient and outpatient providers. See Milestone 6 – Health IT for details. **Kentucky's 1915(i) State Plan Amendment, (Recovery, Independence, Support, and Engagement) RISE Initiative for SMI with Co-Occurring SUD** was approved by CMS on March 27, 2025. During the implementation phase Kentucky will work towards the offering of a comprehensive collection of home and community-based services (HCBS). The program services provide individuals with a primary diagnosis of an SMI or SMI with co-occurring SUD to learn skills and receive services to thrive at home or in the community, access to services will include a functional assessment that encompasses housing status for individuals.
	Future Status: **Kentucky's 1915(i) State Plan Option, RISE Initiative for SMI with Co-Occurring SUD** was approved by CMS on March 27, 2025. During the implementation phase, Kentucky will work towards the

Prompts	Summary
	offering of a comprehensive collection of home and community-based services (HCBS). The program services provide individuals with a primary diagnosis of an SMI or SMI with co-occurring SUD to learn skills and receive services to thrive at home or in the community, access to services will include a functional assessment that encompasses housing status for individuals.
	Summary of Actions Needed: N/A - Kentucky currently meets milestone requirements.
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	*Current Status:* The following outlines Kentucky's current housing assessment and coordination efforts capabilities for Medicaid beneficiaries. **Housing Needs Assessments Conducted by Psychiatric Hospitals.** Kentucky psychiatric hospitals conduct social assessments that include housing status evaluations as part of pre-discharge planning. Prior to discharge, a comprehensive physical and behavioral health assessment is conducted to support the successful transition to community-based housing within 14 days of the transition. Some hospitals coordinate with community-based housing providers, but the extent of these partnerships varies by region. **MCO Involvement in Housing Coordination.** MCOs in Kentucky play a key role in assessing housing needs and coordinating housing services for Medicaid beneficiaries through: • **Population Health Management and Complex Care Management (CCM) Programs.** MCOs utilize Health Risk Assessments (HRA) to identify housing instability risks among beneficiaries. Individuals with complex needs (including those with SMI) are referred to care coordinators who assess social determinants of health (SDOH) and assist with housing referrals. • **Partnerships with Housing Providers.** Several Kentucky MCOs collaborate with local housing organizations to provide rental assistance, rapid rehousing, and supportive housing services. MCO case managers work to connect eligible beneficiaries to housing programs, but these efforts are not standardized across all plans. **Kentucky's 1915(i) State Plan Option, RISE Initiative for SMI with Co-Occurring SUD** was approved by CMS on March 27, 2025. During the implementation phase, Kentucky will work towards the offering of a comprehensive collection of home and community-based services (HCBS). The program services provide

Prompts	Summary
	individuals with a primary diagnosis of an SMI or SMI with co-occurring SUD to learn skills and receive services to thrive at home or in the community, access to services will include a functional assessment that encompasses housing status for individuals. **DBHDID and Housing Screening Efforts.** DBHDID oversees CMHCs, which provide housing supports for individuals with SMI. **Kentucky Continuum of Care (CoC):** The Kentucky Housing Corporation (KHC), Lexington-Fayette County CoC, and Louisville Metro CoC; bring together federal and state agencies, behavioral health providers, and housing organizations to coordinate supportive housing solutions for individuals with complex health needs. This collaborative has been instrumental in: • Promoting the integration of Medicaid-funded services with housing programs. • Expanding supportive housing options for individuals with SMI and other high-risk populations. • Improving cross-agency coordination between behavioral health, Medicaid, and housing agencies.
	Future Status: Continued operation of compliance activities. **Kentucky's 1915(i) State Plan Option, RISE Initiative for SMI with Co-Occurring SUD** was approved by CMS on March 27, 2025. During the implementation phase, Kentucky will work towards the offering of a comprehensive collection of home and community-based services (HCBS). The program services provide individuals with a primary diagnosis of an SMI or SMI with co-occurring SUD to learn skills and receive services to thrive at home or in the community, access to services will include a functional assessment that encompasses housing status for individuals.
	Summary of Actions Needed: N/A - Kentucky currently meets milestone requirements.

Prompts	Summary
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge.	*Current State:* Kentucky has existing policies and contractual requirements that establish post-discharge follow-up expectations, including communications between psychiatric hospitals and community-based providers. These policies ensure beneficiaries receive timely follow-up care necessary for reducing hospital readmissions, improving treatment adherence, and maintaining long-term mental health stability. Specifically, contracted MCOs are required, through provider contract provisions, that for all enrollees receiving inpatient behavioral health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge.
	Future State: DMS will continue collaboration with state agencies to establish appropriate MCO requirements for 72-hour post-discharge contact to improve care transitions from psychiatric hospitals and residential treatment settings to community-based providers, Kentucky will implement a comprehensive, standardized approach to post-discharge follow-up. This approach will ensure all individuals discharged from inpatient behavioral health settings receive timely contact and engagement within 72 hours, minimizing the risk of treatment disruptions, emergency department (ED) visits, or hospital readmissions. Kentucky will enhance existing policies and adopt best practices from other states, ensuring that MCOs, psychiatric hospitals, and community-based providers are held accountable for effective post-discharge outreach and engagement strategies. The following outlines the specific details: **Establishing a Uniform, Statewide 72-Hour Post-Discharge Follow-Up Requirement.** Kentucky will explore requirements regarding psychiatric hospitals and MCOs conducting follow-up contact within 72 hours post-discharge, using the most effective method for each beneficiary (e.g., phone call, text message, email, or in-person follow-up). Planned enhancements may include: • **Expanding MCO Contractual Obligations to Strengthen Enforcement of 72-Hour Follow-Ups.** MCOs will be required to: o Ensure direct patient outreach within 72 hours to assess stability and engagement with outpatient care. o Confirm that a follow-up appointment has occurred or is scheduled within seven days of discharge. o Conduct additional outreach attempts if the patient is unresponsive, using multiple contact methods. o If an outpatient follow-up appointment is missed, the MCO will be responsible for ensuring that:

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	▪ A behavioral health provider or case manager contacts the patient within three business days. ▪ A second appointment is scheduled promptly. • **Requiring Psychiatric Hospitals and Residential Treatment Providers to Conduct Direct Patient Follow-Ups.** All inpatient psychiatric and residential treatment facilities will: o Conduct a wellness check within 72 hours to assess post-discharge stability. o Confirm that the individual has access to medication, housing, and transportation to follow-up care. o Communicate discharge details to community-based behavioral health providers to ensure seamless care coordination. • **Exploring use of a Statewide, Standardized Follow-Up Tracking System.** Kentucky will examine the implementation of a Medicaid Follow-Up Tracking System that: o Monitors 72-hour follow-up completion rates. o Tracks missed appointments and re-engagement efforts. o Requires quarterly performance reporting from FFS network, MCOs, and inpatient providers.
	Summary of Actions Needed: **Action 1: Establish Kentucky's Uniform 72-Hour Post-Discharge Follow-Up Requirements** • **Description:** DMS seeks to establish uniform, 72-hour post-discharge follow-up requirements across Kentucky. • **Persons/Entities Responsible:** CHFS • **Timeframe:** Q3, CY 2026.
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	*Current Status:* In Kentucky, various initiatives are in place to identify high utilizers of ED services, reduce unnecessary spending, reduce ED visits, connect individuals to community-based care, and implement crisis intervention strategies. **Identification of Frequent ED Users and Referral to Complex Case Management (CCM) Programs.** Kentucky's MCOs play a significant role in identifying high utilizers of ED services and linking them to appropriate community-based interventions. Current strategies to capture high utilizers of ED services: • **MCOs Use Data Analytics to Identify Frequent ED Users.** MCOs track ED utilization patterns to flag beneficiaries who frequently visit EDs for psychiatric reasons. These beneficiaries are referred to

Prompts	Summary
	CCM programs to reduce repeat visits and ensure better access to behavioral health services. • **Referral to Intensive Care Coordination Programs.** High utilizers are often referred to CCM programs within their MCO. CCM teams assess barriers to care, ensure follow-up with outpatient providers, and coordinate social services such as housing, transportation, and medication access. • **ED Diversion Initiatives in CMHCs.** CMHCs offer crisis response services to stabilize individuals before they require ED visits. Some CMHCs have mobile crisis teams (MCTs) that coordinate with EDs to divert patients to crisis stabilization units (CSUs) when appropriate. **ED-Based Crisis Intervention and Psychiatric Assessment.** To prevent prolonged ED stays, Kentucky hospitals implement crisis intervention and rapid psychiatric evaluation protocols. Current strategies for psychiatric assessment and ED include: • **Emergency Psychiatric Assessment, Treatment and Healing (EmPATH)** is designed to stabilize patients in a therapeutic environment before connecting them to outpatient services. Services include peer support services, medication management, therapy, education, and use of coping strategies. EmPath Psychiatric Unit • **Behavioral Health Triage in EDs.** Many Kentucky hospitals have psychiatric assessment teams or behavioral health specialists embedded in the ED. These teams conduct immediate psychiatric evaluations to determine the LOC required (inpatient admission versus outpatient follow-up). • **Use of Telepsychiatry for Psychiatric Evaluations.** Some hospitals use telepsychiatry to provide real-time psychiatric consultations, reducing delays in care. This allows Kentucky's EDs, especially in rural areas, to access psychiatrists more quickly to determine the best treatment course. **Kentucky's 1915(i) State Plan Option, RISE Initiative for SMI with Co-Occurring SUD** was approved by CMS on March 27, 2025. During the implementation phase, Kentucky will work towards the offering of a comprehensive collection of home and community-based services (HCBS). The program services provide individuals with a primary diagnosis of an SMI or SMI with co-occurring SUD to learn skills and receive services to thrive at home or in the community, access to services will include a functional assessment that encompasses housing status for individuals.
	Future Status: Continued operation of compliance activities. However, Kentucky is currently developing the following initiatives to prevent or decrease LOS in EDs among beneficiaries with SMI or SED prior to admission:

Prompts	Summary

	Kentucky Rapid Response and Stabilization Services (KRRSS) initiatives to provide immediate support to youth and families experiencing behavioral health crises. Services may include therapy, safety planning, skills training, and medication management. Kentucky will strengthen coordination between its MCTs, inpatient facilities, and outpatient behavioral health providers to improve continuity of care post-crisis.
	
	Kentucky's 1915(i) State Plan Option, RISE Initiative for SMI with Co-Occurring SUD was approved by CMS on March 27, 2025. During the implementation phase, Kentucky will work towards the offering of a comprehensive collection of home and community-based services (HCBS). The program services provide individuals with a primary diagnosis of an SMI or SMI with co-occurring SUD to learn skills and receive services to thrive at home or in the community, access to services will include a functional assessment that encompasses housing status for individuals.
	
	Initiatives under consideration. In addition, Kentucky is exploring additional strategies to prevent or decrease LOS in EDs among beneficiaries with SMI or SED prior to admission. These strategies include the following:
	
	Medicaid Strategies to Improve Crisis and ED Diversion Initiatives. Kentucky will leverage existing Medicaid programs and federal waivers to enhance community-based behavioral health care and reduce ED LOS. Planned enhancements:
	
	• Kentucky will use its Section 1115 waiver to enhance access to inpatient services for Medicaid beneficiaries. This expansion will:
	  o Allow for additional days for inpatient mental health treatment, as needed.
	  o Reduce ED utilization and hospital readmission rates.
	
	Strengthen Crisis Stabilization Infrastructure to Reduce ED Utilization. Kentucky will explore opportunities to expand crisis response capacity, providing alternatives to EDs for individuals in psychiatric distress, including:
	
	• Expansion of existing 24/7 Crisis Stabilization Units (CSUs) by increasing the number of CSUs statewide to provide short-term stabilization and treatment options. CSUs my offer up to 24-72 hours of crisis care and serve as an alternative to ED visits.
	• Enhancing the 988 suicide and crisis lifeline response system by ensuring statewide integration of the 988 crisis line with MCOs, hospitals, and CMHCs. As a result, 988 operators will have real-time access

Prompts	Summary
	to crisis stabilization resources, allowing direct referrals to appropriate care settings instead of defaulting to EDs. • Advancing and expanding MCTs to be deployed to divert individuals from EDs by providing immediate on-site intervention. May include MCOs and CMHCs to develop partnerships with mobile crisis providers to coordinate real-time crisis response.
	Summary of Actions Needed: N/A - Kentucky currently meets milestone requirements. The following are additional initiatives in development for implementation. **Action 1: Kentucky Rapid Response and Stabilization Services (KRRSS)** • **Description:** See above. • **Persons/Entities Responsible:** CHFS • **Timeframe:** Q3, CY 2026 **Action 2: Kentucky's 1915(i) State Plan Option, RISE Initiative** • **Description:** CMS Approved 3/27/2025- See Above • **Persons/Entities Responsible:** CHFS • **Timeframe:** Q3, CY 2025
2.e Other State requirements/policies to improve care coordination and connections to community-based care	*Current Status:* The following are current Kentucky requirements and policies used to improve care coordination and connections to community-based care: **Kynect.com.** Kentucky's online portal for residents to connect with Kentucky programs, services, and community supports. Kynect and KHIE have integrated and provides users a broad data set of SDoH information to support closed-looped referrals to community supports. The integration of the two systems allows sharing of assessment results and timely updates to patient information. The integration provides a direct link to kynect resources from within the ePartnerViewer, where users can create referrals for patients to community organizations and services. Community organizations and programs that have been onboarded to the program can manage referral activity and work together with residents to address needs. **CCBHC.** Kentucky is participating in the CCBHC Demonstration Program, which is designed to integrate behavioral health and physical health services while improving access to comprehensive mental health care. The CCBHC model provides enhanced Medicaid funding to clinics that offer a full spectrum of services, including: • 24/7 crisis intervention services; integrated primary and behavioral health care; care coordination with

Prompts	Summary
	hospitals, PCPs, and social services; and screening, assessment, and early intervention for SMI/SED. • By incorporating CCBHCs across the Commonwealth, DMS is ensuring that individuals with behavioral health needs can receive care in settings that also address their physical health, helping to reduce fragmentation of services. **Targeted Case Management (TCM).** Kentucky Medicaid reimburses for TCM services aimed to help individuals with complex needs access essential medical, social, educational, and other support services through a collaborative process of assessment, planning, and coordination of community-based care. TCM is available for individuals with SED and SMI who meet service criteria according to 907 KAR 15:050 or 907 KAR 15:060. TCM is also provided through Title V services for children younger than 21 in the custody/supervision of Department of Community Based Services (DCBS) or at risk of being in DCBS custody, and Medicaid-eligible adults 21 and older who meet the DCBS definition of adult in need of protective services. **MCOs Coordinate Care.** In Kentucky, MCOs coordinate care between hospitals and community-based mental health services by utilizing contracts with each provider type, employing care coordinators to manage patient transitions, utilizing EHRs for data sharing, and leveraging the network of CMHCs to provide a CoC across different settings — all while adhering to state regulations and quality standards set by CHFS to ensure seamless patient care. **Discharge Planning Requirements for Psychiatric Hospitals.** Currently, Kentucky has administrative regulations that require psychiatric hospitals to have written procedures for patient transfers and discharge planning. These procedures ensure that patients can access outpatient care, case management, and social services. See 902 KAR 20:180. **Multisystemic Therapy (MST) Services.** An evidence-based program for youth aged 12-17 years old and their families. MST is designed to uncover and address the functional origins of adolescent behavioral problems, with goals to: (1) eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s); (2) empower parents with the skills and resources needed to independently address the behavior issues; and (3) empower youth to cope with family, peer, school, and neighborhood problems in a healthy manner. **High-Fidelity Wraparound (HFW) Services for Youth with Complex Needs.** Kentucky's wraparound

Prompts	Summary
	services model assists young people with SED in accessing a full continuum of care (CoC) through: • Care coordination across multiple service providers. • Access to evidence-based treatments. • Peer and family support services. • Integration with child welfare and juvenile justice systems. **Kentucky's Section 5121 Consolidated Appropriations Act (CAA), 2023.** The integration of the mandatory service provisions of section 5121 of the 2023 CAA offers promising avenues for supporting justice-involved youth, particularly concerning their behavioral health needs.
	Future Status: Continued operation of compliance activities. However, Kentucky is currently developing the following initiatives to improve care coordination and connections to community-based care: **Kentucky's 1115 Reentry Demonstration** offers promising avenues for supporting justice-involved youth, particularly concerning their behavioral health needs. The emphasis on pre-release behavioral health screenings and diagnostic services helps identify mental health and SUDs prior to release allows for more effective planning and continuity of care. This proactive approach connects youth with appropriate resources and treatment immediately upon reentry, increasing their chances of success and reducing the likelihood of recidivism. Services include screenings, case management connecting with community-based providers, scheduling appointments, and ensuring access to medications and other necessary support services. By addressing behavioral health needs proactively and comprehensively, these initiatives aim to set justice-involved youth on a path towards healthier and more productive lives. **Enhanced Care Coordination Through CCBHCs.** Building on the success of its CCBHC Demonstration, Kentucky plans to expand CCBHCs statewide, increasing access to integrated physical and behavioral health services in primary care clinics, CMHCs, and federally qualified health centers (FQHCs). These clinics will: • Provide 24/7 crisis intervention services to reduce ED visits. • Enhance care coordination between behavioral health, medical, and social service providers to ensure comprehensive treatment. • Expand telehealth services for mental health consultations in primary care and rural areas. • HFW services: HFW is currently grant funded and provided by CMHCs. Kentucky will be adding HFW to the Medicaid State Plan to expand access to and improve outcomes for children/youth and families. High Fidelity Wraparound

Prompts	Summary
	Summary of Actions Needed: **Action 1: Kentucky's 1115 Reentry Demonstration** • **Description:** See above. • **Persons/Entities Responsible:** CHFS • **Timeframe:** October 1, 2025 **Action 2: CCBHC Expansion** • **Description:** Kentucky currently has four providers in the CCBHC Demonstration which lasts at least through December 2027. Kentucky is currently going through the process to expand the CCBHC Demonstration up to 10 providers may be eligible to join. Kentucky is currently developing outreach, planning trainings, and will start collecting applications for the demonstration. • **Persons/Entities Responsible:** CHFS • **Timeframe:** October 1, 2025

Prompts	Summary
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive	*Current Status:* Kentucky's current strategy for conducting annual assessments of mental health provider availability and the continuum of care ensures access to a full continuum of mental health services is critical to supporting individuals with SMI and SED. In Kentucky, annual assessments of provider availability, service capacity, and system gaps are conducted through various mechanisms, including federal reporting requirements, State-led initiatives, and Medicaid monitoring efforts. These assessments track the availability of psychiatrists, other mental health professionals, outpatient and intensive services, inpatient treatment facilities, crisis stabilization services, and FQHCs offering behavioral health care. The following presents details regarding availability assessments in Kentucky.

Prompts	Summary
outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports.	**Medicaid Section 1115 SMI/SED Demonstrations Initial Availability Assessment –** Prior to KY's Demonstration approval, the Commonwealth completed the required initial assessment to assess availability of mental health services throughout the state. KY will complete the assessment annually, providing updates on steps taken to increase availability of mental health services; updates to be included in KY's annual monitoring reports. **SAMHSA Block Grant Annual Assessments for CMHCs.** Kentucky DBHDID conducts annual assessments of the availability and capacity of CMHCs as part of the SAMHSA block grant reporting requirements. These assessments evaluate workforce capacity, including numbers of licensed behavioral health professionals (psychiatrists, psychologists, social workers, and counselors); access to outpatient behavioral health services, including therapy, medication management, and case management; and the availability of specialized programs for individuals with SMI and SED, including Assertive Community Treatment (ACT) and first-episode psychosis (FEP) programs. **CCBHC Demonstration Assessments.** Kentucky's participation in the CCBHC Demonstration Program requires evaluation of provider capacity and service availability across participating behavioral health providers. CCBHC Demonstration requires the following: CCBHCs submit identifiable Medicaid claims or encounter data to the evaluators of the Section 223 Demonstration program annually for assessment purposes. At a minimum, Medicaid claims and encounter data is provided by Kentucky to the national evaluation team, and to CMS through the Transformed Medicaid Statistical Information System (T-MSIS), should include a unique identifier for each person receiving services, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided, and diagnosis. CCBHCs must meet specific service availability criteria informed through the community needs assessment. **FQHCs** offer integrated primary and behavioral health services, including mental health counseling, substance use treatment, and psychiatric care. Kentucky tracks FQHC participation in behavioral health care through state Medicaid data and federal reporting requirements. Some FQHCs have expanded crisis services, but access remains uneven across the Commonwealth, particularly in rural and underserved areas. **Tracking Psychiatric Bed Availability and Crisis Stabilization Services** currently includes psychiatric hospitals self-report capacity, but there is no centralized system to track open beds in real time.

Prompts	Summary
	Crisis Stabilization Service Capacity assessments address the following: • Crisis Stabilization Units (CSUs) are available in some areas, but statewide capacity is limited. • Mobile crisis team (MCTs) provide some ED diversion and community-based crisis response, but coverage varies across regions. • The 988 Suicide and Crisis Lifeline serves as a primary crisis call center, but coordination between 988 operators and MCTs remains an area for improvement. • FindHelpNow. The online treatment locator includes resources for individuals with SUDs and mental health disorders, as well as their family members, friends, and others. The site also directs people in crisis to call 988. **Use of Patient Assessment Tools to Inform Care Placement.** Kentucky DMS requires the use of standardized patient assessment tools to evaluate clinical needs and determine appropriate levels of care. • **LOC Determination.** MCOs and providers use clinical criteria to assess whether an individual requires inpatient or intensive outpatient treatment. • **Standardized Psychiatric Evaluations.** Some hospitals use psychiatric triage assessments to determine whether inpatient admission is necessary or if community-based care is an appropriate LOC.
	Future Status: Continued operation of compliance activities.
	Summary of Actions Needed: Complete the annual Medicaid Section 1115 SMI/SED Demonstration Availability Assessment of mental health services. **Action 1: Assessment of the Availability of Mental Health Services** • **Description:** See above. • **Persons/Entities Responsible:** CHFS • **Timeframe:** Q3, Annual CY

Prompts	Summary
3.b Financing plan	*Current Status:* Please refer to Section 5-Financial Plan for additional information.
	Future Status:

Prompts	Summary
	Please refer to Section 5-Financial Plan for additional information.
	Summary of Actions Needed: Please refer to Section 5-Financial Plan for additional information.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	*Current Status:* The following outlines Kentucky's current strategies to improve their system of tracking the inpatient and crisis stabilization bed availability. • **Self-Reporting by Hospitals and Crisis Providers.** Psychiatric hospitals and CSUs report bed availability manually, often through internal hospital dashboards or periodic updates to referral partners. This approach lacks real-time data and often results in delays in placing individuals in appropriate treatment settings. • **Medicaid and MCO Oversight.** MCOs track utilization and availability of psychiatric inpatient beds for Medicaid beneficiaries, but this information is not centralized or available for real-time crisis coordination. MCOs also have contracts with crisis stabilization providers, but coordination between MCOs, hospitals, and community providers remains inconsistent. • **CMHC Coordination with Crisis Services.** CMHCs work with hospitals, mobile crisis teams and law enforcement to identify available crisis stabilization placements. However, without an integrated tracking system, placement decisions are often delayed, leading to unnecessary inpatient admissions or prolonged ED stays. • **FindHelpNow.** The online treatment locator includes resources for individuals with SUDs and mental health disorders, as well as their family members, friends, and others. The site also directs people in crisis to call 988.
	Future Status: Continued operation of compliance activities. However, in Kentucky, the current system for tracking inpatient and crisis stabilization bed availability is fragmented and often relies on manual reporting methods, which create challenges with ensuring accurate, up-to-date information on service capacity. At present, Kentucky does not have a fully operational statewide psychiatric bed tracking system that provides real-time updates on inpatient and crisis stabilization bed availability. As a result, DMS is currently exploring opportunities to implement improved tracking of inpatient and crisis stabilization beds.
	Summary of Actions Needed: Kentucky will assess the current limited functionality and evaluate strategies to establish a uniform real-time hospital bed management system to support statewide tracking of inpatient and crisis stabilization bed availability across the Commonwealth using the state's health data exchange systems. **Action 1: Real-time Hospital Bed Management and Tracking System**

Prompts	Summary
	• **Description:** See above. • **Persons/Entities Responsible:** CHFS • **Timeframe:** During CY 2026
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	*Current State:* Ensuring that mental health providers in Kentucky utilize a standardized, widely recognized, and publicly available patient assessment tool is critical for determining the appropriate LOC and LOS for individuals with SMI and SED. Currently, Kentucky's use of patient assessment tools varies across provider types, funding mechanisms, and care settings. While some standardized tools are in place, there is no single, uniform requirement mandating their use statewide across all levels of care. **Use of Standardized Patient Assessment Tools.** Several recognized patient assessment tools are used in Kentucky's behavioral health system, but utilization is not yet standardized across all providers: • **Level of Care Utilization System (LOCUS).** Assesses enrollees' harm risk level, functional status, immediate service needs, and quantifies the assessment of services need to determine appropriate LOC and LOS. • **Child and Adolescent Needs and Strengths (CANS) Assessment** is an assessment tool developed for children's services to support person-centered decision-making, including LOC determination, service planning, and to allow for the monitoring of outcomes of services. Used by CMHCs. • **MCO Review and Utilization Criteria.** MCOs oversee authorization for inpatient stays and crisis stabilization admissions. There is variation among MCOs regarding which clinical criteria and patient assessment tools are used to determine LOS. • **DMS and MCO Coordination.** Kentucky MCOs track utilization and authorization of inpatient psychiatric services but rely on individual provider assessments and clinical documentation to determine continued stay. • **The Role of Patient Assessment Tools in Tracking and Placement Decisions.** Kentucky currently utilizes multiple patient assessment tools to determine the appropriate LOC, but these tools are not uniformly applied across crisis response settings. The following are Kentucky's current use of patient assessment tools: o Psychiatric hospitals and CSUs use clinical screening tools to determine eligibility for inpatient or stabilization services. o MCOs and case managers conduct LOC assessments to guide treatment planning and service referrals. o EDs use behavioral health triage tools, but these assessments are not always standardized

Prompts	Summary
	across hospitals. o InterQual Behavioral Health Criteria and MCG (Milliman) are used by Medicaid to determine medical necessity.
	Future Status: Continued operation of compliance activities. Since Kentucky's current use of patient assessment tools varies across provider types, funding mechanisms, and care settings, and there is no single, uniform requirement across the Commonwealth. Kentucky will evaluate the effectiveness of assessment tools, while monitoring and evaluating the utilization of the assessment tools within the CCBHC demonstration as well as 1915(i) SPA demonstration. Based on outcomes and findings, KY will identify standard assessments and develop a timeline and communication plan for statewide implementation.
	Summary of Actions Needed: N/A - Kentucky currently meets milestone requirements.

Prompts	Summary
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	*Current State:* Kentucky has made significant strides in expanding access to a comprehensive continuum of care for individuals with SMI and SED. This includes efforts to strengthen crisis stabilization services, improve response times for individuals in crisis, and enhance coordination among inpatient, residential, and community-based care providers. **Expansion of Mobile Crisis Services.** A key component of Kentucky's crisis response strategy has been the implementation and expansion of mobile crisis services. • Kentucky Medicaid covers Mobile Crisis Response under its behavioral health benefit, allowing for rapid, community-based intervention for individuals experiencing a behavioral health crisis. • Mobile Crisis Teams (MCTs) are available through CMHCs and CCBHCs to provide on-site crisis de-escalation, assessment, and care coordination. • Teams operate 24/7 in designated regions, but coverage gaps exist, particularly in rural and underserved areas. **Integration with 988 Suicide and Crisis Lifeline.** Kentucky has established a strong framework for integrating its crisis response system with the 988 Suicide and Crisis Lifeline, which launched in 2022 as an

Prompts	Summary
	alternative to 911 for behavioral health emergencies. • CMHCs with 988 serves as the Kentucky's primary crisis call centers, connecting individuals with mental health professionals who provide assessment, support, and referrals. • Kentucky's 988 system is staffed by trained crisis counselors who can triage callers and refer them to appropriate crisis services, including MCTs, CSUs, and inpatient care. • Efforts are underway to integrate 988 with emergency responders, law enforcement, and community-based services to create a comprehensive crisis care model. **Crisis Stabilization Units (CSUs) and Residential Services.** Kentucky has made progress in expanding CSUs to provide short-term psychiatric stabilization for individuals experiencing acute mental health crises. • CSUs serve as an alternative to inpatient hospitalization, offering brief stays and intensive crisis interventions. • Kentucky Medicaid covers crisis stabilization services, but access varies by region, and some areas lack sufficient CSU capacity. • Some CMHCs operate residential crisis stabilization programs, but availability is limited, and many CSUs face workforce shortages that limit operational capacity. **Kentucky's 1915(i) State Plan Option, RISE Initiative for SMI with Co-Occurring SUD** was approved by CMS on March 27, 2025. During the implementation phase, Kentucky will work towards the offering of a comprehensive collection of home and community-based services (HCBS). The program services provide individuals with a primary diagnosis of an SMI or SMI with co-occurring SUD to learn skills and receive services to thrive at home or in the community, access to services will include a functional assessment that encompasses housing status for individuals.
	Future State: Kentucky is committed to identify areas of expansion to ensure a comprehensive, community-based behavioral health continuum of care that ensures individuals with SMI and SED receive appropriate, timely, and coordinated care. To achieve this, Kentucky will implement key policy reforms, infrastructure enhancements, and financial strategies to strengthen crisis stabilization, inpatient and residential services, and community-based care supports. By leveraging Medicaid financing, enhancing real-time data tracking, and improving workforce capacity, Kentucky aims to reduce avoidable hospitalizations, increase access to crisis stabilization services, and ensure smoother transitions across all levels of care. **Strengthening Medicaid Financing and Sustainability Strategies.** Kentucky Medicaid will review and

Prompts	Summary
	explore financing options to support the long-term sustainability of crisis services, inpatient psychiatric care, and community-based treatment which include review of the following: • **Kentucky Rapid Response and Stabilization Services (KRRSS)** are community-based programs that provide immediate support to families experiencing behavioral health crises. Services may include therapy, safety planning, skills training, and medication management. Kentucky will integrate to support mobile crisis response and 988 Services, as well as expanding the availability of KRRSS and MCI teams trained in youth-specific crisis intervention. • **Kentucky's 1915(i) State Plan Option, RISE Initiative for SMI with Co-Occurring SUD** was approved by CMS on March 27, 2025. During the implementation phase, Kentucky will work towards the offering of a comprehensive collection of home and community-based services (HCBS). The program services provide individuals with a primary diagnosis of an SMI or SMI with co-occurring SUD to learn skills and receive services to thrive at home or in the community, access to services will include a functional assessment that encompasses housing status for individuals. **Explore the Expansion of Mobile Crisis Services.** A key component of Kentucky's crisis response strategy has been the implementation and expansion of mobile crisis services. • Kentucky Medicaid covers mobile crisis response under its behavioral health benefit, allowing for rapid, community-based intervention for individuals experiencing a behavioral health crisis. • Mobile Crisis Teams (MCTs) are available through CMHCs to provide on-site crisis de-escalation, assessment, and care coordination. • Teams operate 24/7 in designated regions, but coverage gaps exist, particularly in rural and underserved areas. • Kentucky is working to enhance Medicaid reimbursement for mobile crisis response to ensure long-term sustainability.
	Summary of Actions Needed: N/A - Kentucky currently meets milestone requirements. The following are additional initiatives in development for implementation: **Action 1: Kentucky Rapid Response and Stabilization Services (KRRSS)** • **Description:** See above. • **Persons/Entities Responsible:** CHFS • **Timeframe:** Q3, CY 2026

Prompts	Summary
	Action 2: Kentucky's 1915(i) State Plan Option, RISE Initiative • **Description:** CMS Approved 3/27/2025 -See above • **Persons/Entities Responsible:** CHFS • **Timeframe:** Q3, CY 2025 **Action 3: MCO Contract Changes** • **Description:** See above. • **Persons/Entities Responsible:** CHFS, MCOs • **Timeframe:** Q4, CY 2025
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs	*Current State:* In Kentucky, early identification and engagement in treatment for individuals with SMI and SED is supported through a combination of state programs, Medicaid-funded services, and community-based initiatives. These efforts aim to identify at-risk individuals early and connect them to appropriate mental health services, employment support, and community-based resources to improve long-term outcomes. **Screening and Early Identification Efforts.** Kentucky's behavioral health system includes multiple screening and referral mechanisms to identify individuals at risk for SMI/SED before symptoms become severe. Key initiatives include: • **CMHCs.** Kentucky has 14 regional CMHCs that provide early mental health screening, outreach, and assessment to at-risk populations, including children and adults. For example, the iHope Program is an initiative focused on identifying and supporting students with behavioral health challenges, ensuring they receive early intervention and linkages to care. • **Primary Care and School-Based Mental Health Programs.** Many pediatricians, family physicians, and school health providers conduct initial mental health screenings using tools like the Patient Health Questionnaire (PHQ-9) for depression as well as utilization of the CANS assessment.

Prompts	Summary

	• **Behavioral Health Integration with MCOs.** MCOs uses predictive analytics and claims data to identify high-risk individuals who may need early mental health intervention.
	• **Health Access Nurturing Development Services (HANDS) Program.** A voluntary home visitation program that supports families through pregnancy and the first two years of life.
	• **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT):** EPSDT is a Medicaid-funded program in Kentucky that provides comprehensive and preventative health care services for children from birth to age 21. This includes dental, mental health, and specialty services.
	• **Infant and Early Childhood Mental Health Consultation (IECMHC).** IEMCHC is a prevention-based approach that pairs a licensed mental health consultant with adults/caregivers who work with infants and young children in the different settings and equips caregivers to facilitate the healthy social and emotional development of children provided through CMHCs.
	• **Kentucky's Common Kindergarten Entry Screener, the BRIGANCE Early Childhood Kindergarten Screen III** provides an assessment of a child's development in five areas: academic/cognitive, language, development, physical development, and self-help and social-emotional development. Common Kindergarten Entry Screener.
	
	Strategies for Engaging At-Risk Individuals in Treatment. To ensure individuals at risk of SMI/SED engage in treatment earlier, Kentucky employs targeted outreach and engagement strategies, including:
	• **Peer Support and Community-Based Engagement**
	  ○ Kentucky Medicaid reimburses for peer support services, where individuals with lived experience provide peer-to-peer engagement and navigation support for individuals reluctant to enter care.
	  ○ ACT teams provide intensive, community-based care to high-risk individuals, reducing hospitalizations and increasing engagement.
	• **Crisis Intervention and Outreach Programs**
	  ○ Kentucky has MCTs that respond to individuals in crisis and provide immediate linkages to mental health treatment, reducing unnecessary ED visits.
	  ○ The 988 Suicide and Crisis Lifeline connects callers with trained crisis counselors, providing support and referrals to behavioral health treatment providers.
	• **Supported Employment Programs for Individuals with SMI/SED**

Prompts	Summary
	○ Kentucky participates in the Individual Placement and Support program, which helps individuals with mental illness obtain and maintain employment, a key factor in long-term recovery. ○ Vocational rehabilitation programs, in collaboration with Medicaid behavioral health providers, offer job coaching, skills training, and supported employment services. • **High-Fidelity Wraparound (HFW) Services for Youth with Complex Needs.** HFW services are currently grant funded and are Kentucky's wraparound services model assists young people with SED in accessing a full continuum of care through: ○ Care coordination across multiple service providers. ○ Access to evidence-based treatments. ○ Peer and family support services. ○ Integration with child welfare and juvenile justice systems.
	Future Status: Kentucky is committed to enhancing early identification and engagement efforts for individuals at risk of SMI or SED. Kentucky is currently exploring opportunities to build upon existing programs by integrating behavioral health into non-specialty settings, expanding employment and support services, and increasing access to specialized programs for youth and adults with emerging mental health conditions. These opportunities may include, but are not limited to the following: **Expansion of Screening and Early Identification Initiatives.** To improve early identification of SMI/SED, Kentucky will implement the following strategies: • **Increased Mental Health Screening in Schools.** SHINE KY will enhance access to and delivery of school-based services for Medicaid and Children's Health Insurance Program (CHIP)-eligible and enrolled students. Expansion of school-based behavioral health screenings in coordination with local school districts and Medicaid-funded behavioral health providers to identify students in need of early intervention. • **Expand Medicaid Coverage for Intensive Home-Based Behavioral Health Services.** Kentucky will continue working toward ensuring intensive in-home therapy and wraparound services are widely available for young people with emerging mental health needs. • **High Fidelity Wraparound (HFW) Services.** HFW is a holistic, evidence-based model, family-driven way of responding when youth experience serious mental health or behavioral challenges. Wraparound puts the child and family at the center, with support from a team of professionals and natural supports.

Prompts	Summary
	HFW is currently grant funded and provided by CMHCs. Kentucky has plans to add HFW to the Medicaid State Plan to expand access to and improve outcomes for children/youth and families. High Fidelity Wraparound • **Enhance Crisis Response for Youth.** Kentucky will identify opportunities to integrate youth-specific Mobile Crisis Response Teams that provide immediate, on-site behavioral health services in school and community settings into KY's crisis continuum. Kentucky Rapid Response and Stabilization Services (KRRSS) are community-based programs that provide immediate support to families experiencing behavioral health crises. Services may include therapy, safety planning, skills training, and medication management. **Infant and Early Childhood Mental Health Consultation (IECMHC).** Kentucky will work to develop policy to include IEMCHC in the Medicaid state plan.
	Summary of Actions Needed: N/A - Kentucky currently meets milestone requirements.
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	*Current Status:* Kentucky has made significant strides in integrating behavioral health care into non-specialty settings to facilitate earlier identification, engagement, and treatment for individuals with SMI and SED. Kentucky continues to focus on expanding access to behavioral health services within primary care, schools, and maternal health programs, ensuring that individuals at risk for SMI/SED are connected to appropriate care as early as possible, including the following: **CCBHC Demonstration.** Kentucky is participating in the CCBHC Demonstration Program, which is designed to integrate behavioral health and physical health services while improving access to comprehensive mental health care. The CCBHC model provides enhanced Medicaid funding to clinics that offer a full spectrum of services, including: • 24/7 crisis intervention services. • Integrated primary and behavioral health care. • Care coordination with hospitals, PCPs, and social services. • Screening, assessment, and early intervention for SMI/SED. **Enhancement of School-Based Behavioral Health Services.** Kentucky recognizes the importance of schools in identifying and treating children and adolescents with emerging behavioral health conditions. Kentucky has expanded school-based mental health programs, including:

Prompts	Summary
	• School-based health clinics that provide on-site behavioral health counseling. • Medicaid reimbursement for school-based behavioral health services, allowing schools to bill Medicaid for mental health screenings, therapy, and case management. • The iHope Program, a school-based initiative focused on identifying and supporting students with behavioral health challenges, ensuring they receive early intervention and linkages to care. **Medicaid Support for Integrated Behavioral Health in Primary Care.** Kentucky's Medicaid program supports the integration of behavioral health into primary care settings, recognizing the importance of early detection and treatment. Strategies include: • Expansion of Medicaid reimbursement for behavioral health services provided in primary care clinics. • Encouraging FQHCs to integrate behavioral health consultants within their teams, promoting a whole-person approach to care. • Supporting collaborative care models, where PCPs work alongside behavioral health professionals to screen, diagnose, and treat individuals with SMI/SED.

	Future Status: Continued operation of compliance activities. However, Kentucky is currently planning the following activities:
	• **Expand CCBHCs** throughout the Commonwealth, increasing access to integrated physical and behavioral health services in primary care clinics, CMHCs, and FQHCs.
	• **KRRSS** is our crisis intervention model, which emphasizes the need to respond with urgency to the immediate needs of children, youth, young adults, and their caregivers. The model offers rapid response and intervention to help stabilize families with youth experiencing behavioral health challenges and prevent further escalation or harm.
	• **Enhancement of School-Based Behavioral Health Services** by increasing access to behavioral health services within school settings, ensuring early detection and intervention for children and adolescents with SED. Future efforts include:
	  ○ Encouraging universal mental health screenings in schools, integrating them into existing health assessments.
	  ○ Enhancing Medicaid reimbursement for school-based behavioral health services, allowing schools to bill Medicaid for a wider range of behavioral health interventions.
	  ○ Strengthening partnerships between schools and CMHCs, ensuring a seamless referral process for students needing specialized mental health care.

Prompts	Summary
	Summary of Actions Needed: N/A - Kentucky currently meets milestone requirements.

Prompts	Summary
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	*Current State:* While Kentucky has made significant strides in expanding specialized settings and services to support young people experiencing SED and SMI, the following current initiatives aim to provide crisis stabilization, intensive treatment, and long-term support services tailored to the needs of children and adolescents. **Psychiatric Residential Treatment Facilities (PRTFs).** To address the growing need for intensive residential services, Kentucky has invested in PRTFs: • PRTF 1 and PRTF II provide long-term, structured residential care for young individuals requiring highly intensive treatment. • PRTFs aim to close service gaps and ensure that youth with severe psychiatric conditions receive the appropriate LOC. **Assertive Community Treatment (ACT)** Kentucky has implemented ACT teams specializing in adults with complex mental health needs. ACT teams provide: • Multi-disciplinary support, including psychiatric care, therapy, case management, and peer support. • Wraparound services that ensure continuity of care post-crisis stabilization. Family-centered treatment approaches to engage caregivers in the recovery process. **Residential Crisis Stabilization Units (RCSUs).** RCSUs serve as short-term, intensive stabilization programs designed to prevent unnecessary hospitalization and expedite community reintegration. **Medicaid and MCO Support for Youth Mental Health Services.** Kentucky MCOs and Medicaid policies play a key role in ensuring that youth with SED/SMI have access to early intervention, crisis stabilization, and

Prompts	Summary
	specialized inpatient treatment. MCOs are required to: • Cover crisis response services, intensive outpatient treatment, and inpatient psychiatric care for youth. • Implement care coordination models to ensure continuity of care post-crisis. • Monitor utilization and referral patterns to identify service gaps. • **Aetna Supporting Kentucky Youth (SKY)** was developed to provide trauma-focused interventions for children in foster care and those involved in juvenile justice programs. A care coordination team is assigned to each SKY beneficiary who ensures access to primary care, behavioral health services, dental care, specialty care, wraparound services, and social support services, with LOC management tailored to meet individual needs. Kentucky has established a robust framework for early crisis intervention and intensive community-based supports for young people with SED/SMI. These services, supported by mobile crisis response, crisis stabilization units, PRTFs, ACT teams, and Medicaid-funded programs, ensure that youth receive timely, specialized care to improve long-term mental health outcomes.
	Future State: Kentucky will continue to identify areas for expanding crisis stabilization services and specialized treatment settings for young individuals with SED and SMI. Recognizing the importance of early intervention, access to high-intensity services, and community-based supports, DMS aims to develop a comprehensive continuum of care that ensures youth receive immediate crisis stabilization, intensive treatment when necessary, and long-term support to sustain recovery. **Strengthening Integration Between Crisis Response and Other Youth Services** will include: • Exploring opportunities to establishing to provide immediate support to families experiencing behavioral health crises. Services may include therapy, safety planning, skills training, and medication management. • Strengthening coordination between Kentucky MCTs, inpatient facilities, and outpatient behavioral health providers to improve continuity of care post-crisis. • Identifying opportunities to leverage Medicaid funding to enhance crisis intervention reimbursement rates, ensuring that providers are incentivized to expand crisis response services. • Exploring enhancements to RCSU to provide short-term stabilization in a supportive environment before transitioning youth to community-based services. **Exploration of funding opportunities for 23-Hour Crisis Stabilization and Mobile Crisis Services.** Kentucky will explore the following:

Prompts	Summary
	• Opportunities to develop 23-hour crisis stabilization facilities to provide immediate, short-term crisis intervention for youth experiencing psychiatric distress. • Expansion of mobile crisis statewide, ensuring MCTs are available 24/7 to provide on-site de-escalation, assessment, and linkage to care. • Integration of Kentucky's 988 Suicide and Crisis Lifeline into mobile crisis response, allowing real-time dispatch of crisis intervention teams when needed. **Strengthening School-Based Mental Health Interventions** • Kentucky will identify opportunities to enhance the other school-based mental health initiatives, including crisis response services are integrated into school settings. • Schools will have access to behavioral health providers who will work directly with MCTs when a student is in distress. • Kentucky will explore enhancements to Medicaid reimbursement for school-based crisis intervention services to support sustainability.
	Summary of Actions Needed: N/A - Kentucky currently meets milestone requirements; however, Kentucky is currently exploring new opportunities to improve service delivery to further meet the milestone requirements. Kentucky continues to explore areas for enhancements to its continuum of care for youth experiencing SED and SMI by exploring expansion of crisis stabilization services, specialized treatment facilities, and community-based interventions. To achieve these goals, the key actions noted below must be taken to meet the Milestone 4.c criteria. By implementing these strategic actions, Kentucky aims to expand crisis stabilization services, enhance residential treatment options, improve system coordination, and integrate early intervention strategies for youth with SED/SMI. These efforts will create a more comprehensive and responsive behavioral health system, ensuring young individuals receive timely, effective, and accessible care to support long-term recovery and well-being. The following are timelines for implementation: **Action 1: Kentucky Rapid Response and Stabilization Services (KRRSS)** • **Description:** See above. • **Persons/Entities Responsible:** CHFS • **Timeframe:** Q2, CY 2026 **Action 2: Exploration of funding opportunities of 23-Hour Crisis Stabilization and Mobile Crisis Services** • **Description:** See above.

Prompts	Summary
	• **Persons/Entities Responsible:** CHFS • **Timeframe:** Q2, CY 2026 **Action 3: Strengthening School-Based Mental Health Interventions** • **Description:** See above. • **Persons/Entities Responsible:** CHFS, MCOs • **Timeframe:** Q2, CY 2027
4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	*Current Status:* Kentucky is actively implementing various strategies to improve early identification and engagement in treatment for youth with SED and SMI. These strategies focus on early screening, integration of behavioral health in primary care and schools, and specialized programs designed to address the needs of young people at risk of or experiencing behavioral health challenges. **Expansion of School-Based Mental Health Services.** Kentucky has expanded school-based behavioral health services as a strategy to increase early identification and intervention for children and adolescents with SED. Many CMHCs and private behavioral health providers have embedded mental health clinicians in school settings to conduct early screenings, provide counseling, and offer referrals to more intensive services when needed. This effort aligns with Kentucky's Medicaid reimbursement model, allowing providers to bill for school-based services under Medicaid. **First Episode Psychosis (FEP) Programs.** Kentucky has implemented FEP programs aimed at young people experiencing early symptoms of psychosis. These programs, funded through SAMHSA block grants, follow CSC models, which emphasize: • Early detection and intervention for psychosis. • Comprehensive, team-based treatment, including medication management, psychotherapy, family education, and peer support. • Supported employment and education assistance. Early Interventions for First Episode Psychosis. **Behavioral Health Integration in Pediatric Primary Care.** To enhance early detection and engagement, Kentucky has expanded behavioral health integration into pediatric primary care settings. Many FQHCs and primary care practices have integrated behavioral health consultants or licensed mental health professionals into their teams to: • Conduct routine mental health screenings during well-child visits.

Prompts	Summary
	• Provide brief interventions for common mental health concerns. • Refer patients to specialized behavioral health services as needed. **Mobile Crisis Response and 988 Suicide Prevention Services.** Kentucky has implemented 988, the national suicide and crisis lifeline, which connects individuals to trained crisis counselors who can provide immediate assistance and, if necessary, coordinate MCT responses. MCTs are trained in de-escalation, risk assessment, and linkage to ongoing treatment and serve as an essential early intervention tool for individuals in mental health distress. Crisis Prevention and Response System 988 Suicide & Crisis Lifeline **Early Childhood Mental Health Consultation (ECMHC) –** The ECMHC program through Kentucky's CMHCs aims to improve emotional well-being in young children by providing mental health consultation services to early childhood education providers, families, and caregivers. Through ECMHC, trained consultants: • Work with childcare centers and preschools to identify and address early signs of emotional and behavioral issues. • Offer training and guidance to teachers and caregivers on mental health promotion strategies. • Provide support to families in navigating behavioral health services for young children. Early Childhood Mental Health Program **System of Care (SOC) Approach to Care.** Kentucky's SOC framework incorporates mental health promotion, prevention, early identification, and early intervention in addition to treatment to address the needs of all children, youth, and young adults. System of Care Approach **High-Fidelity Wraparound (HFW) Services for Youth with Complex Needs.** These services are granted funded and ensure youth with complex mental health needs receive coordinated, family-driven, and youth-guided care. Kentucky's wraparound services model assists young people with SED in accessing a full continuum of care through: • Access to evidence-based treatments. • Peer and family support services. • Integration with child welfare and juvenile justice systems.

Prompts	Summary
	Trauma-Informed Care and Screening Initiatives. Kentucky has emphasized trauma-informed care approaches across child-serving systems, ensuring that health care providers, educators, and child welfare professionals are trained in recognizing and responding to adverse childhood experiences. Trauma screenings are now widely used in pediatric settings, mental health clinics, and social service agencies to identify children who may be at risk for developing SED. Kentucky has made significant progress in increasing early identification, engagement, and integration of behavioral health services for youth with SED/SMI. Through school-based mental health programs, early psychosis interventions, behavioral health integration in pediatric primary care, mobile crisis response, early childhood mental health initiatives, and trauma-informed care strategies, Kentucky is working to connect young people to the right services at the right time. 1. **The Health Access Nurturing Development Services (HANDS**) program is a voluntary home visitation program that supports families through pregnancy and the first two years of life. HANDS supports families as they build healthy, safe environments for the optimal growth and development of children. 2. **Supporting Kentucky Youth (SKY)** was developed to provide trauma-focused interventions for children in foster care and those involved in juvenile justice programs. A care coordination team is assigned to each SKY beneficiary who ensures access to primary care, behavioral health services, dental care, specialty care, wraparound services, and social support services, with LOC management tailored to meet individual needs. 3. **Multisystemic Therapy (MST) Pilot** currently provides in-home family to families when a child is at risk of being placed out of the home, typically due to behaviors involving the legal system or truancy at school. 4. **Transition Age Youth Launching Realized Dreams (TAYLRD)** was developed to address the unique needs of transition-age youth, Kentucky will explore the creation of specialized behavioral health centers focused on young adults ages 16-25. These centers will provide age-appropriate mental health care, substance use treatment, and peer support services. Offer education and employment assistance, life skills training, and housing support for youth transitioning to adulthood. Serve as centralized hubs for connecting young people with long-term, community-based services. This initiative is based on successful models from other states that have demonstrated positive outcomes in reducing crisis episodes and improving treatment engagement among young adults. 5. **The Workforce Innovation and Development (WID) Collaborative.** Kentucky recognizes that expanding access to early intervention and behavioral health integration requires a strong workforce. Kentucky plans to invest in: • Workforce training programs to recruit and retain mental health professionals, particularly in rural and underserved areas.

Prompts	Summary
	• Training programs focused on evidence-based interventions for youth, including trauma-informed care and family-centered therapy. • Evaluate the performance and satisfaction of the behavioral health, developmental, and intellectual disabilities workforce.
	Future Status: Kentucky continues to explore opportunities to expand early identification and engagement strategies, enhancing integration of behavioral health services in non-specialty settings, and developing additional specialized programs for young people experiencing SED and SMI. Kentucky aims to strengthen these efforts through policy enhancements, expanded access to services, and increased coordination between child-serving systems. The following outlines Kentucky's planned initiatives to satisfy the milestone requirements: **Families First** is a comprehensive, multi-year initiative aimed at enhancing the existing SOC for all Kentucky children and youth. The initiative seeks to create a unified, integrated, and child-centered care framework that addresses the diverse needs of Kentucky's young population. By enhancing coordination across health, education, social services, and other key sectors, Families First aims to ensure that every child and youth receives the necessary support to achieve their full potential. Kentucky will continue to explore opportunities for Families First to provide an array of initiatives to support youth and families. Additional initiatives include: • Increased coordination between child welfare, juvenile justice, and behavioral health systems. To enhance early identification and engagement for youth involved in the child welfare and juvenile justice systems, Kentucky will: o Comply with Section 5121 CAA, 2023. The integration of the mandatory service provisions of section 5121 of the 2023 CAA offers promising avenues for supporting justice-involved youth, particularly concerning their behavioral health needs. o Develop cross-agency data-sharing agreements to improve identification of at-risk youth. o Expand MST to continue in-home family to families when a child is at risk of being placed out of the home, typically due to behaviors involving the legal system or truancy at school. o Increase access to community-based alternatives to detention for youth with behavioral health needs. **Integration of Behavioral Health Services in Primary Care and Pediatric Settings.** Kentucky will explore the expansion of integrating behavioral health services in primary care and pediatric settings through:

Prompts	Summary
	• Implementation of standardized mental health screenings during pediatric well-child visits. • Embedding behavioral health clinicians in FQHCs and pediatric offices to provide early intervention services. • Encouraging VBP models that incentivize PCPs to engage in mental health prevention, screening, and treatment efforts. **Enhance Mobile Crisis Response and 988 Services.** Kentucky is committed to exploring the enhancement crisis response services for youth and identify opportunities to: • Establish KRRSS to support mobile crisis response and 988 services. • Expand the availability of mobile crisis teams trained in youth-specific crisis intervention. • Enhance coordination between the 988-crisis hotline and community-based crisis services to ensure rapid response for young people in mental health distress. •
	Summary of Actions Needed: N/A - Kentucky currently meets milestone requirements. The following are additional initiatives in development for implementation. **Action 1: Kentucky Rapid Response and Stabilization Services (KRRSS)** • **Description:** See above. • **Persons/Entities Responsible:** CHFS • **Timeframe:** Q2, CY 2026 **Action 2: Kentucky's Family First** • **Description: See above.** • **Persons/Entities Responsible:** CHFS • **Timeframe:** Q2, CY 2026

Prompts	Summary
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included	

Prompts	Summary
in the state's application.	
F.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	*Current Status* Kentucky Medicaid has secured state general funds to support anticipated 1115 SMI Demonstration expenditures through state fiscal year (SFY) 2026. In addition, KY provides the following non-hospital, non-residential crisis stabilization services: **Expansion of Mobile Crisis Services.** A key component of Kentucky's crisis response strategy has been the implementation and expansion of mobile crisis services. • Kentucky Medicaid covers Mobile Crisis Response under its behavioral health benefit, allowing for rapid, community-based intervention for individuals experiencing a behavioral health crisis. • Mobile Crisis Teams (MCTs) are available through CMHCs and CCBHCs to provide on-site crisis de-escalation, assessment, and care coordination. • Teams operate 24/7 in designated regions, but coverage gaps exist, particularly in rural and underserved areas. **Integration with 988 Suicide and Crisis Lifeline.** Kentucky has established a strong framework for integrating its crisis response system with the 988 Suicide and Crisis Lifeline, which launched in 2022 as an alternative to 911 for behavioral health emergencies. • CMHCs with 988 serves as the Kentucky's primary crisis call centers, connecting individuals with mental health professionals who provide assessment, support, and referrals. • Kentucky's 988 system is staffed by trained crisis counselors who can triage callers and refer them to appropriate crisis services, including MCTs, CSUs, and inpatient care. • Efforts are underway to integrate 988 with emergency responders, law enforcement, and community-based services to create a comprehensive crisis care model. **Kentucky's Community Crisis Co-Response (CCCR) Grant Program** embeds behavioral health professionals or paraprofessionals as co-responders within the municipality team of law enforcements and first responders. Kentucky has awarded seven local-government organizations grants to support forming partnerships between behavioral-health professionals, law enforcement or other first responders and local governments in order to lower the distress of individuals in crisis and avoid unnecessary hospitalizations and incarcerations while extending crisis services to communities.

Prompts	Summary
	Kentucky's 1915(i) State Plan Option, RISE Initiative for SMI with Co-Occurring SUD was approved by CMS on March 27, 2025. During the implementation phase, Kentucky will work towards the offering of a comprehensive collection of home and community-based services (HCBS). The program services provide individuals with a primary diagnosis of an SMI or SMI with co-occurring SUD to learn skills and receive services to thrive at home or in the community, access to services will include a functional assessment that encompasses housing status for individuals.
	Future Status: Kentucky currently meets milestone requirements and will continue to request funding to support ongoing implementation. **Exploration of funding opportunities for 23-Hour Crisis Stabilization and Mobile Crisis Services.** Kentucky will explore the following: • Opportunities to develop 23-hour crisis stabilization facilities to provide immediate, short-term crisis intervention for youth experiencing psychiatric distress. • Expansion of mobile crisis statewide, ensuring MCTs are available 24/7 to provide on-site de-escalation, assessment, and linkage to care. • Integration of Kentucky's 988 Suicide and Crisis Lifeline into mobile crisis response, allowing real-time dispatch of crisis intervention teams when needed **Enhance Mobile Crisis Response and 988 Services.** Kentucky is committed to exploring the enhancement crisis response services for youth and identify opportunities to: • Establish KRRSS to support mobile crisis response and 988 services. • Expand the availability of mobile crisis teams trained in youth-specific crisis intervention. • Enhance coordination between the 988-crisis hotline and community-based crisis services to ensure rapid response for young people in mental health distress.
	Summary of Actions Needed: Kentucky Medicaid will continue to monitor actual service experience and budgetary needs to better inform future budget requests. Additionally, Kentucky Medicaid plans to utilize their 1915(i) SPA waiver to support the identification of gaps across non- hospital and non-residential crisis stabilization services, Braided and blended funding, such as block grant dollars via sister agencies to support services which are not typically reimbursable by Medicaid will continue to be utilized.

Prompts	Summary
	Action 1: Monitoring and Budget Requests • **Description: See above.** • **Persons/Entities Responsible:** CHFS **Action 2: Kentucky's 1915(i) State Plan Option, RISE Initiative** • **Description:** CMS Approved 3/27/2025 -See above • **Persons/Entities Responsible:** CHFS • **Timeframe:** Q3, CY 2025 **Action 3: Kentucky Rapid Response and Stabilization Services (KRRSS)** • **Description:** See above. • **Persons/Entities Responsible:** CHFS • **Timeframe:** Q2, CY 2026 **Action 4 : Exploration of funding opportunities of 23-Hour Crisis Stabilization and Mobile Crisis Services** • **Description:** See above. • **Persons/Entities Responsible:** CHFS • **Timeframe:** Q2, CY 2026 **Timeframe: Ongoing**
F.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	*Current Status:* **CCBHC Demonstration.** Kentucky is participating in the CCBHC Demonstration Program, which is designed to integrate behavioral health and physical health services while improving access to comprehensive mental health care. The CCBHC model provides enhanced Medicaid funding to clinics that offer a full spectrum of services, including: • 24/7 crisis intervention services. • Integrated primary and behavioral health care. • Care coordination with hospitals, PCPs, and social services. • Screening, assessment, and early intervention for SMI/SED. Kentucky currently has four providers in the CCBHC Demonstration which lasts at least through December 2027.

Prompts	Summary
	Kentucky's 1915(i) State Plan Option, RISE Initiative for SMI with Co-Occurring SUD was approved by CMS on March 27, 2025. During the implementation phase, Kentucky will work towards the offering of a comprehensive collection of home and community-based services (HCBS). The program services provide individuals with a primary diagnosis of an SMI or SMI with co-occurring SUD to learn skills and receive services to thrive at home or in the community, access to services will include a functional assessment that encompasses housing status for individuals.
	Future Status: . **Expand CCBHCs** throughout the Commonwealth, increasing access to integrated physical and behavioral health services in primary care clinics, CMHCs, and FQHCs. The Commonwealth plans to expand the CCBHC Demonstration; Kentucky is currently developing outreach, planning trainings, and will start collecting applications for the demonstration expansion. **Kentucky Rapid Response and Stabilization Services (KRRSS)** are community-based programs that provide immediate support to families experiencing behavioral health crises. Services may include therapy, safety planning, skills training, and medication management. Kentucky will integrate to support mobile crisis response and 988 Services, as well as expanding the availability of KRRSS and MCI teams trained in youth-specific crisis intervention. **Kentucky's 1915(i) State Plan Option, RISE Initiative for SMI with Co-Occurring SUD** was approved by CMS on March 27, 2025. During the implementation phase, Kentucky will work towards the offering of a comprehensive collection of home and community-based services (HCBS). The program services provide individuals with a primary diagnosis of an SMI or SMI with co-occurring SUD to learn skills and receive services to thrive at home or in the community, access to services will include a functional assessment that encompasses housing status for individuals.
	Summary of Actions Needed: To support CCBHC expansion, a public-facing website is being developed to distribute application materials, cost repot templates, and other information related to the expansion to gather information from applicants to determine eligibility. **Action 1: CCBHC Expansion** • **Description: See above.**

Prompts	Summary
	• **Persons/Entities Responsible:** CHFS • **Timeframe:** Q4, CY 2025 **Action 2: Kentucky Rapid Response and Stabilization Services (KRRSS)** • **Description:** See above. • **Persons/Entities Responsible:** CHFS • **Timeframe:** Q2, CY 2026 **Action 3: Kentucky's 1915(i) State Plan Option, RISE Project** • **Description:** CMS Approved 3/27/2025 -See above • **Persons/Entities Responsible:** CHFS • **Timeframe:** Q3, CY 2025

Prompts	Summary
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[1] *The HIT Plan should also describe, among other items, the:* • *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* • *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	

Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period.	CHFS houses the KHIE, an interoperability engine for connecting health care technology systems to exchange electronic protected health information (ePHI). KHIE is currently connected to every hospital in the Commonwealth of Kentucky and actively exchanging ePHI on their behalf. Additionally, KHIE is connected to over 2,000 businesses across 18,000 data feeds where it exchanges an average of 35 million messages a month across 10 million unique lives. Ninety-eight percent of Medicaid providers are currently engaged with KHIE for some level of information exchange. The KHIE system provides real time access to clinical information to both clinicians and CHFS staff. KHIE additionally facilitates public health reporting for all incoming electronically submitted information, facilitating immunization registry submissions, syndromic surveillance, electronic laboratory reporting, and electronic case reporting.
Prompts	**Summary**
Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	Yes, Kentucky has reviewed the last submission of Kentucky's State Medicaid Health IT Plan to verify that it aligns with the SUD Health IT Plan.

Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[2] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	Yes, Kentucky intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[2] and 45 CFR 170 Subpart B and based on that assessment, intends to include them, as appropriate, in subsequent iterations of its Medicaid managed care contracts.
Prompts	**Summary**
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact.[3] *Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."*[4]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider	*Current State:* KHIE actively collaborates with the behavioral health community to securely integrate behavioral health records in the health information exchange (HIE), including alcohol and substance abuse. The following presents the most recent statistics: • Total number of behavioral health centers signed KHIE Participation Agreement: 208. • Total not sharing data: 47. • Total behavioral health centers (ambulatory) sharing data: 161.

	• 77% of organizations with signed PA are sharing data: 161 divided by 208 = 77%. Total number of organizations (breakdown by data feeds shared with KHIE): • Immunization submission/immunization query feeds: 12. • Patient demographics (Admit- Discharge-Transfer (ADT) feeds): 73. • Continuity of care document exchange (clinical document exchange): 73. • Electronic laboratory reporting (public health reporting of communicable disease lab results): 3.
	Future State: KHIE will continue to conduct outreach, education, and onboarding to behavioral health facilities to increase the number of facilities reporting and the amount of information each facility is sending. Currently, no state behavioral health hospital sends data to KHIE. Kentucky will continue to explore closed-loop referral capabilities for behavioral health providers and organizations.
	Summary of Actions Needed: Currently, Kentucky's state-run behavioral health hospitals do not exchange data. DMS will engage these hospitals to initiate and develop data sharing capabilities.
Prompts	**Summary**
1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider	*Current State:* KHIE offers ePartner Viewer portal which provides a comprehensive view of real-time and historical clinical data from multiple health care sources. Features include Event Notification, SDOH referrals, manual notes, direct secure messaging, and export and print clinical documentation. KHIE offers an event notification service to support care coordination across disparate providers. Notifications available include ED admission and discharge, admission or discharge to/from the hospital, hospital readmission, behavioral health admit/discharge, overutilization, specialty visit, toxicology screen, result ready for review, COVID-19 positive. Through KHIE, providers can also view Medicaid claims to further close gaps in care through targeted outreach initiatives. Kynect is Kentucky's online portal for residents to connect with Kentucky programs, services, and community supports. Kynect and KHIE have integrated and provides users a broad data set of SDOH information to support referrals to community supports. The integration of the two systems allows sharing of assessment results and timely updates to patient information. The integration provides a direct link to kynect resources from within the ePartnerViewer, where users can create referrals for patients to community organizations and services. Community organizations and programs that have been onboarded to the program can manage referral activity and work together with residents to address needs.

	Future State: Kentucky is considering adding closed-loop referral capability to KHIE's features and functionality.
	Summary of Actions Needed: Actions to be identified.
1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports	*Current State: Describe the current state of the health IT functionalities outlined below:* *Example: The state is planning to conduct beneficiary phone surveys and track beneficiaries who are not reporting hours due to technical difficulties. If the state identifies a substantial number of beneficiaries are not reporting hours due to technical difficulties, the state will consider providing additional notices to beneficiaries and/or training CE partner entities who help beneficiaries enter hours into the state's online portal.* KHIE offers ePartner Viewer portal which provides a comprehensive view of real-time and historical clinical data from multiple health care sources. Features include event notification, SDOH referrals, manual notes, direct secure messaging, and export and print clinical documentation. KHIE offers an event notification service to support care coordination across disparate providers. Notifications available include ED admission and discharge, admission or discharge to/from the hospital, hospital readmission, behavioral health admit/discharge, overutilization, specialty visit, toxicology screen, result ready for review, COVID-19 positive. Through KHIE, providers can also view Medicaid claims to further close gaps in care through targeted outreach initiatives.
	Future State: Kentucky is considering adding closed-loop referral capability to KHIE's features and functionality.
	Summary of Actions Needed: Kentucky will continue to explore considerations to add close-loop referrals and actions will be identified.
Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	*Current State:* Care plan information from health care facilities is available in KHIE. There is a place for notes to be added inside the portal and could be used for care plan information back to health care providers. The Manual Notes tab in ePartnerViewer from KHIE is intended to allow health care clinicians the ability to add notes to patients' medical records when their organization is not interoperable with the HIE or when their shared data does not capture an important piece of a patient's medical record. There is currently a limit of 2,500

	characters.
	Future State: Requirement met.
	Summary of Actions Needed: Kentucky currently meets milestone requirements.
Prompts	**Summary**
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	*Current State:* Enrollee person-centered care plan information from health care facilities is available in KHIE. They are interoperable, accessible by Medicaid providers and beneficiaries, and available for physical and mental health providers.
	Future State: Requirement met.
	Summary of Actions Needed: Kentucky currently meets milestone requirements.
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* KHIE is Kentucky's statewide HIE and provides interoperable connectivity to health care systems where adult and children's data is stored and accessible for minimum necessary purposes.
	Future State: Requirement met.
	Summary of Actions Needed: Kentucky currently meets milestone requirements.
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	*Current State:* KHIE is Kentucky's statewide HIE and provides interoperable connectivity to health care systems where adult and children's data is stored and accessible for minimum necessary purposes.
	Future State: Requirement met.
	Summary of Actions Needed: Kentucky currently meets milestone requirements.

Prompts	**Summary**
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	*Current State:* The robust network within KHIE, as well as the exchange of ePHI facilitates transitions of care in a meaningful way. KHIE offers direct secure messaging, event notifications, and secure electronic sharing of notes and clinical data. Kynect is Kentucky's online portal for residents to connect with and gain access to programs, services, and community supports across the Commonwealth. Kynect and KHIE have integrated and provides users a broad data set of SDOH information to support referrals to community supports. The integration of the two systems allows sharing of assessment results and timely updates to patient information. The integration provides a direct link to kynect resources from within the ePartnerViewer where users can create referrals for patients to community organizations and services. Community organizations and programs that have been onboarded to the program can manage referral activity and work together with residents to address needs.
	Future State: Continue collaboration with MCOs on program development and further integrate with the kynect

Prompts	Summary
	platform. Currently, two MCOs onboarded to the system, which gives MCO access to SDOH data for analysis and long-term studies and improved access to services and health equity. Data collected will be used by DMS to guide MCOs and design pilot programs to target specific, data-identified community needs.
	Summary of Actions Needed: Kentucky currently meets milestone requirements.
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	*Current State:* Kentucky is an opt-out state for clinical information, meaning patient data is automatically exchanged unless they opt out. The only exception is 42 CFR Part 2 data in which patients must opt in. Patient health information that requires additional written consent to share, such as the information that falls under 42 CFR Part 2, also requires consent from a patient to share that health information in an HIE such as KHIE. This is typically health information that is related to the treatment of substance and alcohol use disorders. KHIE participants are responsible for obtaining consent from their patients and subsequently ensuring their electronic medical record/EHR allows or prevents the flow of data to KHIE.
	Future State: Requirement met.
	Summary of Actions Needed: Kentucky currently meets milestone requirements.
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	*Current State:* Kentucky follows Health Level 7 and Integrating the Healthcare Enterprise standards for most of the data we exchange. KHIE participants have access to patient demographics, lab results and pathology, transcribed radiology reports and other reports, summaries of care, ADT data, immunizations, behavioral health data, data from correctional facilities, emergency medical services data, Medicaid claims data, and SDOH data. Kynect is Kentucky's online portal for residents to connect with Kentucky programs, services, and community supports. Kynect and KHIE have integrated and provides users a broad data set of SDOH information to support referrals to community supports. The integration of the two systems allows sharing of assessment results and timely updates to patient information. The integration provides a direct link to kynect resources from within the ePartnerViewer where users can create referrals for patients to community organizations and services. Community organizations and programs that have been onboarded to the program can manage referral activity and work together with residents to address needs.
	Future State: Requirement met.

Prompts	Summary
	Summary of Actions Needed: Kentucky currently meets milestone requirements.

Prompts	Summary
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	*Current State:* Telehealth technologies are available throughout Kentucky; however, KHIE does not currently offer this feature. Located within OIG, KYTelehealth provides a vetted repository of information and resources aimed to provide increased access to health care within established evidence-based guidelines and standards for safety and quality care. Resources include a Telehealth Provider Directory of providers across the Commonwealth by specialty, including behavioral health and PCPs.
	Future State: Kentucky may consider Project ECHO a model that supports community-based care teams and offers PCPs access to specialists that may not be available at the patient care site. The model can help increase the capacity of PCPs especially and has been used effectively in Kentucky to support team-based treatment for autism[1] and aging adults.[2]
	Summary of Actions Needed: Kentucky DMS is currently considering various telehealth technologies to support collaborative care requirements.
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[5])	*Current State:* KHIE provides the event notifications services (ENS) feature which informs providers as their patients transition from various health care settings back to their practice. Notifications are intended to improve and support care coordination across disparate care providers. Upon receipt of these notifications, providers and care coordinators can effectively focus on the health care needs of their patients who are transitioning in and out of care settings. KHIE's ENS feature, as well as Kentucky CHFS, DMS and the Office of Data Analytics have advanced capabilities to assess and identify beneficiaries who need to be engaged to ensure treatment continues or resumes.
	Future State: Requirements met; however, Kentucky is currently evaluating advanced data analysis capabilities.
	Summary of Actions Needed: Kentucky currently meets milestone requirements.

[1] University of Kentucky, College of Medicine. Project ECHO Presentation. Accessed July 2024.
[2] University of Louisville. Project ECHO Care for Older Adults. Accessed July 2024.

Attachment D: SUD/SMI Monitoring Protocol
[To be incorporated after CMS approval.]

ATTACHMENT E: SUD Implementation Plan

Commonwealth of Kentucky
Section 1115 Substance Use Disorder (SUD) Demonstration
Implementation Plan

Date: 10-05-18

Overview

The Commonwealth of Kentucky is facing a substance use crisis of epic proportions. [1] In 2016, the commonwealth lost 1,404 Kentuckians due fatal drug overdoses. Over the past 5 years Kentucky has seen a 38% increase in overdose deaths. Historically among the Substance Use Disorder (SUD) population the number of patients who have one of the common co-morbidities associated with SUD are much greater than patients without an SUD. For example, the state has seen a rapid increase (nearly 115%) in cases of Neonatal Abstinence Syndrome (NAS).[2] Of those cases, Medicaid accounted for over 80%. In 2016 the Center for Disease Control (CDC) identified 220 counties in the United States that are most susceptible for Human Immunodeficiency Virus (HIV) outbreak, of the 220 counties 54 reside in the Commonwealth of Kentucky.

Kentucky has created multiple initiatives to combat the SUD crisis and increase awareness. Below are a number of programs that have either been implemented or are under development:

- In 2012, Kentucky passed sweeping legislation that has become a national model. This statute required; the use of Prescription Drug Monitoring Program (PDMP) for all prescribers of controlled substances, regulated pain clinics by requiring them to be physician or hospital owned, and fostered increased cooperation among the PDMP, Kentucky licensure boards and law enforcement.
- In 2015, Kentucky passed several harm reduction measures including; Syringe Exchange, Naloxone Distribution and the Good Samaritan Law.
- In 2015, the Kentucky Board of Medical Licensure (KBML) promulgated a regulation containing buprenorphine prescribing guidelines to help improve the effectiveness of medication assisted treatment with buprenorphine.

[1] Slide 5 SUD DMS Provider Forums 2017 (using 2011-2016 data)
[2] Produced by the Kentucky Injury Prevention and Research Center, May 2016. Kentucky Inpatient Hospitalization Claims Files, Frankfort, KY, [2000-2015]; Cabinet for Health and Family Services, Office of Health Policy. Data for 2010-2015 are provisional; therefore these results are subject to change.

- In 2017 House Bill 333 – Introduced as the professional standard of a 3-day prescribing limit on Schedule II controlled substances for acute pain.
- Kentucky Opioid Response Effort (KORE) Initiatives:
  - ER Bridge Clinics – Established Bridge Clinics in three (3) major Hospital Systems, where individuals admitted to the Emergency Room as a result of drug overdose will have the option to begin treatment at a "Bridge Clinic", which will then be able to provide Medication Assisted Treatment (MAT). Peer Support Specialists will also meet with individuals in the ED to provide support around accessing treatment and recovery services. Following discharge, Peer Support Specialists as well as other treatment staff (e.g., case managers, certified providers, and licensed evaluator) will contact individuals as part of an assertive, ongoing engagement effort. Individuals accepting services will have rapid access to treatment, including MAT, by being transferred to a Bridge clinic located nearby.
  - Sponsoring opioid stewardship aimed at prescriber education and reducing the dependence on opioids for pain management.
  - Expand prevention programs Sources of Strength in middle, high and post-secondary institutions.
- Department for Behavioral Health Developmental and Intellectual Disabilities (DBHDID) Grant > Behavioral Health & Primary Care Integration.
- State Wide Screening referral service for substance abuse treatment Helpline.
- In 2018 Kentucky will implement –a Web based treatment locator designed for referrals from Primary Care Physicians, Emergency Room and Health Departments.
- Addition of Methadone coverage for SUD treatment via state plan.

Section I – Milestone Completion

Milestones

1. Access to Critical Levels of Care for OUD and Other SUDs

To improve access to Opioid Use Disorder (OUD) and SUD treatment services for Medicaid beneficiaries, it is important to offer a range of services at varying levels of intensity across a continuum of care since the type of treatment or level of care needed may be more or less effective depending on the individual beneficiary.

- Outpatient Services;
- Intensive Outpatient Services;
- Medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state);
- Intensive levels of care in residential and inpatient settings; and
- Medically supervised withdrawal management

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of outpatient services	Department for Medicaid Services (DMS) currently provides a comprehensive array of behavioral health services including; Screening, Assessment, Crisis Intervention, Partial Hospitalization, Individual, Group and Family therapies, Peer Support, Targeted Case	Will add treatment plan development for alcohol and/or substance abuse to the array of services allowed in State Plan. Will continue providing coverage of outpatient services through the State Plan.	• Amend State Plan to include service planning for SUD treatment. • Update regulations to reflect added service. DMS Division of Policy and Operations will oversee completion of tasks.

	Management, and residential service for SUD. DMS also provides medication assisted treatment with buprenorphine, and vivitrol. These services will continue under Kentucky's State Plan. Click Here for State Plan Amendment		• DMS Senior Behavioral Health Policy Advisor will oversee completion of tasks. • Estimated completion September 12, 2019.
Coverage of intensive outpatient services	Intensive Outpatient Program (IOP) is currently a covered service through Kentucky's State Plan and is an alternative to or transition from inpatient hospitalization or partial hospitalization for mental health or substance use disorders. IOP must be provided at least three (3) hours per day and at least three (3) days per week. This service will continue under Kentucky's State Plan. Partial Hospitalization is a short-term (average of four (4) to six (6) weeks), less than 24 hour, intensive treatment program for individuals experiencing significant impairment to daily functioning due to substance	Currently Partial Hospitalization may be provided in a hospital or Community Mental Health Center (CMHC). Propose to add Behavioral Health Services Organization (BHSO) as an allowable setting to perform partial hospitalization services. Will continue to cover IOP throughout the demonstration under State Plan.	• Amend regulations adding partial hospitalization to the service array for a BHSO. • DMS Senior Behavioral Health Policy Advisor will oversee completion of tasks. • September 12, 2019 completion time from approval of implementation plan.

	use disorders, mental health disorders or co-occurring mental health and substance use disorders. This service is designed for individuals who cannot effectively be served in community-based therapies or IOP. Click Here for State Plan Amendment		
Coverage of medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state)	DMS currently covers MAT for Buprenorphine and Vivitrol.	DMS will expand MAT to cover Methadone for the treatment of Substance Use Disorders.	• DMS will amend the State Plan to include coverage of Methadone for MAT. • Amend behavioral health services organization regulation to include narcotic treatment program. • DMS Senior Behavioral Health Policy Advisor will oversee completion of tasks. • Estimated Time Frame: September 12, 2019.
Coverage of intensive levels of care in residential and inpatient settings	DMS currently provides coverage of residential services for Substance Use Disorders (SUD) in the State Plan. Services must be provided under the medical direction of a physician and provide continuous nursing	Kentucky will perform its own certification program developing forms for on-site visits with a four-person team from Department for Medicaid Services Behavioral Health Policy Team. DMS will certify providers to the	State Plan Amendment and Regulation changes to reflect certification levels • DMS Senior Behavioral Health Policy Advisor will oversee completion of tasks.

	services in which a registered nurse shall be on-site during traditional first shift hours, continuously available by phone after hours' and on-site as needed in follow-up to telephone consultation after hours. Residential coverage have two levels of treatment. Short term services should have twenty-four (24) hour staff and have a duration of less than thirty (30) days. Long term services should have twenty-four (24) hour staff as required by licensing regulations with lengths of stay thirty (30) to ninety (90) days. DMS will not pay for this service in a unit of more than 16 beds or multiple units operating as one unified facility with more than 16 aggregated beds except for services furnished pursuant to the state plan benefit "inpatient psychiatric services for individuals under twenty-one (21)" (section 1905(a)(16) of the Act; 42 CFR 440.160) or pursuant to an exclusion for individuals age 65 or older who reside in institutions that	appropriate ASAM level for residential services in the current edition of The ASAM criteria.	• On-Site certification forms completed by October 15, 2018 • On-Site provider certification completed by 01/15/2019.

	are Institution for Mental Disease (IMDs) (section 1905(a) of the Act; 42 CFR 440.140.). Require BHSO to be licensed as a non-medical and non-hospital based alcohol and other drug treatment program in accordance with state licensing regulations. Click Here for State Plan Amendment		
Coverage of medically supervised withdrawal management(WM)	DMS currently covers medical detox in a hospital setting.	DMS will incorporate all levels of withdrawal management (Level 1 –WM Ambulatory withdrawal management without extended on-site monitoring, Level 2-WM Ambulatory withdrawal management with extended on-site monitoring, Level 3-WM Residential/inpatient withdrawal management and Level 3.2-WM Clinically managed residential withdrawal management, Level 3.7-WM medically monitored inpatient withdrawal management and Level 4- WM Medically managed intensive inpatient	• Amend service definitions to include withdrawal management at appropriate levels of care within State Plan and KY regulations. • DMS Senior Behavioral Health Policy Advisor will oversee completion of tasks. • Completed by September 12, 2019.

		withdrawal management) within the continuum of care offered in Kentucky.	

Kentucky defines the following categories of providers that are able to provide State Plan Services Behavioral Health and Substance Use Disorder services:

- Individual Practitioner: An individual practitioner who is licensed by the respective board in the Commonwealth of Kentucky or who is supervised by a licensed practitioner to render health services and/or bill DMS. The practitioners include: Licensed Professional Art Therapist, Applied Behavior Analyst, Licensed Professional Clinical Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Psychological Practitioner, Licensed Psychologist, Physician, Advanced Registered Nurse Practitioner with Psychiatry Specialty and Physician Assistant.
- Provider Group: A group of more than one individually licensed practitioner who forms a business entity to render behavioral health services and bill DMS.
- Licensed Organization: A business entity that employs licensed and non-licensed health professionals and is licensed to render behavioral health services and bill DMS. This organization must also meet the following criteria:
    (1) Be enrolled as a Medicaid provider in the Commonwealth of Kentucky;
    (2) Demonstrate experience serving the population of individuals with behavioral health disorders relevant to the particular services provided;
    (3) Have the administrative capacity to provide quality of services in accordance with state and federal requirements;
    (4) Use a financial management system that provides documentation of services and costs; and
    (5) Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements.

The Licensed Organizations include: Behavioral Health Services Organization and Community Mental Health Centers.

All providers must operate within the scope of their license. Providing services to Medicaid recipients outside a provider's licensure is considered fraud.

2. Use of Evidence-based, SUD-specific Patient Placement Criteria

Implementation of evidence-based, SUD-specific patient placement criteria is identified as a critical milestone that states are to address as part of the demonstration. To meet this milestone, states must ensure that the following criteria are met:

- Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines; and
- Utilization management approaches are implemented to ensure that (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, and (c) there is an independent process for reviewing placement in residential treatment settings.

Currently DMS, through Managed Care Contracts require the use of ASAM Criteria for authorization regarding Level of Care (LOC) for SUD treatment. Managed Care Organizations (MCO) apply ASAM to both outpatient and residential services with no predetermined limits of care established for these services. Continued involvement in a level of care is based on individual need determined through medical necessity criteria. DMS will continue to require ASAM Criteria for authorization of treatment and recovery services for individuals with an SUD through the contractual requirement with the MCO's. Below is the language utilized in the MCO contracts to address utilization management.

> [3]The MCO's shall have in place mechanisms to check the consistency of application of review criteria. The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate. The Medical Director and Behavioral Health Director shall supervise the UM program and shall be accessible and available for consultation as needed. Criteria approved under a prior contract must be resubmitted to ensure it meets the requirements of this Contract. Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a physician who has appropriate clinical expertise in treating the Member's condition or disease. The clinical reason for the denial, in whole or in part,

[3] Language from MCO SFY 18 Contracts

specific to the Member shall be cited. Physician consultants from appropriate medical, surgical and psychiatric specialties shall be accessible and available for consultation as needed. The Medical Necessity review process shall be completed within two (2) business days of receiving the request and shall include a provision for expedited reviews in urgent decisions. Post-service review requests shall be completed within fourteen (14) days or, if the Member or the Provider requests an extension or the Contractor justifies a need for additional information and how the extension is in the Member's interest, may extend up to an additional fourteen (14) days.

A. The MCO's shall submit its request to change any prior authorization requirement to Department for Medicaid Services (DMS) for review.

B. For the processing of requests for initial and continuing authorization of services, the Contractor shall require that its subcontractors have in place written policies and procedures and have in effect a mechanism to ensure consistent application of review criteria for authorization decisions.

C. In the event that a Member or Provider requests written confirmation of an approval, the Contractor shall provide written confirmation of its decision within three working days of providing notification of a decision if the initial decision was not in writing. The written confirmation shall be written in accordance with Member Rights and Responsibilities.

D. The Contractor shall have written policies and procedures that show how the Contractor will monitor to ensure clinically appropriate overall continuity of care.

E. The Contractor shall have written policies to ensure the coordination of services:

1. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;
2. With the services the Member receives from any other MCO;
3. With the services the member receives in Fee for Service (FFS); and
4. With the services the Member receives from community and social support providers.

F. The MCO shall have written policies and procedures that explain how prior authorization data will be incorporated into the MCO's overall Quality Improvement Plan.

DMS providers perform an assessment and collect other relevant information that will assist in determining the most appropriate level of care. DMS does not require the provider to utilize one specific multi-dimensional tool. In regulation, DMS defines assessment to include gathering information and engaging in a process with the individual that enables the provider to:

- Establish the presence or absence of a mental health disorder, substance use disorder, or co-occurring disorders;
- Determine the individual's readiness for change;
- Identify the individual's strengths or problem areas that may affect the treatment and recovery processes; and
- Engage the individual in developing an appropriate treatment relationship;

- Establish or rule out the existence of a clinical disorder or service need;
- Include working with the individual to develop a treatment and service plan; and
- Does not include psychological or psychiatric evaluations or assessments.

As part of the new waiver benefit, Kentucky will require utilization of ASAM's six dimensions of multidimensional assessment to ensure consistency in the assessment and treatment planning process for treatment of substance use disorders. The dimensions will assist the provider to create a holistic, biopsychosocial assessment of the recipient that will assist the provider with development of the treatment planning for any person seeking SUD services. The dimensions include acute intoxication and/or withdrawal potential; biomedical conditions and complications; emotional, behavioral or cognitive conditions and complications; readiness to change; relapse, continued use, or continued problem potential and recovery/living environment.

DMS will ensure that providers are utilizing the appropriate clinician to perform the assessment which include a credentialed counselor or clinician, a certified addiction registered nurse, a psychologist or a physician. DMS will require all SUD providers to incorporate these dimensions as part of their assessment by September 12, 2019. DMS will outline requirements within regulations and ensure all providers will be trained on ASAM criteria. The estimated timeline for completion of changes in regulations related to assessment criteria is September 12, 2019. DMS Division of Policy and Operations will oversee completion of task.

3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Through the new Section 1115 initiative, states will have an opportunity to receive federal financial participation (FFP) for a continuum of SUD services, including services provided to Medicaid enrollees residing in residential treatment facilities that qualify as institutions for mental diseases. To meet this milestone, states must ensure that the following criteria are met:

- Implementation of residential treatment provider qualifications (in licensure requirements, policy manuals, managed care contracts, or other guidance) that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding the types of services, hours of clinical care and credentials of staff for residential treatment settings;

- Implementation of a state process for reviewing residential treatment providers to assure compliance with these standards; and

- Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off site.

Currently DMS only reimburses residential SUD treatment with providers who have less than sixteen (16) bed facilities or for recipients who are under the age of twenty-one (21) or over the age of sixty-four (64). CMHC's, BHSO's and hospitals are DMS provider types licensed through Office of Inspector General (OIG) and provide residential SUD services. These services are based on individual need and may include screening, assessment, service planning, peer support, individual, group and family outpatient therapy. DMS requires residential services be provided under the medical direction of a physician and provide continuous nursing services on site during traditional first shift hours Monday through Friday and continuously available for telephone consultation afterhours and onsite as needed.

The Commonwealth of Kentucky will conduct a statewide survey to assess the current landscape of behavioral health providers. We began with a survey sent out to all Medicaid enrolled residential substance use disorder providers. One component of this survey was for the residential providers to self-attest to their level of ASAM residential care. This survey is currently underway for our residential SUD treatment providers, with an expected completion date of October 15, 2018. This will align with the DMS led certification process. Based on the self-attestation Kentucky would allow for reimbursement of residential services up to 96 beds in an IMD pending certification by the State conducted certification process. DMS is internally considering payment adjustment based on residential level of care.

In order for a SUD residential provider to be eligible for the Institution of Mental Disease (IMD) exclusion, Kentucky will require the provider to be certified to the ASAM residential levels of care which are; 3.1 Clinically Managed Low-Intensity Residential Services, 3.3 Clinically Managed Population Specific High Intensity Residential Services, 3.5 Clinically Managed High-Intensity Residential Services, 3.7 Medically Monitored Intensive Inpatient Services. Kentucky Revised Statutes (KRS) 216B.015 defines the Office of Inspector General, Division of Health Care responsible for inspecting, monitoring, licensing and certifying all health care facilities. This includes acute care hospitals, which DMS designate as Medically Managed Intensive Inpatient Services. Kentucky feels the licensure requirement is sufficient and does not require this level of care to be certified. The SUD residential providers that are ASAM certified will then be able to receive the IMD exclusion for up to 192 beds for short-term residential treatment. Short-term residential treatment is defined as a statewide average length of stay of thirty (30) days.

Kentucky will perform its own certification program of residential levels: 3.1 Clinically Managed Low-Intensity Residential Services, 3.3 Clinically Managed Population Specific High Intensity Residential Services, 3.5 Clinically Managed High-Intensity Residential Services, and 3.7 Medically Monitored Intensive Inpatient Services. Kentucky is developing forms for on-site visits with a four-person team from Department for Medicaid Services Behavioral Health Policy team. Beginning October 15, 2018 this team will

begin to conduct onsite visits of all Medicaid enrolled SUD residential providers to review settings, staff requirements, co-occurring capacity, and programming utilizing state created forms. Certification of all Medicaid enrolled residential SUD providers will be completed by January 15, 2019. Moving forward DMS will continue to explore engaging with ASAM to participate in the pilot for level of care certification.

DMS currently offers all the service components of MAT within the State Plan. Methadone is currently payable for pain not for SUD treatment. DMS is adding the coverage of Methadone to our State Plan services for the treatment of SUD and will ensure residential providers are providing MAT on-site or facilitating access off site, by conducting a provider survey. The offsite facilitation of MAT for residential providers that do not provide medication as part of their treatment continuum will allow individuals who opt for medication as a part of their plan of care to receive the medication services outside of the residential provider. As part of the care coordination in a residential setting, the care coordinator will assist in the logistics of locating, scheduling and transporting an individual for their offsite medication services.

Kentucky has legislation to require the Cabinet of Health and Family Services (CHFS) to develop enhanced licensure and quality standards. These will be based on nationally recognized and evidence-based standards for substance use disorder treatment and recovery that include residential, outpatient and medication-assisted treatment (MAT) services. This legislation requires enhanced and streamline licensure requirements for SUD treatment providers as well as create statewide standards and outcome measures to ensure quality. DMS Division of Policy and Operations Senior Behavior Health Policy Advisor will oversee completion. Estimated for completion by September 12, 2019.

4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

To meet this milestone, states must complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care listed in Milestone 1. This assessment must determine availability of treatment for Medicaid beneficiaries in each of these levels of care, as well as availability of MAT and medically supervised withdrawal management, throughout the state. This assessment should help to identify gaps in availability of services for beneficiaries in the critical levels of care.

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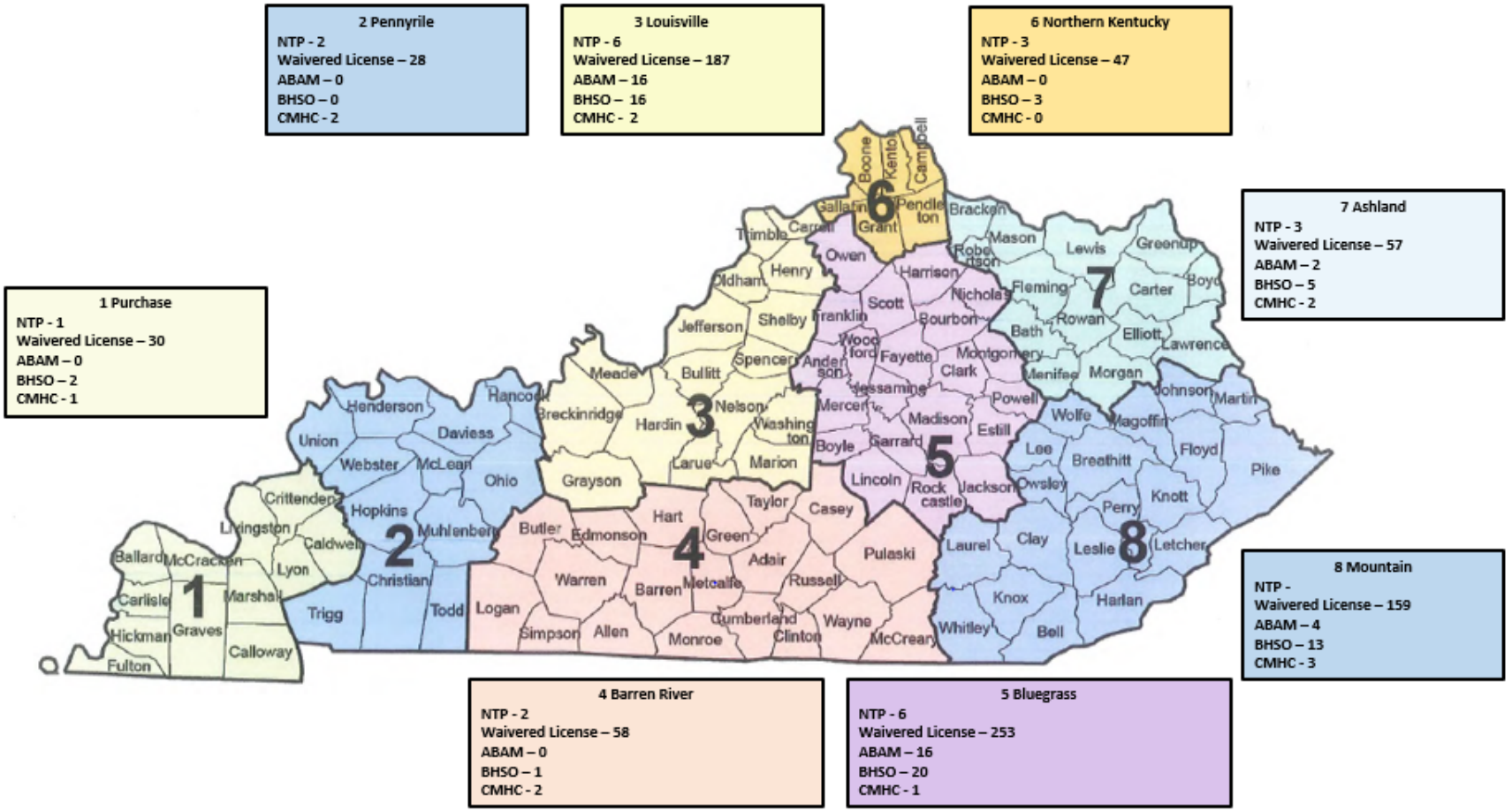

DMS to develop and conduct a survey for Medicaid and Non-Medicaid providers to determine what services they provide related to SUD levels of care and potential for Medicaid enrollment. As part of the survey, Kentucky will be looking at medication assisted treatment (MAT) service capability. Through onsite visits we will verify MAT is offered on-site or facilitated offsite. Completion of provider survey will be within twelve (12) months of Implementation Plan approval. DMS Division of Policy and Operations is responsible for completion of task.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT: Outpatient Services; Intensive Outpatient Services; Medication Assisted Treatment (medications as well as counseling and other services); Intensive Care in Residential and Inpatient Settings; Medically Supervised Withdrawal Management.		Kentucky Medicaid is conducting a statewide survey of treatment providers that currently offer outpatient, Intensive Outpatient services, MAT and Residential services. With pending changes to licensure requirements for SUD treatment and recovery providers, Kentucky Medicaid will create a Preferred prescriber program that incorporates DMS Pharmacy prescribing program. Participation in the preferred provider program will reduce the administrative burden on the provider. The following are the requirements for participation: • Providing treatment under the license of a buprenorphine waivered practitioner and co-located credentialed addiction treatment practitioners, • Can distribute buprenorphine products during induction • Provide prescriptions for buprenorphine products	• Develop preferred prescriber program in alignment with Pharmacy prescribing program. • DSM Senior Behavioral Health Policy Advisor and DMS Pharmacy Director will oversee completion of task. • Completion by September 12, 2019

		• Provide psychosocial treatment for opioid use disorder that include assessment of psychosocial needs, individual and/or group counseling, linkage and referral to community based services and support systems, care coordination of on-site and off-site treatment services, medical/prescription monitoring.	

5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

To meet this milestone, states must ensure that the following criteria are met:

- Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse;
- Expanded coverage of and access to naloxone for overdose reversal; and
- Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse	Prescribers are required to; obtain a report on beneficiaries from the prescription drug monitoring program (PDMP), obtain drug screens and encourage the patient's active participation	Revised buprenorphine criteria to increase response access and treatment. Streamlined administrative burden for quality care and qualified providers.	Develop program draft including revised clinical criteria and prior authorization forms -DMS Pharmacy Director is responsible for completion of this task

	in a behavioral modification program. DMS has implemented a 3 day supply limitation for controlled substances. (See statute link below) Click Here for KRS 218A.205	The Department for Medicaid Services (DMS) will align the Prior Authorization requirements (PA) for prescribing or dispensing buprenorphine –mono-product or buprenorphine combined with naloxone, with the professional standards from the KBML. (See regulation link below) Click Here for 201 KAR 9:270 Opioid Utilization Program that will include revised criteria to apply varying utilization controls to long acting opiates and short acting opiates; plus, the implementation of a Morphine Milligram Equivalent (MME) dosing limitations program, including treatment plan agreements and opiate PA requirements.	-Expected on or before 11/1/18 Develop two (2) prior authorization forms. The first form aligning with KBML standards, the second form for the buprenorphine program. -DMS Pharmacy Director is responsible for completion of this task - Following alignment of requirements there will be a 90 day provider notice and education period before changes can Go-Live. Expected on or before 11/1/18. In-Progress -DMS Pharmacy Director is responsible for completion of this task -Approved by KY P&T Committee on 5/01/18; Go-Live 09/04/18

		A brief summary of the utilization controls being reviewed include: limitations on Short Acting (SA) opioids for the treatment of acute pain, limitations on the treatment of chronic, non-cancer pain in non-hospice patients, other class limitations such as age limits, daily dose limits, limits on cough and cold opioid containing products, limits on codeine and tramadol products, and required review of overlapping claims for opioids and benzodiazepines. The MME dosing limitations involve a claim by claim analysis of current member utilization of both Long Acting (LA) and SA opioids. Once complete we will have a better understanding of how members may be utilizing multiple prescriptions to achieve higher cumulative MME and their per day dosing. A simplified conversion factor of 4 MME/unit for methadone will	

		be used to resolve the IT systems limitations surrounding sliding scale as recommended by CMS, until there is a new software release. Analysis will reveal the most common products contributing to the MME per day over 180 and over 300 both for FFS and the MCO populations. The program will allow exceptions for certain disease states such as cancer, sickle cell, and hospice. Additional considerations will apply for others like Long Term Care (LTC), acute surgical procedures, and Narcotic Treatment Program (NTP). We will establish MME thresholds for SA, LA, and combo use of opioids. And employ a step down methodology to reduce overall MME. Prior Authorizations will be revised to allow for new initial limits of opioids without PA up to a certain threshold MME (eg.. 90MME/day), while higher quantities require post limit	

		PA, with an overall max MME threshold (e.g.. 200MME/day). Post limit PA approvals will be limited in duration for acute pain treatment (30 days) but one year for chronic pain care. This will include some required patient reassessment interval (eg.3 mo.) which exceptions for those actively battling cancer.	
Expanded coverage of, and access to, naloxone for overdose reversal	All Kentucky Health Plans currently cover naloxone Nasal Spray and syringes without a co-pay or prior authorization. Although a prescription is required, under a collaborative care agreement pharmacists throughout the Commonwealth are permitted to initiate protocol driven orders for naloxone products. As part Kentucky's Opioid Response Effort, Narcan kits (set of 2 doses) are distributed in the highest-risk regions of the Commonwealth through the Department for Public Health's mobile pharmacy as well as individual pharmacies who enter into an agreement	Increase access to Medication Assisted Treatment (MAT) providers to connect services between emergency room discharge for overdose or high risk to primary provider care and treatment. Resources and connectivity to those for beneficiaries in treatment or within a high risk populations will also be increased.	This effort to educate; beneficiaries, prescribers, dispensers, families and schools will be on-going.

	with KPhA to dispense KORE-funded kits. KPhA is also helping to establish partnerships between community pharmacies and residential treatment programs to ensure individuals have free take-home Narcan upon discharge. A pharmacist comes to the treatment centers to provide the kits as well as training on their use. People Advocating Recovery (PAR) is distributing Narcan kits in community settings targeting eastern Kentucky, other underserved counties, and Oxford Houses. In addition to training on use, education is provided on signs and symptoms, stigma, and Good Samaritan law. In addition 1,000 Narcan kits are being distributed across four Emergency Departments (UK, UL, St. Elizabeth, and St. Claire) to individuals having experienced or at risk for opioid overdose.		

6. Improved Care Coordination and Transitions between Levels of Care

To meet this milestone, states must implement policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Additional policies to ensure coordination of care for co-occurring physical and mental health conditions	Kentucky currently offers targeted case management for individuals with a SUD and for individuals with SUD and a chronic/complex physical health issue. This level of case management is individuals with a moderate to severe SUD.	Kentucky Medicaid will implement care coordination services for all individuals within residential treatment to ensure services are coordinated for co-occurring conditions as well as link the recipient to appropriate community services by facilitating medical and behavioral health follow-ups and linking to appropriate level of substance use treatment within the continuum in order to provide ongoing support for recipients.	Amend State Plan to include care coordination within the SUD residential treatment definition outlining the duties of care coordination. Amend State Regulations to include care coordination duties to the SUD residential treatment definition. • DMS Senior Behavioral Health Policy Advisor will oversee completion of tasks. • Completed by September 12, 2019.

DMS is in the early stages of a learning opportunity with other states related to integration of primary and behavioral health care. This learning lab will assist Kentucky with development of a strategic plan to implement policy for integration of physical and behavioral health. Kentucky's vision is to improve outcomes and reduce cost for; adults with serious mental illness and/or substance use disorder, criminal justice, children and youth with social-emotional disturbance, children in state custody who may have juvenile justice involvement.

Through the Learning Lab opportunity Kentucky intends to improve linkages among health, behavioral health and criminal justice data.

Section II – Implementation Administration

Please provide the contact information for the state's point of contact for the Implementation plan.

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Section III – Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

Attachment A – Template for SUD Health Information Technology (IT) Plan

Section I.

As a component of Milestone 5, Implementation of Strategies to Increase Utilization and Improve Functionality of Prescription Drug Monitoring Programs (PDMP), in the SMD #17-003, states with approved Section 1115 SUD demonstrations are generally required to submit an SUD Health IT Plan as described in the STCs for these demonstrations within 90 days of demonstration approval.

The SUD Health IT Plan will be a section within the state's SUD Implementation Plan Protocol and, as such, the state may not claim FFP for services provided in IMDs until this Plan has been approved by CMS.

In completing this plan, the following resources are available to the state:

a. Health IT.Gov in "Section 4: Opioid Epidemic and Health IT."[4]
b. CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" and, specifically, the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.[5]

As the state develops its SUD Health IT Plan, it may also request technical assistance to conduct an assessment and develop its plan to ensure it has the specific health IT infrastructure with regards to the state's PDMP plan and, more generally, to meet the goals of the demonstration. Contacts for technical assistance can be found in the guidance documents.

In the event that the state believes it has already made sufficient progress with regards to the health IT programmatic goals described in the STCs (i.e. PDMP functionalities, PDMP query capabilities, supporting prescribing clinicians with using and checking the PDMPs, and master patient index and identity management), it must provide an assurance to that effect via the assessment and plan below (see Table 1, "Current State").

[4] Available at https://www.healthit.gov/playbook/opioid-epidemic-and-health-it.
[5] Available at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html.

SUD Demonstration Milestone 5.0, Specification 3: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP

The specific milestones to be achieved by developing and implementing an SUD Health IT Plan include:

- Enhancing the health IT functionality to support PDMP interoperability; and
- Enhancing and/or supporting clinicians in their usage of the state's PDMP.

The state should provide CMS with an analysis of the current status of its health IT infrastructure/"ecosystem" to assess its readiness to support PDMP interoperability. Once completed, the analysis will serve as the basis for the health IT functionalities to be addressed over the course of the demonstration—or the assurance described above.

The SUD Health IT Plan should detail the current and planned future state for each functionality/capability/support—and specific actions and a timeline to be completed over the course of the demonstration—to address needed enhancements. In addition to completing the summary table below, the state may provide additional information for each Health IT/PDMP milestone criteria to further describe its plan.

Table 1. State Health IT / PDMP Assessment & Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed	Measurements
5. Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and OUD, that is: --Enhance the state's health IT functionality to support its PDMP; and --Enhance and/or support clinicians in their usage of the state's PDMP.	*Provide an overview of current PDMP capabilities, health IT functionalities to support the PDMP, and supports to enhance clinicians' use of the state's health IT functionality to achieve the goals of the PDMP.*	*Provide an overview of plans for enhancing the state's PDMP, related enhancements to its health IT functionalities, and related enhancements to support clinicians' use of the health IT functionality to achieve the goals of the PDMP.*	*Specify a list of action items needed to be completed to meet the HIT/PDMP milestones identified in the first column. Include persons or entities responsible for completion of each action item. Include timeframe for*	

			completion of each action item	
Prescription Drug Monitoring Program (PDMP) Functionalities				
Enhanced interstate data sharing in order to better track patient specific prescription data	1.1 The Kentucky PDMP (KASPER) is housed in the Cabinet for Health and Family Services (CHFS) Office of Inspector General (OIG). KASPER is currently able to share data with 12 states including our six border states that have PDMPs. 1.2 Interstate data is available for prescriber and pharmacist PDMP users. KASPER users currently have no tools or analytics available to assist them with identifying other state PDMPs for which a data request may be appropriate for a specific patient (informed data sharing.)	1.1 CHFS plans to enhance KASPER to support more efficient onboarding of additional states. 1.2 CHFS is beginning to work with the Bureau of Justice Assistance and PDMP Training and Technical Assistance Center to investigate the use of data analytics to inform end users of high probability patient data matching states to select when performing an interstate request	1.1 Onboard additional interstate data sharing states. Responsibility: KASPER Integration Project Manager (OATS). Target completion: July 2021. 1.2 Develop data analytic functionality to allow prescriber/pharmacist users to make a more informed decision on other states from which to request data based on their practice location and patient demographic information. Responsibility: KASPER Project Manager. Target completion: April 2020.	1.1 New States will be added at a rate of approximately 1 per month beginning in July, 2018. Monthly meetings are held. Currently we are sharing data with 12 states. The plan is to be connected to the remaining states and D.C. by July of 2021. 1.2 This "Informed Data Sharing" is to be completed by April of 2020. The plan begins with KASPER data only, but will spread to the regional and national level after proper

				analysis and testing. Monthly meetings will be held.
Enhanced "ease of use" for prescribers and other state and federal stakeholders	KASPER provides real-time access to Schedule II through V controlled substance prescription data for authorized health care providers, state and federal law enforcement officers and prosecutors, the Kentucky Medicaid program and other stakeholders. It allows for delegates to request reports on behalf of prescribers and dispensers, and allows for institutional accounts to simplify access for providers in hospitals and long term care facilities. The available controlled substance information includes opioid morphine milligram equivalent (MME) information, basic Prescriber Report Card data, and the ability to review the prescriber	1.1 The KASPER code was developed in 2005, and is in need of modernization. CHFS is planning development of a new KASPER system using a modular design. Included in the modular design will be integrating with Electronic Health Record (EHR) system's and the statewide Kentucky Health Information Exchange (KHIE). 1.2 To increase KASPER effectiveness, the modernization project will include development of an enhanced Prescriber Report Card that will	1.1 Develop a new modular KASPER system designed to provide improved ease of use and operational efficiency. The new system modules will include 1.1.1 User management module, 1.1.2 PDMP System Application Module, 1.1.3 PDMP Sharing Module. Responsibility: KASPER Project Manager. Target completion: September 2020. 1.2 Implement phase 2 of the enhanced KASPER Prescriber Report Card. Responsibility: KASPER Project Manager.	1.1.1 User management module, 4/2019. 1.1.2 PDMP System Application Module, 12/2019 1.1.3 PDMP Sharing Module, 9/2020. Weekly Meetings will be held thru-out the entire project. 1.2 This drill down option is expected by early 2020. This phase 2 option will have monthly meetings between KASPER IT team and OIG.

	controlled substance prescribing history to detect errors or fraud.	include patient level data allowing prescribers easier identification of at-risk patients.	Target: completion date: 4/2020.	
Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange	There is currently limited connectivity between KASPER and the statewide health information exchange, KHIE.	Planned projects to integrate KASPER with KHIE include the following: 1.1 Prescriber and pharmacist users can request medical information based on a suspected drug overdose in an Emergency Department (ED). 1.2 Integration with KHIE, so prescriber and pharmacist KHIE users will be able to access KASPER patient data via KHIE without leaving the KHIE process workflow.	1.1 Drug toxicity screen results are being reported by the EDs to KHIE. The technical interface between KASPER and KHIE to obtain information regarding the presence of those results is under development. Responsibility: KASPER Project Manager. Target completion: 12/2018 1.2 Develop and implement technology to allow integrated data requests and responses between KASPER and KHIE. Responsibility: KASPER Project Manager. Target completion: 12/2020.	1.1 This interface is nearly complete. Will be ready by 12/2018. Weekly meetings are currently held. 1.2 This second phase of KASPER to KHIE integration will begin in 2019. Monthly meetings will be held. Should be completed by 12/2020.

Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns[6] (see also "Use of PDMP" #2 below)	1. KASPER currently identifies and flags patients who are receiving a current daily morphine milligram equivalent dose level of 100 or more. This includes a warning that these patients may be at a higher risk of drug overdose, and that increased clinical vigilance may be appropriate.	1.1 KASPER reports are going to be updated to include warning flags for overlapping opioid prescriptions and overlapping opioid and benzodiazepine prescriptions. 1.2 OIG will utilize an epidemiologist to study the correlation between initial opioid use and ongoing use and abuse.	1.1 Modify KASPER reports to reflect overlapping controlled substance prescriptions. Responsibility: KASPER Project Manager. Target completion: 12/2019. 1.2 Study correlations between initial opioid use and patient misuse and abuse patterns, as well as potentially problematic controlled substance prescribing practices. Responsibility: OIG Epidemiologist. Target completion: ongoing.	1.1 This modification will take BA and Development work. Weekly meetings will be held. 12/2019. 1.2 This is an ongoing study that the Epidemiologist will lead.
Current and Future PDMP Query Capabilities				
Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e.	1.1 KASPER currently utilizes advanced data analytics to match controlled	1.1 In March 2017 CHFS implemented a new KASPER Data Collection	1.1 Continue KASPER data quality improvement efforts. This is needed to ensure	1.1 This includes Business Analysts and Resource Management Analysts. This is an

[6] Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr.mm6610a1.

the state's master patient index (MPI) strategy with regard to PDMP query)	substance prescription records to patients.	System. Via this system, CHFS is implementing new data reporting edits that are helping to improve the quality of data collected. The improved data quality results in increased probability of accurate patient data matching. 1.2 CHFS is planning to implement an Enterprise Data Warehouse (EDW) that will house KASPER data.	and improve data quality. Responsibility: KASPER Project Manager and Project Administrator. Target completion: ongoing. 1.2 Coordinate KASPER patient data matching processes and analytics to be consistent and support a Master Patient Indexing (MPI) within the EDW. Responsibility: KASPER Project Manager. Target completion: 6/2020.	ongoing, daily happening. 1.2 This will be done in conjunction with the Data Analytics group within the Commonwealth. Weekly meetings will be held. Target completion of 6/2020.
Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes				
Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled	The KASPER system is currently fully integrated with a major pharmacy chain, and CHFS has received requests from additional health systems to integrate with their	Integrate with additional EHR and pharmacy systems using solutions that present KASPER data directly in the physician workflow. Capitalize on	1.1 To support additional KASPER/EHR integration and KASPER/KHIE integration, OATS is conducting capacity	1.1 This process may be included in the KASPER Modernization project. Weekly meetings will be

substance to address the issues which follow	EHR systems. The existing pharmacy integration allows the pharmacists to access KASPER data in one simple step without leaving their pharmacy management system workflow.	the integration work done by EHR/Pharmacy system vendors in other states.	planning reviews to ensure sufficient resources to support new integration projects. CHFS is supporting federal efforts to develop an API/Web service for PDMP/EHR integration and may also develop an in-house API/Web service to support integration projects. Responsibility: KASPER Project Manager. Target completion: 9/2020.	held during this process.
Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription	KASPER currently provides detailed prescription history and opioid MME data to health care provider users. Additional functionality is needed to improve the level of care.	1.1 Implement the ability for all KASPER users to obtain class A misdemeanor and felony drug conviction data for the patient. 1.2 Implement a patient dashboard capability to make it easier for healthcare provider KASPER users to identify overlapping	1.1 Implement a link to the Administrative Office of the Courts (AOC) CourtNet system to allow KASPER users to see drug conviction data for the previous five years. Responsibility: KASPER and AOC Project Managers. Target completion: 07/2018.	1.1 This link is currently in the testing phase and will be completed by 7/2018. Weekly meetings are currently being held. 1.2 This evaluation will need to done prior to the modernization project.

		prescriptions, early refills, multiple provider episodes, potential drug interactions and other indicators that may indicate overdose risk, or controlled substance abuse or diversion.	1.2 Evaluate existing patient dashboard tools and capabilities, and determine whether they can be implemented into the current KASPER system or as part of the KASPER modernization project. Responsibility: OIG and OATS. Target completion: 12/2019	
Master Patient Index / Identity Management				
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	While KASPER and KHIE are not currently integrated, KHIE has a defined algorithm MPI that provides match, merge and search capability.	1.1 As noted above, a KASPER/KHIE integration project is in the planning stage. As part of this project KHIE will utilize the enterprise MPI solution for querying KASPER.	1.1 Procurement of a new KHIE vendor solution was just completed. The KASPER/KHIE integration project will be undertaken after implementation of the new KHIE system. Responsibility: KASPER and KHIE Project Managers. Target completion: 11/2019.	1.1 This MPI will be part of the KHIE system. This will require weekly meetings to properly identify the appropriate matching parameters.
Overall Objective for Enhancing PDMP Functionality & Interoperability				

Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids	1.1 KASPER currently includes a Prescriber Report Card that provides aggregated controlled substance prescribing data and allows prescribers to compare their controlled substance prescribing with all Kentucky prescribers and with prescribers in their specialty area.	1.1 Phase 2 of the Prescriber Report Card will include patient level data allowing prescribers easier identification of at-risk patients (drill down options) These Prescriber Report Cards are available to the Kentucky prescriber licensure boards to assist with reviewing for inappropriate or illegal controlled substance prescribing.	1.1 Implement phase 2: the enhanced KASPER Prescriber Report Card. Responsibility: KASPER Project Manager. Target: completion date: 4/2020.	1.1 This drill down option is expected by early 2020. This phase 2 option will have monthly meetings between KASPER IT team and OIG.

The Commonwealth of Kentucky has assessed the current infrastructure/"ecosystem" that will be necessary to achieve the goals of the demonstration. The necessary changes have been identified and captured in the Kentucky HEALTH High Level Requirements (HLR) document which will be used to help determine cost and timeline as well as to monitor the overall status throughout development and implementation.

We have reviewed our last submission of the State Medicaid Health IT Plan (SMHP), Health Information Technology Plan to verify that SUD is aligned with the plan, it is. This has been addressed in the plan with integration to eKASPER and KHIE which also includes behavioral health data. It will become more tightly integrated and aligned as the Kentucky HEALTH demonstration project moves forward.

As applicable the Commonwealth of Kentucky will advance the standards referenced in the ISA and 45 CFR Subpart B, and the Manage Care Contractor (MCO) contracts will be updated to comply with the requirements.

Attachment A, Section II – Implementation Administration

Please provide the contact information for the state's point of contact for the SUD Health IT Plan.

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Attachment A, Section III – Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

TEAMKY Section 1115 Reentry Demonstration Evaluation Design

Commonwealth of Kentucky

December 29, 2024

Updated June 10, 2025

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Section 1
General Background Information

On July 2, 2024, the Commonwealth of Kentucky (Commonwealth) received approval from the Centers for Medicare & Medicaid Services (CMS) to amend its Section 1115 Demonstration to include pre-release services. The TEAMKY Demonstration (Project Numbers 11-W-00306/4 and 21-W-00067/4) is a comprehensive Demonstration that includes multiple components, including substance use disorder (SUD) and former foster care youth waivers. The pre-release services, or reentry, Demonstration (here after referred to as the Demonstration) allows the Commonwealth to provide certain services to eligible individuals who are incarcerated in Commonwealth prisons or youth correctional facilities. The TEAMKY Demonstration was approved for a five-year extension on December 12, 2024. To meet CMS' Special Terms and Conditions (STCs), the Kentucky Division of Medicaid Services (DMS) must contract with an independent third party to evaluate the Demonstration. DMS contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop the Evaluation Design for the reentry Demonstration. The Mercer team includes Mercer and its subcontractors, TriWest Group and HealthTech Solutions.
This document provides an overview of the planned evaluation for assessing the effects of the Demonstration and follows CMS' recommended structure for evaluation designs.

Demonstration History

The Commonwealth has leveraged section 1115 demonstrations in the past to address serious healthcare needs for its beneficiaries. The TEAMKY (formerly KYHealth) Demonstration was initially approved on January 12, 2018. The comprehensive Demonstration includes expenditure authority that allows the Commonwealth to provide services to otherwise eligible members with an SUD who are short-term residents in an Institution for Mental Diseases (IMD) and includes coverage of former foster care youth who were in foster care in another state. On June 16, 2020, the Commonwealth received approval to remove a community engagement component of the waiver that was never implemented. In November 2020, the Commonwealth submitted an application to provide substance use treatment for eligible incarcerated members; this amendment was withdrawn and the approved reentry Demonstration amendment was submitted in its stead to be consistent with State Medicaid Directors Letter #23-003.[4] On December 12, 2024,[5] CMS approved the TEAMKY Demonstration for a further five year extension. The approval included approval of additional components, including providing the Commonwealth expenditure authority to provide services to members with a serious mental illness (SMI)

[4] CMS. "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals who are Incarcerated." April 17, 2023. https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf
[5] CMS. Special Terms and Conditions. December 12, 2024. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ky-teamky-dmnstn-appvl-12122024.pdf

who are short-term residents in an IMD, provide recuperative care services to adult beneficiaries who are homeless or at risk of homelessness, and provide recovery residence support services for individuals with an SUD for up to 90 days post-release from incarceration.

Since 1970, there has been steady growth in the prison and jail population in Kentucky.[6] The Commonwealth chose to pursue a pre-release services Demonstration to address the physical and behavioral health needs of its population. In 2022, 19,744 and 22,292 individuals were incarcerated in prisons and jails in Kentucky, respectively, resulting in an incarceration rate of 437 per 100,000 people.[7]

Incarcerated individuals have high rates of mental health conditions and SUDs. Estimates put the prevalence of mental health conditions as high as 16% or 17% of incarcerated individuals in state prisons and jails, compared to 5.5% of adults in the general population.[8] 53% of incarcerated individuals in state prisons and 68% of individuals in jails have an SUD, compared to 16.5% of individuals aged 12 years and older in the general population. Estimates suggest that one-third to two-thirds of incarcerated individuals have co-occurring mental health disorders and SUDs. Individuals with a history of incarceration have higher rates of asthma, high blood pressure, cancer, arthritis, tuberculosis, HIV, and hepatitis than the general public.[9] Juvenile incarceration is associated with poorer physical and mental health outcomes than youth never incarcerated or incarcerated as an adult.[10]

A significant portion of incarcerated individuals in the US are pregnant or parenting individuals. In data from 2020 through 2021, 12% of children in Kentucky reported having had a parent who was ever incarcerated.[11] Parental incarceration has been found to be associated with youth substance use[12] and mental health conditions, such as depression, among children.[13] Additionally, a higher proportion of veterans are criminal justice-involved than the civilian population. Studies have found that a large percentage of veterans involved in the justice system have mental health and substance use diagnoses.[14] Research has also

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[6] Vera. "Incarceration Trends: Kentucky." October 16, 2024. https://trends.vera.org/state/KY.

[7] National Institute of Corrections. Kentucky. 2022. https://nicic.gov/resources/nic-library/state-statistics/2022/kentucky-2022

[8] Substance Abuse and Mental Health Services Administration (SAMHSA). "Best Practices for Successful Reentry From Criminal Justice Settings for People Living With Mental Health Conditions and/or Substance Use Disorders." SAMHSA Publication No. PEP23-06-06-001. Rockville, MD: National Mental Health and Substance Use Policy Laboratory. SAMHSA, 2023.https://store.samhsa.gov/sites/default/files/pep23-06-06-001.pdf

[9] Office of Disease Prevention and Health Promotion. "Incarceration." Accessed December 13, 2024. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/incarceration

[10] Barnert, Elizabeth S. et al. "Child Incarceration and long-term adult health outcomes: a longitudinal study." Int J Prison Health. March 2018: 26–33. https://pmc.ncbi.nlm.nih.gov/articles/PMC6527101/#:~:text=Additionally%2C%20individuals%20incarcerated%20as%20children,older%20ages%20or%20never%20incarcerated.

[11] The Annie E. Casey Foundation. "Kids Count Data Center: Commonwealth of Kentucky." May 2023. https://datacenter.aecf.org/data/tables/9688-children-who-had-a-parent-who-was-ever-incarcerated?loc=19&loct=2#detailed/2/19/false/2043,1769,1696,1648,1603/any/18927,18928

[12] Davis, Laurel and Rebecca J Shlafer. *Smith Coll Stud Soc Work.* December 2016: 53–58. https://pmc.ncbi.nlm.nih.gov/articles/PMC5695888/#:~:text=Both%20present%20and%20past%20parental%20incarceration%20was%20significantly%20associated%20with,practice%20and%20research%20are%20discussed.

[13] Martin, Eric. "Hidden Consequences: The Impact of Incarceration on Dependent Children. National Institute of Justice." March 1, 2017. https://nij.ojp.gov/topics/articles/hidden-consequences-impact-incarceration-dependent-children

[14] Holliday, Stephanie Brokers et al. "Identifying Promising Prevention Strategies and Interventions to Support Justice-Involved Veterans." Rand. June 12, 2023. *https://www.rand.org/pubs/perspectives/PEA1363-8.html*

found that criminal justice involvement is associated with a higher suicide risk for veterans.[15] In 2016, veterans composed 8% of the state prison population in the US.[16]

The Commonwealth has a long history of addressing incarceration and its associated health needs through legislative and policy actions. Bills passed in 2011 (House Bill 463) and 2015 (Senate Bill 192) emphasized treatment over incarceration through the creation of a drug treatment court program and the Alternative Sentencing Worker Program and expanding access to treatment. Senate Bill 90, passed in 2022, created the Behavioral Health Conditional Dismissal Program, in which individuals receive behavioral health treatment in lieu of incarceration; successful completion results in a dismissal of charges. Senate Bill 162 and House Bill 3 passed in 2023 provide resources for youth who have mental illness. Since 2016, the Kentucky Department of Corrections (DOC) has provided incarcerated individuals with counseling and Vivitrol®; inmates can currently access buprenorphine for opioid use disorder (OUD) at six state prisons. DOC also operates the Supporting Others in Active Recovery program, in which participants engage in an evidence-based program and reentry programs.

The Criminal Justice Kentucky Treatment Outcome Study, conducted by the Center on Drug and Alcohol Research at the University of Kentucky, researches the outcomes and experiences of individuals who participated in SUD treatment while incarcerated in the Commonwealth. Data from July 2020 through June 30, 2021, found that 88.9% of those who engaged in the substance use treatment program were living in stable housing and 76.7% were employed 12 months following release. 23.3% of individuals had received medication-assisted treatment (MAT) for opioids or alcohol.[17]

The Medicaid inmate exclusion policy prohibits Medicaid funds from being used for medical services for inmates while incarcerated, except during an inpatient hospital admission. Historically, states were allowed to terminate rather than suspend Medicaid enrollment for incarcerated individuals. The Commonwealth has suspended rather than terminated Medicaid enrollment for incarcerated individuals since 2020. The TEAMKY reentry Demonstration provides the Commonwealth with the opportunity to build on its already significant work supporting incarcerated and newly released individuals.

Demonstration Overview

On December 12, 2024, the TEAMKY Demonstration was approved for January 1, 2025 through December 31, 2029. The reentry Demonstration had been temporary approved for July 2, 2024 through December 31, 2024. The evaluation described in this design document will include both an implementation assessment and outcome evaluation of the Demonstration over the entire period: July 2, 2024 through December 31, 2029. Details for each evaluation period are included in the Methodology section of this design.

[15] Corr, Allison. "Veterans Who Have Been Arrested or Incarcerated Are at Heightened Risk for Suicide." Pew Charitable Trusts. November 8, 2023. https://www.pewtrusts.org/en/research-and-analysis/articles/2023/11/08/veterans-who-have-been-arrested-or-incarcerated-are-at-heightened-risk-for-suicide

[16] Office for Access to Justice. "Fact Sheet: Access to Justice is Access for Veterans." Department of Justice. May 31, 2024. https://www.justice.gov/atj/fact-sheet-access-justice-access-veterans

[17] Tillson, Martha et al. CJKTOS: Criminal Justice Kentucky Treatment Outcome Study FY2021. February 2022. Criminal Justice Kentucky Treatment Outcome Study

Demonstration Goals

The Demonstration's overarching goal is to improve health and well-being for Medicaid members who are incarcerated. The Demonstration will achieve this goal by increasing access and continuity of care for incarcerated individuals by improving connections and collaboration between carceral settings, community-based organizations (CBOs) and providers, and state agencies. The Commonwealth's goals are:

1. Improve access to services by increasing coverage, continuity of coverage, and appropriate service uptake for eligible incarcerated adults and placed youths.
2. Improve coordination, communication, and connections between correctional systems, Medicaid systems and processes, managed care plans, and community-based service providers delivering enhanced services to maximize successful reentry post-release.
3. Reduce the number of avoidable emergency department (ED) visits, inpatient hospitalizations, and all-cause mortality.
4. Increase additional investments in healthcare and related services to improve quality of care for Medicaid beneficiaries in carceral settings and post-release reentry community services.

Demonstration Activities

The Demonstration allows the Commonwealth to provide a suite of pre-release services for individuals who are incarcerated in state prisons or youth correctional facilities. The Commonwealth is authorized to provide:

- Case management to assess and address physical and behavioral health needs.
- MAT services for all types of SUD as clinically appropriate, with accompanying counseling/behavioral therapies.
- A 30-day supply of all prescription medications that have been prescribed for the individual at the time of release and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid and Children's Health Insurance Plan (CHIP) State Plan coverage authority and policy.

Case management will also facilitate continuity of care and ensure continuity of service in the community post-release from incarceration. These services can be provided no earlier than 60 days prior to release. Individuals qualify for pre-release services if they were found eligible for Medicaid or CHIP prior to or during incarceration.

The Commonwealth will achieve the above goals and provide the services noted above by following the initiatives and actions outlined in the Commonwealth's implementation plan. The Commonwealth's actions include:

- **Maintaining and expanding coverage policies**
  - Continue to suspend rather than terminate Medicaid coverage.
  - Adopt presumptive eligibility for justice-involved individuals.
  - Consider a modified suspension policy for those with shorter incarceration stays.

- **Investing in improved information systems**
  - Implement automated functionality for Medicaid and CHIP applications.
  - Integrated disparate information systems.
  - Utilize an automated system to predict and send alerts about release dates.
- **Training and educating staff and beneficiaries**
  - Train facility staff on Medicaid and CHIP eligibility and applications.
  - Implement comprehensive training programs for case managers.
  - Educate incarcerated beneficiaries about their Medicaid and CHIP eligibility and enrollment information.
- **Developing standardized protocols and procedures**
- **Expanding cross-sector collaboration and communication**
  - Utilizing person-centered care plans to refer individuals to appropriate services.
  - Develop mechanisms for information sharing between case managers and providers.

Impacted Population Groups

The Demonstration is open to individuals who are inmates in state prisons or youth correctional facilities, were deemed Medicaid- or CHIP-eligible prior to or during incarceration, and have a release date no later than 60 days after initiation of services. The Commonwealth utilizes a managed care delivery system for Medicaid and CHIP. Eligible state prisons and youth correctional facilities operate in specific counties in the Commonwealth. Eligible prisons operate in Bell, Caldwell, Elliot, Fayette, Floyd, Lee, Lyon, Mercer, Morgan, Muhlenberg, Shelby, and Oldham counties. The six youth correctional facilities operate in Adair, Graves, Kenton, Morgan, Rowan, and Wayne counties.

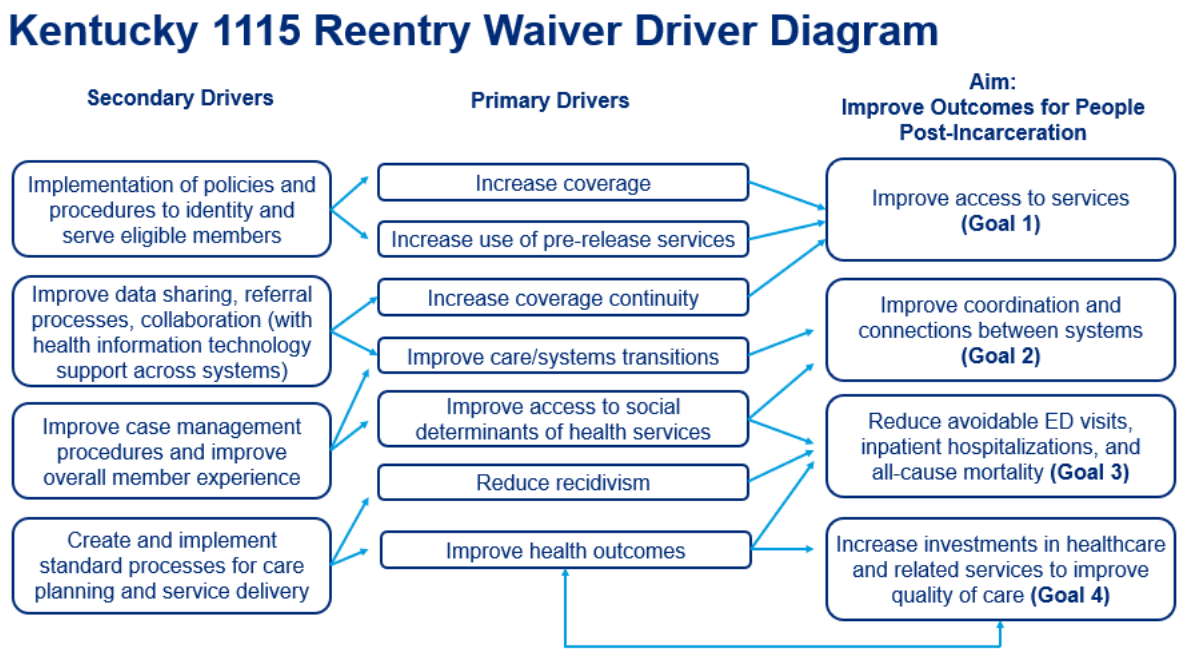
Section 2

Evaluation Questions and Hypotheses

The previous section outlined the Demonstration's goals and activities. The driver diagram below shows how the goals and activities from the Implementation Plan will advance the key aims of the Demonstration, improve health outcomes, reduce all-cause deaths, and reduce overdoses. We additionally hypothesize that the Demonstration will reduce recidivism, which will support the long-term achievement of the Demonstration's aims.

Driver Diagram

Figure 1. Driver Diagram



Hypotheses and Research Questions

The research questions and hypotheses below align with the aims and goals of the Demonstration. Research questions will be used to test each hypothesis, and quantitative and/or qualitative measures will be used to answer each research question. Refer to Section 3 for more detail and a complete list of research questions, hypotheses, and measures.

- **Goal 1: Improve access to services by increasing coverage, continuity of coverage, and appropriate service uptake for eligible incarcerated adults and placed youths.**
  - RQ 1.1: Does the Demonstration increase coverage?
    - Hypothesis 1: The Demonstration will increase the number of individuals who have Medicaid after release from incarceration.
  - RQ 1.2: Does the Demonstration increase the uptake of appropriate services pre-release?

    - Hypothesis 1: The Demonstration will increase the uptake of appropriate services pre-release.
  - RQ 1.3: Does the Demonstration improve continuity of coverage and care?
    - Hypothesis 1: The Demonstration will increase the number of individuals who access Medicaid services post release.
- **Goal 2: Improve coordination, communication, and connections between correctional systems, Medicaid systems and processes, managed care plans, and community-based service providers delivering enhanced services to maximize successful reentry post-release.**
  - RQ 2.1: Did the Demonstration improve coordination and communication between correctional systems, Medicaid, managed care plans, and community-based providers?
    - Hypothesis 1: The Demonstration will improve coordination and communication across sectors.
  - RQ 2.2: Does the Demonstration improve access to health-related social needs (HRSN) services?
    - Hypothesis 1: The Demonstration will increase the number of individuals connected to HRSN services.
  - RQ 2.3: Does the Demonstration improve transitions of care?
    - Hypothesis 1: The Demonstration will improve transitions of care.
- **Goal 3: Reduce the number of avoidable ED visits, inpatient hospitalizations, and all-cause mortality.**
  - RQ 3.1: Does the Demonstration improve healthcare outcomes?
    - Hypothesis 1: The Demonstration will improve healthcare outcomes.
  - RQ 3.2: Does the Demonstration reduce ED visits and inpatient hospitalizations?
    - Hypothesis 1: The Demonstration will reduce ED visits.
    - Hypothesis 2: The Demonstration will decrease preventable inpatient admissions.
    - Hypothesis 3: The Demonstration will decrease the 30-day readmission rate.
  - RQ 3.3: Does the Demonstration decrease the number of overdoses?
    - Hypothesis 1: The Demonstration will decrease the number of overdoses.
    - Hypothesis 2: The Demonstration will decrease the number of OUD overdoses.
  - RQ 3.4: Does the Demonstration reduce all-cause deaths in the near-term post-release?
    - Hypothesis 1: The Demonstration will decrease all-cause deaths in the first six months following release.

    - Hypothesis 1: The Demonstration will decrease overdose deaths in the first six months following release.
  - RQ 3.5: Does the Demonstration decrease the recidivism rate?
    - Hypothesis 1: The Demonstration will decrease the recidivism rate.
- **Goal 4: Increase additional investments in healthcare and related services to improve quality of care for Medicaid beneficiaries in carceral settings and post-release reentry community services.**
  - RQ 4.1: Did the Demonstration increase additional investments in healthcare and related services through the reinvestment plan?
    - Hypothesis 1: The Demonstration will increase investment in additional healthcare and related services through the reinvestment plan.
  - RQ 4.2: How does the Demonstration impact costs?
    - Hypothesis 1: The Demonstration will maintain or reduce per member per month (PMPM) costs for members who received pre-release services.

Section 3
Methodology

Evaluation Design

The evaluation of the Demonstration will use a mixed-methods design that combines both an implementation (process) and outcome evaluation to:

- Describe the progress made on specific Demonstration activities.
- Demonstrate change/accomplishments in each of the Demonstration drivers.
- Demonstrate progress on each of the Demonstration's goals.

Mercer will utilize a mixture of qualitative and quantitative methods to evaluate the Demonstration. Quantitative methods will include a mix of descriptive statistics, pre-/post-tests, and the use of comparison groups when methodologically feasible. When possible, Mercer will use interrupted time series (ITS) analysis to support an assessment on the degree to which Demonstration activities impacted changes over time. Mercer will conduct t-tests, ANOVA tests and/or multivariable regression to compare differences between subpopulations to understand potential disparate impacts of the Demonstration. Qualitative methods will include a series of interviews and focus groups with key informants at different timepoints in the Demonstration: close to the go-live date of October 1, 2025, mid- to late 2027, and early to mid-2030. The timing of the qualitative data collection will support Mercer in understanding the barriers and facilitators to implementation and the role of the Commonwealth's actions in implementing the Demonstration. Key informants will be key partners, potentially including:

- State officials/agency staff (DMS, DOC, Department of Juvenile Justice [DJJ])
- Case managers and/or managed care organization (MCO) representatives
- Workgroups and advisory committees (Advisory and Community Collaboration for Reentry Services [ACRES], Behavioral Health Technical Advisory Committee [TAC], and Persons Returning to Society from Incarceration TAC)
- Beneficiaries (with a specific effort to recruit parenting individuals and veterans)
- Community providers and CBOs

Thematic analysis (TA) and content analysis will be used to draw conclusions from data collected for qualitative review. TA is a method for identifying, analyzing, and interpreting patterns of meaning within qualitative data. Since key informant interview and focus group data includes individual opinions and subjective perspectives, TA allows for comparisons across different stakeholders and stakeholder groups and uses systematic procedures for generating text coding and themes.[18]

Medicaid beneficiaries will include members of important subpopulation groups, such as veterans and pregnant and/or parenting beneficiaries. This stratification supports Mercer in

[18] Clarke, V., & Braun, V. "Thematic analysis." (2017). The Journal of Positive Psychology, 12(3), 297–298

understanding whether groups experienced Demonstration activities differently based on differing levels of need.

Mercer will stratify metrics, when methodologically feasible and based on data availability, by age, gender/sex, risk level/acuity level, race/ethnicity, geography, pregnancy status, and veteran status. Research shows an association between incarceration and suicide for veterans, as well as an association between poor outcomes and parental incarceration for children. Mercer does not hypothesize that the Demonstration will have an **intentional** impact on different subpopulations, as the Demonstration is not targeting activities to specific groups. However, subpopulations interact with the medical community and justice systems in differing ways, which may have an unintentional impact on the uptake and continuation of services. Therefore, stratifying data by these subpopulations could highlight areas for future Demonstration activities or other state actions.

To assess the extent to which the 60-days pre-release coverage timeline facilitated improved outcomes beyond that of a more time-limited 30 days of pre-release coverage, Mercer will additionally stratify analyses, when feasible and appropriate, by pre-release service level (i.e., those beneficiaries who received services between 31 days to 60 days pre-release period and those who only received services up to 30-days prior to release). This stratification will help identify differences in outcomes based on service provision timing. Additionally, Mercer will include "days of pre-release service provision," counted as the days between the first claim for pre-release services to release date, as a control variable in the analyses to assess whether a longer period of pre-release service provision contributed to improved outcomes.

Mercer is working with the Commonwealth to identify the data elements available to properly define all subpopulations and control variables. Mercer is investigating using the presence of pre-incarceration Medicaid or CHIP coverage as a control variable in the Demonstration. Mercer is still working with the Commonwealth to determine the best geographical unit to include in the Demonstration evaluation. Individuals released from incarceration may first reside in a half-way home or other post-release housing before eventually moving to other areas of the Commonwealth. This makes efforts to understand impacts by geography difficult, as beneficiaries may interact with multiple different community care systems during the life of the Demonstration. In places where Mercer is unable to identify the proper data element or data is unavailable to conduct quantitative analysis, Mercer will leverage qualitative data collection to investigate perceived disparities in outcomes and barriers and facilitators to service delivery and cross-sector collaboration and coordination.

Target and Comparison Populations

The target population of the evaluation is Medicaid and CHIP members who are eligible for the Demonstration. As noted above, the Demonstration is open to individuals who are inmates in state prisons or youth correctional facilities, were deemed Medicaid- or CHIP-eligible prior to or during incarceration, and have a release date no later than 60 days after initiation of services.

In Kentucky, inmates in DOC custody are generally held in a state operated correctional facility. Due to capacity constraints at state operated prisons, DOC also partners with county/local jails to house DOC inmates. Since reentry services through this 1115 authority are only available at state prisons and youth correctional facilities, some DOC inmates despite their eligibility for reentry services, may not receive them because they are housed in facilities where reentry services are not available. Demonstration services are also voluntary, and incarcerated individuals can refuse to participate in pre-release services. Mercer investigated the use of two potential comparison populations: 1) DOC inmates housed in county/local jails where 1115 reentry services are not available and 2) DOC inmates of state run prisons who refuse pre-release services.

Mercer identified some potential challenges that may limit our ability to utilize the aforementioned comparison groups. The ability to use a comparison population is based on the ability to: 1) identify the population and 2) have data for the comparison population for all measures. While Kentucky Medicaid data can determine the time period someone is incarcerated, it alone cannot distinguish between a person incarcerated in a state operated prison versus a county/local jail. To identify the location of incarceration, Medicaid data would need to be matched to DOC data. Kentucky is in the process of including DOC and DJJ data in the Kentucky Health Information Exchange (KHIE) and Mercer is working with the Commonwealth to understand if it will be possible to use DOC and Medicaid data to identify the target and comparison population in the historical data. Some other limitations of these comparison groups include small sample sizes and selection bias; Mercer will discuss the implications of these limitations in the Interim and Summative Evaluation Reports.

Mercer may also make comparisons between the subpopulations described above, in order to better understand potential unintended differential impacts of the Demonstration on certain groups. These comparisons may also help the Commonwealth to better understand whether modifications of outreach, referral, or service delivery strategies are needed to reduce disparities among some subpopulations.

Evaluation Period

The Demonstration is approved for January 1, 2025 through December 31, 2029. The Evaluation Design described in this document includes both an implementation evaluation and an outcome evaluation that will together encompass the entire Demonstration period, as well as the temporary extension period of July 2, 2024 through December 31, 2024. The full evaluation period is July 2, 2024 through December 31, 2029. Evaluation periods are defined below.

Midpoint Assessment

The Midpoint Assessment will discuss early findings from the implementation evaluation period. The primary goal will be to assess progress in achieving the milestones of the project and conducting activities with fidelity to the original implementation plan. The outcome evaluation data presented in the midpoint assessment will include a descriptive analysis of available measures.

- Midpoint Implementation Evaluation Period: July 2, 2024 through January 2027

- Midpoint Outcome Evaluation Period (descriptive only):
  - Pre-Demonstration Period: January 1, 2024 to September 30, 2025
  - Post-Demonstration Period: October 31, 2025 to January 31, 2027

Interim Evaluation Report

The Interim Evaluation Report will discuss implementation successes and challenges of the waiver, particularly in the context of the Commonwealth's ability to provide services with fidelity to the original implementation plan (implementation evaluation) and early indications of the effects of Demonstration activities (outcome evaluation). The interim evaluation report will be submitted with a renewal application or by December 31, 2028.

- Interim Implementation Evaluation Period: July 2, 2024 through July 2027
- Interim Outcome Evaluation Period:
  - Pre-Demonstration Period: January 2024 to September 2025
  - Post-Demonstration Period: October 2025 to July 31, 2027

Summative Evaluation Report

The Summative Evaluation Report will focus primarily on the outcomes for people participating in the Demonstration and costs to the Commonwealth. It will include the degree to which implementation challenges and successes may have impacted results and summarize key Commonwealth learnings.

- Summative Implementation Evaluation Period: July 2, 2024 through December 31, 2029
  - Interim Outcome Evaluation Period:
    - Pre-Demonstration Period: January 1, 2024 to September 30, 2025
    - Post-Demonstration Period: October 1, 2025 to December 31, 2029

Evaluation Measures and Data Sources

Mercer chose the measures for the evaluation that provide the most reliable data on which to determine the impact of the evaluation on the outcomes of interest, namely improved health outcomes and reduced deaths. Mercer is using both process measures and outcome measures in its evaluation. When possible, evaluation metrics have been chosen from nationally recognized measure stewards and from the Commonwealth's submitted reentry Monitoring Protocol. In some instances, Mercer will need to deviate from approved technical specifications for established quality measures in order to capture the Demonstration population. For example, Mercer may use a larger age range for some measures and will restrict the inclusion criteria to those beneficiaries in the Demonstration population (i.e., incarcerated people who were eligible for and/or accessed pre-release services).

Table 1 below lists the proposed research questions, hypotheses, and measures for the Demonstration evaluation, organized by goal. The table includes the measure steward, if

applicable, and all potential data source(s) and proposed analytical method(s). Mercer is working with the Commonwealth and other relevant parties to determine data availability to inform the final measures, analytical methods, and other specifications. Mercer will potentially use data from Medicaid claims and encounters for the Commonwealth, DOC (Kentucky Offender Management System [KOMS]) or DJJ systems (Juvenile Kentucky Offender Management System [JKOMS]), the KHIE, Vital Statistics, case manager notes, and data from kynect resources. kynect resources is a platform through which individuals can find community organizations to address needs such as housing and transportation. Community organizations can manage referrals and collaborate with other organizations through the platform.[19] Mercer is working with the Commonwealth and other partners to determine the data sources needed for all measures proposed below.

Mercer will also conduct TA on qualitative data collected through key informant interviews and focus groups. Qualitative analysis will be used to understand the barriers and facilitators to implementation of the Demonstration, as well as to provide context to the quantitative findings. Mercer will interview a diverse set of key informants to capture the broadest range of experiences possible.

[19] The Commonwealth of Kentucky. "Kynect resources. Community Partners. Frequency Asked Questions." Accessed December 19, 2024. https://www.chfs.ky.gov/agencies/dms/kynect/krFAQCommunityPartners.pdf

Table 1. Evaluation Measures

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
Goal 1: Improve access to services by increasing coverage, continuity of coverage, and appropriate service uptake for eligible incarcerated adults and placed youths.					
RQ 1.1: Does the Demonstration increase coverage?					
Hypothesis 1: The Demonstration will increase the number of individuals who have Medicaid after release from incarceration.					
Individuals eligible for pre-release services	n/a	Count of individuals eligible for pre-release services (i.e., incarcerated in eligible facilities, eligible for Medicaid except for incarceration status)	n/a	Claims/encounter data Eligibility systems KOMS and JKOMS	Descriptive trends over time (one-group post-test-only design) Multivariable regression ANOVA/t-test
Individuals newly enrolled in Medicaid following release	n/a	Number of individuals enrolled in Medicaid at release who were not enrolled in Medicaid at time of incarceration	Number of individuals not enrolled in Medicaid at time of incarceration	Claims/encounter data Eligibility systems	Descriptive trends over time (one-group post-test-only design) Multivariable regression ANOVA/t-test
RQ 1.2: Does the Demonstration increase the uptake of appropriate services pre-release?					
Hypothesis 1: The Demonstration will increase the uptake of appropriate services pre-release.					
Individuals receiving reentry services prior to release from incarceration (and by type of service)	n/a	Number of individuals who received any pre-release service	Number of individuals eligible for pre-release services	Claims/encounter data Eligibility data KOMS and JKOMS	Descriptive trends over time (one-group post-test-only design) Multivariable regression ANOVA/t-test
Commonwealth actions to increase uptake of Demonstration pre-release services (implementation of policies and procedures to identity and serve eligible members, changes in	n/a	n/a	n/a	Interviews and focus groups with Medicaid beneficiaries, case managers, Kentucky ACRES/advisory groups,	TA

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
technology and information management/sharing) Member and case manager experience with pre-release services				and DMS/DOC/DJJ representatives	
RQ 1.3 Does the Demonstration improve continuity of coverage and care?					
Hypothesis 1: The Demonstration will increase the number of individuals who access Medicaid-services post-release.					
Percentage of individuals who accessed community-based/ essential services within 7 days post-release	n/a	Number of released individuals who access essential services within 7 days post-release	Number of individuals eligible for pre-release services and have been released	Claims/encounter data Eligibility data KOMS and JKOMS KHIE	Descriptive trends over time (one-group post-test-only design) Multivariable regression ITS (pending data availability) ANOVA/t-test
Percentage of members who continued to access community-based providers within 30 days, 6 months, and 1 year following release	n/a	Number of released individuals who accessed essential services within 30 days, 6 months, and 1 year post-release (3 rates)	Number of individuals who were eligible for pre-release who accessed essential services within 7 days post-release	Claims/encounter data Eligibility data KOMS and JKOMS KHIE	Descriptive trends over time (one-group post-test-only design) Multivariable regression ITS (pending data availability) ANOVA/t-test
Percentage of individuals who complete post-release follow-up with case manager	n/a	Number of released individuals who had at least one post-release follow-up with case manager within 30 days of release	Number of individuals who were eligible for pre-release services and have been released	Claims/encounter data Eligibility data KOMS and JKOMS KHIE	Descriptive trends over time (one-group post-test-only design) Multivariable regression ITS (pending data availability) ANOVA/t-test
Percentage of members who continued with MAT following release	CMS Adjusted SUD Metric #12	Number of released individuals who received at least one MAT service post-release	Number of individuals who received MAT during their 60-day pre-release period and have been released	Claims/encounter data Eligibility data KOMS and JKOMS	Descriptive trends over time (one-group post-test-only design) Multivariable regression

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
				KHIE	ITS (pending data availability) ANOVA/t-test
Percentage of members who accessed preventative and routine healthcare visits (i.e., annual check-ups) following release	CMS/HEDIS Adjusted SUD Metric #32	Number of released individuals who received at least one preventative and routine healthcare visit post-release	Number of individuals who were eligible for pre-release services and have been released	Claims/encounter data Eligibility data KOMS and JKOMS KHIE	Descriptive trends over time (one-group post-test-only design) Multivariable regression ITS (pending data availability) ANOVA/t-test
Percentage of members who accessed behavioral health services, among those with a SUD or SMI, following release	n/a	Number of released individuals who have at least one behavioral healthcare visit post-release	Number of individuals who were eligible for pre-release services, have been released, and have an SUD/SMI diagnosis	Claims/encounter data Eligibility data KOMS and JKOMS KHIE	Descriptive trends over time (one-group post-test-only design) Multivariable regression ITS (pending data availability) ANOVA/t-test
Perceptions on the Demonstration's impact on access to healthcare services	n/a	n/a	n/a	Interviews and focus groups with Medicaid beneficiaries, case managers, ACRES/advisory groups, and DMS/DOC/DJJ representatives	TA
Goal 2: Improve coordination, communication, and connections between correctional systems, Medicaid systems and processes, managed care plans, and community-based service providers delivering enhanced services to maximize successful reentry post-release.					
RQ 2.1: Did the Demonstration improve coordination and communication between correctional systems, Medicaid, managed care plans, and community-based providers?					
Hypothesis 1: The Demonstration will improve coordination and communication across sectors.					
Changes to data and information sharing processes	n/a	n/a	n/a	Interviews and focus groups with Medicaid beneficiaries,	TA

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
Commonwealth actions to develop and implement referral processes and information sharing Changes to cross-sector communication and collaboration Commonwealth efforts to support cross-sector collaboration (i.e., trainings, outreach plans, establishment of ACRES, policy standardization) Implementation, expansion, and use of health information technology/health information exchange to support collaboration				CBOs/providers, MCOs, ACRES/advisory groups, and DMS/DOC/DJJ representatives Document review	
RQ 2.2: Does the Demonstration improve access to HRSN services?					
Hypothesis 1: The Demonstration will increase the number of individuals connected to HRSN services.					
CBO referrals	n/a	Count of individuals referred to CBOs	Individuals who were eligible for pre-release services and are now released	Claims/encounter data Eligibility data kynect resources	Descriptive trends over time (one-group post-test-only design) Multivariable regression ITS (pending data availability) ANOVA/t-test
Number and percentage of individuals in stable housing 6 months post-release	n/a	Number of individuals in stable housing	Number of released individuals eligible for pre-release reentry services.	Claims/encounter data Eligibility data kynect resources	Descriptive trends over time (one-group post-test-only design) Multivariable regression ITS (pending data availability) ANOVA/t-test

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
Number and percentage of individuals connected to employment 6 months post-release	n/a	Number of individuals employed	Number of released individuals eligible for pre-release reentry services.	Claims/encounter data Eligibility data kynect resources	Descriptive trends over time (one-group post-test-only design) Multivariable regression ITS (pending data availability) ANOVA/t-test
RQ 2.3: Does the Demonstration improve transitions of care?					
Hypothesis 1: The Demonstration will improve transitions of care.					
Commonwealth actions to create and implement standard processes for care planning and service delivery Changes in technology and information management/sharing Member experience with transitions of care and continuity of care	n/a	n/a	n/a	Interviews and focus groups with Medicaid beneficiaries, CBOs/providers, MCOs, ACRES/advisory groups, and DMS/DOC/DJJ representatives Document review	TA
Goal 3: Reduce the number of avoidable ED visits, inpatient hospitalizations, and all-cause mortality.					
RQ 3.1: Does the Demonstration improve healthcare outcomes?					
Hypothesis 1: The Demonstration will improve healthcare outcomes.					
Glycemic Status Assessment for Patients with Diabetes	CMS Adult Core Set (National Committee for Quality Assurance [NCQA] #1820)	Number of individuals whose most recent glycemic status was < 8.0%	Number of individuals aged 18 years–75 years with a dx of diabetes who were eligible for pre-release services	Claims/encounter data Eligibility data Health records KHIE	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test
Controlling Blood Pressure	NCQA #167	Number of individuals whose most recent blood pressure reading during the	Number of individuals aged 18 years–75	Claims/encounter data Eligibility data	Descriptive trends over time (one-group post-test-only design)

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
		measurement year was <140/90	years with a diagnosis of hypertension who were eligible for pre-release services	Health records KHIE	ITS (pending data availability) Multivariable regression ANOVA/t-test
Continuity of Pharmacotherapy for OUD	National Quality Forum #3175	Number of individuals with at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days	Number of individuals aged 18+ years with a qualifying encounter during the performance year, and a diagnosis of OUD and pharmacotherapy for OUD during the denominator identification period who were eligible for pre-release services	Claims/encounter data Eligibility data KHIE	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test
HIV Viral Load Suppression	CMS Adult Core Set Measure — (Health Resources and Services Administration #325)	Number of individuals who had a HIV viral load less than 200 copies/ml at last test during measurement year	Number of individuals 18+ years with a diagnosis of HIV who were eligible for pre-release services	Claims/encounter data Eligibility data Health records KHIE	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test
Beneficiary self-report on improved health outcomes				Interviews and focus groups with Medicaid beneficiaries	TA
RQ 3.2: Does the Demonstration reduce ED visits and inpatient hospitalizations?					
Hypothesis 1: The Demonstration will decrease unnecessary ED visits.					

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
ED visits	CMS Adjusted SUD Metric #23	Number of ED visits for SUD	Number of released individuals who were eligible for pre-release services	Claims/encounter data Eligibility data KHIE	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test
Hypothesis 2: The Demonstration will decrease preventable inpatient admissions.					
Inpatient admissions	CMS Adjusted SUD Metric #24	Number of inpatient discharges related to SUD	Number of released individuals who were eligible for pre-release services	Claims/encounter data Eligibility data KHIE	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test
Hypothesis 3: The Demonstration will decrease the 30-day readmission rate.					
30-day readmission rate	CMS Adjusted SUD Metric #25	Count of 30-day readmissions	Number of released individuals who were eligible for pre-release services	Claims/encounter data Eligibility data KHIE	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test
RQ 3.3: Does the Demonstration decrease the number of overdoses?					
Hypothesis 1: The Demonstration will decrease the number of overdoses.					
Overdoses	n/a	Number of overdoses	Number of released individuals who received pre-release services	Claims/encounter data Eligibility data KHIE Vital Statistics	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
					ANOVA/t-test
Hypothesis 2: The Demonstration will decrease the number of opioids overdoses.					
Opioid overdoses	n/a	Number of opioid overdoses	Number of released individuals who received pre-release services	Claims/encounter data Eligibility data KHIE Vital Statistics	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test
RQ 3.4: Does the Demonstration reduce all cause deaths in the near term post release?					
Hypothesis 1: The Demonstration will decrease all cause deaths in the first 6 months following release.					
All-cause deaths	n/a	Number of deaths within 6 months post release	Number of released individuals who received pre-release services	Claims/encounter data Eligibility data Vital statistics	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test
Hypothesis 2: The Demonstration will decrease overdose deaths in the first 6 months following release.					
Overdose deaths	CMS Adjusted SUD Metric #27	Number of overdose deaths within 6 months post-release	Number of released individuals who received pre-release services	Claims/encounter data Eligibility data Vital statistics	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test
RQ 3.5: Does the Demonstration decrease the recidivism rate?					
Hypothesis 1: The Demonstration will decrease the recidivism rate.					

Measure(s)	Measure Steward	Numerator	Denominator	Potential Data Sources	Potential Analytical Method
Recidivism rate	Based on DOC's recidivism definition.[20]	Number of new felony convictions or return to custody within 24 months of release	Number of individuals released from custody	DOC/DJJ data DOC annual report Claims/encounter data Eligibility data	Descriptive trends over time (one-group post-test-only design) ANOVA/t-test
Goal 4: Increase additional investments in healthcare and related services to improve quality of care for Medicaid beneficiaries in carceral settings and post-release reentry community services					
RQ 4.1: Did the Demonstration increase additional investments in healthcare and related services through the reinvestment plan?					
Hypothesis 1: The Demonstration will increase investment in additional healthcare and related services through the reinvestment plan.					
Changes in investments Commonwealth efforts to improve quality of care through investments	n/a	n/a	n/a	Interviews and focus groups with CBOs, MCO, ACRES, and DMS/DOC/DJJ representatives Document review	TA
RQ 4.2: How does the Demonstration impact costs?					
Hypothesis 1: The Demonstration will reduce or maintain PMPM costs for members who received pre-release services.					
PMPM cost for members who received pre-release services	n/a	Total costs for people who received pre-release services	Total member months for people who received pre-release services	Claims/encounter data	Descriptive trends over time (one-group post-test-only design) ITS (pending data availability) Multivariable regression ANOVA/t-test

[20] Kentucky Department of Corrections. 2023 Annual Report. September 18, 2024. https://corrections.ky.gov/public-information/researchandstats/Documents/Annual%20Reports/2023%20DOC%20Annual%20Report%20-%20final%20(1).pdf

Analytical Methods

As noted above in Table 1, Mercer will use a combination of quantitative and qualitative analytical methods to evaluate the Demonstration. Quantitative methods will include the use of ITS, multivariable regression, and statistical tests such as t-tests, based on data availability and methodological appropriateness. Qualitative methods will include TA of key informant interviews and focus groups and document review.

ITS analysis will be used if sufficient historical data from incarcerated facilities or Medicaid is available. As mentioned in the Target and Comparison Group section above, The Commonwealth is in the process of integrating data from carceral facilities into KHIE. The Commonwealth suspends, rather than terminates, Medicaid coverage when an individual is incarcerated and transitions the individual to fee-for-service (FFS). Those who were not Medicaid beneficiaries at the time of incarceration will be assessed for Medicaid eligibility; individuals identified as likely eligible for Medicaid will have an application submitted by DOC to initiate FFS benefits. Mercer will assess FFS Medicaid enrollment to determine whether this data element can help identify individuals who were incarcerated and released prior to the start of the reentry Demonstration to assess post-incarceration outcomes. Mercer will also work with the Commonwealth to understand if it can use DOC or DJJ data to identify those who are incarcerated in eligible facilities in order to construct comparison populations.

Specific outcome measure(s) will be collected for multiple time periods both before and after the start of the intervention. Segmented regression analysis will be used to statistically measure the changes in level and slope in the post-intervention period (after the Demonstration was implemented) compared to the pre-intervention period (before the Demonstration was implemented). If used, the ITS design will be dependent on the availability of historical data for specific outcome measures (see Section 4, “Methodology Limitations,” for more information). The ITS design uses historical data to forecast the **counterfactual** of the evaluation (i.e., what would happen if the Demonstration did not occur). Mercer proposes using basic time series linear modeling to forecast these **counterfactual** rates for three years following the Demonstration implementation. The more historical data available, the better these predictions will be. Mercer will use October 1, 2025 as the start of the post-implementation period for any ITS analysis. October 1, 2025 is the Commonwealth’s anticipated “go-live” date when it will begin providing pre-release services to incarcerated individuals. If the “go-live” date changes, analyses will be adjusted to accommodate that change.

In ITS analyses, the t-test statistic will be reviewed to understand the significance of changes across evaluation time periods: pre-Demonstration and the Demonstration period.

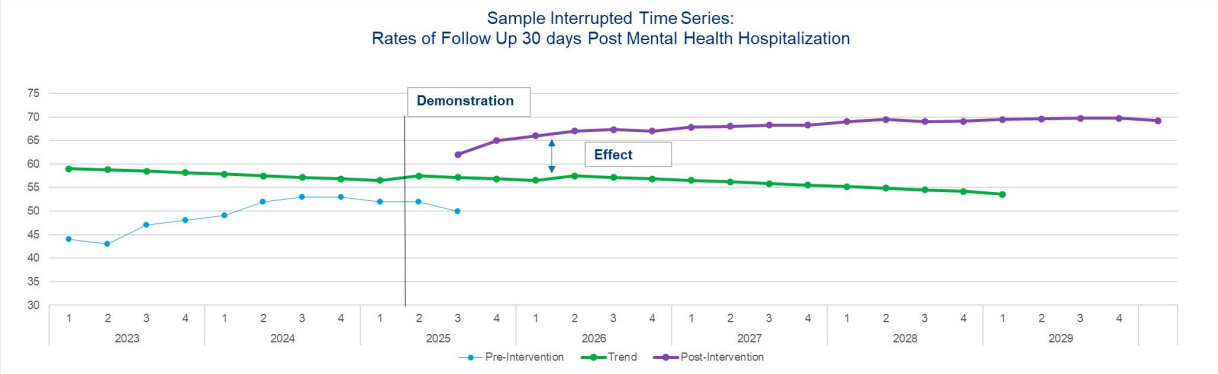
For this Demonstration, establishing the counterfactual is somewhat nuanced. The Driver Diagram and evaluation hypotheses assume that Demonstration activities will have overall positive impacts on outcome measures. The figure below illustrates an ITS design that uses basic regression forecasting to establish the counterfactual. The counterfactual is based on historical data (the blue line). It uses time series averaging (trend smoothing) and linear regression to create a predicted trend line (shown below as the green line). The purple line

in the graph is the (sample) actual observed data. Segmented regression analysis will be used to statistically measure the changes in level and slope in the post-intervention period compared to the predicted trend (see "effect" in the graph below).
The ITS regression equation is depicted below.

$$Y_{i,t} = \beta_0 + \beta_1 Time_t + \beta_2 Treatment_t + \beta_3 (Treatment_t \times Time_t) + \gamma X_{i,t} + \varepsilon_{i,t}$$

Where β_0 represents the baseline observation, β_1 is the change in the measure associated with a time unit (quarter or year) increase (representing the underlying pre-intervention trend), β_2 is the level change following the treatment (Demonstration implementation), and β_3 is the slope change following the treatment (using the interaction between time and treatment: $Treatment_t \times Time_t$).[21] $X_{i,t}$ is a vector of control variables and $\varepsilon_{i,t}$ represents unobservable factors that may affect the outcome.
This can be represented graphically as follows.

Figure 3: Example of ITS Graphical Representation



Additionally, Mercer will conduct multivariable regression analyses to assess the associational relationship between the Demonstration and outcomes of interest, as well as stratified analyses by subpopulation to understand how differences in beneficiary characteristics,[22] such as age, sex, and pregnancy status, contribute to the relationship between the Demonstration and outcomes of interest.
The multivariable regression equation is depicted below:

$$Y_{i,t} = \beta_0 + \beta_1 Treatment_{i,t} + \gamma X_{i,t} + \varepsilon_{i,t}$$

Where β_0 represents the baseline observation and β_1 represents the relationship between receipt of reentry services and the outcome $Y_{i,t}$. $X_{i,t}$ is a vector of control variables and $\varepsilon_{i,t}$ represents unobservable factors that may affect the outcome. The above regression can be adjusted and stratified by subpopulations of interest, as noted above, to assess whether the relationship between receiving reentry services through the Demonstration (Treatment) varies by subpopulation categories.

[21] Bernal JL, Cummins S, Gasparrini A. "Interrupted time series regression for the evaluation of public health interventions: a tutorial." (2017 Feb). International Journal of Epidemiology 46(1): 348–355.
[22] https://academic.oup.com/ejcts/article/55/2/179/5265263

Mercer assessed the possibility of utilizing DID analyses. Due to data limitations, namely the lack of pre-Demonstration data on the reentry population and the lack of an appropriate comparison group that would facilitate quasi-experimental analyses to identify causal effects of the reentry Demonstration. As such, DID analyses are most likely not feasible for this evaluation.

Mercer will conduct qualitative data collection at three time points: late 2025 and early 2026, mid- to late 2027, and early to mid-2030. The first round of data collection will capture the early implementation activities and actions that occurred early in the Demonstration's implementation (i.e., "ramp up" period). The second round of qualitative data collection will capture the early period of service provision. The third round of qualitative data collection will occur once the Demonstration has matured and will help illuminate how processes have changed over time, as well as individual's perceptions on the barriers and facilitators to Demonstration success. Standardized interview guides will be developed based on the driver diagram and leverage aspects of the "Consolidated Framework for Implementation Research."[23] Mercer will develop a code book based on the standardized interview guides to analyze the interview transcripts. TA of qualitative data will allow Mercer to draw conclusions from a diverse range of experiences and viewpoints.

[23] Center for Clinical Management Research. 2024, https://cfirguide.org/

Section 4
Methodological Limitations

All analyses are subject to data availability and completeness. Some data sources may be insufficient to complete the analyses as proposed or contain errors that will impact the analysis. Proposed analytical measures (such as ITS, t-tests, multivariable regression, or descriptive time series) do not allow Mercer to draw causal inferences and directly attribute changes to the Demonstration. ITS requires a sufficient number of pre- and post-implementation data points. The amount and accuracy of historical data, especially for those without pre-incarceration Medicaid or CHIP coverage, could impact the usability of that method. Mercer will work closely with the Commonwealth to determine whether pre-Demonstration DOC and DJJ data will be included in the KHIE. However, if pre-Demonstration data is not included, Mercer will not be able to conduct analyses that require pre-implementation data or a comparison group. In such case, Mercer will utilize a one-group post-test-only design (also referred to as "descriptive trends over time" analyses) that will track outcomes over time to assess trends post-implementation, consistent with CMS recommendations in "Selecting the Best Comparison Group and Evaluation Design: A Guidance Document for State Section 1115 Demonstration Evaluations."[24]

Furthermore, the target population and design of the Demonstration introduces its own limitations into the evaluation. The population is relatively narrow, comprising only those who are incarcerated in eligible facilities with a release date that is 60 days in the future. Therefore, it is highly possible that the population of the total Demonstration and/or subpopulations may be too small from which to draw meaningful conclusions. Mercer will leverage qualitative analyses to supplement findings when quantitative analyses are insufficiently powered to yield definitive conclusions. In instances when national data is sufficiently available, such as overdose fatalities post-incarceration, Mercer will conduct benchmarking analyses to evaluate the Commonwealth's performance through the reentry Demonstration in relation to the broader United States.

Additionally, members may get "exposed" to the intervention multiple times, as a result of changes in release dates that may allow a person to be eligible for pre-release services more than once or being incarcerated and released multiple times during the Demonstration period. Mercer will address this through sensitivity tests either by including a control variable that accounts for multiple exposures due to release date changes or by re-running analyses that limit consideration to individuals leaving incarceration who did not have their release date change.

As has been stated previously in the Evaluation Design, Mercer is continuing to work with the Commonwealth to define all the proposed metrics and identify data sources. There is a possibility that the data needed for some metrics will not be available or will require a high level of cleaning/matching between sources to create a useable data set for analysis that may not be feasible due to resource limitations. Additionally, the Commonwealth is working

[24] https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/comparison-grp-eval-dsgn.pdf

to integrate disparate data sources, which may cause delays in data availability or other issues which may impact the data's usability. Once data sources are identified, Mercer will work with the Commonwealth and subcontractors as needed to acquire and integrate data sources. If any proposed metrics are not feasible, Mercer will assess the data from the Commonwealth and its partners to determine whether an alternative measure is feasible and appropriate. If that is the case, Mercer will document any changes and rationale in the Interim and/or Summative Evaluation Reports, as applicable.

Although Mercer will use qualitative data collected from key informant interviews and focus groups to understand policy and implementation changes that may impact the quantitative findings, qualitative research methods have their own set of methodological limitations. Qualitative research focuses on a specific group of individuals' experiences with a policy or policy change and therefore has limited generalizability. Qualitative data is also subject to bias and reflects the individual informant's perspective and experience of the program. Mercer will attempt to limit the impact of this by collecting data from a variety of sources and the use of standardized interview guides. Mercer will check for inter-rater reliability when coding interviews.

Section 5
Attachments

As part of the STCs, as set forth by CMS, the Commonwealth is required to arrange with an independent party to conduct an evaluation of the reentry Demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses.

Mercer was chosen as the independent evaluator through an Individual Project Request process. Mercer will develop the Evaluation Design, calculate the results of the study, evaluate the results for conclusions, and write the Interim and Summative Evaluation Reports. Mercer has over 25 years of experience assisting state governments with the design, implementation, and evaluation of publicly sponsored healthcare programs. Mercer currently has over 25 states under contract and has worked with over 35 different states in total. They have assisted states like Arizona, Connecticut, Missouri, and New Jersey in performing independent evaluations of their Medicaid programs; many of which include 1115 Demonstration waiver evaluation experience. Given their extensive experience, the Mercer team is well equipped to work effectively as the external evaluator for the Demonstration project.

The table below includes contact information for the lead coordinators from Mercer for the evaluation.

Name	Position	Email Address
Nicole Comeaux	Engagement Leader	nicole.comeaux@mercer.com
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Appendix A
Conflict of Interest

Mercer's Government specialty practice does not have any conflicts of interest, such as providing services to any MSO or healthcare providers doing business in the Commonwealth under the Commonwealth program or providing direct services to individual recipients. One of the byproducts of being a nationally operated group dedicated to the public sector is the ability to identify and avoid potential conflicts of interest with our firm's multitude of clients. To accomplish this, market space lines have been agreed to by our senior leadership. Mercer's Government group is the designated primary operating group in the Medicaid space.

Before signing a contract to work in the Medicaid market, either at the state level or otherwise, we require any Mercer entity to discuss the potential work with Mercer's Government group. If there is a potential conflict (i.e., work for a Medicaid health plan or provider), the engagement is not accepted. If there is a potential for a perceived conflict of interest, Mercer's Government group will ask our state client if they approve of this engagement, and we develop appropriate safeguards such as keeping separate teams, restricting access to files, and establish process firewalls to avoid the perception of any conflict of interest. If our client does not approve, the engagement will not be accepted. Mercer has collectively turned down a multitude of potential assignments over the years to avoid a conflict of interest.

Mercer is a technical assistance provider for the Commonwealth on a separate Medicaid project. Given that Mercer is acting as both technical assistance provider and independent evaluator for this project, Mercer has implemented measures to ensure there are no perceived conflicts of interest and project teams do not overlap. The Mercer and TriWest teams are functionally and physically separate from the technical assistance team, and the contract does not include any performance incentives that would contribute to a perception of conflicted interests between technical assistance services and the independence of the evaluation process.

In regards to Mercer's proposed subcontractors, all have assured Mercer there will be no conflicts and that they will take any steps required by Mercer or DMS to mitigate any perceived conflict of interest. To the extent that we need to implement a conflict mitigation plan with any of our valued subcontractors, we will do so. Mercer, through our contract with DMS, has assured that it presently has no interest and will not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services. Mercer has further assured that in the performance of this contract, it will not knowingly employ any person having such interest. Mercer additionally certified that no member of Mercer's Board or any of its officers or directors has such an adverse interest.

Appendix B
Evaluation Budget

Table B.1 below presents the budget for the evaluation for the TEAMKY reentry Demonstration. Budget estimates include hours for staff, development of data collection instruments, development of metrics and determination of data sources, data cleaning and ingestion, data collection, analysis, and report writing.

Table B.1 Evaluation Budget

Category	State Fiscal Year 2025 (SFY25)	SFY26	SFY27	SFY28	SFY29	SFY30	SFY31	SFY32	Total
Project Management	$61,187	$61,187	$61,187	$61,187	$61,187	$61,187	$61,187	$61,187	**$489,500**
Evaluation Design	$68,625	x	x	x	x	x	x	x	**$68,625**
Interim Evaluation Report	x	$26,294	$26,294	$26,294	$26,294	$19,000	x	x	**$124,175**
Midpoint Assessment	x	x	x	$46,000	$10,000	x	x	x	**$56,000**
Summative Evaluation Report	x	x	x	x	x		$42,800	$19,000	**$61,800**
Data	$162,762	$294,094	$309,703	$309,703	$309,703	$309,703	x	x	**$1,695,671**
Total	**$292,575**	**$381,575**	**$397,185**	**$443,185**	**$407,185**	**$389,891**	**$103,988**	**$80,168**	**$2,495,771**

Table B.2 Hours by Evaluation Staff Role

Year	Project Director	Principal Consultants	Senior Consultants	Consultant	Junior Consultant	Project and Administrative Support	Total Hours
SFY25	175	359	265	135	100	95	**1,129**
SFY26	375	359	255	245	110	95	**1,439**
SFY27	375	359	255	245	110	95	**1,439**
SFY28	375	359	255	245	110	95	**1,439**
SFY29	375	359	255	245	110	95	**1,439**
SFY30	375	359	255	245	110	95	**1,439**
SFY31	375	359	255	245	110	95	**1,439**
SFY32	100	180	125	135	55	45	**640**
Final Total	**2,425**	**2,513**	**1,795**	**1,605**	**760**	**665**	**10,403**

Appendix C
Potential Timeline and Major Deliverables

The table below highlights key evaluation milestones and activities for the Demonstration and the dates for completion. Dates are estimated based on a full approval date of January 1, 2025.

Table C.1 Deliverables

Deliverable	STC Reference	Date
Submit Evaluation Design to CMS	68	December 29, 2024
Final Evaluation Design	69	60 days after comments received from CMS
Midpoint Assessment Due	37	60 days after December 12, 2027
Draft Interim Evaluation Report	72	December 31, 2028
Final Interim Evaluation Report	72	60 days after CMS comments received
Draft Summative Evaluation Report Due 18 Months Following End of the Demonstration	73	July 2031
Final Summative Evaluation Report	73	60 days after CMS comments received

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Evaluation Plan

Commonwealth of Kentucky
Section 1115 Substance Use Disorder Demonstration

February 18, 2020

The UPenn Kentucky HEALTH Study Group, based at the University of Pennsylvania, is the independent evaluator of the Kentucky Section 1115 Substance Use Disorder (SUD) Demonstration.

Principal Investigators: Kristen Underhill, Atheendar Venkataramani, Kevin Volpp.
Co-Investigators: Genevieve Kanter (SUD), Kristin Linn (Statistician)
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A. GENERAL BACKGROUND INFORMATION

A.1. Purpose

Although the opioid crisis is national in scope, the Commonwealth of Kentucky has been particularly acutely affected, ranking among the top 10 states in opioid-related overdose deaths [1]. Furthermore, about 40% of adults with opioid addiction are within the Medicaid-insured population [2], and 80% of hospitalizations for neonatal abstinence syndrome in Kentucky are reimbursed by Medicaid [3].

Kentucky Medicaid proposed a Substance Use Disorder (SUD) demonstration project as part of its larger application for a Section 1115 demonstration project, "TEAMKY" (formerly KY HEALTH), to buttress its ongoing efforts to address the opioid crisis. The proposal for the 1115 SUD demonstration project was approved by the Centers for Medicare and Medicaid Services (CMS) on January 12, 2018. The implementation plan for the demonstration has been approved twice—first on October 5, 2018 [4], and most recently as part of an amended approval granted on November 28, 2018 [5].

The purpose of the SUD demonstration project is to increase access to SUD treatment services and reduce opioid-related overdose injuries and deaths. To achieve this purpose, Kentucky Medicaid will implement a plan to increase beneficiary access to SUD providers offering treatment services and expand SUD treatment benefits available to enrollees.

The **central features of this demonstration** are:

1. increased access to SUD providers by assessing Medicaid SUD provider capacity at critical levels of care and certifying residential treatment providers according to nationally-recognized standards for SUD treatment;
2. waiver of the Medicaid Institutions for Mental Disease (IMD) exclusion, allowing reimbursement for SUD treatment during short-term residential stays at certified IMD facilities with greater than 16 beds; and
3. expanded coverage of medication-assisted treatment (MAT) services, including methadone.

A.2. Brief Description of Demonstration and Implementation Plan

The Commonwealth of Kentucky and Kentucky Medicaid have already launched a range of SUD initiatives, and Kentucky Medicaid currently covers many services across the continuum of care for SUD, including outpatient and intensive outpatient services, partial hospitalization treatment, residential treatment, and medication-assisted treatment with buprenorphine and naltrexone.

The SUD demonstration will build on these initiatives and expand Medicaid SUD benefits to strengthen efforts to combat the opioid crisis. As described in STC 93, the key goals of the SUD demonstration are to:

1. improve access to critical levels of care for Opioid Use Disorder (OUD) and other SUDs for Medicaid beneficiaries;

2. require the use of evidence-based SUD-specific criteria for patient placement in outpatient and residential care, with the goal of improving SUD screening and patient care and retention;
3. apply nationally-recognized SUD-specific program standards for the certification of residential treatment facilities;
4. assess provider capacity at critical levels of care, including for medication-assisted treatment for OUD, with the goal of ensuring greater access to care;
5. implement strategies directed at prescribers and dispensers to dampen prescription drug abuse;
6. improve care coordination and transitions between levels of SUD care.

A brief summary of key actions associated with each goal is listed in Table 1. Please refer to the implementation plan for a detailed description of the full set of proposed actions [5].

Table 1. Summary of Key Actions Associated with Demonstration Goals

Goal	Key Actions (Estimated Completion Date)
1. improve access to critical levels of care for Opioid Use Disorder (OUD) and other SUDs for Medicaid beneficiaries	1a. amend state plan to include coverage of SUD treatment planning (7/1/2019) 1b. amend regulations to include partial hospitalization as an allowable service for Behavioral Health Services Organizations/ BHSOs (7/1/2019) 1c. amend state plan to include coverage of methadone for medication-assisted treatment, with a waiver of the non-emergency medical transportation assurance except for children under age 21, former foster care youth, and pregnant women (7/1/2019) 1d. expand, through state certification process [Goal #3], number of residential treatment providers eligible for the Institution of Mental Disease (IMD) exclusion (1/1/2020) 1e. amend service definitions to include withdrawal management in all levels of care, i.e., beyond hospital setting (7/1/2019)
2. require the use of evidence-based SUD-specific criteria for patient placement in outpatient and residential care, with the goal of improving SUD screening and patient care and retention	2a. amend state plan to require all SUD providers to incorporate ASAM's 6-dimensional assessment into their patient assessment in determining placement into treatment (7/1/2019)

3. apply nationally-recognized SUD-specific program standards for the certification of residential treatment facilities	3a. based on self-attestation to American Society of Addiction Medicine (ASAM) level of care in statewide survey, issue pending certification to eligible IMD facilities with 96 or fewer beds, permitting them to qualify for temporary IMD exclusion (4/1/2019) 3b. certify, through state certification program, residential treatment providers to ASAM levels of care, permitting certified IMD facilities with up to 96 beds to qualify for IMD exclusion (1/1/2020)
4. assess provider capacity at critical levels of care, including for medication-assisted treatment for OUD with the goal of ensuring greater access to care	4a. conduct statewide survey of services, hours, staffing, and other characteristics of Medicaid-enrolled residential SUD providers (10/15/2018) 4b. conduct statewide survey of Medicaid outpatient and residential SUD treatment providers, assessing SUD levels of care, services offered—particularly medication-assisted treatment (on-site or facilitated off-site)—and potential Medicaid enrollment (9/12/2019)
5. implement strategies directed at prescribers and dispensers to dampen prescription drug abuse	5a. as part of an opioid utilization program, develop criteria for applying utilization controls of long acting and short acting opioids (e.g., limitations on short acting opiates for the treatment of acute pain, daily dose limits) (9/4/2018) 5b. as part of an opioid utilization program, establish morphine milligram equivalent (MME) thresholds for short acting, long acting, and combination opioids, and employ a step down methodology to reduce overall MME dosing limitations (9/4/2018)
6. improve care coordination and transitions between levels of SUD care	6a. amend state plan to include care coordination within the definition of residential SUD treatment (7/1/2019) 6b. amend state regulations to include care coordination duties to the definition of residential SUD treatment (7/1/2019)

Although there are many parts to the SUD implementation plan, the **primary focus of the demonstration is to improve access to and utilization of treatment for SUD**, and accordingly, the evaluation will focus on this aspect of the demonstration.

A.3. Population Groups Impacted by the Demonstration

The population group affected by this demonstration will be Kentucky Medicaid beneficiaries with a substance use disorder.

B. EVALUATION QUESTIONS AND HYPOTHESES

B.1. Overview

Given the focus of the demonstration on increasing access to SUD treatment, the evaluation will concentrate on the areas most likely to be affected by demonstration initiatives, namely:

1. availability of provider services and capacity of treatment facilities available to Medicaid beneficiaries;
2. utilization of SUD services in residential facilities, particularly facilities affected by the IMD exclusion; and
3. utilization of SUD treatment services, especially medication-assisted treatment (MAT) and methadone as part of MAT.

As secondary outcomes, the evaluation will also examine selected opioid-related metrics, including overdose deaths, ED and hospital admissions for SUD, and self-reported survey measures of health and substance use. Per CMS technical specifications, the evaluation will also analyze Medicaid SUD expenditures.

B.2. Driver Diagram

The driver diagram—depicting the relationship between the purpose of the demonstration, the primary drivers that contribute directly to realizing that purpose, and the secondary drivers necessary to achieve the primary drivers—is shown in Figure 1.

Figure 1. Driver Diagram

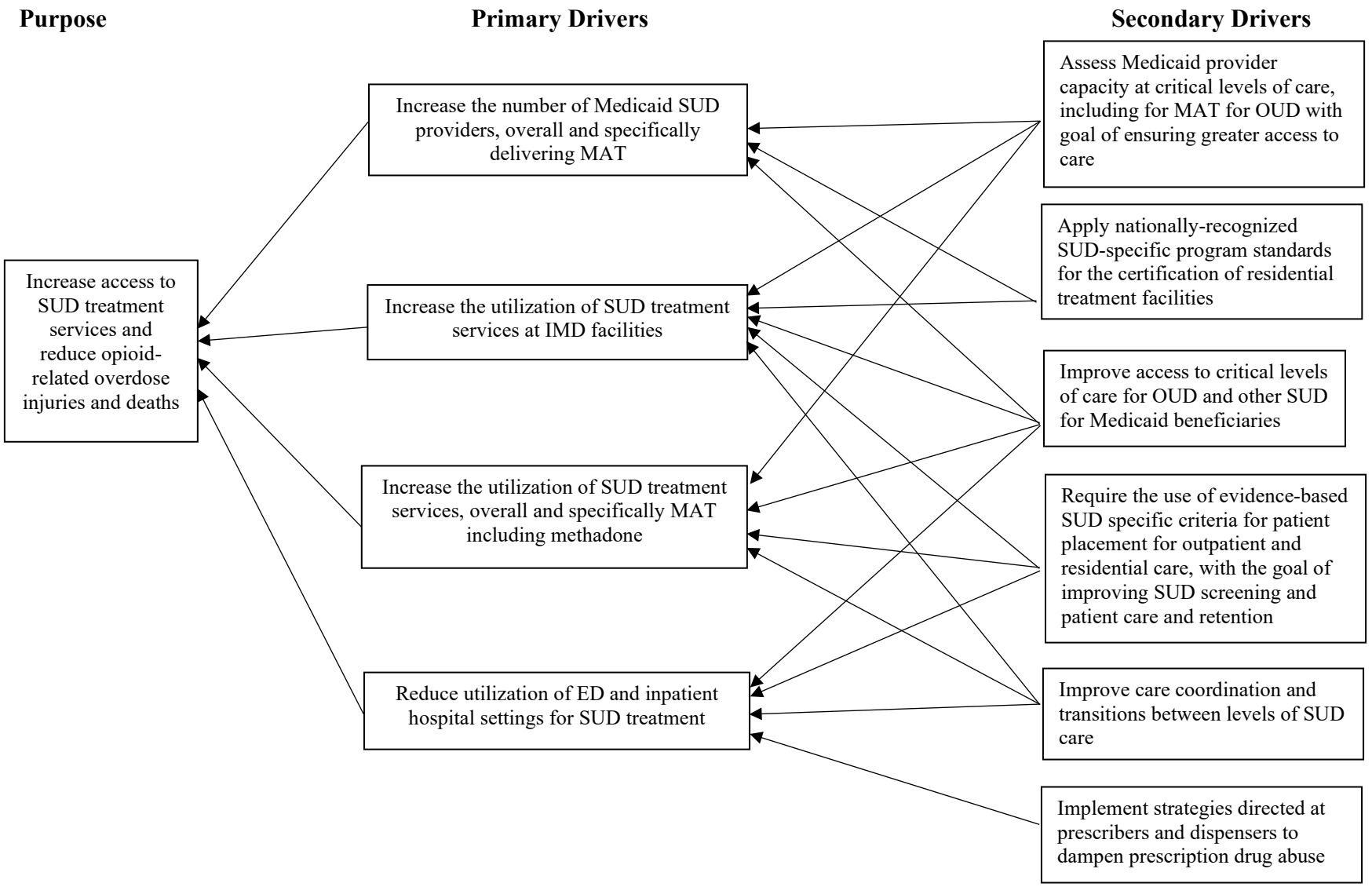

Table 2. Summary of Key Evaluation Questions, Hypotheses, Data Sources, and Analytic Approaches

*Denotes a metric that is also part of the Monitoring Plan

Evaluation Question 1: Did access to and utilization of SUD treatment services improve?						
Demonstration Goal: Increased number of outpatient Medicaid SUD providers, especially those offering medication-assisted treatment (MAT) and methadone as part of MAT, in areas of greatest need. Evaluation Hypothesis: The demonstration will increase the number of outpatient Medicaid SUD providers overall, and those specifically offering MAT and methadone as part of MAT, in areas of greatest need.						
Driver	Measure Description	Steward	Numerator	Denominator	Data Sources	Analytic Approach
Primary Driver (Increase the number of Medicaid SUD providers, overall and specifically delivering MAT)	Providers offering SUD services	N/A	Number of providers billing for SUD treatment services	Total number of beneficiaries	Claims data Provider enrollment data	Descriptive statistics Interrupted time series without comparison group
	Providers offering MAT	N/A	Number of providers prescribing any medication that is part of MAT	Total number of beneficiaries		
	Providers offering methadone as part of MAT	N/A	Number of providers prescribing methadone as part of MAT	Total number of beneficiaries		
	Providers offering SUD services in areas of greatest need	CCBHC 2.a.3	Number of providers billing for SUD treatment services, by county	Total number of beneficiaries, by county	Claims data Provider enrollment data	Descriptive statistics
	Providers offering MAT in areas of greatest need	CCBHC 2.a.3	Number of providers prescribing any medication that is part of MAT, by county	Total number of beneficiaries, by county		
	Providers offering methadone as part of MAT in areas of greatest need	CCBHC 2.a.3	Number of providers prescribing methadone as part of MAT, by county	Total number of beneficiaries, by county		

Demonstration Goal: Increased number of SUD providers offering residential treatment, especially IMDs. Evaluation Hypothesis: The demonstration will increase the number of SUD providers offering residential treatment, especially IMDs.						
Primary Driver (Increase the number of Medicaid SUD providers, overall and specifically delivering MAT)	Providers offering residential treatment for SUD	N/A	Number of providers billing for residential treatment for SUD	Total number of beneficiaries	Claims data Provider enrollment data	Descriptive statistics Interrupted time series without comparison group
	IMD facilities offering treatment for SUD	N/A	Number of IMD facilities billing for treatment for SUD	Total number of beneficiaries		
	Providers offering residential treatment for SUD in areas with greatest need	N/A	Number of providers billing for residential treatment for SUD, by county	Total number of beneficiaries, by county	Claims data Provider enrollment data	Descriptive statistics
	IMD facilities offering treatment for SUD in areas with greatest need	N/A	Number of IMD facilities billing for treatment for SUD, by county	Total number of beneficiaries, by county		
Demonstration Goal: Increased utilization of SUD treatment services. Evaluation Hypothesis: The demonstration will increase the utilization of SUD treatment services.						
Primary Driver (Increase the utilization of SUD treatment services, overall and specifically MAT including methadone)	Percentage of beneficiaries with newly initiated SUD treatment/diagnosis	N/A	Number of beneficiaries with SUD diagnosis and SUD-related service but not in 3 months preceding measurement period	Total number of beneficiaries	Claims data	Descriptive statistics Interrupted time series without comparison group
	Percentage of beneficiaries with SUD diagnosis who used outpatient services for SUD	N/A	Number of beneficiaries with SUD diagnosis who used outpatient services for SUD	Total number of beneficiaries		
	Percentage of beneficiaries with SUD diagnosis who used residential treatment services for SUD	N/A	Number of beneficiaries with SUD diagnosis who used residential treatment services for SUD	Total number of beneficiaries		
	Percentage of beneficiaries with SUD (OUD) diagnosis who used MAT	N/A	Number of beneficiaries with SUD diagnosis who used MAT	Total number of beneficiaries		
	Percentage of beneficiaries with SUD (OUD) diagnosis who received methadone as part of MAT	N/A	Number of beneficiaries with SUD diagnosis who received methadone as part of MAT	Total number of beneficiaries		
	Continuity of pharmacotherapy for OUD*	NQF #3175	Number of beneficiaries who have at least 180 days of continuous pharmacotherapy	Number of beneficiaries with a diagnosis of OUD		

			for OUD without a gap of more than 7 days	and at least one claim for OUD medication		
Primary Driver (Increase the utilization of SUD treatment services at IMD facilities)	Percentage of beneficiaries with SUD diagnosis who used SUD services at IMD facility	N/A	Number of beneficiaries with SUD diagnosis who used SUD services at IMD facility	Total number of beneficiaries		
Demonstration Goal: Reduced utilization of ED and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services. Evaluation Hypothesis: The demonstration will decrease the rate of emergency department visits and inpatient admissions within the beneficiary population for SUD.						
Primary Driver (Reduce utilization of ED and inpatient hospital settings for SUD treatment)	Emergency department visits for SUD (OUD) related diagnosis*	N/A	Number of ED visits for SUD (OUD) related diagnosis	Total number of beneficiaries	Claims data	Descriptive statistics Interrupted time series without comparison group
	Inpatient admissions for SUD and specifically OUD*	N/A	Number of beneficiaries with an inpatient admission for SUD and specifically for OUD	Total number of beneficiaries		

Evaluation Question 2: Did beneficiaries receiving SUD services experience improved health outcomes?						
Demonstration Goal: Reduced utilization of emergency department services for SUD for beneficiaries receiving SUD care. Evaluation Hypothesis: Among beneficiaries receiving care for SUD, the demonstration will decrease the rate of emergency department visits for SUD.						
Primary Driver (Reduce utilization of ED and inpatient hospital settings for SUD treatment)	Emergency department visits with primary SUD (OUD) related diagnosis for individuals receiving SUD (OUD) treatment	N/A	Number of emergency department visits with primary SUD (OUD) related diagnosis among beneficiaries who used SUD (OUD) services within 30 days	Number of beneficiaries who used SUD (OUD) services within 30 days	Claims data	Descriptive statistics Interrupted time series without comparison group
	Emergency department visits with primary SUD (OUD) related diagnosis for individuals receiving outpatient SUD (OUD) treatment	N/A	Number of emergency department visits with primary SUD (OUD) related diagnosis among beneficiaries receiving outpatient SUD (OUD) services within 30 days	Number of beneficiaries who used outpatient SUD (OUD) services within 30 days		
	Emergency department visits with primary SUD (OUD) related diagnosis, following ED discharge for SUD (OUD)	NQF #2605	Number of emergency department visits with primary SUD (OUD) related diagnosis within 7 days ED discharge for SUD (OUD) Number of emergency department visits with primary SUD (OUD) related diagnosis within 30 days ED discharge for SUD (OUD)	Number of beneficiaries discharged from ED with primary diagnosis of SUD (OUD)		
Demonstration Goal: Fewer hospital readmissions for SUD for beneficiaries receiving SUD care. Evaluation Hypothesis: Among beneficiaries receiving care for SUD, the demonstration will reduce hospital readmissions for SUD care.						
Primary Driver (Reduce utilization of ED and inpatient hospital settings for SUD treatment)	30-day readmission rate following hospitalization with SUD (OUD) related diagnosis	N/A	Number of beneficiaries readmitted to the hospital within 30 days of an index hospitalization with SUD (OUD) related diagnosis	Total number of beneficiaries who were admitted to the hospital with SUD (OUD) related diagnosis	Claims data	Descriptive statistics Interrupted time series without comparison group

Demonstration Goal: Improved physical and mental health for beneficiaries receiving SUD care. Evaluation Hypothesis: Among beneficiaries receiving care for SUD, the demonstration will improve physical and mental health.						
Primary Driver (Increase the utilization of SUD treatment services, overall and specifically MAT including methadone) Secondary Driver (Improve access to critical levels of care for OUD and other SUD for Medicaid beneficiaries) Secondary Driver (Require the use of evidence-based criteria for patient placement in outpatient and residential care) Secondary Driver (Improve care coordination and transitions between levels of SUD care)	Self-reported health in past 6 months	N/A	Rating on 5-point Likert-like scale of overall health	N/A	KTOS KORTOS	Descriptive statistics Interrupted time series without comparison group
	Self-reported days of poor physical health within past 30 days	N/A	Number of days of poor physical health within past 30 days	N/A		
	Self-reported days of poor mental health within past 30 days	N/A	Number of days of poor mental health within past 30 days	N/A		
	Self-reported attendance at AA, NA, MA, or other self-help group meetings within past 30 days	N/A	Number of times attended AA, NA, MA, or other self-help group meetings within past 30 days	N/A		
	Self-reported use of prescription opiates/opioids within past 6 (KORTOS) / 12 (KTOS) months / 30 days (KTOS)	N/A	Use of prescription opiates/opioids within past 6 months	N/A		
	Self-reported use of heroin within past 6 (KORTOS) / 12 (KTOS) months / 30 days (KTOS)	N/A	Use of heroin within past 6 months	N/A		
	Self-reported continued substance use within past 6 months (KORTOS) / 12 months (KTOS)	N/A	Substance use within past 6 months	N/A		

Evaluation Question 3: Did rates of opioid-related overdose deaths decrease?						
Demonstrated Goal: Reduction in opioid-related overdose deaths. Evaluation Hypothesis: The demonstration will decrease the rate of overdose deaths due to opioids.						
Primary Driver (Increase the utilization of SUD treatment services at IMD facilities)	Use of opioids at high dosage in persons without cancer*	NQF #2940	Number of beneficiaries with opioid prescription claims for a morphine equivalent dose of greater than 120 mg for 90 consecutive days	Number of beneficiaries with 2+ prescription claims for opioids filled on at least 2 separate dates, for which the sum of days' supply ≥ 15	Claims data	Descriptive statistics Interrupted time series without comparison group
Primary Driver (Increase the utilization of SUD treatment services, overall and specifically MAT including methadone)	Rate of overdose deaths, specifically overdose deaths due to any opioid*	N/A	Number of overdose deaths	Number of beneficiaries	Claims data Administrative data [vital statistics]	Descriptive statistics Interrupted time series without comparison group
	Rate of overdose deaths, specifically overdose deaths due to any opioid		Number of overdose deaths, by county	Number of beneficiaries	Claims data Administrative data [vital statistics]	Descriptive statistics

In addition, we will be analyzing changes in total costs (expenditures) associated with care provided to Medicaid beneficiaries diagnosed with substance use disorders. Because almost all Kentucky Medicaid beneficiaries are enrolled in managed care plans, expenditures will be calculated from encounter data reported by managed care organizations and regularly compiled by the Kentucky Cabinet for Health and Family Services. We will use descriptive statistics and the interrupted-time-series-without-comparison-group method to estimate the effect of the demonstration on care expenditures.

C. METHODOLOGY

C.1. Overview

Although the broader objective of Kentucky's opioid strategy is to reduce the number of opioid-related injuries and deaths, the sheer magnitude of SUD challenges in the state and the many ongoing federal, state, and privately funded initiatives directed towards the state's SUD crisis mean that the incremental effect of the 1115 SUD demonstration will be challenging to detect using population-level health measures such as opioid-related deaths. This is because these injuries and deaths are the result of complex and overlapping demographic, social, economic, disease, health care, public health, and institutional factors. For this reason, **the evaluation will focus on monitoring and evaluating outcome measures** that are **most directly affected by the central features of the demonstration**, which are the enhancement of the Medicaid SUD provider capacity, waiver of the IMD exclusion, and expansion of MAT coverage for SUD.

Because the SUD demonstration will be implemented statewide, there is **no obvious contemporaneous internal comparison group.** The evaluation team considered comparison states with similar demographic profiles as Kentucky, but these candidate states were launching similar SUD initiatives and therefore could not serve as comparison populations for evaluating the key features of Kentucky's SUD demonstration. For this reason, we will use an **interrupted time series analysis without comparison group** approach to evaluate the effect of the SUD demonstration.

C.2. Target and Comparison Population

The target population for the evaluation will be Kentucky Medicaid beneficiaries with a substance use disorder. More specifically, following CMS guidance, beneficiaries observed to have been diagnosed with an SUD or who have used SUD treatment services in a given month will be considered to have an active substance use disorder (and included in the target population) that month as well as for an additional 11 months after the initial diagnosis or care episode. Individuals without an SUD diagnosis or record of SUD treatment after this 12-month period will be considered to not have an active SUD and will be excluded from the target population in subsequent months unless there is another triggering SUD diagnosis or care visit. For the reasons noted above, there is no comparison population available.

C.3. Evaluation Period

The SUD demonstration is scheduled to begin July 2019. We are requesting data for the period July 2017-September 2023, i.e., beginning two years prior to implementation and continuing through the expiration of the demonstration waiver.

C.4. Data Sources

The core data for the evaluation will be Medicaid encounter data. These data will be supplemented with data from administrative vital statistics; a provider enrollment database; ongoing smaller-scale surveys of individuals enrolling in treatment for SUD; and a qualitative survey of Medicaid beneficiaries with SUD.

C.4.1. Medicaid encounter data

Because most of Kentucky's Medicaid beneficiaries receive benefits administered by managed care organizations (MCOs), we will be using Kentucky Medicaid encounter data reported by these MCOs. These encounter data contain records of outpatient, emergency department, inpatient, and long-term care services provided for SUD, as well as prescription drugs dispensed. They also include information on billing providers (facilities and physicians) and on payments made to these providers by the MCOs.

In submitting its encounters to the state Medicaid Management Information System (MMIS), each MCO is required to submit data that follows a consistent format and that must pass a range of edits and audits. These validated encounter data then undergo state review for quality—including completeness/missingness assessments, internal consistency checks, and other data validation reviews—prior to submission by the state to the federal Transformed Medicaid Statistical Information System (T-MSIS). According to the state, "these processes… ensure a high level of confidence in the quality of the encounter data."[6] Encounter data are available on a quarterly basis with a 6-month lag. Limitations of these data are that they do not include direct measures of health status or substance use.

C.4.2. Administrative vital statistics data

Vital statistics data capture deaths attributable to accidental poisonings, including overdoses. These data are available on a quarterly basis with a 9-month lag. Limitations of these data are the measurement error in the attribution of overdose deaths to opioids.

C.4.3. Provider enrollment data

Kentucky Medicaid will launch the Kentucky Medicaid Partner Portal Application (KY MPPA), a Medicaid provider enrollment system, in mid-2019. Data from KY MPPA will be available annually with a 6-month lag and will be used to cross-validate provider information obtained from Medicare claims. Prior to KY MPPA, provider enrollment was done through a manual reporting process. A limitation of this data source is that data on provider enrollment prior to implementation will need to be manually aggregated and processed to convert it into a format suitable for the evaluation.

C.4.4. Kentucky Treatment Outcome Study (KTOS) and Kentucky Opiate Replacement Treatment Outcome Study (KORTOS)

KTOS and KORTOS are two ongoing studies conducted by the University of Kentucky Center on Drug and Alcohol Research in collaboration with the Kentucky Department of Behavioral Health, Developmental, and Intellectual Disabilities. KTOS is a study of patients enrolling in SUD treatment programs (including outpatient, residential, and inpatient programs), and KORTOS is a study of patients enrolling in opiate treatment programs. KTOS enrolls about 1200 patients annually (of whom 950 are Medicaid-insured) who complete surveys at intake and at 12 months; KORTOS enrolls about 240 patients annually (of whom 150 are Medicaid-insured) who complete surveys at intake and at 6 months. We will use self-reported measures of physical health, mental health, and substance use from KTOS and KORTOS to evaluate the effect of the demonstration on improvements in beneficiary health and care.

The major limitations of these surveys are the voluntary participation in the surveys, the 35%-40% attrition rates for Medicaid-insured respondents, and the relatively small sample sizes, all of which may lead to selection bias and limit the scope of inferences. Because of these limitations, evaluation of these measures should be viewed with particular caution. Nevertheless, KTOS and KORTOS provide important measures of health and substance use of the demonstration's target population that are not easily obtainable elsewhere.

We have been informed that, because of funding difficulties, there is a possibility that these surveys could be discontinued during the demonstration period. If this is the case, or if KTOS and KORTOS are not able to provide sufficient information for the proposed evaluation of patient outcomes, the Penn team will re-evaluate and may propose conducting a separate beneficiary survey. As well, if the available information on provider enrollment is insufficient to meet the stated goals of the evaluation, the Penn team may propose conducting a novel provider survey.

C.4.5. Qualitative beneficiary survey

As part of the evaluation of the larger non-SUD 1115 demonstration, the University of Pennsylvania fielded a survey of Medicaid beneficiaries in 2018. For the qualitative SUD beneficiary survey, respondents from the general demonstration survey who meet SUD criteria will be contacted for qualitative interviews on substance use, enrollment in SUD treatment, and experience with SUD providers.

C.5. Analytic Methods

A mixed methods approach will be used in the evaluation of the SUD demonstration. Quantitative analyses will be used to assess the impact of the demonstration, while qualitative analyses will be used to provide detail and depth to beneficiary experience of provider and treatment aspects of the demonstration.

C.5.1. Quantitative analyses

The purpose of these analyses is to quantitatively describe and statistically evaluate the effect of the demonstration. Although a quasi-experimental design would have been ideal, the comprehensive statewide implementation of the demonstration means that internal comparisons are not feasible. As stated above, we investigated the possibility of an external comparison group but were unable to identify states with similar demographic and institutional characteristics that were not also implementing comparable SUD programs, namely the waiver of the IMD exclusion

and expanded coverage of MAT to include methadone. For these reasons, we will use the interrupted time series without comparison group method to evaluate the demonstration.

For each of the outcomes identified in Table 2 (provider capacity, utilization, health, substance use, mortality), we will provide descriptive summary statistics for the two pre-demonstration years, as well as each successive year of the evaluation.

For the outcomes identified in Table 1 that are available monthly (provider capacity, utilization, mortality), we will estimate the following model:

$$Y_{m,c} = \beta_0 + \beta_1 \text{time}_m + \beta_2 I[\text{post}]_{m,c} + \beta_3 \text{time}_m \times I[\text{post}]_{m,c} + \beta' \text{controls}_{m,c} + \gamma'_c + \varepsilon_{m,c}$$

where Y is the outcome of interest; time is a linear time trend; I[post] is a binary indicator of demonstration implementation (1 if yes, 0 otherwise); controls are a vector of covariates (e.g., provider and population characteristics); γ_c is a vector of county fixed effects; ε is the disturbance term; m indexes the month; and c indexes the county.

The coefficient β_2 reflects the shift in outcome levels in the post-demonstration period (after accounting for secular time trends), while β_3 reflects the effect of the demonstration. Both coefficients will be of interest in the evaluation.

Our power analyses suggest that we will be able to detect moderate changes in the utilization of treatment services. We were not able to obtain data from all proposed measures for which to conduct power analyses, but as an illustration, we will be able to detect, at α=0.05 with 80% power:

- a change of 1.14 in the monthly number of inpatient stays for SUD per 1,000 beneficiaries (monthly average: 6.01)
- a change of 15.3 in the monthly number of beneficiaries who have a claim for MAT (monthly average: 594).

C.5.2. Qualitative analyses

The purpose of the qualitative interviews is to describe the Medicaid experiences of individuals affected by SUD, including access to care and uptake of treatment. Qualitative interviews will address questions such as how well Medicaid members understand new treatment options, how people learned about these services, and what engagement in these services has been like in comparison to past services. Interviews will also explore a narrative of the person's SUD, the impact on daily life, current medical needs and health status, past and current experiences with Medicaid, both for overall health and SUD, access to SUD treatment through any means of payment as well as Medicaid, barriers to SUD treatment services, and any SUD treatment needs not currently covered by Medicaid or other insurance.

The interviews will be semi-structured, using written agendas with flexibility to explore unexpected responses. Interviews will be conducted by phone, and voice recorded and transcribed for analysis. We will aim for approximately 25 beneficiaries in each interview cycle—a sample size consistent with best practices for qualitative interviews—monitoring for data saturation. Data

collection will occur yearly in order to monitor changes in each year of the program, with the first data collection period anticipated to occur around March 2020-May 2020.

Throughout the duration of the SUD waiver, we will conduct a mix of longitudinal cohort interviews, with the initially-identified population, and one-time interviews, in order to represent a variety of experiences. That is, we anticipate primarily a cross-sectional design, with a smaller longitudinal cohort.

For the first cohort, we plan to recruit participants from three sources. We will contact beneficiaries identified through the 2018 beneficiary survey whose responses were reflective of a possible substance use disorder, recruit from treatment facilities offering methadone for MAT, and recruit from inpatient facilities expanding access through the lifting of the IMD exclusion. For subsequent cohorts, we will recruit from treatment facilities, as well as consider other direct recruitment options based on the makeup of our sample; for example, we may recruit from non-treatment facilities such as primary care facilities to capture the experience of people not engaged in active treatment.

Thematic analysis will be done with multiple trained coders to identify themes throughout the interviews, and mixed-methods analysis will be performed, using the qualitative interviews to further explain and elucidate results from the quantitative data.

As the evaluation progresses and interviews are analyzed, the Penn team will evaluate the need for additional qualitative interviews to cover any areas where more experiences should be captured. This could include beneficiaries experiencing barriers to treatment or the addition of provider interviews as needed.

C.5.3. Cost (expenditure) analyses

Pursuant to CMS requirements for all SUD section 1115 demonstrations, we will be conducting analyses of costs (expenditures) associated with the Kentucky SUD demonstration. The econometric structure of these analyses will be the same as those outlined in section C.5.1 (Quantitative analyses), using descriptive summary statistics and the interrupted time series without comparison group method to evaluate the effect of the demonstration on expenditures.

Because almost all Kentucky Medicaid beneficiaries are enrolled in managed care plans and because data on negotiated capitated payments will not be available for this analysis, we will be using data on encounters reported by Medicaid managed care organizations (MCOs) and compiled by the Kentucky Cabinet for Health and Family Services. As described in Section C.4 (Data sources), these data provide information on health care services provided to beneficiaries and information on payments made to providers by MCOs for these services. Although these data do not reflect contemporaneous costs incurred by Medicaid for care provided to beneficiaries—because Medicaid pays a capitated rate to the MCOs—they are used by the state Medicaid program, in combination with other factors, to determine capitated MCO rates. For this reason, they can provide a useful if imperfect measure of costs incurred by the Medicaid program.

Following CMS recommendations, we will be conducting analyses at three different levels:

- total expenditures;
- SUD and non-SUD expenditures (with SUD expenditures disaggregated into IMD and non-IMD expenditures);
- expenditures disaggregated by source of treatment—namely, inpatient expenditures, emergency department (ED) expenditures, non-ED outpatient expenditures, pharmacy expenditures, and long-term care expenditures.

Because of the demonstration's focus on SUD care, the sample population for which expenditures will be calculated will consist of Medicaid beneficiaries with an SUD diagnosis or who have used SUD treatment services during the period of interest. In particular, following the protocol specified in Attachment A of the SUD Evaluation Guidance Technical Assistance document, beneficiaries will be included in monthly expenditure calculations if they have received an SUD diagnosis or have used SUD treatment services that month or in the previous 11 months. If there is no SUD diagnosis or SUD treatment service utilization after these 12 months, beneficiaries will be excluded from subsequent expenditure calculations. Monthly expenditures will thus be based on pooled cross-sectional samples rather than a specific cohort of beneficiaries. To identify beneficiaries with an SUD diagnosis or who have used SUD treatment services, we will use codes in the value sets specified in Appendix A of the SUD Evaluation Guidance Technical Assistance document.

As with quantitative analyses of utilization, we will report summary statistics of expenditures for the two pre-demonstration years, as well as each successive year of the evaluation. We will also estimate the following model:

$$Y_{i,m} = \beta_0 + \beta_1 \, time_m + \beta_2 \, I[post]_m + \beta_3 \, time_m \times I[post]_m + \beta' \, controls_{i,m} + \varepsilon_{i,m}$$

where Y denotes expenditures; time is a linear time trend; I[post] is a binary indicator of demonstration implementation (1 if yes, 0 otherwise); controls are a vector of covariates (e.g., beneficiary characteristics); ε is the disturbance term; m indexes the month; and i indexes the individual beneficiary. The outcome measure of interest for the cost analyses is average monthly expenditure per (SUD) beneficiary.

For the expenditure analyses, we are interested in β_2, which reflects the shift in spending in the post-demonstration period, and β_3, which reflects the expenditure effect of the demonstration. We hypothesize that expenditures for outpatient visits will initially increase, while spending for more costly services such as inpatient care and ED visits will decrease, generating net cost-savings over time.

We are aware that the validity of the cost analysis is dependent on the quality and completeness of the financial measures in the MCO encounter data. The Penn team's preliminary analysis of the data suggests a relatively high-quality dataset with plausible beneficiary and case counts, few missing values, and plausible paid amount values and distributions. For the evaluation, we will conduct a more thorough graphical and statistical analysis of the expenditure measures, checking for missing and implausible extreme values, anomalous distributions, and signs of selection bias (based on beneficiary characteristics). Prior to formal statistical analyses, we will take care to clean the data, correcting errors as necessary.

D. Methodological Limitations

An important limitation of this evaluation is the absence of a comparison group. This is due to the statewide nature of the SUD demonstration and the lack of a comparable state not implementing similar SUD policies. The lack of a comparison group could generate bias in our estimate of the effect of the evaluation because we might be erroneously attributing changes in SUD-related outcomes to the demonstration. We will attempt to minimize this bias by including a rich set of covariates, but there remains a chance of bias due to factors we are unable to include in our model.

A second limitation, specific to the cost analysis, is the potential heterogeneity in the quality of the financial measures in the MCO encounter data. CMS's experience has been that Medicaid MCOs vary in the quality and completeness of their reporting; consequently, inference of expenditure effects could be confounded because of variation in financial data quality across plans and over time. If there is measurement error in the expenditure fields, standard errors will be inflated and analyses may understate the expenditure effects of the demonstration. Although we cannot rule out selection bias in the MCO encounter data, the Penn team's preliminary analyses of the financial data suggest that errors in these data fields appear to be small.

E. Attachments

E.1. Independent Evaluator

As experts in the implementation and evaluation of large randomized field experiments, the University of Pennsylvania was selected to be the independent evaluator of the full 1115 Medicaid waiver. Because the SUD demonstration was originally part of this broader 1115 waiver, the state contracted with University of Pennsylvania to evaluate the SUD demonstration as well.

In its role as evaluator of the larger waiver, the University of Pennsylvania team has developed significant experience conducting beneficiary surveys and collecting detailed qualitative interview data in Kentucky. The team also brings pre-existing deep expertise and experience working with administrative data, large datasets, survey data, and causal inference methods. The team will bring these skills and experience to bear on the SUD evaluation.

The University of Pennsylvania evaluation team commits to performing a fully independent evaluation of the Commonwealth of Kentucky’s Section 1115 Waiver demonstration. We attest to our independence in this evaluation, and agree to present our results to CMS and the general public through white papers and peer-reviewed journal articles without being influenced by any external partners, including the Commonwealth of Kentucky.

E.2. Evaluation Budget

The budget for the SUD evaluation was initially encapsulated within the budget for the full 1115 waiver and was not developed as a separate budget. Below, we have estimated the total budget for the SUD evaluation as it would be if the evaluation of the SUD-specific part of the waiver were a completely separate evaluation. Since there are efficiencies in conducting both evaluations simultaneously, this SUD-only budget includes fixed costs that would have been spread out across the broader evaluation of the full demonstration.

The budget estimate includes salaries for all University of Pennsylvania faculty and staff involved in the evaluation project, with benefits at the university rate of 30.2%. Data analysis costs are included separately; these costs include data analysts, post-doctoral researchers, and qualitative coding and analysis, as well as the funding for Professor Kristen Underhill, our co-PI who is located at Columbia University, School of Law. We have also accounted for additional costs such as travel to Kentucky to meet with our partners within the Commonwealth of Kentucky, as well as publication and dissemination costs. We separate out our total direct costs and our current overhead Facilities and Administration (F&A) costs, which are set at 61%, the negotiated rate for the university.

Estimated Budget	**Year 01**	**Year 02**	**Year 03**	**Year 04**	**Year 05**	**Total**
Category	7/1/2019 6/30/2020	7/1/2020 6/30/2021	7/1/2021 6/30/2022	7/1/2022 6/30/2023	7/1/2023 6/30/2024	7/1/2019 6/30/2024
Salaries	151,280	155,818	160,492	165,307	170,266	803,163
Benefits @ 30.2%	45,686	47,057	48,469	49,923	51,420	242,555
Data Analysis (including analysts, post-doctoral researchers, and Columbia Subcontract)	192,023	194,784	197,628	200,556	203,573	988,564
Travel	15,000	15,000	15,000	15,000	15,000	75,000
Publication Fees	6,000	6,000	6,000	6,000	6,000	30,000
Total Direct Costs	409,989	418,659	427,589	436,786	446,259	2,139,282
F&A @61%	250,093	255,382	260,829	266,439	272,218	1,304,962
Total	**660,082**	**674,041**	**688,418**	**703,225**	**718,477**	**3,444,244**

E.3. Timeline and Major Milestones

Activity	Jan-June 2018	July-Dec 2018	Jan-June 2019	July-Dec 2019	Jan-June 2020	July-Dec 2020	Jan-June 2021	July-Dec 2021	Jan-June 2022	July-Dec 2022	Jan-June 2023	July-Dec 2023	Jan-June 2024
Demonstration Year 1 Q1-Q2: (Pre-Implementation) Consultation with KY on data sources for evaluation													
Demonstration Year 1 Q3-Q4: (Pre-Implementation) Continuing consultation with KY and preparation for proposed evaluation plan													
Demonstration Year 2 Q1-Q2: (Pre-Implementation) Preparation for and revision of proposed evaluation plan													
KY implementation of waiver of IMD exclusion and expanded coverage of MAT													
Demonstration Year 2 Q3-Q4 (Implementation Year 1) Preparation for data collection and analysis													

Demonstration Year 3 Q1-Q2: (Implementation Year 1) Preparation for data collection and analysis													
Demonstration Year 3 Q3-Q4: (Implementation Year 2) Data collection and analysis[a]													
Demonstration Year 4 Q1-Q2: (Implementation Year 2) Data collection and analysis[a]													
Demonstration Year 4 Q3-Q4: (Implementation Year 3) Preparation for interim evaluation report													
Interim Evaluation Report completed (December 2021)													
Demonstration Year 5 Q1-Q2: (Implementation Year 3) Data collection and analysis[b]													
Demonstration Year 5 Q3-Q4: (Implementation Year 3) Data collection and analysis[b]													
Post-Demonstration Year 1 Q1-Q2 (Implementation Year 4) Data collection and analysis[b]													
Post-Demonstration Year 1 Q3-Q4													

(Implementation Year 4) Data collection and analysis[b]													
Summative Evaluation Report completed (June 2024)													

[a] contingent on plan approval and data availability
[b] contingent on data availability

E.4. References

1. NIDA. Kentucky opioid summary. URL: https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/kentucky-opioid-summary. Accessed August 23, 2019.
2. Zur J, Tolbert J. The opioid epidemic and Medicaid's role in facilitating access to treatment. KFF Issue Brief. April 2018.
3. Winning the fight against opioid abuse in Kentucky. URL: https://chfs.ky.gov/agencies/dms/dpqo/Documents/SUD_DMSProviderForums_2017GCL_webpostcopy.pdf.
4. Centers for Medicare and Medicaid Services. Kentucky SUD Implementation Protocol and SUD Health IT Plan Approval. October 5, 2018. URL: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/health/ky-health-sud-implement-protocol-apprvl-10052018.pdf
5. Centers for Medicare and Medicaid Services. KY HEALTH Demonstration Approval. URL: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf.
6. Kentucky Cabinet for Health and Family Services. Encounter Data Submission and Review Process. August 15, 2018.

Attachment G: Reentry Demonstration Initiative Implementation Plan (reserved)

Attachment H: Reentry Demonstration Initiative Reinvestment Plan (reserved)

Attachment I: Monitoring Protocol (reserved)

Attachment J: RRSS Service Description

RECOVERY RESIDENCE SUPPORT SERVICE (RRSS)
Does not include Room and Board

SERVICE COMPONENT DESCRIPTIONS

The following RRSS components will be required to be provided by RRSS providers for all beneficiaries:

Service	Purpose	Person Responsible	Frequency
Intake	Admit participant to program utilizing intake protocols including orientation to the program, services to be provided and program expectations.	RRSS Staff	Upon admission
Assessment	Review of the assessment completed prior to admission including strengths, personal assets, supportive relationships, coping skills, resilience factors, cultural background, spirituality, and recovery capital to inform recovery management planning and leverage existing resources in the recovery process.	RRSS Staff	Within 72 hours of admission
Recovery Management Planning	Develop a person-centered Recovery Management Plan including an assessment of strengths and resources, addressing readiness to engage in recovery pathway and establishing goals for achieving recovery.	RRSS Staff	Within 72 hours of admission.
Recovery Management Plan Review	Engage participant in a review of their Recovery Management Plan including a review of progress toward identified goals, updates to the plan, addition of new goals and review of transition planning.	RRSS Staff	Monthly
Facilitate Health Care Needs	Recognize co-occurring medical conditions, ensure access to medications, promote health maintenance and prevention, assist with identification of primary health care provider and referral if needed.	RRSS Staff	Upon admission
Coordinate Treatment for Co-	Collaborate with community partners to coordinate care for co-occurring disorders including medication management,	RRSS Staff	Upon admission; 1-2 units per week.

Occurring Disorder	medication for SUD/OUD, follow-up appointments and coordination of care.		
Coordinate Health Care Related Issues	Coordinate services with community partners to address health care needs including medication assisted treatment, treatment of chronic conditions and treatment of alcohol and drug related illness (COPD, gastroenteritis, liver disease, etc.)	RRSS Staff	1-2 units per week as needed
Transition Planning	Addresses the individual's needs for continued recovery, personal growth, and community reintegration including housing, transportation, employment, and ongoing services and supports to maintain recovery.	RRSS Staff	Within 30 days of completion of the program

The following RRSS components to be provided as needed by RRSS providers:

Service	Purpose	Person Responsible	Frequency
Individual Recovery Coaching	A personalized and collaborative service designed to assist individuals in initiating and maintaining their recovery. Recovery coaches provide guidance, encouragement, and practical assistance to help individuals overcome obstacles and achieve their recovery goals.	Peer support staff	1-2 x week
Recovery Support Class	Provide mutual assistance, employing principles of empathy, accountability, and confidentiality to foster a sense of community and promote sustained progress in achieving and maintaining recovery goals. Participants practice interpersonal and group living skills receiving feedback from their peers.	Peer support staff	3-5 x week
Life Skills Training	Education sessions address topics such as communication skills, decision-making, problem-solving, time management, stress management, financial literacy, goal setting, job search and application, conflict resolution, and interpersonal relationships. Participants practice interpersonal and group living skills within the context of the RH environment *(Services may include: "Contingence*	Peer support staff/external experts	2-4 x week

	Management" or SMART Recovery Life Skills curriculum as a part of their RH program).		
Recovery Management Skills	Sessions that focus on a curriculum that provides information on understanding addiction, its causes, effects on the brain, behavior and progression of the disorder, practical skills, techniques and coping mechanisms to manage cravings, triggers and stressors encountered during the recovery process, including relapse prevention strategies and healthy lifestyle practices.	Peer support staff/external experts with lived experience	2 x daily
Community/ House Meetings	A community/house meeting is a structured and collaborative gathering within a recovery setting where individuals come together to discuss issues, share experiences, provide support, and engage in therapeutic activities aimed at fostering personal growth, recovery, and community cohesion.	RRSS staff	1-5 x week
Mutual Aid Groups	Mutual aid groups are sessions onsite or in the community that assist individuals in addressing their SUD issues through a structured program based on guiding principles. These groups provide a safe and non-judgmental environment where members can share their experiences, receive support, and work together towards personal growth and recovery.	Peer Supports	3-7 x week
Peer Support Meetings	Peer support meetings focus on challenges and achievements in SUD recovery, normalizing experiences and reducing feelings of isolation and shame. They emphasize the value of sharing and connecting to like-minded individuals. They further assist participants in regulating emotions and practicing coping skills.	Peer Supports	1-5 x week
Continuing Care/Transition Planning	Planning for ongoing recovery needs including mutual help involvement, job search/placement, affordable housing, childcare, transportation, return to use prevention and intervention, leisure activities, family involvement, community involvement, etc.	RRSS Staff	Within 30 days of admission
Supporting Career Training and Education	Coordinate with community resources to provide support for ongoing training/education opportunities and work	RRSS Staff	As needed

	closely with KY Adult Education to schedule appointments, assure that appointments are kept and that opportunities for further education and training are available.		
Coordinating Legal Services and Supports	Referrals to assist participants in addressing legal issues.	RRSS staff	As needed
Transitional Support Services	Support the individual with the ability to transition to housing and maintain housing once secured; this may include linkage to pre-tenancy supports for obtaining affordable and accessible housing, and developing a community integration plan based on functional needs assessment.	RRSS staff	Within 30 days of admission
Employment Supports	Link individuals to employment services such as vocational training for employment assessments, planning and job training, as well as job coaching and transportation arrangements.	RRSS staff	Within 30 days of admission
Family Support Services	Assist family members in understanding SUD and facilitate individual's participation in the family, if appropriate. Family Support Services provided to family or collaterals are for the direct benefit of the beneficiary, in accordance with their needs and goals in recovery.	RRSS staff	As needed

Attachment K:
Protocol for Assessment of Beneficiary Eligibility and Needs, and Provider Qualifications

Services Protocol

List of Medicaid Covered Health-Related Social Needs (HRSN) Services

Medicaid covered HRSN services and housing-related supportive services include:

1. Short Term Pre-Procedure Housing
2. Short Term Post Transition Housing

HRSN service description, frequency, duration, setting and provider requirements, and minimum eligibility criteria are described in Exhibit 1.

Eligible provider types and requirements for each service are indicated in Exhibit 2.

Services under the TEAMKY Recuperative Care Pilot benefit will be provided to individuals who reside and receive services in their home or in the community, not in an institution.

Establish Eligibility and Medical Necessity for TEAMKY Recuperative Care Pilot HRSN Services

Eligibility:

All Kentucky beneficiaries eligible through mandatory, optional, or expansion eligibility groups, receiving full Medicaid coverage, ages 18 or older, with income up to 213 percent of the federal poverty level (FPL), who meet the clinical and social risk factors described below, will be eligible for HRSN services.

Individuals eligible for the TEAMKY 1115 Recuperative Care Pilot must be experiencing homelessness or at risk of homelessness, as defined under federal regulation 24 CFR 91.5 except for the annual income requirement in 24 CFR 91.5 (1)(i). These definitions encompass a broad range of housing instability scenarios, such as individuals without access to a fixed, regular, and adequate over-night residence, or those at imminent risk of losing their primary housing due to financial hardship or other life circumstances.

Eligible individuals must also face a heightened risk of hospitalization or readmission and have specific aftercare needs. This includes those recently discharged from an acute care facility or emergency department, as well as individuals requiring pre- or post-procedure care for planned medical interventions such as surgeries, chemotherapy, or other intensive treatments. The model provides critical support for stabilizing their medical condition during this vulnerable period.

To qualify, individuals must be at least 18 years of age, Medicaid eligible, have a primary medical diagnosis, be independently mobile (with or without the use of assistive devices), and capable of performing basic Activities of Daily Living (ADLs). These criteria ensure that participants are able to engage with the care provided while maintaining a level of personal independence crucial for successful recuperative outcomes. This targeted support aims to address the medical and social vulnerabilities of these individuals, fostering recovery and facilitating a pathway to long-term stability.

Table 1. Eligibility Criteria

Eligibility Criteria Category	Age	Clinical and Social Risk Criteria Definition
Medicaid Eligible	18+	All Kentucky beneficiaries eligible through mandatory, optional, or expansion eligibility groups, receiving full Medicaid coverage, ages 18 or older, with income up to 213 percent of the FPL, will be eligible for the HRSN service.
Primary Medical Diagnosis	18+	Individuals must have a documented primary medical diagnosis requiring post-acute care, preparation for planned medical procedures, or episodic treatment. This diagnosis serves as the foundation for determining the medical necessity of Recuperative Care Pilot services.
Homelessness or Risk of Homelessness	18+	Individuals experiencing homelessness or at risk of homelessness as defined by 24 CFR 91.5 except for the annual income requirement in 24 CFR 91.5 (1)(i).
Hospitalization Risk	18+	At risk of hospitalization or readmission with aftercare needs, including: • Post-discharge from acute care or emergency department. • Planned medical procedures requiring preparation care. • Planned treatments (e.g., chemotherapy) requiring pre-/post-treatment care.
Physical Mobility	18+	Must be independently mobile, with or without an assistive device.
Activities of Daily Living	18+	Able to perform ADLs.

The table above outlines the eligibility criteria for populations who will receive services under the Kentucky Department for Medicaid Services (DMS) Recuperative Care Pilot. This program focuses on individuals aged 18 and older who are experiencing homelessness or are at risk of

homelessness, as defined by 24 CFR 91.5 except for the annual income requirement in 24 CFR 91.5 (1)(i). It also targets those at risk of hospitalization or readmission requiring post-discharge support, pre-procedure preparation, or ongoing treatment for conditions such as chemotherapy. Eligible individuals must be independently mobile, able to perform ADLs and have a primary medical diagnosis to ensure alignment with the program's goals of stabilizing health and reducing preventable hospitalizations.

Process for Identifying Medical Necessity for Recuperative Care Pilot Services

The TEAMKY Recuperative Care Pilot employs a structured, comprehensive process to identify medical necessity and ensure services are aligned with the health and social needs of eligible individuals. Medical necessity is assessed upon referral, during admission, and throughout the individual's stay, using clearly defined criteria and evidence-based practices. This approach ensures that care is targeted, appropriate, and effectively meets the requirements of Medicaid-eligible individuals who are experiencing or at risk of homelessness.

Upon referral to a recuperative care program, an individual undergoes an eligibility screening to determine if they meet the core criteria: being at risk of or experiencing homelessness (as defined by 24 CFR 91.5), having a primary medical diagnosis, and facing hospitalization or readmission risks with specific aftercare needs. Examples of qualifying needs include post-acute discharge care, pre-procedure preparation, or episodic treatment such as chemotherapy. Additionally, the individual must be aged 18 or older, independently mobile (with or without assistive devices), and capable of performing basic ADLs.

Once admitted to the program, a **detailed nursing assessment is conducted within 24 hours by a licensed clinical professional with a minimum qualification of a Registered Nurse**. This assessment involves a comprehensive review of the individual's discharge instructions, vitals, living situation, patient and mental status, impairments, medication reconciliation, ADLs, and elimination needs. The findings of this assessment inform the development of a personalized care plan, ensuring alignment with the patient's medical, behavioral, and social requirements.

Daily evaluations are integral to monitoring and validating the ongoing medical necessity of services. Registered nurses perform daily wellness checks that include vital assessments, pain management, care plan reviews, and progress tracking. These evaluations assess compliance with treatment, participation in self-care, and any changes in condition that may require adjustments to the care plan. A key component of these checks is medication monitoring, which includes ensuring access to prescribed medications, educating patients on self-administration, and fostering independence in medication management.

Behavioral health services, when identified as medically necessary, are incorporated into the care plan. Licensed behavioral health practitioners provide screenings, brief interventions, and referrals to community-based services as needed. Care coordination further supports the process by addressing social determinants of health (SDOH) and ensuring the integration of medical, behavioral, and social services. A care coordination plan is established within 72 hours of

admission, including an assessment of medical, behavioral, and social needs, along with defined goals and regular reviews.

The TEAMKY Recuperative Care Pilot ensures that medical necessity is continuously evaluated, leveraging ongoing monitoring and assessments to address the dynamic needs of patients. This patient-centered approach, supported by highly trained staff and structured processes, allows the program to effectively provide targeted care for vulnerable populations, while fostering recovery and stability.

Eligibility Screening

The state's comprehensive assessment tool is designed to support Kentucky residents in identifying and addressing their needs across various SDOH.

The tool will have a bi-directional connection with Kentucky's health information exchange to share SDOH information captured by a patient's provider to resources, so community providers can better understand resident needs. The assessment tool will also allow for a **closed-loop referral process** to guide improved outcomes, strengthen partnerships, and promote wrap around services to residents. By using the eligibility assessment, Kentucky residents can proactively identify areas where they need support and connect with the appropriate local resources. This valuable tool not only helps individuals address their immediate needs, but also empowers them.

Clinical Criteria Considerations for Kentucky's Recuperative Care Pilot

The TEAMKY Recuperative Care Pilot establishes robust clinical criteria and an administrative process to streamline eligibility determination and ensure effective communication among community partners. This integrated approach ensures that Kentucky Medicaid members receive timely, medically necessary services while maintaining alignment with program requirements and Medicaid guidelines.

Eligibility Determination and Administrative Coordination

Eligibility for the TEAMKY Recuperative Care Pilot is based on a comprehensive evaluation of clinical and social criteria, including homelessness or risk of homelessness as defined by 24 CFR 91.5 except for the annual income requirement in 24 CFR 91.5 (1)(i). Individuals must be at least 18 years old, independently mobile (with or without assistive devices), able to perform ADLs and possess a primary medical diagnosis. Additionally, the pilot targets those at risk of hospitalization or readmission who require post-acute care, pre-procedural preparation, or episodic treatment such as chemotherapy.

To facilitate this process, Kentucky Medicaid will designate a centralized point of contact to validate member eligibility. Providers initiate the eligibility verification process by submitting referrals to this point of contact, who ensures alignment with the established criteria. This administrative entity communicates verified eligibility to relevant individuals, including physical and behavioral health providers, Managed Care Organizations (MCOs), and Recuperative Care

Pilot providers. The streamlined communication process minimizes delays and ensures that members receive services efficiently.

Member Eligibility Process

The member eligibility process begins with a detailed assessment conducted upon referral. Licensed clinical staff evaluate the individual's medical and social conditions, verifying alignment with the program's criteria. If deemed eligible, the state designated administrative point of contact ensures that the member's information is updated and shared with MCOs and care providers. Eligibility is reassessed periodically throughout the member's stay to ensure that services remain appropriate to their evolving needs. This ongoing evaluation safeguards resources while maintaining high-quality care.

Managed Care Organization Requirements

MCOs play a pivotal role in the Recuperative Care Pilot by coordinating care and facilitating seamless transitions between medical and social services. They are required to integrate recuperative care into their service offerings, collaborating closely with Kentucky Medicaid and Recuperative Care Pilot providers. MCOs must also track outcomes and report utilization metrics, ensuring accountability and continuous improvement of the program.

Information Transparency on Kentucky DMS Website

To promote transparency and accessibility, Kentucky DMS provides comprehensive information about the Recuperative Care Pilot on its official website. This includes eligibility criteria, clinical and social risk criteria, program requirements, and details on the administrative processes. By maintaining a centralized repository of information, Kentucky DMS empowers providers, MCOs, and members to understand the program's scope and navigate its processes effectively. This open communication fosters trust and ensures consistent application of clinical criteria across the state.

Through these administrative and clinical processes, the TEAMKY Recuperative Care Pilot ensures that Medicaid members receive appropriate, patient-centered care while maintaining efficiency and accountability in service delivery. This approach reflects Kentucky's commitment to addressing health-related social needs and improving outcomes for its most vulnerable populations.

Member Medical Record Documentation and Secure Data Exchange via KHIE

DMS is implementing a robust process for gathering member medical record documentation and ensuring secure data exchange through the KHIE. This process supports the TEAMKY Recuperative Care Pilot by enabling efficient communication among providers, MCOs, and other community partners. These efforts are essential to ensure high-quality, coordinated care for Medicaid members experiencing homelessness or at risk of homelessness.

Transparency and Provider Support

Kentucky DMS will maintain a central repository of information about documentation requirements and KHIE participation on its official website. This resource will include detailed guidelines for providers, technical support for KHIE integration, and updates on program expectations. By fostering transparency and providing clear resources, DMS ensures that providers are well-equipped to meet the documentation and data exchange standards of the Recuperative Care Pilot.

Through meticulous record-keeping and secure data exchange, DMS's integration of KHIE into the Recuperative Care Pilot enhances the efficiency, quality, and continuity of care for Medicaid members. This initiative underscores Kentucky's commitment to leveraging technology and innovation to improve health outcomes for its most vulnerable populations.

This structured approach ensures that HRSN care plans remain dynamic and responsive to each individual's needs, maximizing the potential for successful outcomes.

Care Plan Review: weekly review of patient's plan of care by Recuperative Care Pilot care team. Integration with Kentucky's kynect resources

The inclusion of Kentucky's kynect resources platform enhances the care planning process by providing members with access to a broad network of local programs and services. The platform's Eligibility Assessment helps care teams identify and prioritize SDOH-related needs, ensuring that referrals to housing support, food pantries, and transportation assistance are tailored to the member's circumstances. This integration allows care plans to address not only medical issues but also the social barriers that impact health outcomes.

Ongoing Review and Adaptation

The care coordination plan is designed to be dynamic, with ongoing reviews conducted weekly or as needed to reflect changes in the member's condition. Adjustments are made to ensure the plan continues to meet the member's evolving needs, such as changes in medical status, behavioral health priorities, or access to resources.

EXHIBIT 1: Breakdown of HRSN Services

The following reflects breakdown of HRSN services comprehensively, highlighting the nuanced categories and requirements, specifically the structure for both pre-procedure and post-transition housing under the program.

1. Short-Term Pre-Procedure Housing

Table 2. Short-Term Pre-Procedure Housing

Description/Definition	Frequency	Duration	Detailed Setting/Provider Requirements	Minimum Eligibility Criteria
Episodic housing interventions with clinical services with room and board, limited to a clinically appropriate amount of time, including: • Short-term pre-procedure housing, where a provider has determined that preparatory steps are required for an upcoming procedure or treatment and integrated, clinically oriented recuperative or rehabilitative services and supports are provided.	Provided on an as-needed basis, depending on the individual's pre-procedures preparation schedule and care plan. Short term pre procedure housing services can be provided for more than one stay for up to 6 months in a rolling year if determined medically necessary and patient meets eligibility criteria	Duration depends on the specific pre-procedure needs, typically ranging from 1 to 7 days prior to the procedure. Short term pre procedure housing services can be provided for more than one stay, not to exceed6 months in a rolling year, if determined medically necessary and patient meets	Must be a recuperative care facility with: • 24/7 staffing by clinical professionals, allied health professionals, and/or paraprofessional staff. • Daily wellness checks, vital sign monitoring, and pain management. • Medication monitoring and secure double-locked storage. • Capability to provide 3 meals per day. • Capability to arrange for transportation for follow-up appointments, and access to	• Must be Medicaid eligible. • At least 18 years of age. • Have a primary medical diagnosis requiring a planned procedure. • Must be independently mobile, with or without assistive devices. • Capable of performing basic ADLs. • Demonstrates risk of hospitalization or other adverse outcomes without housing support during the pre-

Description/Definition	Frequency	Duration	Detailed Setting/Provider Requirements	Minimum Eligibility Criteria
		eligibility criteria There is a total combined cap of 6 months for both Short-term pre-procedure housing and Short-term post-transition housing, per beneficiary, in any 12-month period.	telehealth services. • Staff trained in behavioral health, trauma-informed care, and motivational interviewing to support holistic recovery, and culturally responsive care. • Facilities must be accessible for individuals with mobility aids and capable of providing privacy for recovery. • Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g. gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from demonstrations.	procedure period as determined by licensed clinical staff. Measurement or determination uses a combination of clinical, social, and environmental factors. Such factors may include: 1. Medical History and Clinical Risk – by evaluating the individual's health status, comorbidities, and the complexity of the procedure to assess their vulnerability to complications. 2. Social Determinates of Health – assessing factors such as lack of stable housing which is underway in this HRSN, access to healthcare, and availability of social support,

Description/Definition	Frequency	Duration	Detailed Setting/Provider Requirements	Minimum Eligibility Criteria
				which influence recovery and outcomes. 3. Logistical Challenges – barriers to following pre-procedure instructions, attending appointments, or adhering to post-procedure care plans due to instability in living conditions. 4. Clinical Judgment – considering input from healthcare providers who assess individual circumstances, including mental health, substance use, and ability to manage pre-procedure requirements.

2. Short-Term Post-Transition Housing

Table 3. Short-Term Post-Transition Housing

Description/Definition	Frequency	Duration	Detailed Setting/Provider Requirements	Minimum Eligibility Criteria
Episodic housing interventions with clinical services with room and board, limited to a clinically appropriate amount of time, including: • Short-term post-transition housing (e.g., post-hospitalization), where integrated, clinically oriented rehabilitative services and supports are provided, but ongoing monitoring of the individual's condition by clinicians is not required.	Short term post transition housing services can be provided for more than one stay up to 6 months in a rolling year when determined medically necessary and patient meets eligibility criteria.	Typically lasts between 1 and 45 days, based upon medical necessity Short term post transition housing services can be provided for more than one stay, not to exceed 6 months in a rolling year, when determined medically necessary and individual's meet eligibility criteria There is a total combined cap of 6 months for both Short-term pre-procedure housing and Short-term post-transition	Must be a recuperative care facility with: • 24/7 staffing by clinical professionals, allied health professionals, and/or paraprofessional staff. • Daily wellness checks, vital sign monitoring, and pain management. • Medication monitoring and secure double-locked storage. • Capability to provide 3 meals per day. • Capability to arrange for transportation for follow-up appointments, and access to telehealth services. • Staff trained in behavioral health, trauma-informed care, and motivational interviewing to support holistic recovery, and	• Must be Medicaid eligible. • At least 18 years of age. • Upon discharge from a procedure or hospital stay requiring recovery support. • Must have a primary medical diagnosis necessitating post-procedure care. • Must be independently mobile, with or without assistive devices. • Capable of performing basic ADLs. • Demonstrates risk of readmission or complications without housing and support during the recovery period as determined by

Description/Definition	Frequency	Duration	Detailed Setting/Provider Requirements	Minimum Eligibility Criteria
		housing, per beneficiary, in any 12-month period.	culturally responsive care. • Facilities must be accessible for individuals with mobility aids and capable of providing privacy for recovery. • Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g. gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from demonstrations.	licensed clinical staff. Measurement or determination uses a combination of clinical, social, and environmental factors.

Components of Short-Term Pre-Procedure and Post-Transition Housing Services

The following are components within the Short-Term Pre-Procedure and Post-Transition Housing.

- Nursing Services
  - Nursing assessment within 24 hours of admission.
  - Daily wellness check conducted by licensed clinical staff (minimum RN).
  - Assessment of medical stability and ability to participate in care planning and self-care management.
- Medication Monitoring
  - Safe and secure medication storage (preferably double-locked).
  - Medication reconciliation to ensure accuracy and appropriateness of prescribed treatments.
  - Education and skill-building on medication self-management. Clinical staff provide training to promote independence in medication use, including adherence strategies and managing side effects.
  - Support accessing prescribed medications from local pharmacies or hospitals. Recuperative care staff coordinate with pharmacies to ensure timely delivery and availability of medications.
- Behavioral Health Services
  - Behavioral health screening
  - Screenings identify behavioral health needs and risk factors, leading to appropriate referrals or brief intervention.
  - Access to on-site or community behavioral health services for ongoing care. Staff provide brief interventions, or make appropriate referrals for behavioral health.
  - Brief interventions and referrals for severe or escalating behavioral health needs.
- Care Coordination
  - Care Coordination Plan developed within 72 hours of admission.
  - Onsite care coordination for aftercare appointments (medical, behavioral health, ancillary services).
  - Screening and referral to community-based services for SDOH needs.
  - Linkage to a Primary Care Physician (PCP) if one is not already established.
- General Recuperative Care Services
  - 24-hour staffed program with clinical and non-clinical support.
  - Provision of three meals daily
  - Secure storage for personal belongings and telecommunication access for medical purposes.
  - Wellness checks by medical professionals.
- Coordination of transportation to medical appointments, housing services, or community resources

Exhibit 2: HRSN Services Provider Types and Requirements

A new provider type will be created through program integrity and recuperative care providers will need to apply to become the newly established provider type to be reimbursed by Kentucky Medicaid for recuperative care services through the pilot program. Providers will be reimbursed by a per diem rate for the provision of services, which meet the criteria that Kentucky Medicaid has set for the service. The provider types will also need to be registered through the National Institute for Medical Respite Care (NIMRC) Directory to qualify for certification once it becomes available. Providers will be expected to adhere to the national standards of recuperative care set forth by NIMRC. Self-attestation will be a mandatory requirement.

Table 4. HRSN Services Provider Types and Requirements

Service	Eligible Provider Type/Setting	Certification	Other Standard (if applicable)
Short-term Pre-Procedure Housing.	Recuperative care facility, interim housing, or medical respite setting. Staffed 24/7 by licensed clinical professionals, allied health professionals, or paraprofessional staff.	Listed on the NIMRC Directory and follows NIMRC standards of care.	Meets all requirements listed in Exhibit 1.
Short-term Post-Transition Housing.	Recuperative care facility or other approved setting with 24/7 staffing by licensed clinical personnel, allied health professionals, or paraprofessional staff.	Listed on the NIMRC Directory and follows NIMRC Standards of Care.	Meets all requirements listed in Exhibit 1.

Attachment L: Interim Evaluation Report (reserved)

Attachment M: Summative Evaluation Report (reserved)

Attachment N: HRSN Service Matrix

Target Populations	Service	All full-benefit Medicaid eligibles age 18 and over who meet social and clinical risk criteria
Housing Services with Room and Board	Short-term pre-procedure and/or post-hospitalization housing	**X**
	Short-term post-transition housing	**X**

	Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Housing Services with Room and Board	Short-term pre-procedure housing	All full-benefit Medicaid eligibles age 18 and over who meet social and clinical risk criteria	Individuals who are homeless, or at risk of homelessness	Have a primary medical diagnosis, and are at risk of hospitalization and/or readmission with a medical need and: Have a planned medical procedure requiring preparation care, or Have a planned medical treatment (i.e.: chemotherapy treatment) requiring care prior to the treatment
	Short-term post-transition housing	All full-benefit Medicaid eligibles age 18 and over who meet social and clinical risk criteria	Individuals who are homeless, or at risk of homelessness	Have a primary medical diagnosis, and are at risk of hospitalization and/or readmission with a medical need following discharge from acute care facility or Emergency Department, or Have a planned medical treatment (i.e.: chemotherapy treatment) requiring care following the treatment

Clinical Risk Factor	Clinical Criteria Detail
Risk Factor 1	Have a primary medical diagnosis, and are at risk of hospitalization as determined by licensed clinical staff and/or readmission with a medical need: 1) following discharge from acute care facility or Emergency Department, or 2) Have a planned medical procedure requiring preparation care, or Have a planned medical treatment (i.e.: chemotherapy treatment) requiring care prior to or following the treatment

Social Risk Factor	Social Criteria Detail
Risk Factor 1	Individuals who are homeless, or at risk of homelessness who meet criteria based upon definitions in 24 CFR 91.5, except for the annual income requirement in 24 CFR

Attachment O:
Health Related Social Needs (HRSN) Infrastructure Protocol

HRSN Infrastructure. In accordance with the state's Section 1115 Demonstration and Special Terms and Conditions this protocol provides additional detail on the requirements on infrastructure investments for the Health-Related Social Needs (HRSN) program, as specifically required by STC 27. The state's HRSN program allows qualifying Medicaid beneficiaries to receive evidence-based clinically-appropriate services. Over the course of the demonstration the state is authorized to spend up to $2,738,299 on infrastructure investments necessary to support the development and implementation of HRSN services for Kentucky's Recuperative Care Pilot program. This protocol outlines the proposed uses of HRSN infrastructure expenditures, types of entities that will receive funding, intended purposes of funding, projected expenditure amounts and implementation timeline.

HRSN Infrastructure

I. Implementation Timeline and Approach

a. Timeline for Disbursement of Infrastructure Funding

i. The state intends to begin awarding infrastructure funds to eligible entities no sooner than July 1, 2025. The state will utilize a phased approach to disbursing infrastructure funds to ensure providers beginning their participation at different times have sufficient infrastructure and capacity. The state will fund one or all HRSN service categories as needed to support implementation goals.

ii. Eligible entities may apply for HRSN infrastructure funding on an ongoing basis, depending on availability of funds.

b. Approach to Infrastructure Funding Applications and Disbursements

i. The state will conduct the following activities, either directly or via existing contracted fiscal relationships:

1. Design and develop an infrastructure funding process, including application(s).

2. Establish and provide outreach and educational resources to eligible entities regarding available infrastructure funding opportunities.

3. Evaluate applications to ensure they meeting minimum eligibility criteria for entities.

4. Assess funding request budget templates to confirm compliance with established requirements.

5. Grant infrastructure funding to entities that meet eligibility requirements.

6. Facilitate the disbursement of awarded funds to designated entities.

7. Oversee the use of infrastructure funding or verify the achievement of milestone-based outcomes among eligible entities to prevent fraud, wase, and abuse.

8. Design and distribute reporting templates for awardees to document funding usage or milestone-based outcomes.

9. Conduct a structured review of reports submitted by awardees to tracking funding usage or verify milestone-based achievements.

c. Monitoring and Oversight

i. The state will ensure that any HRSN infrastructure fund disbursements are consistent with these STCs. The state will ensure that any HRSN infrastructure funding is subject to program integrity standards, including:

1. **Participating in audit processes.** The state, either directly or via existing or contracted fiscal relationships, will conduct spot audits as needed to ensure that infrastructure funds are being spent on permissible uses and are being documented and appropriately reported.

2. **Taking action to address non-compliance**. The state will ensure that action is taken to address any identified non-compliance with HRSN infrastructure funding parameters. If the funding recipient has failed to demonstrate appropriate performance, the state may impose corrective actions (e.g., caps on funding, discontinuation of funding and/or recoupment of funding). The state will provide notice to any funding recipient prior to initiating corrective action.

3. **Ensuring non-duplication of funds**. Funding recipients will be required to attest to non-duplication of funding with other federal, state and local funds. The state will monitor for funding irregularities and potential duplication of funds.

4. **Monitoring for fraud, waste and abuse.** The state, either directly or via existing or contracted fiscal relationships, will actively monitor all HRSN infrastructure disbursements for instances of fraud, waste and abuse. The state will suspend and/or terminate infrastructure funding in cases of confirmed fraud, waste, and/or abuse. The state reserves the right to recoup funding as necessary.

II. Eligible Entities

a. The following entities may be eligible to apply for and receive HRSN infrastructure funding:

i. Principle eligible entities include:

1. Existing recuperative care programs that meet HRSN provider criteria outlined in Attachment K and who are listed in the National Institute for Medical Respite Care (NIMRC) Directory as Recuperative Care (Medical Respite) providers in KY. These providers will specifically provide the HRSN services "short-term pre-procedure housing" and "short-term post-transition housing" as authorized by CMS. This can include but is not limited to entities like housing providers, social service agencies, traditional health care providers, and community-based organizations.

ii. Additional eligible entities include:

1. Entities that have the capacity to support the delivery of HRSN services, including state, city, county, and local governments; community-based organizations; or other entities who support HRSN contracting, implementation, invoicing and service delivery; and,

2. State agencies, local government, or contracted partners to facilitate setup, operation, and ongoing oversight of HRSN programs.

b. In addition, the entities must meet the following minimum eligibility criteria in order to be considered eligible for the HRSN infrastructure funding. Minimum eligibility criteria may include:

i. The entity is capable of providing or supporting the provision of one or more HRSN services to Medicaid beneficiaries within the state of KY.

ii. The entity has attested to being financially stable, as defined by the state of KY.

III. Intended Purpose and Proposed Uses of HRSN Infrastructure Funding.

a. Technology

b. Development of business or operational practices

c. Workforce Development

d. Outreach, education and stakeholder convening

The State intends to provide infrastructure funding to eligible entities for the following activities:

a. **Technology.** Qualifying entities can leverage HRSN infrastructure funding to support a range of technology needs, including those that support closed-loop referral platforms and other community information exchange priorities. KY is requesting the following activities to be covered by HRSN Infrastructure funds as needed. If additional activities arise and need to be included, KY will formally

request funding for those specific activities in the future from CMS. The allowable activities are as follows:

i. Procuring IT infrastructure/data platforms/systems needed to enable, for example:

1. Authorization of HRSN services.
2. Documentation of eligibility for HRSN services and track enrollment.
3. Closed loop referral to HRSN services.
4. Record plans of care.
5. HRSN service delivery.
6. HRSN service billing.
7. HRSN program oversight, monitoring and reporting, including for activities beyond HRSN infrastructure (e.g., reporting on HRSN services delivered, monitoring to ensure members receive the services for which they were authorized, activities to prevent fraud, waste and abuse across the HRSN program).
8. Determine eligibility for other federal, state and local programs including Supplemental Nutrition Assistance Program (SNAP) and/or Women, Infants and Children (WIC).

ii. Modifying existing systems (e.g., community information exchange) to support HRSN.

iii. Development of an HRSN eligibility/services screening tool.

iv. Integration of data platforms/systems/tools.

v. Onboarding to new, modified or existing systems.

vi. Training for use of new, modified or existing systems.

b. Development of business or operational practices

i. Development of polices/procedures related to:

1. HRSN referral, service delivery workflows, and care plans;
2. Billing/invoicing;
3. Data sharing/reporting;
4. Program oversight/monitoring;
5. Evaluation; or

6. Privacy and confidentiality.

ii. Training/technical assistance on HRSN program and roles/responsibilities.

iii. Procurement of administrative supports to assist implementation of HRSN.

c. Workforce development

i. Training provided by a technical assistance organization to support one or more HRSN providers.

ii. Cost of recruiting, hiring, and training new staff to provide HRSN.

iii. Salary and fringe for staff that will have a direct role in overseeing, designing, implementing, and/or executing HRSN responsibilities, time limited to a period of 18 months.

iv. Necessary certifications, training, technical assistance and/or education for staff participating in the HRSN program (e.g., on culturally competent and/or trauma informed care).

v. Privacy/confidentiality training/technical assistance (TA) related to HRSN service delivery.

vi. Production costs for training materials and/or experts as it pertains to the HRSN program.

d. Outreach, education, and stakeholder convening

i. Production of materials necessary for marketing, outreach, training and/or education related to HRSN.

ii. Translation materials.

iii. Planning for and facilitation of community-based outreach events to support awareness of HRSN services.

iv. Planning for a facilitation of learning collaboratives of stakeholder convenings for HRSN.

v. Community engagement activities necessary to support HRSN program implementation and launch (e.g. roundtable discussion to solicit feedback on guidance documents).

vi. Administrative or overhead costs associated with outreach, education, or convening directly tied to HRSN.

IV. **Projected Expenditure Amounts:** The state estimates the following infrastructure expenditure amounts by allowable use category over the course of the demonstration. The state used the annual infrastructure spending amounts articulated in the states'

STCs, and an analysis of anticipated need across the state to develop the estimates below. The state anticipates that the percentage of spend permissible uses categories (as illustrated in the table below) will stay relatively constant across the Demonstration Years.

Allowable Use Category	% of Spend	Estimated Amount
Technology	47%	$1,289,739
Development of Operational or Business Practices	27%	$728,387
Workforce Development	5%	$131,438
Outreach, Education and Stakeholder Convening	21%	$588,735
Total	**100%**	**$2,738,299**

Attachment P: HRSN Implementation Plan

INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) approved an extension of the TEAMKY 1115 Demonstration on December 12, 2024, through December 31, 2029 to include the Health Related Social Needs (HRSN) Demonstration. On December 31, 2024, CMS approved Kentucky's Attachment O: Infrastructure Protocol and on January 7, 2025, CMS approved Kentucky's Attachment K: Services Protocol and Attachment N: Updated Services Matrix.

HRSN services approved under the Demonstration are for episodic housing interventions with clinical services with room and board to include short-term pre-procedure housing and short-term post transition housing. TEAMKY HRSN 1115 services include the Recuperative Care (RC) Pilot Program which is the vessel for the delivery of the approved HRSN services.

The Implementation plan is organized by the following milestones:

Milestone 1	Establish and Advance Data Sharing and Partnerships (STC 39.c.i.).
Milestone 2	Strengthen Key Partnerships and Community Collaboration (STC 39.c.iI.)
Milestone 3	Enhance Information Technology (IT) Infrastructure to Support HRSN Implementation (STC 39.c.iII.).
Milestone 4	Track and Improve Benefit Utilization and Access to Care (STC 39.c.iv.)
Milestone 5	RC Pilot Readiness Assessment (STC 39.a.)

For each milestone in the Implementation Plan, Kentucky describes the activities, key strategies, and timelines for achieving activities.

MILESTONES AND STRATEGIES

Milestone 1: Establish and Advance Data Sharing and Partnerships

STC 39.c.i: *A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services stakeholders interested parties to the extent those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation.*

1.1. Overview and Purpose of Data-Sharing Framework

Kentucky's data-sharing framework is designed to ensure timely, secure, and accurate access to information needed to coordinate care, verify eligibility and document service delivery to beneficiaries. Effective data exchange is central to implementation, spanning screening, referral, eligibility, consent, service provision, and transition.

- ❖ Kentucky intends to examine the features and functionality of the Kentucky Health Information Exchange (KHIE) and it's capacity to serve as the initiative's data-sharing backbone, linking the Commonwealth's managed care organizations (MCOs), providers, and community-based organizations (CBOs) to monitor services in real time.
- ❖ Kentucky intends to collect longitudinal data on reach, fidelity, outcomes, and alignment with programs like the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
- ❖ Kentucky will explore cross-sector governance with a goal to achieve real-time interoperability across health, housing, and social service systems, with equity, security, and sustainability as guiding principles.

1.2 Key Partners Involved in Data Exchange

Data exchange may involve the following community partner groups:

- Kentucky CHFS.
- Kentucky DMS
- Kentucky Hospital Association (KHA).
- Medicaid MCOs.
- KHIE, kynect Resources, and other state specific data collection tools.
- Housing providers.
- RC Pilot Providers.
- National Institute for Medical Respite Care.
- Community Based Organizations (CBOs).
- Hospital and Emergency Department systems.
- Continuums of Care (CoC) and Public Housing Authorities (PHAs).
- Kentucky Housing Corporation (KHC)
- Healthcare for the Homeless Council and state homeless councils and coalitions.

- Kentucky Department for Community-Based Services (DCBS) responsible for administering SNAP, TANF, WIC.
- Kentucky Office of Application Technology Services (OATS).
- Kentucky Office of Data Analytics (ODA).
- State agencies administering SNAP, TANF, WIC, and housing benefits.

1.3 Data Elements for Exchange – By Function

The following presents the anticipated data elements which may be used for information sharing:

- **Screening and Eligibility Data:** Housing status, social risk factors, clinical triggers, ADLs, diagnosis codes, screening metadata, and requested HRSN service.
- **Referral Data:** Source, beneficiary, dates, service type, rationale, acceptance/denial with reasons, outcome status, service start date, and provider details.
- **Service Provision Data:** Type of service, dates, discharge information, assessments, occupancy logs, diagnoses, supportive services, staffing logs, case notes, discharge plans, follow-up care recommendations, care coordination efforts, adverse incidents, treatment plans, care plans, person-centered service plans, and billing identifiers.
- **Utilization and Outcomes Data:** ED visits, hospitalizations, readmissions, behavioral health engagement, housing transitions, benefit uptake, continuity of care, mortality, length of stay (LOS), preventive care visits, and disparities.
- **Consent Documentation:** may include informed consent for the provision of services, a release of information including authorized sharing partners, and a beneficiary's acceptance of any additional referrals/services. All documentation must follow a set of guidelines for data and consent collection and follow all state and federal guidelines.

1.4 Data Systems Infrastructure, Legal Agreements, and Consent Management

KHIE's capabilities are being evaluated to determine its capacity, in current or potential expanded forms, to provide the necessary support as the primary infrastructure; in order to provide supportive referral management, structured data storage, analytics, dashboards, and cross-sector access. Anticipated enhancements include specific templates and interoperability with external platforms for HRSN related services. MCOs will maintain care management systems as appropriate. Kentucky will look to leverage other supportive data infrastructures such as kynect (https://kynect.ky.gov/), which is primarily an eligibility and enrollment system for Medicaid and other public benefits, such as SNAP, TANF, etc; to better close gaps and improve current data systems.

All platforms utilized by DMS within the HRSN programs will apply State-defined and federally mandated data standards. KY will continue to explore a centralized integration layer for consolidated beneficiary records, crosswalks, and CMS reporting. All systems are intended to comply with the Health Insurance Portability and Accountability Act (HIPAA), 42 Code of Federal

Regulation (CFR) Part 2, and state law, with role-based access, encryption, and audit logs. Consent may be centrally tracked and enforced in application programming interfaces (APIs), where applicable. As part of the Cabinet's existing processes and protocols, legal and IT oversight bodies perform audits and privacy impact assessments.

Data Use Agreement (DUA), Business Associate Agreement (BAA), Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), and Maintenance of Effort (MOE) will be utilized across community partners and in alignment with state-defined standards. Standardized consent processes may define who collects consent, documentation and storage methods, communication across systems, and procedures for revocation, expiration, or renewal. Kentucky will explore current functionalities in the kynect resources consent management system in an attempt to leverage current data infrastructure to support the 1115 HRSN programs in meeting milestones related to data-sharing and IT infrastructure purposes.

1.5 Monitoring and Quality Assurance Support

DMS intends to establish a Data Monitoring Framework for HRSN services with identified key partners and/or systems accountable for data completeness, accuracy, and timeliness. Requirements may include:

- Screening and referral and service data within specific timeframes, including discharge records within specific business days.
- MCO monthly summary reports on timeliness and error correction.
- KHIE time-stamped ingestion logs and alerts for incomplete or late data.
- Integrity reviews by DMS.

Quality control may include, but not limited to validation checks, dashboards with real-time performance indicators, quarterly audits, and structured feedback protocols. Noncompliance may trigger corrective action plans or financial penalties. Training and technical assistance (TA) may address recurring issues, supported by collaboratives, templates, and site-level support. Data is intended to complete CMS monitoring reports, evaluator access, and crosswalks with Medicaid and public benefit data. Where necessary, existing KHIE, kynect, MCO reporting, claims data, and other identified data reporting dashboards may be enhanced to allow for program and demonstration monitoring and evaluation.

1.6 Risk Mitigation and Contingency Planning

Kentucky will evaluate and mitigate possible risks, including provider readiness variability, interoperability gaps, privacy constraints, data quality issues, duplicative referrals, and system downtime. If necessary, existing mitigation strategies such as introducing interim flat-file reporting, manual workflows during downtime, targeted TA for low-capacity providers, and/or the temporary use of other state data exchange programs may be deployed. KHIE maintains downtime logs and confirms reconciliation protocols in compliance with state outlined requirements. TA may

include onboarding, training, regional workshops, and help desk support. Contingency solutions will comply with HIPAA and 42 CFR Part 2.

1.7 Alignment with Broader Statewide Data Initiatives

Kentucky's strategy aligns with its behavioral health and social determinants of health (SDoH) data system modernization, KHIE infrastructure upgrade and expansion, and Medicaid quality improvement priorities. Data collection related to HRSN services and/or the RC Pilot Program aims to support standardized screening, automated referrals, and analytics. Kentucky continues to explore capabilities to include closed-loop referral functionality, dashboards, and CBO onboarding to the Commonwealth's health information exchange platform.

Data may be utilized to inform population health metrics and public health dashboards. Predictive analytics and a social care referral exchange which are in development and overseen by a technical governance council, may be utilized as appropriate. Integration with SNAP, TANF, WIC, and housing programs may be utilized to identify unserved but eligible beneficiaries, support cross-program outreach, and enable data linkages with housing systems and other care providers. These efforts ensure approved Infrastructure investments to reinforce broader Kentucky Medicaid and public health transformation.

Key Strategies, Activities, and Implementation Timeline for Milestone 1

Strategy Area	Key Strategies and Activities	Implementation Timeline
Data-Sharing Framework	Enhance existing interoperable systems to support real-time information exchange across multiple health providers (i.e. physical, behavioral, mental, supportive services, etc.), housing resources, and social service providers/resources. Explore ways to leverage KHIE and affiliate data structures as the central interoperable infrastructure for data inputs and/or collections related to HRSN needs and services.	Q3 2025-Q3 2026
Partner Engagement	Formalize agreements with MCOs, CBOs, hospitals, CoCs, state agencies, and others, as needed. Partner with CBOs, hospitals, and other community partners through the development of a comprehensive communications plan, including TA, resources, training, and other supports, as needed, for implementation of data sharing with needed entities. Create and maintain cross-sector governance to build trust, reduce duplication, and ensure accountability.	Q1-Q3 2026; ongoing
Screening and Eligibility Data	Conduct analysis and evaluation of current data collection practices to standardize collection of housing status, social risk factors, medical indicators, ADLs, and diagnosis codes. Capture and store data in existing and expanded data sharing infrastructure for access by identified partners and providers.	Q4 2025-Q1 2026
Referral Data	Leverage existing referral platforms, such as kynect resources to explore capabilities and existing integration with KHIE and assess for enhancements to ensure closed-loop referral tracking across key systems. Explore use of KHIE as the	Q3-Q4 2025

	primary host for data sharing to ensure documentation of referral source, beneficiary, service type, acceptance/denial, and outcomes.	
Service Provision Data	RC Pilot Program Providers and other data collection systems begin to submit real-time service documentation (service type, dates, diagnosis, daily utilization, discharge details, supportive services provided). Link data to billing identifiers and Medicaid claims.	Q2-Q3 2026
Utilization and Outcomes Data	Utilize Kentucky's existing monitoring infrastructure to track ED visits, hospitalizations, readmissions, behavioral health engagement, housing connections, benefit enrollment, follow-up care, and disparities. Support CMS reporting and evaluation.	Q2-Q3 2026-ongoing with reporting to CMS
Consent Management	Where necessary, standardize informed consent processes across providers. Document date, scope, duration, and status in the identified data structure. Ensure compliance with HIPAA, 42 CFR Part 2, and state privacy laws. Leverage existing systems and create plans to enhance these infrastructures, as appropriate.	Q3 2025-Q2 2026
Data Quality and Monitoring	Deploy validation checks, quality dashboards, audits, and corrective mechanisms as necessary. Require MCOs to include RC Pilot Program data to quality reports. Establish performance standards and monitoring teams at DMS.	Q2-Q3 2026
Risk Mitigation	As needed, implement mitigation strategies that provide interim reporting via flat files, establish manual workflows during system downtime, offer TA to low-capacity providers, and allow temporary use of alternative platforms with data integration.	Q3 2025-Q2 2026
Alignment and Integration	Align HRSN data with broader CHFS modernization, KHIE infrastructure, and functionality expansion with interoperable connections with SNAP, TANF, WIC, and housing programs, where applicable.	In progress and ongoing

Milestone 2: Strengthen Key Partnerships and Community Collaboration

STC 39.c.ii: *Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries).*

2.1 Overview and Strategic Intent

Kentucky's HRSN 1115 demonstration embeds multisector partnerships as the foundation for the RC Pilot Program. These partnerships are central to equity, program efficiency and effectiveness, and long-term sustainability. The model relies on distributed service delivery, with DMS and MCOs coordinating networks that include, but are not limited to: RC Pilot Providers, housing navigators, behavioral health entities, primary care providers, hospitals, discharge planners, surgery centers, cancer centers, and recovery networks.

The strategy prioritizes investment in local workforce development, network adequacy for CBOs, equitable access across urban and rural communities, and inclusion of historically excluded organizations. Equity and accountability are built into governance through utilization of a standardized racial equity accountability tool across CHFS to reduce disparities and improve health outcomes and access to services across the design, implementation, and evaluation phases of this demonstration.

2.2 Inventory of Current and Planned Partnerships

- **State-Level Partners:** DMS (program administration and oversight), the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) (behavioral health integration), DCBS (public benefits and child welfare), KHC (housing programs and long-term housing alignment), state homeless councils and coalitions (regional guidance across the commonwealth), and ODA (data infrastructure). These entities will lead the HRSN Services Cross-Agency Leadership Group and Operations Workgroup to provide governance and technical guidance, coordinate policy, and equity oversight of approved HRSN services.

- **MCOs:** All Kentucky contracted MCOs are responsible for building and managing delivery networks, contracting with RC Pilot Program Providers, and ensuring culturally responsive services. MCOs are responsible for contracting with these organizations to support care coordination, provide technical guidance and assistance, and establish network adequacy.

- **Community Partners:** CBOs, CoCs, federally qualified health centers (FQHCs), community mental health centers (CMHCs), recovery organizations, and existing recuperative care providers will be essential to providing direct services through the RC Pilot Program as well as additional services offered, such as housing navigation, case management, behavioral health care, food support, and linking to other community resources that align with the person centered service plan to promote health for beneficiaries. Throughout the 1115 demonstration, Kentucky will expand its partner portfolio through community partner mapping, outreach campaigns, collaboratives, etc.

- **RC Pilot Program Providers:** Providers who have undergone readiness criteria approval and have been approved and enrolled as a RC Pilot Program Provider Type and are able to deliver RC Pilot Program approved services in the commonwealth.

- **Beneficiary:** A beneficiary is considered someone who is receiving services under the RC Pilot Program. Beneficiaries and individuals with lived experience actively participate in Kentucky's Technical Advisory Committees and Medicaid Advisory Committee. Individuals with lived experience may be consulted as experts incorporating their voice in the process when and where possible. Participatory evaluation structures may include beneficiary surveys, focus groups, key informant interviews, and learning collaboratives

- **Community Collaboration:** Current mechanisms include MCO advisory councils, and community homelessness councils and coalitions. The engagement model includes CoC outreach programs, hospital discharge programs, collaboration with Voices of the Commonwealth and those with lived experience, the Government Alliance on Race and Equity (GARE) tool for demonstration accountability, as well as learning collaboratives organized by community partners.

2.3 Capacity Building Strategies for HRSN Services

Kentucky treats capacity building as central to implementation and equity. Capacity domains include organizational readiness, administrative systems, billing and compliance, workforce development, IT and data systems, and quality improvement.

Delivery mechanisms may include MCO-led support, statewide TA, learning collaboratives, and where possible, grant or mini funding opportunities. KY will explore if policy interventions are needed to address systemic barriers, which may include credentialing reform, flexible contracting, and payment innovation to reflect the true cost of services. Progress may be tracked through provider communications, outreach, and engagement metrics, enrollment data, TA participation, and service access benchmarks.

Kentucky's communication strategy emphasizes transparency, dialogue, and accountability. Such strategy is developed and implemented by the dedicated CHFS communications team lead and staffed by marketing and public relations professionals, where appropriate.

Key Strategies, Activities, and Implementation Timeline for Milestone 2

Strategy Area	Key Strategies and Activities	Implementation Timeline
Partnership Model	Utilize existing practices for engaging partners, and leverage identified State-Level Partners, MCO's, Community Partners, RC Pilot Providers, Beneficiaries, and community collaboration aspects using communication plans and strategic implementation of services.	Q1-Q3 2026
State-Level Partnerships, including Governance and Shared Accountability	Identified partners will lead the HRSN Services Cross-Agency Leadership Group and Operations Workgroup to provide governance, technical guidance, coordinate policy, and equity oversight of approved HRSN services. Status meetings, workgroup meetings, and other means of internal communications may be used to share impertinent information.	Q3-Q4 2025; ongoing
MCOs	DMS intends to use the following communication methods to effectively implement services: schedule kick-off meetings, provide a MCO Program Requirements Implementation guide, TA, MCO contract language adjustments, a provider letter, policy guidance letter, and others as needed.	Q1 2026

Community Partners	DMS, MCO's, and RC Pilot providers to engage with CBOs, CoCs, FQHCs, CMHCs, and other organizations as trusted. Engagement will take a variety of forms, including but not limited to, soliciting feedback, organizing trainings, webinars, plain-language brochures, email, social media campaigns, public service announcements, and attending workgroup meetings.	Q4 2025; ongoing
RC Pilot Providers	Utilize provider readiness materials, provider manuals, billing guides, trainings, webinars, TA, designated e-mail box, provider policy guidance letters, fee schedules, frequently asked questions, the DMS public facing website page, and work group meetings to onboard, orient, implement, and maintain provider participation. Partner with TA, MCO, and other community partners as needed to effectively implement the RC Pilot Program	Q1 2026; ongoing
Community Collaboration	Expand beneficiary engagement and those with lived experience through MCO advisory councils, peer networks, CHW coalitions, rural advisory circles, and leverage those existing partnerships with provider networks, hospital association and discharge planning teams, surgery center staff and other groups, as available. Use feedback loops, community forums, and learning collaboratives to shape implementation.	Current; ongoing
Capacity Building	Develop operational processes and provide TA regarding provider and organizational readiness, billing, compliance, workforce development, IT and data systems, and quality improvement. Extend support where possible.	Development: Q4 2025-Q2 2026 Provide TA: Q2 2026; ongoing
Strategic Communications	Kentucky may leverage existing feedback loops, including surveys, focus groups, interviews, suggestion boxes, technical advisory councils, designated email addresses, implementation teams, and lived experience panels. DMS plans to provide clear and transparent guides and instructional tools on the DMS website for ease of access and use. DMS plans to engage all of the above-mentioned parties in communications and continued community partners collaboration.	Q4 2025-Q2 2026

Milestone 3: Enhance IT Infrastructure to Support HRSN Implementation

STC 39.c.iii: *Plans for changes to IT infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, qualification and consent to receive HRSN services, screening, referrals, and service provision.*

3.1 Purpose and Strategic Objectives

As reflected in the approved Attachment O: Infrastructure Protocol, Kentucky's vision is to build a seamless, secure, and interoperable digital ecosystem that underpins HRSN services, including the approved RC Pilot Program. Assessing current capabilities and possible expansions within

existing data partnerships, to explore enhancements in eligibility, closed-loop referrals, consent, service documentation, and outcomes are identified as core principles. Linking data structures such as KHIE with Medicaid claims, MCO platforms, kynect resources, and social service databases will allow for proactive service and program monitoring.

Kentucky emphasizes inclusion of small and rural CBOs through onboarding support, simplified interfaces, and TA, ensuring equitable participation in the HRSN services ecosystem. Dashboards and real-time analytics can help to guide CQI and program evaluation, while aligning with broader state modernization ensures long-term scalability and sustainability.

3.2 Planned Changes to IT Systems

Kentucky intends to leverage existing and expanded data sharing systems referenced throughout this document to serve as the operational backbone for HRSN services. IT systems are intended to include the capabilities to be able to:

- Manage service delivery through exploring a closed-loop referral structure to include capturing screenings, eligibility, and consents and will be interoperable with referral sources from kynect. Providers and MCOs may document admissions, diagnosis, LOS, assessments, person-centered care, discharge, and coordination notes in accessible systems.
- Ensure data integrity via structured templates, validation logic, audit trails, and real-time dashboards.
- Monitor compliance with federal and state requirements by flagging missing documentation, expired eligibility, or overuse. Explore how alerts and designated compliance reports can drive corrective action and TA.
- Inform outcomes by linking requested RC Pilot Program related data to Medicaid claims, housing/social benefit systems, enabling tracking of avoided hospitalizations, housing stability, care transitions, and uptake of SNAP, WIC, or TANF.

3.3 Core System Functions and Requirements

Minimum functions may include:

- Capturing demographics, screenings, and ADLs.
- Applying eligibility rules combining social risks and clinical data.
- Recording multiformat consents and linking them to referrals/services.
- Facilitating referrals with full status tracking.
- Documenting authorizations, utilization, and service episodes.
- Exchanging data with the Medicaid Management Information System and other related systems, as needed, for claims/payment validation.
- Aggregating data for dashboards, monitoring, and CMS reporting.

3.4 Systems Involved

- KHIE and its affiliate partners for the statewide central repository and data exchange for screenings, referrals, and analytics.
- MCO systems for authorizations, case management, integration with KHIE and/or other state data systems, and required monitoring/ reporting
- Referral sources, such as kynect may be integrated to make resources available within closed-loop workflows.
- Provider-level systems and EHR's aligned with State standards.
- Data aggregation and monitoring tools to meet CMS requirements for oversight and reporting.

3.5 Consent and Privacy Management

Where necessary, Kentucky will assess capabilities for comprehensive consent processes, and will aim to incorporate these into the KHIE structure while maintaining compliance with HIPAA and 42 CFR Part 2. Features may include:

- Electronic and paper consent capture with time-stamped records and auditability.
- Granular consents allowing beneficiaries to share some data, while restricting others.
- Real-time verification of consent across MCOs and platforms.
- Revocation workflows that automatically restrict access when consent is withdrawn.
- Training for providers on culturally appropriate consent processes, with multilingual materials and plain-language forms.

3.6 Data Standards, Interoperability, and Integration Strategy

Where necessary, Kentucky will ensure adoption of Health Level 7 (HL7) v2, HL7 Fast Healthcare Interoperability Resources, Consolidated Clinical Document Architecture, and United States Core Data for Interoperability standards, enabling real-time secure API exchanges or batch uploads, when necessary. A master patient index may link records across KHIE, MCOs, and CBOs. Integration with SNAP, TANF, WIC, and housing is intended to coordinate eligibility and referrals and strengthen access to services. Cross-sector data sharing is intended to follow federal guidance and rely on standardized HRSN elements.

3.7 Training and Technical Assistance

Kentucky will deliver role-specific onboarding and TA to users (MCOs, CBOs, hospitals, RC Pilot providers, state agencies, etc). Supports may include live and virtual training, on-demand modules, refreshers, and recertification as indicated by need. KHIE and designated data structures may host help desks, office hours, and targeted TA for low-performing partners. Accessibility features include multilingual materials, American Sign Language, culturally tailored content, and mobile TA teams for rural areas. Performance will be monitored via the states identified systems, such as Adobe Learning Management Systems (ALMS) data, surveys, and help desk logs.

3.8 Monitoring, Quality Assurance, and System Performance Metrics

Kentucky will explore automated data integrity checks, dashboards, quarterly audits, and incident management protocols. Metrics may span technical performance (uptime, latency, error rates), data quality (completeness, logical consistency, duplicate rates), and user satisfaction (usability surveys, help desk resolution times). Dashboards should enable real-time oversight and corrective action.

3.9 Alignment with Broader Initiatives

IT infrastructure is embedded within Medicaid Enterprise System (MES) modernization, behavioral health exchange expansions, and SDoH integration. Enhancements to KHIE will qualify for 90/10 match and align with MES modules (provider enrollment, claims, case management). Cross-sector integration pilots will link Medicaid with SNAP, TANF, and housing. This alignment is key to delivering of HRSN services as well as sustaining the RC Pilot Program.

Key Strategies, Activities, and Implementation Timeline for Milestone 3

Strategy Area	Key Strategies and Activities	Implementation Timeline
KHIE Enhancements	Explore KHIE capabilities and expansions needed to serve as the backbone for HRSN services data, adding referral management, structured templates, RC Pilot Program-specific service codes, dashboards, analytics, and cross-sector access.	Q2-Q4 2026
MCO Care Management Systems	Leverage existing and/or enhance bidirectional interfaces with KHIE/data sharing entities utilized by the state for enhancing ability to perform real-time updates regarding beneficiary eligibility, referrals, authorizations, and service utilization. Where necessary, harmonize data standards and submission schedules under DMS oversight.	Q2-Q4 2026
Integrated Eligibility, Enrollment, and Referral Platforms	The goal is to incorporate a robust closed-loop referral process and functionality supporting HRSN services and the delivery of services provided by the RC Pilot Program. Kentucky is evaluating the current KHIE integration with kynect as potential platforms for integration.	Q3 2025-Q4 2026
Privacy and Compliance	Ensure data-sharing systems embed HIPAA, 42 CFR Part 2, and state-level privacy protections across all IT systems. May use role-based access, encryption, consent tracking, and DUAs/BAAs to govern lawful data exchange.	Continuous evaluation aligned with best practices.
Quality and Monitoring	Require HRSN services and RC Pilot Program Data to be included in MCO reporting. May use audit trails and metadata to support accountability and CMS-required monitoring.	Q2-Q4 2026
Governance	Continue to employ OATS, KHIE, and ODA to oversee IT strategy, integration testing, and performance. Use governance committees to align technical development with equity goals and federal requirements.	Current CHFS ongoing practices.

Alignment with Statewide Initiatives	As noted in Attachment O: HRSN Infrastructure Protocol, Kentucky will integrate IT investments with behavioral health/SDoH modernization, Medicaid quality improvement, and public health surveillance. Pilot predictive analytics and cross-program linkages to support a learning health system.	Q1-Q3 2026

Milestone 4: Track and Improve Benefit Access and Utilization

STC: 39.c.iv. A plan for tracking and improving the share of Medicaid demonstration beneficiaries in the state who are eligible and enrolled in SNAP, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Temporary Assistance for Needy Families (TANF), and/or federal, state, and local housing and/or other nutrition assistance programs, relative to the number of total eligible demonstration beneficiaries in the state (including those who are eligible but unenrolled);

4.1 Purpose and Strategic Alignment

Kentucky intends to establish a structured system to identify Medicaid beneficiaries who are eligible for public benefit programs, track their enrollment status, and improve uptake of supports that address HRSN related needs. This includes food, income, and housing programs, such as SNAP, WIC, TANF, federal and state housing initiatives, and other nutrition supports. The goal is to reduce unmet needs, mitigate inequities in access, and integrate benefit enrollment into care coordination for the overall of the TEAMKY 1115 HRSN demonstration.

The RC Pilot Program, as a central point of entry, where screenings and referrals will identify beneficiaries with acute and long-term housing and nutrition needs in addition to short-term pre-procedure and post-procedure housing. The strategy aligns Medicaid infrastructure with public benefits systems to reduce duplication, streamline enrollment, and improve continuity of care.

4.2 Programs in Scope

The scope of this milestone extends across multiple federal, state, and local programs.

- **Nutrition supports:** SNAP and WIC.
- **Income supports:** TANF, workforce participation subsidies, and State-supported cash assistance programs.
- **Housing supports:** Federal Housing Choice Vouchers, public housing, CoCs (including rapid rehousing and supportive housing), KHC administered programs, and state emergency shelter and transitional housing funds.
- **Other supports:** Energy assistance, childcare subsidies, food pantry partnerships, and specialized housing programs for youth aging out of foster care, justice-involved individuals, and seniors.

Kentucky's strategy ensures that Medicaid and HRSN services systems, including integrated KHIE and MCO platforms, are able to identify potential eligibility, route referrals, and confirm benefit enrollment across these program areas.

4.3 Identification of Eligible Populations and Outreach Prioritization

Kentucky intends to leverage KHIE, and affiliate data partners, screening results, kynect data, Medicaid enrollment files, hospital referrals, primary care physicians, other providers, and MCO case management inputs to identify likely eligible beneficiaries. Kentucky aims to join with other initiatives within the state in which focus on standardized needs assessments for SDoH and partner to establish gaps in coverage for beneficiaries. Kentucky intends to leverage existing equity practices to assist with deploying outreach where under-enrollment persists. Care Coordination is pivotal to the RC Pilot Program model and service delivery and will assist in promoting other services such as SNAP, WIC, TANF in which beneficiaries may be eligible.

4.4 Partnerships and Coordination with State and Local Entities

Kentucky will determine necessary data sharing and governance agreements to support tracking and improving beneficiaries who are eligible and/or enrolled in SNAP, WIC, TANF, and other support programs.

Key Strategies, Activities, and Implementation Timeline for Milestone 4

Strategy Area	Key Strategies and Activities	Implementation Timeline
Health Care Utilization Tracking	Kentucky will explore current functions of data systems and work to design, develop, and implement technology capabilities to monitor ED visits, inpatient admissions, and hospital readmissions before and after implementation of the RC Pilot Program to assess reductions in avoidable utilization, as needed.	Q4 2025-Q3 2026
Housing Stability Outcomes	Measure successful transitions from RC Pilot Program services to permanent housing programs (e.g., supportive housing vouchers, coordinated entry, KHC programs).	Q4 2025-Q3 2026
Public Benefits Uptake	Leverage KHIE integration with kynect resources to link HRSN/SDoH related data and/or assessments with SNAP, TANF, and WIC programs to track enrollment, continuity of benefits, and service delivery.	Ongoing
Service Quality	Track LOS relative to clinical benchmarks, daily service provision (e.g., registered nurse [RN] visits, meals, care coordination), and discharge planning. May utilize audit criteria to assess as needed.	From service delivery start-Ongoing
Data Infrastructure and Reporting	Explore the abilities of KHIE to use dashboards for real-time utilization tracking. Where determined necessary, create crosswalks between KHIE, Medicaid claims, and benefit program data. Align reports with CMS reporting and evaluation requirements.	Q4 2025-Q3 2026
Community Collaboration	Involve beneficiaries and people with lived experience in reviewing utilization data, validating findings, and recommending course corrections.	Q4 2025-Q3 2026; ongoing

Milestone 5: TEAMKY Recuperative Care Pilot Readiness Assessment

STC39.a*. The state is required to submit a HRSN Implementation Plan that will elaborate upon and further specify requirements for the provision of HRSN services and will be expected to provide additional details not captured in the STCs regarding implementation of demonstration policies that are outlined in the STCs.*

5.1 Purpose and Overview

The set of readiness criteria for Kentucky's RC Pilot Program is intended to ensure RC Pilot Program Providers are fully prepared to launch and sustain implementation of the short-term pre-procedure housing and short-term post-transition housing services as outlined in the State's approved Attachment K: HRSN Services Protocol and STCs. RC Pilot Program Provider materials establish a baseline standard for enrolling and maintaining RC Pilot Program Providers as a new Medicaid provider type.

The criteria reflect Kentucky's dual priorities: 1) safeguarding beneficiary health and safety in recovery settings; and 2) ensuring compliance with federal and state Medicaid requirements. They also provide a structured framework to help providers identify gaps and prepare for successful participation in the pilots.

5.2 Minimum Readiness Criteria for Recuperative Care Providers

At a minimum, RC Pilot Program Providers must demonstrate the following capabilities before pilot implementation:

- **Ability to deliver RC services** in full compliance with Kentucky's HRSN Services Protocol, including provision of short-term pre-procedure housing and short-term post-transition housing within the global six-month service cap per rolling year as defined in the STCs.
- **Ability to perform medical necessity and eligibility assessments**, including intake screening, nursing assessment within 24 hours, and daily wellness checks documented in the beneficiary's care plan.
- **Ability to develop and maintain person-centered service plans,** that are culturally responsive, trauma-informed, and developed in consultation with the beneficiary. Plans must document medical appropriateness as required in STCs.
- **Ability to provide required facility supports**, including private or semi-private recovery space, three meals daily, secure double-locked medication storage, care coordination, and transportation to medical appointments.
- **Ability to securely exchange data** required to support beneficiary access to social supports which may include integrate with KHIE and kynect systems.
- **Ability to contract with Medicaid and all Kentucky MCO's**, as to not limit access to any Medicaid beneficiary who may qualify for the service. Must meet all provider enrollment qualifications and obtain Medicaid ID number and keep up-to-date and accurate

records with all parties. Must also provide requested documentation to ensure quality and prevent fraud, waste, and abuse.

- **Ability to coordinate care with MCOs**, including weekly review of care plans, referrals to behavioral health and primary care providers, and discharge planning for long-term stability.
- **Ability to provide and report data**, including encounter data, utilization metrics, and quality outcomes as specified in the STCs.
- **Ability to maintain staffing standards**, including 24/7 staffing, RN-led assessments. All staff (clinical and non-clinical) trained in cardiopulmonary resuscitation (CPR), emergency procedures, emergency response, and de-escalation; professional boundaries, ethics, and confidentiality; naloxone administration; and overdose response. Clinical staff additionally trained in Housing First or Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.
- **Ability to comply with program integrity and oversight requirements**, including certification as a RC Pilot Program Provider (as available), listing in the National Institute for Medical Respite Care (NIMRC) directory, and adherence to NIMRC standards of care.
- **Ability to support beneficiary dignity and independence**, ensuring accommodations for ADLs, mobility, privacy, and engagement in recovery activities.
- **Ability to demonstrate Medicaid billing readiness**, including encounter data submission, compliance with claims processing, and financial solvency to support operations.
- **Ability to implement and maintain beneficiary grievance and feedback mechanisms**, ensuring beneficiaries have safe and accessible channels to raise concerns.
- **Ability to provide language access services**, including translation, interpretation, and accessible materials, and ensure cultural competence across staff training and service delivery.
- **Ability to demonstrate readiness for emergency response and safety protocols**, including behavioral health emergency management, medical transfer agreements, and facility safety procedures; naloxone administration; de-escalation strategies; CPR, emergency procedures, emergency response and de-escalation; boundaries, ethics, and confidentiality; naloxone administration and overdose response; clinical staff trained in: Housing First or Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

5.3 State Oversight and Provider Support

DMS intends to implement a robust monitoring and oversight strategy to track provider readiness and performance throughout the RC Pilot Program. This may include:

- Regular review of provider reports and encounter data to verify accuracy, completeness, and compliance with STCs.

- Structured communication channels with providers, including scheduled readiness check-ins, feedback loops, and TA.
- Ongoing evaluation of provider challenges in meeting RC standards, with responsive support from the State to address gaps in infrastructure, staffing, or data integration.
- Coordination with MCOs to ensure beneficiary access, continuity of care, and accountability for outcomes.

Kentucky anticipates that providers may face challenges as they adapt to the RC Pilot Program model. DMS will work in tandem with providers and MCOs to troubleshoot implementation issues, share best practices, and refine processes. This collaborative approach hopes to ensure the pilot programs meet the dual goals of improving health outcomes for vulnerable populations and fulfilling federal accountability requirements under the TEAMKY 1115 Demonstration. Kentucky intends to leverage other states recuperative care/medical respite care pilot programs (such as California and Washington) insights, tools, kits, and lessons learned to help with implementing these services as a part of the demonstration and continues to explore ways to improve planning practices throughout each stage of the RC pilot program demonstration.

Key Strategies, Activities, and Implementation Timeline for Milestone 5

Strategy Area	Key Strategies and Activities	Implementation Timeline
Readiness Assessment Criteria and Tools	Utilize Readiness Criteria to ensure providers have the ability to deliver RC Pilot Program services in full compliance with HRSN Services Protocol (Attachment K), including intake assessments, nursing evaluations within 24 hours, daily wellness checks, and person-centered service plans. KY intends to use readiness criteria, tools, communication plan, and kits for providers to have a understanding of the requirements being asked of them.	Q1-Q2 2026 (verification prior to enrollment as a RC Pilot Provider)
Service Delivery Readiness	Utilize Readiness Criteria to ensure providers have the ability to deliver RC Pilot Program services in full compliance with HRSN Services Protocol (Attachment K). Provider the RC Pilot Program with a letter stating readiness criteria has been met before enrolling as a Medicaid Provider Type for RC.	Q1-Q2 2026 (verification prior to enrollment as a RC Pilot Provider)
Facility Standards	Prior to the NIMRC certification process, DMS staff, or designated persons will be responsible for verifying that providers meet facilityprogram requirements including the specifications and exclusions as listed in the approved STC's and previously mentioned attachments. Providers must also self-attest to uphold the standards of medical respite care as set forth by the National Institute for Medical Respite Care.	Q1-Q2 2026 (verification prior to enrollment as a RC Pilot Provider)

Data and Systems Integration	May require providers to complete test submissions demonstrating ability to document service provisions as previously described and to be outlined in provider guides, which may include KHIE and kynect integration, referral closure, and encounter data submission prior to launch, to be specified in provider materials.	Q1-Q2 2026
Care Coordination	Ensure providers establish review processes with MCOs, referral pathways to behavioral health and primary care, and discharge planning for long-term stability.	Q2 2026; ongoing
Staffing Standards	Validate staffing, 24/7 coverage, RN-led assessments, and comprehensive staff training.	Q1-Q2 2026 (verification prior to enrollment as a RC Pilot Provider)
Emergency and Safety Preparedness	Require providers to maintain emergency management protocols, emergency medical transfer agreements, and facility safety plans.	Q1-Q2 2026 (pre-certification)
Financial and Administrative Readiness	Assess Medicaid billing capability, encounter data readiness, and provider financial solvency to ensure sustainable operations.	Q1-Q2 2026
Beneficiary Experience and Dignity	Establish beneficiary grievance and feedback processes, privacy protections, and accommodations for ADLs, mobility, and engagement in recovery activities.	Q1 2026; ongoing
Provider Onboarding, State Oversight, and TA	Implement DMS oversight through readiness assessment and check-ins, data monitoring, and structured feedback loops. Provide onboarding activities and communications, including TA to providers facing infrastructure, staffing, or integration challenges.	Q1 2026; ongoing

TEAMKY
Health-Related Social Needs (HRSN)
Maintenance of Effort (MOE)

As required by the TEAMKY Section 1115(a) Demonstration — Special Terms and Conditions (STCs) 37, Maintenance of Effort (MOE). Kentucky is submitting a plan to the Centers for Medicare & Medicaid Services (CMS) that specifies how the state will determine baseline spending on these services throughout the state. According to STC 37, Kentucky must maintain a baseline level of state funding for Recuperative Care HRSN services to ensure that federal funds supplement, rather than replace, existing state investments. This baseline excludes one-time or non-recurring funding. Kentucky has developed a plan to determine baseline spending, allowing for continuous monitoring and annual MOE reporting as part of the Annual Monitoring Report outlined in STC 58.

Identifying Relevant Kentucky State-Funded Recuperative Care HRSN Programs

Recuperative care services, also known as medical respite care, provide short-term medical and social support for individuals who are experiencing or at risk of homelessness following hospital discharge. To implement this, Kentucky will conduct an inventory of existing housing transition supports that include short-term pre-procedure and post-hospitalization medical respite services, temporary housing with medical oversight, coordination with primary care, and behavioral health supports. It will identify emergency shelters or transitional care programs operating in Kentucky and categorize those receiving state funding under Recuperative care HRSN. Programs relying on one-time or temporary funding sources, such as grants or pilot programs, will be excluded.

Establishment of a Baseline Funding Level

To establish a baseline funding level, Kentucky will analyze historical state expenditures on housing HRSN-related services over a five-year period, if available. As Recuperative care does not currently exist in the state Medicaid program, historical expenditure analysis will focus on housing transition supports offered across the state. The analysis will determine the extent of state funding in each program and measure year-over-year hospital trends, as the demand for housing supports may fluctuate seasonally. Baseline calculations will include per-patient costs associated with medical oversight, housing expenses, inflation adjustments, and changes in service utilization. A fixed baseline funding amount will be established and maintained throughout the demonstration period, ensuring transparency in funding trends and allocations.

***See below detailed plan for analysis of historical state expenditures on recuperative care HRSN Services.**

Historical Expenditures on Housing

Kentucky has defined the scope of its recuperative care and health-related social needs (HRSN) services, including housing transition supports. As part of this effort, the state identified local and state organizations that currently deliver similar services across Kentucky to help determine a baseline funding level for these activities.

Based on this assessment, the total amount of state funds allocated to housing and housing-related supports is $7,224,575.

***See attached worksheet for the analysis of historical state expenditures on housing and related housing expenditures.**

Development of a Formal MOE Plan

To solidify its commitment, Kentucky will develop a formal MOE plan, emphasizing recuperative care as a cost-saving measure that reduces hospital length of stay, reduces emergency department (ED) admissions, and prevents unnecessary hospital readmissions. The plan will specify MOE requirements for both medical and social services, including clinical assessments, care coordination, medication management, and on-site behavioral health services. It will align with hospital medical care policies, ensure uninterrupted funding, and detail mechanisms to maintain funding stability across state budget cycles.

Integration of MOE into Kentucky's Budgeting Processes

Integrating MOE into Kentucky's budgeting process will require alignment with the state's annual and biennial budget processes. Medicaid managed care organizations (MCOs) will be required to allocate dedicated funds for recuperative care stays without reductions due to federal funding. A braided funding model may incorporate state Medicaid dollars, hospital partnerships, and local health department contributions. Kentucky Department of Medicaid Services (DMS) will request that recuperative care HRSN expenditures are designated as a separate line item in the state budget for traceability.

Implementation of Tracking and Reporting Systems

Tracking and reporting systems will be developed to monitor spending against MOE requirements. Financial reporting mechanisms will be implemented to track expenditures, while service utilization metrics — such as reduced ED admissions, reduced hospital readmission rates, reduced length of stays, and increased post-discharge health outcomes — will measure effectiveness. Kentucky's Cabinet for Health and Family Services (CHFS) agencies and MCOs will be required to report quarterly or annually on Recuperative care HRSN-related expenditures. Performance audits will assess quality outcomes, cost-effectiveness, and compliance with MOE requirements, while an internal compliance monitoring system will identify any potential reductions in state funding.

Submission of Annual MOE Reports to CMS

As required per STC 58, Kentucky will submit an annual report to CMS that will include a breakdown of expenditures and utilization reviews detailing the number of Medicaid beneficiaries accessing Recuperative care services. The data will include Recuperative care-specific quality data related to reduced ED admissions, reduced hospital readmission rates, reduced length of stay, and increased post-discharge health outcomes. Additionally, it will include a comparison of baseline funding before and after the demonstration period. If

fluctuations in funding occur — such as increased hospital referrals — Kentucky will explain their impact on MOE compliance and outline corrective measures.

Adjustment of Funding Strategies as Needed

If Kentucky's spending falls below the required MOE level, the state will adjust its budget to restore funding to the baseline. Adjustments may be based on hospital discharge trends and patient length-of-stay data. In the event of increased demand, the state will explore alternative funding sources, including hospital-provider partnerships. Should CMS modify the demonstration requirements, the MOE funding calculations will be adapted accordingly to sustain service delivery.

Analysis of Historical State Expenditures on Recuperative Care HRSN Services Over a Multi-Year Period (3-5 Years)*

Scope of Recuperative Care HRSN Services

Kentucky will conduct a historical expenditure analysis of Recuperative care HRSN services over a five-year period, if available, to establish a reliable funding baseline. The first step is to define the scope of Recuperative care HRSN services by identifying all state-funded programs that provide these services. The services include Short-Term Pre-Procedure Housing for individuals requiring preparatory support before a procedure, and Short-Term Post-Transition Housing, which provides rehabilitative services after hospitalization without requiring 24/7 ongoing clinical monitoring. Non-recurring funding sources, such as pandemic relief funds and temporary pilot programs, will be excluded. Programs will be assessed to determine whether they are fully state-funded or receive federal or local matching contributions.

Collect Financial Data from Relevant Sources

Financial data will be collected from multiple sources, including Kentucky Medicaid budget reports, legislative appropriations data, MCO spending reports, hospital discharge and referral data, county and state health department reports, and social services funding records. Each dataset will include annual expenditure amounts, breakdowns by service type, and the number of Medicaid beneficiaries served per year.

The primary sources include:

- Kentucky Medicaid budget and financial reports (Medicaid agency reports on direct Recuperative care funding).
- Legislative appropriations data (Kentucky budget office allocations for Recuperative care services, if applicable).
- MCO spending reports (if Recuperative care is reimbursed via Medicaid managed care).
- Hospital discharge and referral data (tracks Medicaid beneficiaries referred to Recuperative care facilities).
- County and state health department reports (state-supported Recuperative Care initiatives and housing programs).
- Social Services funding records (direct state-funded transitional housing linked with medical respite care).

Each dataset will provide:

- Annual expenditure amounts for Recuperative care HRSN services.
- Breakdown by service type (e.g., respite housing, case management, medical coordination, and transportation).
- Number of Medicaid beneficiaries served per year.

Standardize Data for Consistency

To ensure consistency, expenditures will be standardized by adjusting for inflation using the Consumer Price Index or a similar factor. Accounting methods will be standardized across different reporting years, and services will be classified under uniform categories such as Short-Term Pre-Transition Housing and Short-Term Post-Transition Housing. Any data gaps will be addressed through interpolation techniques where necessary.

Calculate Multi-Year Averages and Trends

Using five years, if available, of historical data, annual expenditure trends will be analyzed to identify increases or reductions in spending. The baseline funding level will be calculated as the average annual expenditure over the period with weighted adjustments for service expansions. Seasonal and policy-driven variations will also be considered, such as Medicaid expansion or temporary emergency funding injections, which should not be included in the baseline.

Table 1: Computation of Analysis

A. Determine Annual Expenditure Trends	Compute year-over-year growth rates in spending: **Growth Rate = (Expenditure $_{\text{Year X}}$ – Expenditure $_{\text{Year(X-1)}}$) x 100** **Expenditure $_{\text{Year(X-1)}}$** Identify any increases or reductions in spending within specific Recuperative care categories as an outcome.
B. Calculate the Baseline Funding Level	Compute the average annual expenditure as follows: **Baseline MOE = Total Spending Over Last X Years** **X** If service expansions occurred, use a weighted average to account for policy-driven increases.
C. Identify Seasonal or Policy-Driven Variations	Check for policy changes (e.g., Medicaid expansion covering more Recuperative care services) that may have temporarily increased spending. Account for emergency funding injections (e.g., COVID-19 federal funding for respite care) that should *not* be included in the baseline calculation.

Validate the Baseline with Stakeholders

Stakeholder validation will be conducted by sharing findings with CHFS leadership, Medicaid finance teams, hospital associations, and Recuperative care providers to ensure data accuracy. Results will be compared with federal and state funding projections for cross-verification. Any known policy shifts — such as new Medicaid-covered Recuperative care initiatives or legislative budget amendments — will be factored into the final analysis.

Finalize and Document the Baseline Funding

Finally, Kentucky will finalize and document the baseline funding level through a formal expenditure report, which will include historical spending trends, service inclusion/exclusion justifications, and projected funding needs for the Medicaid demonstration period. This report

will be submitted to CMS, ensuring that Medicaid-funded Recuperative care services remain financially sustainable, that federal funds supplement rather than replace state investments, and that budgeting and reporting align with CMS expectations.

By implementing this structured approach, Kentucky ensures that MOE compliance is maintained, state investments in Recuperative care remain intact, and long-term financial planning supports the sustainability of Medicaid HRSN Recuperative care initiatives.

Agency/Department Name	Program Area	Budget Code	Program Description	Total Program budget	One-time costs (Infrastructure/ costs not ongoing/etc.)	Amount proposed for MOE tracking-go forward amount	Explanation for the amount proposed to be included in the MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	KY Housing Corporation - Housing Inspection for Priority Populations	$60,000.00	$0.00	$60,000.00	
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	WellSprings Inc - Supportive Housing	$1,045,000.00	$0.00	$1,045,000.00	State generated funds that pay for Supportive Housing Services
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	Seven Counties - Community Based Housing	$75,000.00	$0.00	$75,000.00	State generated funds that pay for Community based housing
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	Homeless Prevention Project	$96,500.00		$96,500.00	State generated funds that pay for Homeless Prevention
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	KY River Community Care - Housing Support	$1,561,000.00	$0.00	$1,561,000.00	Included in the BHDID Mental Health Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	New Beginnings Bluegrass - Supportive Housing Services	$1,565,000.00	$0.00	$1,565,000.00	Included in the BHDID Mental Health Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	University of KY - CKRC Management and Operations - Personal care homes - Transitional Living Services	$762,000.00	$0.00	$762,000.00	Included in the BHDID Mental Health Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	Olmstead Wraparound	$800,000.00		$800,000.00	Included in the BHDID Mental Health Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Substance Use Disorder	729N - Substance Use Disorder	KY Housing Corporation - Housing Inspection for Priority Populations	$6,500.00	$0.00	$6,500.00	Included in the BHDID SUD Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Substance Use Disorder	729N - Substance Use Disorder	The Healing Place - Emergency Shelter	$900,000.00	$0.00	$900,000.00	Included in the BHDID SUD Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Substance Use Disorder	729N - Substance Use Disorder	PennyRoyal Reg MH MR BD - Genesis Residential Program	$100,000.00	$0.00	$100,000.00	Included in the BHDID SUD Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Substance Use Disorder	729N - Substance Use Disorder	Oxford House - Substance Use Recovery Housing	$253,575.00	$0.00	$253,575.00	Included in the BHDID SUD Block Grant MOE
Louisville Continuum of Care		State grant funds	The fund is primarily used for matching funds for federal housing programs and homeless prevention aid	$550,000.00	$550,000.00	$0.00	Excluded-One time
Department of Corrections		Appropriation: Transitional and Reentry Housing	Substance use treatment and early intervention services that includes transitional residence and outpatient services	$11,608,550.00	$11,608,550.00	$0.00	Excluded - One-time
Department of Corrections		Appropriation: Transitional Housing Grants	Provide grants to nonprofit organizations that support individuals who are incarcerated by helping perpare them for release and transition back into the community.	$11,608,550.00	$11,608,550.00	$0.00	Excluded - One-time
			Total	**$30,991,675.00**	**$23,767,100.00**	**$7,224,575.00**	

Agency/Department Name	Program Area	Budget Code	Program Description	Total Program budget	One-time costs	Amount	Explanation for the amount
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	KY Housing Corporation - Housing Inspection for Priority Populations	$ 60,000	$ -	$ 60,000	
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	WellSprings Inc - Supportive Housing	$ 1,045,000.0	$ -	$ 1,045,000.0	State generated funds that pay for Supportive Housing Services
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	Seven Counties - Community Based Housing	$ 75,000.0	$ -	$ 75,000.0	State generated funds that pay for Community based housing
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	Homeless Prevention Project	$ 96,500.0		$ 96,500.0	State generated funds that pay for Homeless Prevention
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	KY River Community Care - Housing Support	$ 1,561,000.0	$ -	$ 1,561,000.0	Included in the BHDID Mental Health Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	New Beginnings Bluegrass - Supportive Housing Services	$ 1,565,000.0	$ -	$ 1,565,000.0	Included in the BHDID Mental Health Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	University of KY - CKRC Management and Operations - Personal care homes - Transitional Living Services	$ 762,000.0	$ -	$ 762,000.0	Included in the BHDID Mental Health Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Mental Health	729P - Mental Health	Olmstead Wraparound	$ 800,000.0		$ 800,000.0	Included in the BHDID Mental Health Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Substance Use Disorder	729N - Substance Use Disorder	KY Housing Corporation - Housing Inspection for Priority Populations	$ 6,500.0	$ -	$ 6,500.0	Included in the BHDID SUD Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Substance Use Disorder	729N - Substance Use Disorder	The Healing Place - Emergency Shelter	$ 900,000.0	$ -	$ 900,000.0	Included in the BHDID SUD Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Substance Use Disorder	729N - Substance Use Disorder	PennyRoyal Reg MH MR BD - Genesis Residential Program	$ 100,000.0	$ -	$ 100,000.0	Included in the BHDID SUD Block Grant MOE
729T-Department for Behavioral Health and Intellectual Disabilities	Substance Use Disorder	729N - Substance Use Disorder	Oxford House - Substance Use Recovery Housing	$ 253,575.0	$ -	$ 253,575.0	Included in the BHDID SUD Block Grant MOE
Louisville Continuum of Care		State grant funds	The fund is primarily used for matching funds for federal housing programs and homeless prevention aid	$ 550,000.0	$ 550,000.0		Excluded-One time
Department of Corrections		Appropriation: Transitional and Reentry Housing	Substance use treatment and early intervention services that includes transitional residence and outpatient services	$ 11,608,550.0	$ 11,608,550.0	$ -	Excluded - One-time
Department of Corrections		Appropriation: Transitional	Provide grants to nonprofit organizations that	$ 11,608,550.0	$ 11,608,550.0	$ -	Excluded - One-time
			Total	**$ 30,991,675.0**	**$ 23,767,100.0**	**$ 7,224,575.0**	