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

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Section I - Program Description

Executive Summary

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

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

On September 30, 2022, Kentucky requested to extend the KY HEALTH demonstration for a five-year period. This request is still pending Centers for Medicare and Medicaid Services (CMS) approval; however, there are two new components that require amendment to the demonstration. Specifically, the Commonwealth is requesting authority to: (1) reimburse medically necessary short-term, defined as a state-wide average length of stay of 30 days, inpatient treatment services within settings that qualify as institutions for mental diseases (IMDs) for Medicaid-eligible adults with serious mental illness (SMI); (2) implement a pilot program, specifically recuperative care services, also known as medical respite services, to adult beneficiaries who are homeless or at risk of homelessness, and need additional medical support and care coordination which will also address Health Related Social Needs (HRSN).

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

treatment and poor outcomes for individuals with SMI, particularly in care coordination. DMS is optimistic that providing these additional acute services, individuals with SMI will receive improved and more consistent care resulting in diversion from emergency departments and hospital inpatient stays, while improving health outcomes.

Legislative Background

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

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

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

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

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

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

Caring for the SMI population is of great importance and priority to the state of Kentucky. This is evidenced by the work of many ongoing statewide initiatives, collaborations, committees, and organizations in addition to the services offered through Medicaid State Plan.

Department for Medicaid Services Behavioral Health Services Overview

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

Department for Medicaid Services Initiatives

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

Mobile Crisis Intervention Services Implementation

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

Certified Community Behavioral Health Clinic (CCBHC) Demonstration

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

Kentucky has opened four regional CCBHC's and is in the implementation phase of the demonstration which began on 1/1/2022. The four participating CCBHC's must provide a comprehensive range of behavioral health services to vulnerable individuals, like individuals with SMI, to: increase access to services, stabilize people in crisis, and provide the necessary treatment for those with the most serious, complex mental illnesses and substance use disorders. CCBHC's are available to any individual in need

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

of care, including (but not limited to) people with SMI, SED, long-term chronic addiction, mild or moderate mental illness and substance use disorders, and complex health profiles. CCBHC's will provide care regardless of ability to pay or place of residence, provide care for those who are on Medicaid, underserved, homeless, have low incomes, or are insured/uninsured.

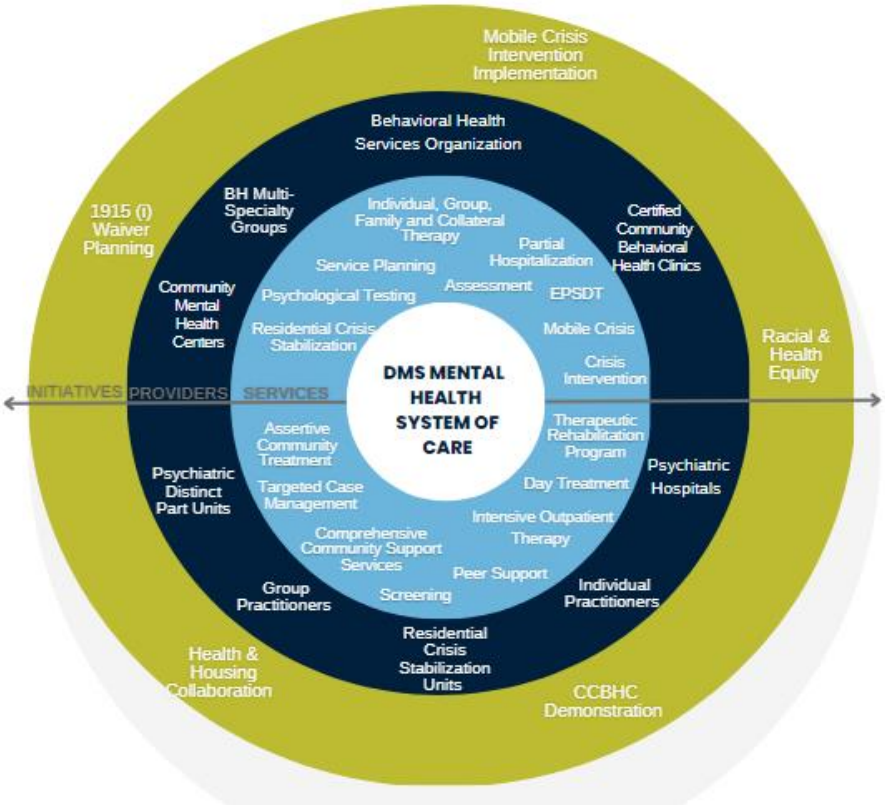
Racial Equity Action Plan

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

Image 1: Behavioral Health Continuum and Initiatives

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

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



Additional State Services and Initiatives

Department for Behavioral Health and Developmental Intellectual Disabilities Initiatives

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

DBHDID Prevention and Early Intervention Initiative

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

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

DBHDID SMI Treatment Initiatives

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

Projects for Assistance in Transition from Homelessness (PATH)

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

SSI/SSDI Outreach Access Recovery (SOAR)

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

Second Amended Settlement Agreement

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

In State Housing Collaborations

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

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

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

Recuperative Care Services in Kentucky

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

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

Objective and Rationale

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

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

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

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

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

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

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

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

[13] U.S. Dept. of Health & Human Services, Healthy People 2023 https://health.gov/healthypeople.

[14] https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf

[15] HUD 2022 Annual Homeless Assessment Report Finds Unsheltered Homelessness on the Rise | National Low Income Housing Coalition (nlihc.org)

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

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

Requested Waivers

Introduction

Kentucky is requesting authority from CMS to expand services that will benefit high need individuals and individuals with SMI. Specifically, the Commonwealth is requesting authority to: (1) reimburse medically necessary short-term, defined as a state-wide average length of stay of 30 days, inpatient treatment services within settings that qualify as institutions for mental diseases (IMDs) for Medicaid-eligible adults with serious mental illness; (2) implement a pilot program, specifically recuperative care services, also known as medical respite services, to adult beneficiaries who are homeless or at risk of homelessness, and need additional medical support and care coordination which will also address Health Related Social Needs. Currently, neither of these services are reimbursable by Medicaid in Kentucky.

Demonstration Goals and Objectives

Kentucky proposes the following preliminary evaluation plan, which has been developed in alignment with the CMS evaluation design guidance for SMI 1115 demonstrations. The State will contract with an independent evaluator to conduct this review. The State's goals are aligned with those of CMS for this waiver opportunity as indicated in SMD #18--011[16]. Kentucky is committed to meeting the milestones outlined by CMS through this demonstration and to engage in regular reporting on progress towards meeting these milestones. The specific component preliminary goals and hypotheses will be outlined below within each respective service description.

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

Institution for Mental Disorders (IMD) Extension

Currently, Kentucky covers up to 15 days for inpatient mental health treatment in IMDs through In Lieu of Services (ILOS). Through this amendment, Kentucky is requesting to reimburse medically necessary short-term, defined as a state-wide average length of stay of 30 days, inpatient treatment services within settings that qualify as institutions for mental diseases (IMDs) for Medicaid-eligible adults with serious mental illness. Kentucky plans on implementing the increase in length of stay in IMDs for mental health treatment immediately following CMS approval of the application and implementation plan for this amendment.

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

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

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

Recuperative Care Pilot Program Description

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

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

1. are homeless, or at risk of homelessness who meet criteria based upon definitions in 24 CFR 91.5[18] , and
2. are at risk of hospitalization and/or readmission with a medical need
    - Following discharge from acute care facility or Emergency Department OR
    - Have a planned medical procedure requiring preparation care OR
    - Have a planned medical treatment (i.e.: chemotherapy treatment) requiring care prior to or following the treatment AND
3. Must have a primary medical Diagnosis

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

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

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

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

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

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

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

Potential Measures	Total expenditures and per member per month cost of services.
Data Source	Claims data

Section II - Demonstration Eligibility

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

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

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

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

3. Must have a primary medical Diagnosis

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

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

Table 4: Eligibility Groups

Eligibility Groups	Social Security Act and CFR Citations	2023 Federal Poverty Limit
Qualified Medicare Beneficiaries	1902(a)(10)(E)(i) 1905(p)	100% FPL
Specified Low Income Medicare Beneficiaries	1902(a)(10)(E)(iii) 1905(p)(3)(A)(ii)	120% FPL
Qualifying Individuals	1902(a)(10)(E)(iv) 1905(p)(3)(A)(ii)	135% FPL
Qualified Disabled and Working Individuals	1902(a)(10)(E)(ii) 1905(s) 1905(p)(3)(A)(i)	200% FPL
Mandatory Poverty Level Related Infants	1902(a)(10)(A)(i)(IV) 1902(l)(1)(B)	200% FPL
Mandatory Poverty Level Related Children aged 1-5	1902(a)(10)(A)(i)(VI) 1902(l)(1)(C)	147% FPL
Mandatory Poverty Level Related Children aged 6-18	1902(a)(10)(A)(i)(VII) 1902(l)(1)(D)	147% FPL
Deemed Eligible Newborns	1902(e)(4) 42 CFR 435.117	-NA-
Institutionalized Individuals Continuously Eligible Since 1973	42 CFR 435.132	-NA-
Limited Services Available to Certain Aliens	42 CFR §435.139	-NA-
Individuals Receiving Home and Community Based Services under Institutional Rules	42 CFR 435.217 1902(a)(10)(A)(ii)(VI)	-NA-
Individuals Participating in a PACE Program under Institutional Rules	1934	-NA-
Institutionalized Individuals Eligible under a Special Income Level	42 CFR 435.236 1902(a)(10)(A)(ii)(V) 1905(a)	Subject to Special Income Standard
Medically Needy Children under 18	1902(a)(10)(C)(ii)(I) 42 CFR 435.301(b)(1)(ii)	-NA-

Projected Medicaid Enrollment

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

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

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

Section III - Demonstration Benefits and Cost Sharing Requirements

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

Section IV - Delivery System and Payment Rates for Services

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

Section V - Implementation of Demonstration

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

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

In accordance with SMDL #18--011 an implementation plan and evaluation design will be developed by DMS, with technical assistance from CMS, to be finalized within 90 days and 180 days of approval of the demonstration respectively.

Section VI - Demonstration Financing and Budget Neutrality

Budget Neutrality Impact:

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

CHIP Allotment:

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

Maintenance of Effort:

In accordance with SMD #18--011, the state understands this waiver request is subject to a maintenance of effort (MOE) requirement to ensure the authority for more flexible inpatient treatment does not reduce the availability of outpatient treatment for these conditions. As demonstrated in **Section I,** *Overview of Kentucky Efforts to Improve Continuum of Care for the SMI Population*, the Commonwealth has many outpatient services, provider types, and initiatives to serve the SMI population which will continue to be available to beneficiaries despite increasing access to inpatient treatment services through this demonstration.

Section VII - List of Proposed Waiver and Expenditure Authorities

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

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

Section VIII - Tribal Notice & Public Notice

Public Notice and Tribal Notice:

In accordance with 42 CFR 431.408, the public had an opportunity to comment on this waiver amendment through a public notice and comment period that ran from April 3, 2023, through May 5, 2023. The public notice and all waiver documents were posted on the DMS Behavioral Health Initiative (BHI) website and made available for review at the DMS office. The official public notice can be found in **Appendix B.** DMS sent email notification regarding the amendment to stakeholder groups individually and via listservs. More detailed information about communications can be seen in **Appendix C**. The state held three public hearings virtually through Microsoft Teams meetings on April 12, 2023, 3:00 EST, April 19, 2023, 10:00 EST, and April 26, 2023, 12:00 EST. An overview description of the waiver amendment as well as specific information about the proposed components of the waiver were shared with attendees during these public

forums. DMS utilized the waiver application preprint for new demonstrations to develop the presentation that was utilized. Statewide accessibility was assured through telephone and web conference capabilities at all three forums. Information about how to make a public comment was shared both in writing via chat and presented orally during the forums to attendees. More information about each public forum, including the link to the forum recordings, can be found in **Appendix D**.

Tribal Notice:

Kentucky has no tribal units.

Public Comments to the State and State Responses:

Prior to submitting KY's Section 1115 Amendment request to CMS, DMS followed all guidelines and procedures according to 42 CFR § 431.408 regarding collection, review of and response to public comments. DMS received 10 public comments via email during the public comment period and zero comments via ground mail. Each comment was considered and DMS responded to each comment individually. All comments and responses and whether they were included in the final application are captured in **Appendix E.**

Section IV- Demonstration Administration

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

Appendix A: Demonstration Financing and Budget Neutrality

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

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

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

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

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

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

Trend Factor and Projection

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

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

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

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

Trend Factor and Projection

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

Demonstration Population 3: Recuperative Care Population

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

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

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

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

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

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

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

Trends Factor and Projection

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

Calculation of Reimbursement Rate

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

Budget Neutrality and Fiscal Summary

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

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

WW and WOW Demonstration Years					
	DY1	DY2	DY3	DY4	DY5
MH IMD MC					
Eligible Member Months	4,780	4,828	4,877	4,925	4,975
PMPM Cost	$1,691.98	$1,795.19	$1,904.70	$2,020.89	$2,144.16
Expenditures Subtotal	*$8,087,664*	*$8,667,177*	*$9,289,222*	*$9,952,883*	*$10,667,196*
MH IMD FFS					
Eligible Member Months	207	209	211	213	215
PMPM Cost	$21,120.24	$22,408.57	$23,775.49	$25,225.79	$26,764.56
Expenditures Subtotal	*$4,371,890*	*$4,683,391*	*$5,016,628*	*$5,373,093*	*$5,754,380*
MH IMD Total Expenditures	*$12,459,554*	*$13,350,568*	*$14,305,850*	*$15,325,976*	*$16,421,576*
Recuperative Care					
Eligible Member Months	1,248	1,260	1,273	1,285	1,298
PMPM Cost	$2,155.74	$2,287.24	$2,426.76	$2,574.79	$2,731.85
Recuperative Care Subtotal	*$2,690,364*	*$2,881,922*	*$3,089,265*	*$3,308,605*	*$3,545,941*

[1] Note, the Commonwealth is currently authorized to receive FFP for expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet

the definition of an institution for mental disease (IMD) (Project Nos. 11-W-00306/4 and 21-W-00067/4). In this context, “short-term” is defined as a statewide average length of stay (ALOS) of thirty (30) days.

Appendix B: Official Public Notice

KENTUCKY DEPARTMENT FOR MEDICAID SERVICES
PUBLIC NOTICE

1115 Waiver Amendment Application: Improving Health Outcomes for Individuals with Serious Mental Illness and Health Related Social Needs

In accordance with 42 CFR 431.408, the Cabinet for Health and Family Services (CHFS), Department for Medicaid Services (DMS) announces its intention to file an 1115 Amendment Application with the Centers for Medicare and Medicaid Services (CMS). DMS is requesting an amendment to the Commonwealth's Section 1115(a) Demonstration, entitled "Kentucky Helping to Engage and Achieve Long Term Health" (KY HEALTH) (Project Nos. 11-W-00306/4 and 21-W00067/4) and requesting Medicaid coverage to (1) reimburse medically necessary short-term, defined as a state-wide average length of stay no longer than 30 days, inpatient treatment services within settings that qualify as institutions for mental diseases (IMDs) for Medicaid-eligible adults with serious mental illness; (2) implement a pilot program to provide Health-Related Social Needs (HRSN) services, specifically recuperative care services, also known as medical respite care, to adult beneficiaries, who are homeless or at risk of homelessness, and who need additional medical support and care coordination.

Public Comments
Copies of this notice are available on the DMS BHI Website
In addition, DMS will hold 3 Virtual Town hall Meetings on the following dates:
April 12, 2023, 3:00 EST
April 19, 2023, 10:00 EST
April 26, 2023, 12:00 EST

Join by Microsoft Teams Meeting: Click here to join the meeting
Meeting ID: 279 612 657 461
Passcode: 6wTdNE
Join by Phone:
502-632-6289
Phone Conference ID: 791 546 355#

Comments or inquiries should be submitted via email received on or before May 5, 2023, to: DMS.Issues@ky.gov .
Written comments must be mailed to the address below and postmarked by May 5, 2023.
A copy of this notice is available for public review at the Department for Medicaid Services at the address listed below:

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

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

Appendix C: Public Notice Communications

The following email was sent from the DMS BHI Team to each constituent listed in the chart below:

“To Whom It May Concern:

The Kentucky Department of Medicaid Services (DMS) announces its intention to file an 1115 Waiver amendment entitled “Improving Health Outcomes for Individuals with Serious Mental Illness and Health Related Social Needs”. This waiver amendment application will be filed under the current 1115 Demonstration “Kentucky Helping to Engage and Achieve Long Term Health (KY HEALTH)”. You can find the public notice outlining the public comment parameters for this application as well as the current draft of the waiver amendment application on the DMS website at the address below:

KY 1115 Amendment Public Notice

Contact	Method	Date
General Public	DMS Website Posting	4/3/23
Department for Behavioral Health Developmental and Intellectual Disabilities (DBHDID)	Email DBHDID leadership team	4/3/23
Community Mental Health Centers (CMHCs)	Email to Steve Shannon & Bart Baldwin	4/3/23
KY Advocacy	Email to Sheila Schuster	4/3/23
NAMI Representative	Email to Kelly Gunning	4/10/23
MAC and TACS	Email to Kelly Sheets and Erin Bickers	4/10/23
DMS Commissioner’s Office	Email to Executive Team	4/3/23
Behavioral Health Initiative Team in DMS	Email sent to team	4/3/23
Managed Care Organizations Behavioral Health Directors	Email to all 6 regulatory boxes, individual directors, and Jeremy DeRossit	4/3/23 and 4/10/23
DMS Social Media Platforms	Posted 4/3 via Beth Fisher	4/3/23
Recuperative Care Providers	Emails to Danielle Amrine, Brian VanArsdale, Rachel Spetz, Rhondell Miller, Jamie Cody, Tom Walton	4/3/23

Kentucky Housing Corporation	Emails to Margaret Smith, Kenzie Strubank, Curtis Stauffer	4/3/23
Individual Placement and Supports	Email to Lori Norton	4/3/23
Center for Supportive Housing	Email to Katie Kitchin and Marcella McGuire	4/3/23
Department for Aging and Independent Living	Email to Victoria Eldridge	4/3/23
Office of Inspector General	Email to Adam Mathers, Stephanie Bramer-Barnes, and Cara Daniel	4/10/23
DMS Division of Long-Term Services and Supports	Email to Pam Smith	4/3/23
Office of Vocational Rehabilitation	Email to Ronnie O'Hare	4/3/23
Money Follows the Person	Email to Sharon Wheatley	4/10/23
Kentucky Hospital Association	Email to Nancy Galvagni	4/10/23
Children's Alliance	Email to Michelle Sanborne and Kathy Adams	4/10/23

Appendix D: Public Forum Summary and Presentations

To view the recordings and the power point presentation from the three public forums, click on the link below:

https://www.chfs.ky.gov/agencies/dms/Pages/bhi.aspx

The chart below summarizes each public form and the attendees.

Table : Public Forum Summaries	
Title	Kentucky Medicaid Section 1115 Demonstration Amendments Public Forum #1
Date	Wednesday, April 12, 2023
Time	3:00 pm EST to 4:00 pm EST
Location	https://teams.microsoft.com/l/meetup-join/19%3ameeting_N2U0MzRjNzMtMDlmNy00YjhmLWExNWItYmYyMzY0MTc0YjE1%40thread.v2/0?context=%7b%22Tid%22%3a%22d77c7f4d-d767-461f-b625-0628792e9e2a%22%2c%22Oid%22%3a%22f1f8ef42-11bb-4f0f-b2c9-13df1f78778e%22%7d
Log In/Dial In Information	Meeting ID:279612657461 Password: 6wTdNE Phone:5026326289 Conference Code:791546355#
Attendees	KY DMS: Leslie Hoffmann, Angela Sparrow, Sherri Staley, Jodi Allen, Kristen Shroyer, James Geralds, Leigh Ann Fitzpatrick, Victoria Smith, Dana McKenna State Agencies: Matt Mooring Providers/Advocacy Organizations/Stakeholders: Sheila Schuster, Tammy Hermann, Tom Rourke, Mary-Kay Lamb, Steve Shannon, Jim Benson, Brenda Benson Unknown: 0
Comments	No Comments received during forum
Title	Kentucky Medicaid Section 1115 Demonstration Amendments Public Forum #2
Date	Wednesday, April 19, 2023
Time	10:00 am EST to 11:00 am EST
Location	https://teams.microsoft.com/l/meetup-join/19%3ameeting_N2U0MzRjNzMtMDlmNy00YjhmLWExNWItYmYyMzY0MTc0YjE1%40thread.v2/0?context=%7b%22Tid%22%3a%22d77c7f4d-d767-461f-b625-0628792e9e2a%22%2c%22Oid%22%3a%22f1f8ef42-11bb-4f0f-b2c9-13df1f78778e%22%7d
Log In/Dial In Information	Meeting ID:279612657461 Password: 6wTdNE Phone:5026326289 Conference Code:791546355#

Attendees	KY DMS: Jodi Allen, Leigh Ann Fitzpatrick, Kristen Shroyer, Amanda Adams, Dana McKenna, Victoria Smith State Agencies: Heidi Schissler Lanham, Robin O'Neal Providers/Advocacy Organizations/Stakeholders: Leslie Vann, Susan Buchino, Stephanie Koenig, Carrie Richerson, Tina Nelson, Billy Noble Unknown: 0
Comments	No Comments received during forum
Title	Kentucky Medicaid Section 1115 Demonstration Amendments Public Forum #3
Date	Wednesday, April 26, 2023
Time	12:00 EST to 1:00 pm EST
Location	https://teams.microsoft.com/l/meetup-join/19%3ameeting_N2U0MzRjNzMtMDlmNy00YjhmLWExNWItYmYyMzY0MTc0YjE1%40thread.v2/0?context=%7b%22Tid%22%3a%22d77c7f4d-d767-461f-b625-0628792e9e2a%22%2c%22Oid%22%3a%22f1f8ef42-11bb-4f0f-b2c9-13df1f78778e%22%7d
Log In/Dial In Information	Meeting ID:279612657461 Password: 6wTdNE Phone:5026326289 Conference Code:791546355#
Attendees	KY DMS: Jodi Allen, Leigh Ann Fitzpatrick, James Geralds, Sherri Staley, Dana McKenna, State Agencies: Stephanie Brammer-Barnes, Robin O'Neal, Dustin Pugel Providers/Advocacy Organizations/Stakeholders: Bart Baldwin, Steve Shannon, Adrienne Bush, Casie Kichler, Katie Palmer, Rebecca Drinkard, Sarah Kidder, Nikki Stanaitis Unknown: 1
Comments	No Comments received during forum

Appendix E: Public Comments and DMS Responses

All public comments and DMS responses to each comment are captured in the table below. If a change was made to the application prior to official submission to CMS, that is noted on the chart below the response from DMS with an asterisk.

Date Received	Agency Submitting Comment	Comment	Response
5/5/2023	Kentucky Voices for Health (KVH)	Thank you for the opportunity to comment on the Kentucky Department of Medicaid Services' (DMS) Section 1115 KY HEALTH Waiver Amendment regarding serious mental illness (SMI) and a pilot program to provide Health Related Social Needs (HRSN) services, specifically medical respite care. I am writing on behalf of Kentucky Voices for Health (KVH), a nonpartisan 501(c)(3) statewide coalition of consumer advocates that represents hundreds of individual and organizational members from across the commonwealth working to address the underlying causes of poor health through policy advocacy. KVH is deeply supportive of increasing Kentuckians' access to quality healthcare, and therefore we support both Kentuckians with SMI having access to more treatment time when needed and providing recuperative care services/medical respite care to adult Kentuckians who are homeless or at risk of homelessness especially.	Thank you for your vested interest in the SMI 1115 Waiver Amendment application entitled "Improving Health Outcomes for Individuals with Serious Mental Illness and Health Related Social Needs". DMS appreciates and values your feedback. We understand that the needs of individuals with SMI and homelessness are greater than the services we are proposing for this 1115 waiver amendment can meet alone. Therefore DMS is also in the process of developing a 1915 (i) waiver which will include supportive housing services for individuals with SMI as well as other community support services as part of a comprehensive plan to expand services. For more information about the 1915 (i), please see Section 1

		We would like to voice our appreciation for the attention given to the populations targeted in both areas of amendments, including #1 the SMI section or Institutional For Mental Diseases (IMD) Extension, and #2 the HRSN section, the Recuperative Care Pilot Program. We believe this demonstration bridges healthcare access for Kentuckians experiencing serious mental illness. KVH supports these stated goals with one caveat; none of this is likely to produce the stability and security for the Kentuckians who need these services without additional supportive permanent housing. Extending inpatient care opportunities and creating much needed respite 1/5 care cannot and will not replace the need for permanent supportive housing for Kentuckians with serious mental illness, especially those currently experiencing homelessness. We would like to support and echo the comments and questions from the Kentucky Mental Health Coalition submitted by Dr. Sheila Schuster . We support that a “Wellness Check” should be able to be performed by a Peer Support Specialist. Expanding reimbursements for certified peer support is, in our experience, an	of the 1115 application. As Recuperative care is a medical model of care, DMS stands behind the decision that the daily wellness check which we will now call a “daily medical check” will be conducted by a medical professional for the fidelity of the model of care. Thank you for mentioning the concern about the need for Recuperative Care in the Western Kentucky area. DMS is proposing that any provider in state that is currently providing Recuperative Care at the time that the application is approved, can provide the model of care that DMS is proposing, and is listed on the NIMRC medical respite directory is eligible to become a provider in the Recuperative Care Pilot Program. DMS will utilize the GARE tool in decision making about this waiver to stay accountable with intentionally reducing racial and health disparities and increasing racial and health equity throughout the demonstration period.

		excellent investment. Similarly, we fully support the comments submitted by Adrienne Bush on behalf of the Homeless and Housing Coalition of Kentucky (HHCK). We expressly want to reiterate HHCK's concerns around release from rural areas like Hazard Appalachian Regional Healthcare Center and Western State Hospital. BACKGROUND KVH closely follows the activities of our General Assembly when it comes to access to healthcare and delivery of high quality, affordable health services to Kentuckians, and therefore attended many of the meetings of the two task forces around SMI over the past few years.1,2 It is clear that there are Kentuckians in need of different levels of care, including those who are still struggling with a substance use crisis that has been decades in the making. There are still too many Kentuckians who need medical care for addiction and recovery services3,4, and many of those who are falling through gaps in our care have serious mental illness. CURRENT LANDSCAPE As we consider the design and implementation of this proposed demonstration project, it is important to recognize that Kentucky is currently experiencing an	Thank you for your recommendations for monitoring outcomes of the goals and hypotheses. These will be considered as we move forward with development of the implementation and monitoring plan which will be submitted following approval of the application by CMS. *DMS changed language in the Recuperative Care description from "daily wellness check" to "daily medical check" prior to submission of application to CMS.

		evolving housing crisis where housing is unavailable and/or unaffordable for far too many Kentuckians, but especially those with very low incomes, which includes so many Kentuckians who are currently homeless or at risk of homelessness.5 Homelessness does not affect Kentuckians evenly. Black and Latinx Kentuckians are more likely to experience homelessness and stay in need of shelter longer than white Kentuckians on average.6 Therefore, our solutions must be intentionally anti-racist to not only provide appropriate respite care, but to those who need it disproportionately. Respite care can not, will not, and should not be expected to solve our housing crisis, because it is about appropriate level of care rather than housing, but the two go hand-in-hand. We look forward to hearing more about the needs for permanent and supportive housing, which are referenced in this project. RECOMMENDATIONS FOR INSTITUTION FOR MENTAL DISORDERS (IMD) EXTENSION KVH supports medically necessary extensions of inpatient treatment from 15 days for inpatient mental health treatment in IMDs through In Lieu of Services to up to 30 days. In Table 2 on page 12, the potential measurement is Emergency	

		Department use and or Readmissions to inpatient psychiatric or crisis residential settings. We recommend tracking outcomes through patient quality-of-life surveys and, hopefully, reduced interactions with emergency responders, including law enforcement. If possible, KVH recommends that the data around interactions and involvement with the justice system for individuals before and after this demonstration project be tracked and made available to the public. Several of the hypotheses in Table 2 on page 12 and 13 include reference to crisis stabilization services, which we hope will also be improved statewide as a result of continued utilization and improvement of 988.7 Our easier-to-dial and easier-to-remember crisis line should work together with improvements to all of the hypotheses included in Table 2 and we hope that is a part of the reporting and data sources when determining necessary environmental factors for this demonstration project. RECOMMENDATIONS FOR RECUPERATIVE CARE PILOT PROGRAM Kentucky Voices for Health applauds the inclusion of medical respite programs in this project. The period immediately following hospital stays, for any reason, is ripe with health risks for a significant period when physical or mental health needs do	

		not rise to the level of care for a hospital setting. This demonstration project we believe will prevent at least some incarceration for Kentuckians with serious mental illness. Currently, Kentucky incarcerates more individuals with serious mental illness than we hospitalize.8 This demonstration has the potential to greatly improve the delivery of appropriate care for our neighbors with SMI. In Table 3, Goal 3 -“Reduce health disparities by improving access to community-based services to address health related social needs”- we are concerned that referrals do not inherently do much for people, especially people in circumstances such that follow up and follow through is prohibitive, the exact people intended to be served by this project. We suggest surveying enrolled members about services, organizations, and agencies they have interacted with, as well as through possible case management from a known agency, in addition to the claims data and medical records. Thank you again for the opportunity to provide comments on this 1115 KY HEALTH Waiver Amendment. We appreciate the broad scope of this proposed demonstration and support the improved access to care in both new hypotheses. Kentucky Voices for Health appreciates the thoughtful preparation given to this	

		proposal already, and thank you for continuing to consider potential changes. We request any response prepared to these comments and others be sent to cara@kyvoicesforhealth.org.	
5/5/2023	Kentucky Equal Justice Center	Kentucky Equal Justice Center (KEJC) submits these comments in response to the above-referenced 1115 waiver amendment application by DMS. KEJC is a 501(c)(3) organization working for and alongside low-income and marginalized Kentuckians to address what are fundamentally unmet health-related social needs. KEJC lauds this amendment application as an important first step towards meeting 2022 SJR 72's requirements and the needs of Kentuckians with serious mental illness (SMI) and thanks you for the opportunity to present our comments on and concerns with the application. Broadly speaking, we encourage DMS to consider greater specificity in the language used within the waiver amendment application. One of several undefined but critical terms used is "wellness check" within the DMS model of recuperative care; this is a loaded term, typically associated with police intervention. While the application states that medical providers will perform these checks, it is critical to define this term to remedy the existing implication of police involvement, particularly given the long-standing over-policing of people with SMI.	Thank you for your vested interest in the SMI 1115 Waiver Amendment application entitled “Improving Health Outcomes for Individuals with Serious Mental Illness and Health Related Social Needs”. DMS appreciates and values your feedback. Thank you for the suggestion of changing the language from the recuperative care model from “wellness check” to something less associated with police intervention. We will change the wording to “daily medical check” in the application. Thank you for the recommendation on the verbiage regarding mandatory trainings for Recuperative Care Staff. This will be considered going forward as we develop our implementation plan which will be submitted following approval of the application by CMS.

		Relatedly, the application language regarding mandatory training should specify that training content must include de-escalation tactics that not only grapple with considerations relevant to people with SMI more broadly, but also with the unique traumas associated with prior incarceration and lack of consistent housing. We are interested in whether and to what extent (1) the requested waivers will achieve stated goals and (2) the potential measurements will accurately gauge listed hypotheses. We look forward to reading the 1915(i) state plan amendment later this summer, which we anticipate will address the enormous need for supported employment and housing for Kentuckians with SMI. Thank you for this opportunity to comment and for your consideration,	*DMS changed language in the Recuperative Care description from “daily wellness check” to “daily medical check” prior to submission of application to CMS.
5/5/2023	Individual	These are both much needed additions to the services offered to individuals with SMI. Thank you! Re: the extension for inpatient treatment—does the definition of medically necessary short-term, “a state-wide average length of stay no longer than 30 days, inpatient treatment services” cover up to 30 days/month (which was the way it was presented in the Town Hall meeting), or does the use the state-wide average mean that some people can stay through the month in its entirety, even when there are 31 days in that month? I’m hopeful the definition does not mean there may be a day-long gap of services in a month with 31 days. Additionally, what coverage is offered for	Thank you for your vested interest in the SMI 1115 Waiver Amendment application entitled “Improving Health Outcomes for Individuals with Serious Mental Illness and Health Related Social Needs”. DMS appreciates and values your feedback. The definition for expansion of IMD for mental health is intended to serve beneficiaries for a statewide average length of stay of 30

		individuals ages 18-20, since only individuals over age 21 are eligible for this additional coverage? Additional, vital recuperative care services that are needed for the model to be successful include detox supports and non-congregate (single occupancy) rooms, in which a partner could also stay. This population has been poorly treated by providers, especially in regards to substance-dependence (including nicotine). They will not remain in the setting if they are not treated for dope sickness; in fact, they will demonstrate signs of behavior health crisis before leaving AMA. They will also refuse services if they are unable to stay with a partner. These two issues should be addressed explicitly in the waiver (accounting for their associated costs). Finally, these two items for expansion are not enough. Despite the title, neither of these expansions address social needs, because they are not community-based services, offered in one's *permanent* home. The report cites the extensive unmet needs of individuals who are homeless or at risk of homelessness with SMI, as well as a goal to improve access to community-based services, however the community-based services that exist are not substantial enough to address the community-based needs. There is a shortage of behavioral health providers in Kentucky, especially who offer services in the community to address daily living skills. Individuals with SMI may struggle with generalizing skills from one setting to another, and the stressors of societal and social expectations may exacerbate one's symptoms. Thus, it	days. Therefore, some individuals may be discharged prior to 30 days stay and some individuals, for those with medical necessity, discharged longer than 30 days stay as long as the statewide average does not exceed 30 days per beneficiary. The Recuperative Care pilot program is focused on individuals with a primary medical diagnosis as the main eligibility criteria. The Medicaid Program continues to provide a full continuum of care for individuals with SUD and this will include withdraw management supports for individuals who need it. Regarding single occupancy rooms, that would be up to the individual provider whether they would allow others to stay with the person receiving Recuperative Care Services. We understand that the needs of individuals with SMI and homelessness are greater than the services we are proposing for this 1115 waiver amendment can meet alone. Therefore, DMS

		is important to aid individuals with SMI in setting up routines in their own homes, especially when they are at high risk of homelessness. Increasing days of inpatient care does not result in better outcomes in the community and the ability to remain in a least-restrictive environment, unless there are simultaneously increases in the availability of supports in the least-restrictive environment. The report states that Kentucky utilizes assertive community treatment and supportive housing at lower rates and that Kentucky's SMI population are being treated at a higher rate in inpatient settings with less access to or utilization of other supportive services to help them navigate their daily lives, yet does not offer solutions to increase the provision of evidence-based practices and community supports. One such evidence-based service to increase successful community integration is occupational therapy, which aids individuals to do the things they need to do and want to do, by skillfully assessing the individual's capacity to complete a task, the performance environment, and the task. I look forward to the implementation of the suggested "comprehensive plan to increase community support services to address HRSN for individuals with SMI/SUD and complex needs."	is also in the process of developing a 1915 (i) waiver which will include supportive housing services for individuals with SMI as well as other community support services as part of a comprehensive plan to expand services for individuals with SMI. . For more information about the 1915 (i), reference Section 1 of the 1115 application. Thank you for your recommendation of integrating occupational therapy as an EBP for individuals with SMI. This is already a service included in our Medicaid State Plan and can be provided to beneficiaries who demonstrate medical need for the service. . Additionally, the Medicaid State Plan includes a full continuum of outpatient behavioral health services. To address additional care needs, it may be appropriate to address your concerns to the Therapy Technical Advisory Committee (TAC) associated with the Advisory Council for Medical Assistance (MAC). To address concerns for services

			for current recipients, provider appeals or other advocacy may need to be take place within the established processes such as CHFS.LISTENS@ky.gov. *DMS revised the language for IMD Expansion to clarify a state-wide average length of stay of 30 days, inpatient treatment services within settings that qualify as institutions for mental diseases (IMDs) for Medicaid-eligible adults with serious mental illness (SMI);
5/4/2023	NAMI, Lexington	NAMI Lexington is a local affiliate of The NATIONAL ALLIANCE ON MENTAL ILLNESS(NAMI). We have joined the statewide Mental Health Community in strongly advocating for the development of a Medicaid Waiver to provided critically needed supported housing/living and supported employment for individuals diagnosed with serious mental illness (SMI). This same sentiment and sense of urgency was conveyed in the findings and recommendations from the Task Force on Serious Mental Illness which met during the 2021 Interim Session of the General Assembly. To further confirm the importance of this Task Force intent, SJR 72 was filed and overwhelmingly passed during the 2022 General Assembly.	Thank you for your vested interest in the SMI 1115 Waiver Amendment application entitled “Improving Health Outcomes for Individuals with Serious Mental Illness and Health Related Social Needs”. DMS appreciates and values your feedback. DMS understands that the needs of individuals with SMI and homelessness are greater than the services we are proposing for this 1115 waiver amendment can meet

		As an advocacy organization made up of individuals directly impacted by these issues, we cannot overstate the importance of housing and employment (income) as it relates to the ability for these individuals to recover. Too many of our citizens with SMI have no place to call home; many are transient or live deplorably on the street. Many lack the capacity, when impaired by symptom burden – to even access shelter, food and appropriate clothing. Many are also deemed “inappropriate” and are expelled or banned from potential shelters for behaviors that are a direct result of their illness. We look forward to news of the filing of a 1915(i) waiver by DMS to provide for these extremely urgently needed services of supported housing and employment. Comment: The waiver application document (page 8) references the 1915(i) waiver for supported housing and employment to include “behavioral health respite services” Question: Are these services expanded or different from the Recuperative Care Services included in the 1115 waiver KY HEALTH amendment? Comment: (Page 9) - there is a reference to low utilization rates in Kentucky regarding use of supported housing/employment. Kentucky has NEVER had wide availability of those programs/services! Programs that sparsely exist cannot be widely utilized or accessed! We would also like to thank the KY DMS for preparing and filing the proposed amendment to the existing 1115 Waiver KY HEALTH to address the following needs: Comment: IMD EXTENSION	alone. Therefore, DMS is also in the process of developing a 1915 (i) waiver which will include supportive housing services for individuals with SMI as well as other community support services as part of a comprehensive plan to expand services for individuals with SMI. . For more information about the 1915 (i), please see Section 1 of the 1115 application. The definition for expansion of IMD for mental health is intended to serve beneficiaries for a statewide average length of stay of 30 days. Therefore, some individuals may be discharged prior to 30 days stay and some individuals, for those with medical necessity, discharged longer than 30 days stay as long as the statewide average does not exceed 30 days per beneficiary. The behavioral health respite services that were mentioned for the 1915 (i) waiver are different from the Recuperative Care Pilot Program that is being proposed by the 1115 waiver. The

		Both as individuals and caregivers for individuals with SMI we are pleased to have the opportunity for this extension. There are too many barriers to getting someone in crisis hospitalized to begin with. Many times, if an individual is lucky enough to be hospitalized, when needed, the stay is 72 hours or less, hardly enough time for thorough care to take place. Too often, we see patients being discharged who are not in much better shape than when they were hospitalized to begin with. Often times, they have not had enough time to adjust to medication changes or the start of new medications. Many times, we experience poor discharge planning which results in discharges to a shelter, which is really a discharge to the street- often without adequate means of securing needed medications or making follow up continuation of care appointments. This results in high "failure to keep" rates for providers and leads to relapse and escalation of potential crisis for patients and families. We believe an increased hospital stay can allay issues with premature release such as immediate return to crisis status, homelessness, involvement with law enforcement and family crisis. Care should be dictated by need and medical oversight not pre-determined limits on 'days.' This is also a parity issue, in that, SMI should be treated the same as any other 'physical illness'…BECAUSE IT IS A PHYSICAL ILLNESS. Comment: RECUPERATIVE CARE PILOT PROGRAM Thank you once again for including this, as it was another recommended	service description for behavioral health respite services are still being developed presently by the 1915 (i) work group. We appreciate your questions and comments about the implementation and monitoring of the Recuperative Care Pilot Program. We will consider these as we move forward with our implementation and monitoring plan which will be submitted following approval of this application by CMS

		service to SJR 72. We also see this as a parity-related issue, but understand there will be specific, important nuances in the respite/recuperative model as related to SMI/behavioral health. Questions: As stated above there will be specific needs in Recuperative Care models for SMI/Behavioral health such as: Looking at ED visits and readmissions to either psychiatric or other medical facilities – are rates affected in patients that receive adjunct care? How will this outcome be measured? Medication management of both psychiatric medications and meds for physical health needs (oversight? Expertise?) Best practices *in holistic* respite care? Responsibility for care coordination between respite/recuperative care and *existing* psychiatric and community mental health providers – Most individuals with SMI diagnosis will have historical providers in CMHC or Community – how coordinated? EMR/Medical records would be needed from different systems of care. Individuals with SMI may need integration with housing, behavioral health care, benefits such as SSI, SSDI and other entities that make up *a complex* continuation of care delivery system. In closing, thank you for your consideration of these thoughts and comments regarding the SMI Amendment to Kentucky's 1115 Waiver, KY HEALTH. Thank you for this first-step in addressing the huge gaps in services for the many Kentucky citizens whose life experience includes SMI. We look forward to the future opportunity to	

		review and comment on the 1915(i) waiver related to supported HOUSING and employment for the population of individuals with SMI. The need for HOUSING FIRST CANNOT BE OVERSTATED	

5/4/2023	Individual	The DMS model of recuperative care is proposed to include, at minimum, the following components: • Access to a phone for telehealth and/or communications related to medical needs. Comment: Recommended Language: “Access to a phone or other virtual technology for telehealth and/or communications related to medical, behavioral, or case coordination needs.” Background Thoughts: Telehealth billing requirements may be changing since the Public Health Emergency is ending. Typically, a telehealth visit requires the ability for the patient and provider to be able to see and hear each other. This ability needs to be documented in the note. Also, a medical provider will most likely bill a transition of care visit since the patient is being seen within 14 days of discharge. TOC visits work better clinically if they are in-person or telehealth vs a phone conversation. TOC visits also require a medication review which are important for all patients and may be critically important for person living with a serious mental illness. A significant amount of behavioral health visits are conducted via telehealth. While a person is in a recuperative care setting with digital connectivity, a staff person may be available to facilitate the behavioral health visit (e.g., help logging in). Telehealth behavioral health visits may have an even more significant impact if they facilitate the connection of the individual in recuperative care with the person’s existing therapist. • Wellness check at least 1x every 24 hours by medical professional Comments: Need a definition of a ‘Wellness check’	Thank you for your vested interest in the SMI 1115 Waiver Amendment application entitled “Improving Health Outcomes for Individuals with Serious Mental Illness and Health Related Social Needs”. DMS appreciates and values your feedback. Regarding your comment about the mandatory access to telehealth component of the Recuperative Care pilot program, we will change the language to “Access to a HIPPA complaint platform for telehealth purposes”. We appreciate your recommendations on the verbiage and clarifications for providers of Recuperative Care services as well as recommendations for monitoring of services. We will take all these recommendations into consideration as we are developing the implementation and monitoring plan which will be submitted to CMS following approval of the application. *DMS changed language in the

		Need a definition of a 'medical profession' (Does this mean an MD/DO/APRN/PA or RN/LPN/Certified Nursing Assistant/Community Health Worker/Pharmacist/Other?) Background Thoughts: Recuperative care centers will want to comply with providing wellness checks, so some guidance on the content of a wellness check will be helpful. If a licensed provider is required, recuperative centers will need to include this in both their revenue and expense budgets. If a wellness check is billable by a provider, is there a suggested evaluation and management code? For purposes of outcome tracking, it will be helpful to have a CPT code (even if it is not billable) to see how wellness checks impact recuperative care outcomes. • Medication monitoring supervised licensed clinical staff Comment: Recommended Language: "Medication monitoring supervised by licensed clinical staff." Background Thoughts: Need a definition of 'medication monitoring.' Does it mean asking the patient if she/he has taken medications? Since the medications will be stored in patient's room and double locked, will the patient have 1 key and staff person 1 key so staff will be required for patient to access medications in her/his room to take the medications? Does 'licensed clinical staff 'mean an RN/LPN/Clinical Nursing Assistant/Certified Clinical Medical Assistant/Other? The definition of licensed clinical staff will have budget implications given the varying pay scales for licensed clinical staff. There are also workforce considerations, that is it may be more difficult to hire RNs	application to reflect "Access to a HIPPA Complaint platform for telehealth purposes" prior to official submission of application to CMS

		than CNAs. • Required trainings for clinical and non-clinical staff Comments: Recuperative care centers will want some guidance on the required training. They will want the training to positively impact the quality of care they provider to persons with a severe mental illness. It would be helpful to use the same terms for staff throughout the document and define the terms. Terms that might be harmonized include medical professions, licensed clinical staff, clinical, non-clinical. Background Thoughts: Questions might include: Topics (e.g., trauma-informed care, racial equity, mental and behavioral disease-specific care protocols, care for people with multiple co-morbidities) Number and length of trainings (e.g., how many training are required, how long should they last) Format (e.g., in-person, virtual, prerecorded modules) Recuperative Care Hypotheses Goal 1: Reduce utilization of avoidable high-acuity healthcare services through improved access to other continuum of care services. Comment: Recommended Language: Goal 1: "Reduce utilization of avoidable acute healthcare services through improved access to ambulatory, pharmacy, housing, nutrition, and other continuum of care services." Hypothesis 1: Among beneficiaries receiving recuperative care, beneficiaries will experience fewer emergency department visits. Comment: Recommended Language: "Among beneficiaries receiving recuperative care,	

		beneficiaries will experience fewer emergency department visits within 30 days of the index hospital discharge and within 365 days of the index hospital discharge". Background thoughts: The first discharge from a hospital into recuperative care will be considered the index discharge. Hospitals will look at readmission within thirty (30) days. Hopefully, a recuperative care stay will change the utilization of the acute healthcare for a year following the index hospital discharge. Hypothesis 2: Among beneficiaries receiving recuperative care, beneficiaries will experience a reduction in inpatient days. Comment: Recommended Language: "Among beneficiaries receiving recuperative care, within 365 days of the index admission, beneficiaries will experience fewer inpatient admissions, fewer inpatient days, and a shorter average length of stay for each admission". Hypothesis 3: Among beneficiaries receiving recuperative care, beneficiaries will experience a reduction in hospital readmission rates. Comment: Recommended Language: "Among beneficiaries receiving recuperative care, beneficiaries will experience a reduction in 30-day all cause hospital readmission rates."Hypothesis 4: Among beneficiaries receiving recuperative care, beneficiaries utilize services at lower levels of care. Comment: Recommended Language: "Among beneficiaries receiving recuperative	

		care, beneficiaries will utilize services at provider office visits, outpatient therapies, diagnostic services, pharmacies, etc., that is, non-acute care settings". Potential measures: Utilization of: ED visits; inpatient days; outpatient services, and 30-day hospital readmission rates. Comment: Recommended Language "Utilization of: ED visits; inpatient days; outpatient services, ambulatory office visits, filled prescriptions, and 30-day hospital readmission rates". Goal 3: Reduce health disparities by improving access to community-based services to address health related social needs. Data source: Claims data and medical records. Comment: Other language to consider: Option A: Claims data and the recuperative care center's documentations (e.g., medical records, case management notes). Option B: Claims data, hospital medical records, and recuperative care center documentation (e.g., medical records, case management notes). Background thoughts: Recuperative care will provide or coordinate significant care coordination services. If the recuperative care staff provide these services, they may in the organization's medical record system. However, if care coordination is provided by a community-based organization, data may reside in that organization's system of record. To identify the type and dosage of services which have the most impact outcomes, data from	

		multiple systems will need to be gathered and analyzed. Goal 4: Ensure long-term fiscal sustainability of recuperative care services. Potential Measures: Total Expenditures and per member per month cost of services. Comment: Recommended Language: “Total annual expenditures and er member per month cost of services”.	

5/3/2023	Kentucky Mental Health Coalition	The Kentucky Mental Health Coalition (KMHC) was founded in 1982 and is comprised of over 80 organizations representing behavioral health professionals, agencies and facilities, consumers, family members and advocates. As members of the mental health community across Kentucky, we have strongly advocated for the development of a Medicaid Waiver to provide critically-needed supported living and supported employment opportunities for Kentucky adults who have been diagnosed with a serious mental illness (SMI). In the Interim Session of the 2021 KY General Assembly, the Task Force on Severe Mental Illness was convened and met six times. One of the top priority recommendations from the Task Force was that the KY Cabinet for Health & Family Services develop a waiver to provide supported housing and supported employment to the target population of Kentuckians with severe mental illness. As a confirmation of this intent, SJR 72 was filed and overwhelmingly passed by the 2022 KY General Assembly. We appreciate the staff at the KY Department for Medicaid Services (DMS) preparing and filing the proposed Amendment to the existing 1115 Waiver, KY HEALTH, to address some aspects of the needs of our Kentuckians with Serious Mental Illness – namely, allowing for more treatment time in psychiatric hospitals and in providing recuperative care (medical respite) for those who need these services. We eagerly await the filing of a 1915(i) waiver by DMS to provide the most urgently-needed services –	Thank you for your vested interest in the SMI 1115 Waiver Amendment application entitled “Improving Health Outcomes for Individuals with Serious Mental Illness and Health Related Social Needs”. DMS appreciates and values your feedback. DMS is working in concert with CMS to establish a full continuum of crisis care and will be addressing this through the implementation plan and additional parallel actions during the waiver development process. The behavioral health respite services that were mentioned for the 1915 (i) waiver are different from the Recuperative Care Pilot Program that is being proposed by the 1115 waiver. The service description for behavioral health respite services are still being developed at this time by the 1915 (i) work group. As Recuperative care is a medical model of care, DMS stands behind the decision that the daily wellness check which we will

		supported housing and supported employment. The waiver application document (bottom of page 8) references the 1915(i) waiver to be applied for as including supported housing and employment…and also "behavioral health respite services". QUESTION: Are these services different from and in addition to the Recuperative Care Services already included and described in the 1115 Waiver amendment? On page 9 of the document, reference is made to a lower utilization rate by individuals with SMI in Kentucky of supportive housing and supportive employment than is found nationally. This should come as no surprise to the authors, as Kentucky has, for many years, suffered with a lack of those services statewide. Services that do not exist cannot be utilized! INSTITUTION FOR MENTAL DISEASES (IMD) EXTENSION While we are supportive of individuals with SMI having access to longer periods of treatment in Institutions for Mental Diseases (IMDs), we have concerns about how the outcomes from these longer stays will be any different from those of shorter stays. Certainly, access to more therapy and a longer period of time to assess the effectiveness of medications would be helpful to the individual. But the application refers several times to improved discharge planning and coordination of care after a longer stay in the IMD. QUESTION: How will discharge planning and coordination of care be improved in a longer stay in the IMD? The goals outlined in the Hypotheses for extending the stay in IMDs are appropriate for this population and	now call a "daily medical check" will be conducted by a medical professional for the fidelity of the model of care. We appreciate your comments and questions regarding the implementation and monitoring aspects of the IMD expansion and Recuperative Care Pilot Program, especially your concerns about coordination of care. DMS will take these into consideration as the implementation and monitoring protocols are developed and submitted to CMS following approval of the application.

		would certainly lead to an improved quality of life for these individuals, but the means by which the proposed outcomes will be achieved is not clear. QUESTION: How will increased lengths of stay in IMD treatment lead to “improved availability of crisis stabilization services throughout the state” (Hypothesis 3) or to the “increased integration of primary and behavioral health care” (Hypothesis 4)? We certainly endorse these goals, but question how they are correlated with increased inpatient treatment stays? RECUPERATIVE CARE PILOT PROGRAM We were excited to have has a presentation at the Behavioral Health Technical Advisory Committee (BHTAC) some months ago about medical respite programs and their potential to address the needs of individuals with SMI following a stay in the hospital for physical or behavioral health treatment. We worked with legislators to include the service in SJR72. We are very pleased to see thar DMS has included it as “recuperative care” in the proposed 1115 Waiver Amendment for Individuals with SMI. We do, however, have several questions and comments about this aspect of the waiver, notably in the DMS Model of Recuperative Care. COMMENT: The language related to phone or telehealth communications should include behavioral health needs in addition to medical and care coordination. COMMENT: A definition of a “Wellness Check” is needed. Depending on the definition, could a Wellness Check be done by a Certified Peer Specialist (PSS)?	

		QUESTION: What is the current "best practice" for doing medication monitoring" and by whom? This needs to be spelled out, as one of the most significant indicators of moving forward in their recovery process is the regular taking of their prescribed medication(s). COMMENT: There is reference on page 14 to "On-Site or access to community behavioral health services for behavioral health screening and brief intervention and referral as needed." This seems appropriate for individuals needing recuperative care who do not have a serious mental illness…but would not be appropriate for individuals with SMI. This requirement should be rewritten to reflect the involvement of behavioral health providers with those individuals who have an SMI diagnosis. These individuals in all likelihood will already have a history of contacts with behavioral health providers, most likely one of the community mental health centers (CMHCs). The QUESTION is who is responsible for initiating contact with the appropriate CMHC or other behavioral health provider when the individual is discharged from the hospital to the recuperative care setting? COMMENT: Table 3, Goal 1: The goal should be definitive as to inclusion of the "other" continuum of care services – namely, behavioral health, housing, medical, nursing, nutrition, pharmacy and others. QUESTION: Table 3, Potential Measures: Shouldn't the measure reflect a projected decrease in ED visits, inpatient visits, and 30-day hospital readmission rates and a projected increase in outpatient	

		services, ambulatory office visits and filled prescriptions? COMMENT: Table 3, Data Source: The data and medical records should reference “from multiple systems of care” in order to capture the range and breadth of data and medical records to gain an accurate and comprehensive picture of each individual’s functioning and progress. QUESTION: Table 3, Goal 4: Is the hypothesis that beneficiaries who receive recuperative care will have lower healthcare costs than those who did not receive recuperative care services based on lower utilization of inpatient services over outpatient services? And is the hypothesis the same for those beneficiaries with SMI as for those who do not have an SMI diagnosis? QUESTION: To what degree will care coordination be done with the community behavioral health provider? This would seem to be a crucial component of success with the transition planning for discharge of individuals with SMI from the recuperative care setting. COMMENT: The language in the proposal around required trainings for clinical and non-clinical staff should contain specific reference to characteristics of serious mental illness, suggestions for de-escalation with individuals exhibiting signs of distress, possible drug interactions with psychotropic medications, and awareness of difficulties exhibited by individuals who may have been frequently homeless. COMMENT: There are no time periods for data-collection outlined in the proposal, and they should be included. They may best be set in	

		near-time intervals and then spread out over the five-year pilot timeframe. As the 1915(i) waiver is developed, it is recommended that wherever possible, the same data be collected in the same time-frames as in this 1115 Waiver Amendment. Thank you for your consideration of these questions and comments regarding the SMI Amendment to Kentucky's 1115 Waiver, KY HEALTH. We appreciate DMS taking this initial step in addressing the unmet needs of Kentuckians with SMI. We await with great anticipation the opportunity to review and comment on the 1915(i) waiver which will develop supported housing opportunities for this population in dire need. I request that I be provided with a copy of the comments submitted to DMS as well as the replies to those comments.	
5/2/2023	NAMI Murray, KY	We are [redacted] of Murray, KY. We are also founding members and officers of the Murray Kentucky affiliate of the National Alliance on Mental Illness (NAMI). We have an adult son living with a severe mental illness, paranoid schizophrenia. [redacted] began exhibiting symptoms at age 17 and was diagnosed with schizophrenia at the age of 20. He is now 37. As his parents we have lived the experience of the revolving door; psychosis, jail, hospitalization, recovery then repeat. We know first-hand what is missing from Kentucky's mental healthcare system. We have been advocating for long term supported housing for Kentuckians with a severe mental illness for over a decade.	Thank you for your vested interest in the SMI 1115 Waiver Amendment application entitled "Improving Health Outcomes for Individuals with Serious Mental Illness and Health Related Social Needs". DMS appreciates and values your feedback. Currently, DMS is in the process of creating a 1915 (i) waiver as part of a comprehensive plan to expand services for individuals with SMI including those with

		We do appreciate that the Kentucky Department for Medicaid Services is applying for an SMI waiver that would include extending reimbursement for medically necessary in-patient psychiatric care from 15 days to 30 days. Also, a 45 day respite program for when an individual leaves the hospital. We have followed the progress of this waiver, beginning with watching all the SMI Task Force's hearings and presenting our view at the final meeting. Throughout the hearings the need for supported housing was a recurring request for caring for individuals with a severe mental illness. Those with a severe mental illness are often caught in the revolving door of hospitalizations, incarcerations, and/or homelessness. The 45 day respite program followed by increased out-patient care will not solve the problem of the revolving door of these individuals. We believe that the terms behavioral health and mental illness are NOT synonymous! Persons with persistent severe mental illness, such as our son, will not be cured by stabilization and short-term housing and support. Persons like our son are the source of most the homeless and incarcerated in Kentucky today. They need long-term support and long term structured safe housing. Please do not confuse *Serious Mental Illness* with *Persistent Severe Mental Illness*. As stated earlier we have lived experience. We have tried several living arrangements for our son, living with family members, living in an apartment with our support, serving essentially as his ACT Team. During	persistent severe mental illness. For more information on the 1915 (i) waiver, reference Section 1 of the application. The 1915 (i) waiver workgroup is researching and developing criteria for 24/7 staffed residence for individuals with SMI. We understand that this 1115 waiver amendment in isolation will not meet all the needs of individuals with chronic persistent mental illness. Therefore, we are proposing additional services in a complimentary waiver to expand services. Thank you for sharing the model of care in TN. DMS will share this information with the workgroup for the 1915 (i) as part of our process of developing the 1915 (i) waiver.

		these times he was also a client of 4 Rivers Behavioral Health, cycling through 2 therapists and 2 case managers. None of these arrangements worked for him. He needed 24/7 supported housing. He also lived in a personal care home, [redacted] Unfortunately, due to the low reimbursement from Kentucky Medicaid it only covered room and board and bare necessities. We sought and found a system of personal care homes, specifically for the severely mentally ill in Tennessee. We moved our son there in 2021. He is doing well. [redacted] is clean of alcohol and illegal drugs, his psychosis is somewhat under control and he has not been hospitalized since being moved to Tennessee's personal care home model. This is the state of Tennessee's adopted model for supported housing. This model provides wrap-around services along with teaching living skills in a home-like environment setting that is staffed 24/7. We began this journey by writing a letter with these same concerns to Governor Beshear, in February 2020. He referred us to Eric Friedlander at CHFS. We were then put in contact with IG Adam Mather. On several occasions we have tried to introduce this model of care to officials in the state of Kentucky. i.e., Cabinet for Health and Family Services, Department for Medicare Services and the SMI Task Force. This model of care would go a long way in providing care for those with a severe mental illness that need long term supported housing and stop the revolving door. It would also create	

		cost savings to the Commonwealth of Kentucky. The state of Tennessee has the data that confirms this. While we are appreciative of your current effort on this SMI task force recommendation, we feel that it falls short of what we were hoping for and what the Commonwealth of Kentucky needs to end the homelessness and incarceration of the severely mentally Ill. It is our intent to continue to advocate for long-term safe, supportive and structured housing in Kentucky for the severely mentally ill. Thank you for your current effort in addressing some of the needs of the mentally ill and we look forward to addressing the concerns we feel are important to end the revolving door of the *Persistent Severely Mental Ill* in the future.	
5/2/2023	Homeless and Housing Coalition of Kentucky (HHCK)	On behalf of the Homeless and Housing Coalition of Kentucky (HHCK), I am writing to express our comments on the proposed amendment to Kentucky's Section 1115 waiver, KY HEALTH. HHCK is a statewide nonpartisan advocacy organization with a unique perspective on administering housing assistance to people experiencing homelessness. Our mission is to eliminate the threat of homelessness and fulfill the promise of affordable housing. Additionally, we convene and staff the Kentucky Interagency Council on Homelessness, the statewide homeless policy and planning body authorized by Kentucky Revised Statute 194A.735. Our comments will address the Recuperative Care Pilot Program and Supported Housing portions of the application.	Thank you for your vested interest in the SMI 1115 Waiver Amendment application entitled "Improving Health Outcomes for Individuals with Serious Mental Illness and Health Related Social Needs". DMS appreciates and values your feedback. We noted your concern about the Recuperative Care Pilot Program and lack of coverage by providers in the western and eastern parts of the state. The pilot program will be open to any providers who are already

		We commend the Department of Medicaid Services for developing this amendment application in response to the Severe Mental Illness Task Force of 2021 and the passage of Senate Joint Resolution 72 in 2022. In October 2021, with my colleague Tom Walton from the University of Louisville, I testified on the need for high quality medical respite/recuperative care as part of a community's crisis response system to the Medicaid Oversight Advisory Committee, and this testimony was incorporated into the recommendations of the task force. We applaud DMS for designing a Recuperative Care Pilot Program in response to the legislative context. To ensure this aspect of care is available and sustainable, it must become a Medicaid-billable service, and we are glad DMS recognizes this. We also agree with the requirement for providers to register with the National Institute for Medical Respite Care to promote fidelity to quality program models and service delivery. We also think there are some components of the program design that could strengthen the application to CMS and eventual implementation of recuperative care. While we understand the policy rationale of having providers experienced in delivering medical respite participate in this pilot, we are concerned that this leaves a significant number of Kentuckians with Serious Mental Illness and experiencing homelessness without access to recuperative care. According to the application, there are only four providers in the state currently providing such care – most likely in	providing recuperative care services in state on the date the application is approved by CMS and can meet the service model requirements set forth by DMS when program implementation begins. Each program will also need to be registered with the National Institute for Medical Respite Care. Regarding your stated preference that all 3 components of SJR 72 were being addressed by the same waiver, up to this point, medical respite has only been approved by CMS through 1115 waiver authority. Therefore, DMS made the decision to put the Recuperative Care Pilot Program in the 1115 waiver to increase the likelihood that it will be approved for Kentuckians. We appreciate your comments regarding the implementation and monitoring aspects of Recuperative Care Pilot Program. DMS will take these into consideration as the implementation plan and monitoring protocols are

		our urban areas. An analysis of statewide hospital discharge data from 2019 by the Office of Health Data Analytics we presented in our testimony linked above indicated 11,431 patients discharged identified as homeless. If DMS only allows Medicaid-billable recuperative care in 4 cities over the next 5 years, a significant number of people with SMI, especially in the areas served by Western State Hospital and Hazard Appalachian Regional Healthcare Psychiatric Center, will not have access to this care under this demonstration. Additionally, we suggest adding clarifying language to each of the Hypotheses under Table 3. For example, DMS may want to add timeframes to evaluate the hypotheses, such as within 30 days and/or 365 days of the index hospital admission, as applicable. Lastly, we commend DMS for acknowledging, from our perspective, the other essential piece of SJR 72: supported or supportive housing. Recuperative care should never be just another place to warehouse people without shelter; connecting patients to permanent housing is fundamental to recuperative care. With the application's requirement that providers be registered with NIRMC, as well as DMS' participation in the Advancing Housing-Related Supports for Individuals with Substance Use Disorders State Medicaid Learning Collaborative, we know that DMS recognizes this. While the application makes reference to a forthcoming amendment application under Section 1915(i), we would much prefer if all 3 components of SJR 72	developed and submitted to CMS following approval of the application.

		were addressed in the same application for continuity of timeframe/access to services and care for this vulnerable population. Thank you for the opportunity to comment on this important amendment application. Please feel free to contact me should you need additional information. Sincerely,	
4/28/202	Individual	My brother and I have a mental illness diagnosis. We have struggled over the years. He became homeless at the beginning of the year. He struggles off and on. When he is ill, he needs serious intervention. Because of him being sick and homeless, he engaged in behaviors that were dangerous for him and the community. His life was in danger and is still in danger. But, he is now in jail. That is the safest place for him and safer for the community. But, it is not a healthy place. It is not a place to get healthy. It is a holding place. Once he gets out, he'll need housing. Without housing, he can't heal. He can't get better. Additional resources through a Medicaid waiver for Serious Mental Illness (SMI) is needed. For him, healthcare, housing, and employment supports are essential.People with SMI need supported housing.	Thank you for your vested interest in the SMI 1115 Waiver Amendment application entitled "Improving Health Outcomes for Individuals with Serious Mental Illness and Health Related Social Needs". DMS appreciates and values your feedback. Regarding your comment about the need for supportive housing, Kentucky plans on applying for a 1915 (i) waiver to cover supportive housing, supported employment, and other home and community-based support services for individuals with SMI. This will be part of the comprehensive plan to expand services for individuals with SMI across Kentucky. For more information about the 1915 (i) waiver, please reference Section 1 of

			the 1115 waiver application.
5/3/23	NAMI member Murray, KY	Hello, my name is [redacted] from Murray, KY. I'm the mother of a 42 year old man diagnosed 21 years ago with schizophrenia. Unfortunately, this was during the prime of his life! For the past 21 years I have fought hard to get my son supervised 24/7 assisted living arrangements. I was never able to find this type of residency in the state of KY...believe me I've tried! I'm happy to report that last April I finally found a home for my son in Mckenzie, TN. It seems TN has a SMI waiver that supports persons with a severe mental illness as my son has. The name is [redacted] with several of these homes throughout TN. I would encourage KY leaders to take a look into this type of set-up. Please keep in mind this would be for chronic severe mental illnesses. I'm not referring to emotional illnesses at this time. Thank you for looking into these type of home settings for KY.	Thank you for your vested interest in the SMI 1115 Waiver Amendment application entitled “Improving Health Outcomes for Individuals with Serious Mental Illness and Health Related Social Needs”. DMS appreciates and values your feedback. We appreciate you mentioning the TN model of care that includes 24/7 staffed living arrangements for individuals with SMI. The 1915(i) workgroup is currently conducting state research, and we will make sure that this information is shared with them.