

State of Connecticut
Department of Social Services

Connecticut Medicaid Coverage for Justice-Involved Population Re-entry

Substance Use Demonstration Amendment Request Pursuant to Section 1115 of the
Social Security Act

March 26, 2024

Demonstration Project No. 11-W-00372/1 and 21-W-00069/1

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State of Connecticut
Department of Social Services
Section 1115 of the Social Security Act
Demonstration Amendment
Medicaid Coverage for Justice-Involved
Population Re-entry

Section I. Program Description and Objectives

The State of Connecticut Department of Social Services (DSS), Connecticut’s single state agency for Medicaid and the Children’s Health Insurance Program (CHIP) is requesting section 1115 waiver authority from the Centers for Medicare and Medicaid Services (CMS), similar to the authority granted to California on January 26, 2023. Connecticut is requesting this authority to design and implement a “Re-entry Demonstration” that provides:

1. **Medicaid Coverage** for eligible individuals in the State’s correctional system, including all correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile detention¹ centers throughout the State. Eligible individuals include those with behavioral health needs including mental health disorders and substance use disorder (SUD), certain other health conditions and detained youth.
2. **A Targeted Benefit Package** for these individuals to include case management services, medication-assisted treatment for SUD, a 30-day supply of medications upon release, and certain other supportive services.
3. **A Coverage Period of up to 90 Days** immediately prior to the release of the incarcerated individual from the correctional system.
4. **Services to Address Health Related Social Needs** (HRSN) for the justice-involved (JI) population transitioning from correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile detention centers throughout the State.

This suite of coverage provisions and services will be implemented across Connecticut, creating and strengthening connections between carceral settings, government agencies, health and social service entities, and many others – all collaborating to better support individuals’ re-entry

¹ In Connecticut, there are several types of juvenile detention facilities under the control of the Connecticut judicial branch where youth who are adjudicated as delinquent by a court are held involuntarily and not permitted to leave the facility grounds including both “secure” facilities and “staff secure” facilities. Traditionally, Medicaid has not been permitted to be claimed for medical services to youth in any of these detention facilities. We will refer to these facilities as juvenile detention centers. Over the life of the waiver, all types of juvenile detention facilities are expected to be transitioned under the Demonstration.

into the community while maintaining their health and well-being.

Consistent with the CMS goals as outlined in the April 17, 2023, State Medicaid Director (SMD) letter # 23-003, Connecticut's specific goals for the Re-entry Demonstration are to:

1. **Increase coverage, continuity of coverage, and appropriate service uptake** through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release;
2. **Improve access to services** prior to release and improve transitions and continuity of care into the community upon release and during re-entry;
3. **Improve coordination and communication** between correctional systems, Medicaid systems, administrative services organizations, and community-based providers;
4. **Increase additional investments in health care and related services**, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful re-entry post-release;
5. **Improve connections between carceral settings and community services** upon release to address physical health, behavioral health, and health-related social needs (HRSN);
6. **Reduce all-cause deaths** in the near-term post-release; and
7. **Reduce the number of emergency department (ED) visits and inpatient hospitalizations** among recently incarcerated Medicaid beneficiaries through increased receipt of preventive and routine physical and behavioral health care.

Consistent with CMS guidance on HRSN, including an informational bulletin and framework of coverage both posted November 16, 2023 and other guidance, all of which is posted to the CMS website at this link: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/health-related-social-needs/index.html>, the State also intends to help address unmet needs related to a lack of adequate housing support. These conditions contribute to poor health for individuals transitioning from correctional centers (jails and courthouses), correctional institutions (prisons), and juvenile detention centers throughout the State, and addressing them is key to successful re-entry.

The State intends to implement the Demonstration statewide on or after July 1, 2024. The State requests to operate the Demonstration through the end of the current SUD Demonstration approval period, which is March 31, 2027.

This amendment request provides a detailed overview of coverage and service provisions, as well as Re-entry Demonstration objectives, financing, implementation, and monitoring/evaluation.

Background

In October 2018, Congress passed the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the "SUPPORT Act") (Pub. L. No. 115-271) in response to the imperative to implement concrete changes to address the

opioid epidemic. Per section 5032 of the SUPPORT Act, Congress required the Department of Health and Human Services (HHS) to convene a stakeholder group to develop best practices for ensuring continuity of coverage and relevant social services for individuals who are incarcerated and transitioning to the community. The legislation also directed HHS to work with states to develop innovative strategies to help such individuals enroll in Medicaid and to, within a year of enactment, issue an SMD letter regarding opportunities to design section 1115 Demonstration projects to improve care transitions to the community for incarcerated individuals who are eligible for Medicaid.

On April 17, 2023, CMS published SMD letter # 23-003 outlining the opportunities to test transition-related strategies to support community re-entry and improve care transitions for individuals who are incarcerated. This letter, plus the approval of California's Demonstration amendment for incarcerated individuals, provides guidance for the development and submission of an 1115 Demonstration amendment for incarcerated individuals who are transitioning to release. Connecticut is seeking to collaborate with HHS to develop an innovative Demonstration that will help to ensure continuity of care when the State's JI populations transition from incarceration to the community under this new guidance.

National data has shown that the JI population contains a disproportionate number of persons with behavioral health conditions (i.e., SUDs and mental health disorders), as well as HIV and other chronic diseases. Nationally, an estimated 80% of individuals released from prison in the United States each year have an SUD or chronic medical or psychiatric condition.² In 2011-2012, half of people in state and federal prison and local jails reported ever having a chronic condition.³ 21% of people in prisons and 14% of people in jail reported ever having an infectious disease, including tuberculosis, hepatitis B and C, and other sexually transmitted diseases, compared with 4.8% of the general population.⁴

In addition, according to the Bureau of Justice Statistics, 53% of all state prisoners and 45% of all federal prisoners meet the Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth Revision, criteria for drug dependence.⁵ Estimates for the jail population indicate that 47% have issues with alcohol use and 53% suffer from drug dependency or abuse.⁶

The JI population also suffers from mental and behavioral health issues. According to the Bureau of Justice Statistics, in 2005, 56% of people in state prison, 45% of people in federal prison, and 64% of people in jail reported symptoms of a mental health disorder.⁷

On January 7, 2022, the State of Connecticut Department of Correction (DOC) exported mental health diagnoses from its electronic medical record EMR and merged the diagnostic data with information from its administrative database. A team of psychiatrists then sorted the diagnoses in the resulting database into categories based on the DSM, Fifth Revision, the standard authority for psychiatric diagnoses. Their findings related to the Connecticut inmate population

² Shira Shavit et al., "Transitions Clinic Network: Challenges and Lessons in Primary Care for People Released from Prison," *Health Affairs* 36, no. 6 (June 2017): 1006–15

³ L. Maruschak, M. Bersofsky, and J. Unangst. *Medical Problems of State and Federal Prisoners and Jail Inmates*. Bureau of Justice Statistics Special Report (NCJ 248491), U.S. Department of Justice, February 2015

⁴ *Ibid*

⁵ Mumola, C. and Karberg, J. *Drug Use and Dependence, State and Federal Prisoners, 2004*. Bureau of Justice Statistics Special Report (NCJ213530), U.S. Department of Justice, October 2006

⁶ Karberg, K. C., James, D. J. *Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002*. Bureau of Justice Statistics Special Report (NCJ 209588), U.S. Department of Justice, July 2005.

⁷ James, D. and Glaze, L. *Mental Health Problems of Prison and Jail Inmates*. Bureau of Justice Statistics Special Report (NCJ 213600), U.S. Department of Justice, September 2006. Available at: http://www.bjs.gov/index.cfm?ty_pbdetail&iid_789

are below:

- 32% of the incarcerated population was classified as having an active mental health disorder requiring treatment (MH-3 or higher). An additional 41% of the population was classified as having a history of mental health disorders not requiring active treatment (MH-2). The percentage of women with active mental health disorders requiring treatment (81%) was significantly higher than that for men (28%). The rate of active mental health disorders varied significantly across racial groups: Native American (53%), White (41%), Asian (35%), Hispanic (30%), and Black (26%). The rate of active mental health disorders was significantly higher in the unsentenced population (39.7%) than in the sentenced population (25.8%). This rate of active mental health disorders was higher than average for individuals under 26 years old (37.6%).
- 89% of the incarcerated population was classified as having a history of or current substance use problem (T-2 or higher).
 - 15% had a slight history of substance use, with a recommendation for voluntary recovery support services (T-2).
 - 34% had a moderate substance use problem requiring treatment (T-3)
 - 40% of the population had a serious or extremely serious substance use problem requiring residential or intensive outpatient treatment (T-4 and 5).
 - The prevalence of substance use problems requiring treatment (T-3 or higher) was significantly higher for women (84.4%) than for men (73%).
 - This rate varied across racial groups and was higher for White individuals (78.5%) than for Black (73%), Hispanic (71%), Native American (67%) and Asian individuals (60%).
 - This rate was also higher for individuals aged 26 to 55 (77.7%).
- 95.5% of the incarcerated population had at least one or more of (1) a history of mental health disorders, (2) an active mental health disorder requiring treatment, (3) a history of substance use, or (4) an active substance use problem requiring treatment. 80.8% of the incarcerated population had either an active mental health disorder requiring treatment or an active SUD requiring treatment. 24.5% of the population had both.

Governor Lamont's administration, the Connecticut General Assembly, and stakeholders have all expressed an interest in improving access and quality of care for the JI population. For example, in May of 2022, Public Act 22-133, *An Act Requiring the Development of a Plan Concerning the Delivery of Health Care and Mental Health Care Services to Inmates of Correctional Institutions*, was signed into law. The legislation requires the Department of Correction to develop a plan to enhance the provision of health care services to inmates, including additional behavioral health care and dental services.

Connecticut believes uninterrupted health coverage is imperative to ensure this high-risk, high-need population receives much-needed care as they transition back to their communities. To help facilitate this transition, beginning in 2015, Connecticut implemented suspension of benefits for up to three years for all Medicaid programs instead of termination of eligibility for individuals

who are incarcerated. In addition, Connecticut has had a process in place to expedite Medicaid eligibility for nearly a decade. Through this process, eligible individuals whose Medicaid coverage may have expired or who were not on Medicaid previously can immediately access pharmacy and treatment services when released from incarceration. If approved, this specific Demonstration will allow the State to leverage the expedited eligibility process, supplement suspension of benefits, and more seamlessly transition incarcerated individuals to the appropriate Medicaid program during the 90 days prior to release from incarceration.

Goals and Objectives

Under Section 1115 of the Social Security Act, states may implement “experimental, pilot or Demonstration projects which, in the judgment of the Secretary [of Health and Human Services] are likely to assist in promoting the objectives of [Medicaid].” The State believes this Demonstration is likely to promote the objectives of Medicaid by providing transitional services to ensure high-risk JI populations have critical supports in place when released from incarceration.

As mentioned in the introduction, Connecticut’s proposal is consistent with the CMS goals as outlined in SMD letter # 23-003.

Under this Demonstration, the State will be able to bridge relationships between community-based Medicaid providers and JI populations prior to release, thereby improving the chances individuals with a history of SUD, serious mental illness (SMI) and/or chronic diseases receive stable and continuous care. To successfully design and implement the Re-entry Demonstration, Connecticut agrees to the required deliverables and milestones CMS has put forward via recent guidance.

The State will submit a Re-entry Demonstration Initiative implementation plan using the most recent CMS implementation plan guidance to describe its approach to implementing the Re-entry Demonstration Initiative, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The State will submit the draft implementation plan to CMS for review no later than 120 calendar days after approval of the Re-entry Demonstration Initiative.

In the implementation plan, the State will provide additional details regarding the implementation of the Re-entry Demonstration Initiative that are not already captured in the Special Terms and Conditions (STCs). Contingent upon CMS’s approval of the State’s implementation plan, the State may begin claiming Federal Financial Participation (FFP) for services provided through the Re-entry Demonstration Initiative at the time of inclusion of the STCs, expected to begin on or after July 1, 2024.

The implementation plan will describe the implementation settings, the time period that pre-release services are available, and the phase-in approach to implementation, as applicable. Other than providing such contextual information, the core requirement of the implementation plan is for the State to describe the specific processes, including timelines and programmatic content where applicable, for meeting the milestones below, such as to remain on track to achieve the key goals and objectives of the program. For each milestone—and specifically for any associated actions that are integral aspects for attaining the milestone—the implementation plan will document the current state of affairs, the intended end state to meet the milestone, the date by which the milestone is expected to be achieved, and the activities that will be executed by that date for the milestone to be achieved. Furthermore, for each milestone, the

implementation plan will identify the main anticipated implementation challenges and the State's specific plans to address these challenges. The implementation plan will document the State's strategies to drive positive changes in healthcare quality for all beneficiaries, thereby reducing disparities and improving health equity. The State will also provide the following information related to, but not limited to, the following milestones and actions.

Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated. Connecticut has already implemented a state policy for a suspension strategy during incarceration and a process for expedited eligibility for coverage for all individuals leaving a prison, jail, or juvenile detention setting. The State agrees to outline its plans to fully effectuate, no later than two years from approval of the expenditure authority, robust outreach to ensure beneficiary and applicant awareness of the policy and assist individuals with Medicaid application, enrollment, and renewal processes. The State will make available a Medicaid identification number or card to an individual upon release; and establish processes to allow and assist all individuals who are incarcerated at a participating facility to access and complete a Medicaid application, including providing information about where to complete the Medicaid application for another state. Connecticut will ensure that any Medicaid-eligible person, who is incarcerated at a participating facility but not yet enrolled, is afforded the opportunity to apply for Medicaid and is offered assistance with the Medicaid application process. Connecticut will also ensure that all individuals at a participating facility who were enrolled in Medicaid prior to their incarceration are offered assistance with the Medicaid renewal or redetermination process requirements.

Milestone 2: Covering and ensuring access to the expected minimum set of pre-release services for individuals who are incarcerated, to improve care transitions upon return to the community. Connecticut plans to implement a screening process for all individuals to screen for the qualifying criteria outlined in this application. Connecticut will outline how individuals who are screened and determined eligible will access the Demonstration benefit package, as clinically appropriate. This includes ensuring access for individuals screened and determined eligible under the Demonstration to the minimum short-term, pre-release benefit package, including:

- Case management to assess and address identified physical and behavioral health needs and health-related social needs (HRSN);
- Medication-assisted treatment (MAT) services for all types of SUD as clinically appropriate with accompanying counseling; and
- A 30-day supply of medication (as clinically appropriate based on the medication dispensed and the indication) provided to the beneficiary immediately upon release.

In the implementation plan, Connecticut will describe how it will implement processes to assure that all pre-release service providers, as appropriate for the provider type, have the necessary experience and training, and case managers have knowledge of (or means to obtain information about) community-based providers in the communities where individuals will be returning upon release. Further, as applicable, the State will establish state requirements for carceral health providers who are not participating in Medicaid or Children's Health Insurance Program (CHIP) that are similar to Medicaid provider standards, as well as program integrity standards to ensure appropriate billing.

Milestone 3: Promoting continuity of care.

Today, of the 12,000 individuals with chronic conditions released annually, just over half — approximately 6,500 — receive pre-release case management from DOC and the Judicial Branch Court Support Services Division.

- Through DOC discharge planning, re-entry, and MAT case management, adults with intensive medical and/or behavioral health needs receive a person-centered plan for coordination post-release.
- The Cybulski Community Reintegration Center and the DOC Veterans Services Unit also work with individuals pre-release to facilitate transitions post-release.
- The Department of Developmental Services (DDS) provides Re-Entry Case Management for individuals with Intellectual Disabilities.
- Currently, the Department of Mental Health and Addiction Services' (DMHAS) Re-entry Case Management program serves a subset of individuals with substance use disorder who are incarcerated. DMHAS, DOC and community providers collaborate to provide transitional case management to individuals who are re-entering the community in five of DOC's facilities. There are currently four community agencies who are contracted to provide services. It is proposed that during implementation, this service will be made available to inmates in all DOC facilities and to inmates with any qualifying mental health or substance use disorder or concern.
- Before the Coronavirus 2019 (COVID-19) pandemic, CT DMHAS and DOC also collaborated at a subset of facilities to provide pre-release case management and the development of a post-release, person-centered plan for adults (ages 18+) with Severe and Persistent Mental Illness (SPMI). As the state returned to operations following the public health emergency, this program design is being re-assessed.

In the implementation plan, the State will detail the operational steps and timeline to provide or facilitate timely access to post-release medical supplies, equipment, medication, additional exams, or other post-release services to address the physical and behavioral health care needs identified during the case management assessment and the development of the person-centered care plan. Connecticut will outline its processes for promoting and ensuring collaboration between case managers, providers of pre-release services and providers of post-release services, to ensure that appropriate care coordination is taking place.

Milestone 4: Connecting to services available post-release to meet the needs of the reentering population. Connecticut has an extensive network of behavioral health and substance use providers and will implement a system to monitor the delivery of post-release services and ensure that such services are delivered within the appropriate timeframe. The implementation plan will describe how ongoing post-release case management is monitored and adjusted and describe its process to help ensure the scheduling and receipt of needed services, as well as other services needed to address HRSN and LTSS. Additionally, the implementation plan will describe how the state will ensure that case managers are able to effectively serve Medicaid-eligible individuals under the Demonstration who are transitioning into the community.

Milestone 5: Ensuring cross-system collaboration. In the implementation plan, Connecticut will outline how the correctional system will facilitate incarcerated beneficiaries' access to community health care providers, including case managers, either in person or via telehealth.

The implementation plan will also outline its plans for establishing communication and engagement between correctional systems, community supervision entities, health care organizations, the State Medicaid agency, and supported employment and housing organizations. Connecticut has already developed plans to connect its carceral electronic health records to the Connecticut Health Information Exchange (Connie). The State will utilize these systems to monitor individuals' health care needs, HRSN, and their access to and receipt of health care services pre- and post-release and identify anticipated challenges and potential solutions. Furthermore, the State will develop and share its strategies to improve awareness about Medicaid coverage and access among stakeholders, including those who are incarcerated.

Implementation of Health-Related Social Needs (HRSN) Services for the JI Population transitioning from incarceration. Connecticut requests FFP for evidence-based HRSN services for the JI population subject to the restrictions described below. Expenditures for HRSN services targeted to the JI population will be limited to costs not otherwise covered under Title XIX, but consistent with Medicaid Demonstration objectives that enable Connecticut to continue to improve health outcomes and increase the efficiency and quality of care.

JI HRSN services will be tailored to the beneficiary and based on medical appropriateness using clinical and other health-related social needs criteria. The state will align JI clinical and social risk criteria across services and with other non-Medicaid human service agencies, to the extent possible, including HUD, SNAP, etc. The HRSN services will not supplant any other available funding sources such as housing supports available to beneficiaries through local, state, or federal programs. The JI HRSN services will be the choice of the JI beneficiary; beneficiaries can opt out of JI HRSN services at any time; and JI HRSN services do not absolve the state of its responsibilities to provide required coverage for other medically necessary services. The State will not condition Medicaid coverage, or coverage of any benefit or service, on receipt of JI HRSN services. The state will submit additional details on covered HRSN services to CMS as outlined in the approved STCs (after CMS approval). State spending on related social services prior to the approval of the 1115 Demonstration will be maintained or increased. The JI HRSN service expenditures will not exceed 3% of the state's annual total Medicaid spend and will not exceed \$50 million or 0.5% of the State's total annual Medicaid spend, whichever is less.

Connecticut will report to CMS on HRSN service implementation, including progress made and challenges experienced; HRSN service utilization; quality of services; and health outcomes for individuals receiving HRSN services. Connecticut will report on all mandatory CMS health equity metrics, stratified as required.

Connecticut requests authority to cover HRSN Housing Support services for the JI population when an individual transitioning from correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile detention centers have a documented need for the services in their care plan or medical record.

Connecticut requests authority to claim FFP in HRSN infrastructure investments in order to support the development and implementation of JI HRSN services, not to exceed 15% of the total JI HRSN spend.

Section II. Demonstration Eligibility

Suspension of Coverage. Since 2015, DSS has elected to suspend, rather than terminate, Medicaid coverage when a recipient is incarcerated. In state prison facilities, benefit suspension takes effect when an individual is incarcerated for more than 60 days and may remain in effect for up to three years, at which point the case is terminated if the individual is still incarcerated. If the prison term is less than three years, the suspension is lifted, which negates the need for a Medicaid application⁸.

As is required by CMS for JI 1115 Demonstrations, DSS will work to maintain and enhance this system of suspension to ensure individuals who were enrolled in Medicaid at the time they entered the correctional system can have their coverage quickly and easily reinstated as part of the pre-release planning. DSS will ensure for those who were not enrolled in Medicaid when entering the correctional system, the State will maintain and improve its process for expedited eligibility for Medicaid coverage applicable to all individuals leaving a prison or jail setting, ensuring that individuals receive assistance with completing and submitting an application for Medicaid, unless the individual declines such assistance or wants to decline enrollment.

If an individual who is incarcerated would be eligible for CHIP if not for their incarceration status, and they qualify to receive pre-release services, then pre-release services will be covered under this amendment.

Re-entry Demonstration Initiative populations are defined as persons who are enrolled in Medicaid or who would be eligible for CHIP except for their incarceration status, or who are incarcerated in a State correctional system, including all correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile detention centers who meet the eligibility criteria below. To receive services under the Re-entry Demonstration, a beneficiary will meet the following qualifying criteria:

All of the following:

- Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a State correctional system, including all correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile detention centers; and
- Be enrolled in Medicaid or otherwise eligible for CHIP if not for their incarceration status; and
- Identified as expected to be released in the next 90 days and identified for participation in the Demonstration; AND

One of the following conditions:

- Is an individual incarcerated in a juvenile detention center⁹; or
- Is an adult and meets one or more of the following diagnosis or population requirements:
 - Mental illness (MI);
 - SUD;
 - Co-occurring MI/SUD;
 - Chronic condition or significant non-chronic clinical condition;
 - Intellectual disability;
 - Acquired brain injury, including traumatic brain injury;
 - Positive test or diagnosis of HIV/AIDS; or

⁸ <https://www.cga.ct.gov/2016/rpt/pdf/2016-R-0261.pdf>

⁹

- Currently pregnant or within a 12-month postpartum period.

Table 1. Adult Health Care Need Criteria Definitions for the Re-entry Demonstration Initiative

Qualifying Condition	Definition
Mental Illness	<p>A person with a “mental illness” is a person who is currently receiving mental health services or medications OR meets both of the following criteria:</p> <ol style="list-style-type: none"> i. The beneficiary has one or both of the following: <ol style="list-style-type: none"> a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities; AND/OR b. A reasonable probability of significant deterioration in an important area of life functioning; AND ii. The beneficiary’s condition as described in paragraph (i) is due to either of the following: <ol style="list-style-type: none"> a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems, OR b. A suspected mental disorder that has not yet been diagnosed.
Substance Use Disorder (SUD)	<p>A person with a “substance use disorder” or “SUD” is a person who either:</p> <ol style="list-style-type: none"> i. Meets SUD criteria, according to the criteria of the current editions of the DSM and/or the International Statistical Classification of Diseases and Related Health Problems, OR ii. Has a suspected SUD diagnosis that is currently being assessed through either National Institute of Drug Abuse (NIDA)-modified Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), American Society of Addiction Medicine (ASAM) criteria, Global Appraisal of Individual Needs (GAIN), or other state-approved screening tool.
Co-occurring MI/SUD	<p>A person with a “mental illness” AND a “substance use disorder” as defined above.</p>
Chronic Condition or Significant Non-Chronic Clinical Condition	<p>A person with a “chronic condition” or a “significant non-chronic clinical condition” has ongoing and frequent medical needs that require treatment and can include one or more of the following diagnoses, as indicated by the individual, and may be receiving treatment for the condition, as indicated:</p> <ul style="list-style-type: none"> • Active cancer • Active coronavirus disease 2019 (COVID-19) or Long COVID-19 • Active hepatitis A, B, C, D, or E • Advanced liver disease • Advanced renal (kidney) disease • Dementia, including, but not limited to Alzheimer’s disease • Autoimmune disease, including, but not limited to rheumatoid arthritis, Lupus, inflammatory bowel disease, and/or multiple sclerosis • Chronic musculoskeletal disorders that impact functionality of activities of daily living, including, but not limited to arthritis and muscular dystrophy • Chronic neurological disorder

Qualifying Condition	Definition
	<ul style="list-style-type: none"> • Severe chronic pain • Congestive heart failure • Connective tissue disease • Coronary artery disease • Currently undergoing a course of treatment for any other diagnosis that will require medication management of three or more medications or one or more complex medications that requires monitoring (e.g., anticoagulation) therapy after re-entry • Cystic fibrosis and other metabolic development disorder • Epilepsy or seizures • Foot, hand, arm, or leg amputee • Hip/pelvic fracture • HIV/AIDS • Hyperlipidemia • Hypertension • Incontinence • Severe migraine or chronic headache • Moderate to severe atrial fibrillation/arrhythmia • Moderate to severe mobility or neurosensory impairment including, but not limited to spinal cord injury, multiple sclerosis, transverse myelitis, spinal canal stenosis, peripheral neuropathy • Obesity • Peripheral vascular disease • Pressure injury or chronic ulcers (vascular, neuropathic, moisture-related) • Previous stroke or transient ischemic attack • Receiving gender-affirming care • Active respiratory conditions, including, but not limited to severe bronchitis, chronic obstructive pulmonary disease, asthma, or emphysema • Several viral, bacterial, or fungal infections • Sickle cell disease or other hematological disorders • Significant hearing or visual impairment • Spina bifida or other congenital anomalies of the nervous system • Tuberculosis OR • Type 1 or 2 diabetes.
Intellectual Disability	A person with an “intellectual disability,” is defined in section 1-1g of the Connecticut General Statutes and originates before eighteen years of age.
Acquired Brain Injury (ABI) including Traumatic Brain Injury (TBI)	A person with an “acquired brain injury” or “ABI” includes Traumatic Brain Injury and is defined in section 17b-260a-3 of the Regulations of Connecticut State Agencies.
HIV/AIDS	A person with “HIV/AIDS” means a person who has tested positive for either human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) at any point in their life.
Pregnant or Postpartum	A person who is “pregnant” or “postpartum” is a person who is either currently pregnant or within 12 months following the end of the pregnancy.

Individuals deemed a “qualified inmate” will have eligibility determined for the appropriate Medicaid program for which they meet eligibility requirements. For example, if a “qualified inmate” meets the eligibility criteria for the Adult Expansion Medicaid program, then they would

be enrolled in that specific Medicaid program.

A “qualified inmate” must meet general Medicaid program requirements. These include:

1. Must be a Connecticut resident;
2. Must be a U.S. Citizen or qualified alien¹⁰; and
3. Must meet the income and asset standards for the applicable Medicaid program.

Possible Medicaid programs include, but are not limited to:

1. TANF or related children and adult caretaker groups (HUSKY A)
2. CHIP (HUSKY B)
3. Aged, Blind or Disabled Medicaid or related groups (HUSKY C)
4. Adult Expansion Medicaid (HUSKY D)

The tables below indicate estimates of the incarcerated population in the State of Connecticut that may be impacted by this Demonstration.

Table 2A. Adult Population.

Aggregate Releases	Average Daily Population	2022 Annual Releases by Episode	2022 Count by Unique Inmates	2022 Count by Inmates Under Age 18 at Exit
Adult Population	9,990 ¹¹	6,219 Sentenced 8,501 Unsentenced 14,720 ¹² Total	5,835 Sentenced 7,442 Unsentenced 13,277 Total	7 Sentenced 45 Unsentenced 52 Total

Table 2B. Juvenile Population.

Aggregate	Annual Releases 2022	Average Daily Population	Monthly Releases in 2022	Expected Releases in 2023 Per Month
Secure Facilities	645	70	12	15.5
Staff Secure	27		2	2.25
Residential Staff Secure	138		11	11.5

¹⁰ Medicaid coverage for non-qualified non-citizens consists only of the emergency Only program pursuant to 42 CFR § 435.139.

¹¹ The July 1, 2022, daily count was 9,990 according to the OPM CJPPD December 15, 2022, report of which 9,296 were males and 694 were females, p. 15-16.

¹² DOC Direct Facility Releases and Discharges by Sentenced and Unsentenced Inmates

Section III. Demonstration Benefits and Cost-Sharing Requirements

The pre-release services authorized under the Re-entry Demonstration Initiative include the provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth. All facilities must implement service level one. The State may begin claiming FFP for services covered through the initiative, expected to begin on or after July 1, 2024, once the implementation plan is approved by CMS. Cost-sharing requirements will not differ from those provided under the State Plan.

Service level one is structured as the minimum benefit package for pre-release coverage:

- Re-entry transitional case management services to assess and address physical and behavioral health needs and HRSN;
- MAT, for all Food and Drug Administration (FDA)-approved medications, including coverage for counseling; and
- Covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan) provided to the individual immediately upon release from the correctional facility.

The State may define additional service level categories in its implementation plan. A facility must implement all the services within its chosen service level. As applicable, additional service levels may be phased in by facilities in any order (e.g., service level two would not be a prerequisite for phasing in service level three). A participating facility may move between service levels as it is able to stand additional benefits. Participating facilities plans for service level selection and movement will be captured in the implementation plan, including a timeline for initial implementation and any shifting between service levels.

The Re-entry Demonstration Initiative implementation plan will describe the implementation settings, the time period that pre-release services are available, and the State's service level approach to implementation, including facilities opting into each and identification of each. The implementation plan will further describe the State's approach to handling facilities that opt into a service level after the initial implementation of the Demonstration has begun. Additional service levels may include the following services currently covered under the Connecticut Medicaid and CHIP State Plans:

- Physical and behavioral health clinical consultation services provided through telehealth or in-person, as needed, to diagnose health conditions, provide treatment, as appropriate, and support pre-release case managers' development of a post-release treatment plan and discharge planning;
- Laboratory and radiology services;
- Medications and medication administration;

- Services by community health workers to the extent covered under the Medicaid State Plan, including those with lived experience;
- Family planning services;
- Screening for common health conditions within the incarcerated population, such as blood pressure, diabetes, hepatitis C, and HIV;
- Rehabilitative or preventive services, to the extent covered under the Medicaid State Plan including those provided by community health workers, as applicable;
- Treatment for hepatitis C; and
- Provision of durable medical equipment and/or supplies.

In addition to the pre-release services, qualifying beneficiaries may also receive durable medical equipment (DME) upon release, consistent with approved State Plan coverage authority and policy.

Table 3. Service Definitions for the Re-entry Demonstration Initiative

Covered Service	Definition
Service Level One	
Re-entry Transitional Case Management (RTCM)	<p>RTCM will be provided in the period up to 90 days immediately prior to the expected date of release and is intended to facilitate re-entry planning into the community to:</p> <ol style="list-style-type: none"> 1. Support the coordination of services delivered during the pre-release period and upon re-entry; 2. Ensure smooth linkages to social services and support; and 3. Ensure the arrangement of appointments and timely access to appropriate care and pre-release services delivered in the community. Services will include: <ul style="list-style-type: none"> • Conducting a health risk assessment, as appropriate. • Assessing the needs of the individual to inform development, with the client, of a discharge/re-entry person-centered care plan, with input from the clinician providing consultation services and the correctional system’s re-entry planning team: <ul style="list-style-type: none"> — While the re-entry transitional person-centered care plan is created in the pre-release period and is part of the case management pre-release service to assess and address physical and behavioral health needs and HRSN identified, the scope of the plan extends beyond release; • Obtaining informed consent, when needed, to furnish services and/or to share information with other entities to improve coordination of care; • Providing warm linkages with designated care managers (including potentially a care management provider, for which all individuals eligible for pre-release services will be eligible) upon re-entry; • Ensuring that necessary appointments with physical and behavioral health care providers, including, as relevant to care needs, with behavioral health coordinators and providers, are arranged;

Covered Service	Definition
Medication-Assisted Treatment (MAT)	<ul style="list-style-type: none"> • Making warm linkages to community-based services and supports, including, but not limited to educational, social, prevocational, vocational, housing, nutritional, transportation, childcare, child development, and mutual aid support groups; • Providing a warm hand-off, as appropriate, to post-release case managers who will provide services under the Medicaid and CHIP State Plan or other waiver or Demonstration authority; • Ensuring that, as allowed under federal and state laws and through consent with the beneficiary, data are shared and, as relevant, to physical and behavioral health providers to enable timely and seamless hand-offs; • Conducting follow-up with community-based providers to ensure engagement was made with individual and community-based providers as soon as possible and no later than 30 days from release; and • Conducting follow-up with the individual to ensure engagement with community-based providers, behavioral health services, and other aspects of discharge/re-entry planning, as necessary, no later than 30 days from release. <ul style="list-style-type: none"> • MAT for Opioid Use Disorders (OUD) includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Act (42 U.S.C. 262) to treat opioid use disorders as authorized by the Social Security Act Section 1905(a)(29). • MAT for Alcohol Use Disorders (AUD) and Non-Opioid Substance Use Disorders includes all FDA-approved drugs and services to treat AUD and other SUDs. • Psychosocial services delivered in conjunction with MAT for OUD as covered in the State Plan section 1905(a)(29) MAT benefit, and MAT for AUD and Non-Opioid Substance Use Disorders as covered in the State Plan section 1905(a)(13) rehabilitation benefit, including assessment; individual/group counseling; patient education; prescribing, administering, dispensing, ordering, monitoring, and/or managing MAT.
Services Provided Upon Release	<p>Services provided upon release include:</p> <ul style="list-style-type: none"> — Covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with approved Medicaid State Plan).
Service levels above service level one as outlined in the State's implementation plan	
Physical and Behavioral Health Clinical Consultation Services	Physical and behavioral health clinical consultation services include targeted preventive, physical and behavioral health clinical consultation services related to the qualifying conditions. Clinical consultation services are intended to

Covered Service	Definition
	<p>support the creation of a comprehensive, robust and successful re-entry plan, including:</p> <ul style="list-style-type: none"> • Conducting diagnosis, stabilization and treatment in preparation for release (including recommendations or orders for needed labs, radiology, and/or medications); • Providing recommendations or orders for needed medications and DME that will be needed upon release; and • Consulting with the pre-release care manager to help inform the pre-release care plan. <p>Clinical consultation services are also intended to provide opportunities for clients to meet and form relationships with the community-based providers who will be caring for them upon release, including behavioral health providers, and enable information sharing and collaborative clinical care between pre-release providers and the providers who will be caring for the client after release, including behavioral health warm linkages.</p> <p>Services may include, but are not limited to:</p> <ul style="list-style-type: none"> • Addressing service gaps that may exist in correctional facilities; • Diagnosing and stabilizing individuals while incarcerated, preparing them for release; • Providing treatment, as appropriate, to ensure control of qualifying conditions prior to release (e.g., to suggest medication changes or to prescribe appropriate DME for post-release); • Supporting re-entry into the community; and • Providing behavioral health clinical consultation which includes services covered in the State Plan rehabilitation benefit but is not limited to: <ul style="list-style-type: none"> — Clinical assessment, — Patient education, — Therapy/counseling, — Care coordination, — Peer support services, and — Targeted case management covered in the State Plan.
<p>Laboratory and Radiology Services Medications and Medication Administration</p>	<p>Laboratory and radiology services will be provided consistent with the State Plan. Medications and medication administration will be provided consistent with the State Plan.</p>
<p>Community Health Worker (CHW) Services</p>	<p>CHW services will be provided consistent with the State Plan (pending submission).</p>
<p>Rehabilitative or Preventive Services, including those provided by CHWs</p>	<p>Behavioral and preventive health services, including the initial visits while the individual is incarcerated or detained, to transition the individual to a community provider for preventive and/or behavioral health services covered under the State Plan, including:</p>

Covered Service	Definition
	<ul style="list-style-type: none"> — Preventive services covered under the State Plan, including the US Preventive Services Task Force A & B recommendations such as <ul style="list-style-type: none"> • Tobacco counseling services, • Services to treat Autism Spectrum Disorders pursuant to EPSDT, — Services under the Other Licensed Practitioner Option provided by the following practitioner types: <ul style="list-style-type: none"> • Psychologists • Licensed Clinical Social Worker • Licensed Marriage and Family Therapists • Licensed Professional Counselors • Licensed Drug and Alcohol Counselor Services • Physician Assistants • Nurse Practitioners — Psychotropic Medications or other medications for behavioral health/preventive care under the Pharmacy Option — Services under the Clinic Option <ul style="list-style-type: none"> • Behavioral health clinics, — Services under Medication Assisted Treatment for OUD <ul style="list-style-type: none"> • Chemical maintenance clinics — Services under the Rehabilitative Option <ul style="list-style-type: none"> • All American Society of Addiction Medicine ambulatory, residential and hospital levels of care under the Rehabilitative Option and • Services under the Connecticut EPSDT Rehabilitative Option including office-based off-site rehabilitation services, home and community-based behavioral health services, multi-systemic therapy, multi-dimensional family therapy, functional family therapy, intensive in-home child and adolescence psychiatric services (IICAPS), emergency mobile psychiatric services (EMPS), extended day treatment, • Rehabilitation services in a residential setting, including assessment, individual treatment planning & review, individual, group, and family psychotherapy, medical/psychiatric services (medication administration and psychotropic management), rehabilitative counseling, care coordination — CHW services will be provided consistent with the State Plan (pending submission).
Family Planning	Family planning consistent with the Medicaid State Plan requirements, including contraceptives and other birth control.
Treatment for Hepatitis C	Screening, diagnosis, and treatment for hepatitis C consistent with Medicaid State Plan coverage for pharmacy, physician, laboratory, radiology, hospital,
Services Provided Upon Release	Services provided upon release include: <ul style="list-style-type: none"> — DME consistent with Medicaid State Plan

Covered Service	Definition
<p>JI HRSN Services</p>	<p>requirements.</p> <p>Allowable JI HRSN services:</p> <ul style="list-style-type: none"> • Rent/temporary housing for up to six months, specifically for individuals transitioning from correctional centers (jails and courthouses) and correctional institutions (prisons) and youth juvenile detention centers throughout the State; • Utility costs including activation expenses and back payments to secure utilities for individuals receiving rent/temporary housing as described above; • Pre-tenancy and tenancy sustaining services, including tenant rights education and eviction prevention; • Housing transition navigation services; • One-time transition and moving costs (e.g., security deposit, first month’s rent, utility activation fees, movers, relocation expenses, pest eradication, pantry stocking, and the purchase of household goods and furniture); • Housing deposits to secure housing, including application and inspection fees and fees to secure needed identification; • Medically necessary air conditioners, heaters, humidifiers, air filtration devices, generators, and refrigeration units as needed for medical treatment and prevention; • Medically necessary home accessibility modifications and remediation services such as ventilation system repairs/improvements and mold/pest remediation. <p>Excluded JI HRSN services include, but are not limited to:</p> <ul style="list-style-type: none"> • Construction costs (bricks and mortar), except as needed for approved medically necessary home modifications described above; • Capital investments; • Room and board, except as described above; • Research grants and expenditures not related to monitoring and evaluation; • Costs for services in correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile detention centers or services for people who are civilly committed and unable to leave an institutional setting; • Services provided to individuals who are not lawfully present in the United States or are undocumented; • Expenditures that supplant services and activities funded by other state and federal governmental entities; • School-based programs for children that supplant Medicaid State Plan programs; • General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and • Any other projects or activities not specifically approved by CMS as qualifying for coverage as HRSN services under this Demonstration.
<p>JI HRSN Infrastructure</p>	<p>Administrative FFP will be available for the following activities:</p> <ul style="list-style-type: none"> • Technology (e.g., electronic referral systems, shared data platforms, EHR modifications or integrations, screening tools and/or case management systems, databases/data warehouses, data analytics and reporting, data protection and privacy,

Covered Service	Definition
	<p>accounting and billing systems);</p> <ul style="list-style-type: none">• Development of business or operational practices (e.g., procurement and planning, developing policies and workflows for referral management, privacy, quality improvement, trauma-informed practices, evaluation, and member navigation);• Workforce development (e.g., cultural competency training, trauma-informed care training, traditional health worker certification, and training staff on new policies and procedures); and• Outreach, education, and stakeholder convening (e.g., design and production of outreach and education materials, translation, obtaining community input, and investments in stakeholder convening).

Section IV. Delivery System

Connecticut will deliver all benefits through the fee-for-service (FFS) delivery system. FFS reimbursement rates for services will be the same as State Plan provider payment rates for the same provider type.

The pre-release services will be provided in the State correctional system, including all correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile detention centers, or outside of the correctional system with appropriate transportation and security oversight provided by the carceral facility, subject to State approval of a facility's readiness, according to the implementation schedule.

Participating practitioners, including licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under Connecticut state scope of practice statutes, will provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws. Participating practitioners eligible to deliver services under the Re-entry Demonstration Initiative may be either community-based or correctional-facility-based providers. All participating providers, practitioners and staff, including carceral practitioners, will have the necessary experience and receive appropriate training, as applicable to a given carceral facility, prior to furnishing Demonstration-covered pre-release services under the Re-entry Demonstration Initiative. Participating providers of re-entry case management services may be community-based or carceral providers who have expertise working with JI individuals who are enrolled in Medicaid.

Section V. Implementation and Enrollment in Demonstration

The State intends to implement the Demonstration with the Department of Correction (DOC) (state prison and jail system) and with the Judicial Branch Court Support Services Division which operates juvenile detention centers, as a process is already in place for expedited Medicaid eligibility for individuals discharging from state prison within 90 days of their release date.

Delivery of pre-release services under this Demonstration will be implemented using a phased-in approach, as described below. All participating State correctional systems, including all correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile detention centers, must demonstrate readiness, as specified below, prior to participating in this initiative. (FFP will not be available on expenditures for services furnished to qualifying beneficiaries who are incarcerated in a facility before the facility meets the readiness criteria for participation outlined below). Connecticut has three levels of juvenile detention centers for juveniles, all of which will be phased into the Demonstration and an accompanying State Plan Amendment to cover State Plan services for certain JI youth pursuant to sections 5121 and 5122 of the Consolidated Appropriations Act, 2023 (Pub. L. 117-73) by January 1, 2025. Juvenile secure facilities will be in the initial phase, followed by staff secure juvenile facilities and staff secure residential centers in the next two phases. DSS will determine when each applicable facility is ready to participate in the Re-entry Demonstration Initiative based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

1. Pre-release Medicaid and CHIP application and enrollment processes for individuals who are not enrolled in Medicaid or CHIP prior to incarceration and who do not otherwise become enrolled during incarceration;
2. The screening process to determine a beneficiary's qualification for pre-release services;
3. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth. If a facility is not equipped to provide or facilitate the full set of pre-release services, the facility must provide a timeline of when it will be equipped to do so, including concrete steps and their anticipated completion dates that will be necessary to ensure that qualifying beneficiaries are able to receive timely any needed pre-release services;
4. Coordination among partners with a role in furnishing health care, housing, and HRSN services to beneficiaries, including, but not limited to, state agencies and state-contracted providers, as well as administrative services organizations, other behavioral health agencies, and community-based providers, including federally qualified health centers;
5. Appropriate re-entry planning, pre-release care management, and assistance with care transitions to the community, including connecting beneficiaries to physical and behavioral health providers and the administrative services organizations, and making referrals to care management and community support providers that take place throughout the 90-day pre-release period, and providing beneficiaries with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan);
6. Operational approaches related to implementing certain Medicaid and CHIP requirements, including, but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the Re-entry Demonstration Initiative;

7. A data exchange process to support the care coordination and transition activities;
8. Reporting of requested data from DSS to support program monitoring, evaluation, and oversight; and
9. A staffing and project management approach for supporting all aspects of the facility's participation in the Re-entry Demonstration Initiative, including information on the qualifications of the providers that the correctional system will partner with for the provision of pre-release services.

Section VI. Proposed Waiver and Expenditure Authority

The State seeks such waiver authority as necessary under the Demonstration to receive a federal match on costs not otherwise matchable for services rendered to individuals who are incarcerated 90 days prior to their release. The State also requests the following proposed waivers and expenditure authority to operate the Demonstration.

Waiver Authority	Reason and Use of Waiver Authority Will Enable the State To:
<p>Statewide Section 1902(a)(1) 42 CFR 431.50</p>	<p>To enable the State to provide pre-release services, as authorized under this Demonstration, to qualifying beneficiaries on a geographically limited basis according to the statewide implementation phase-in plan, in accordance with the Re-entry Demonstration Initiative implementation plan.</p> <p>To enable the State to cover Health-Related Social Needs (HRSN) services on a geographically limited basis during the phase-in process.</p>
<p>Amount, Duration, and Scope of Services and Comparability Section 1902(a)(10)(B) and 1902(a)(17)</p>	<p>To enable the State to provide only a limited set of pre-release services, as specified in these STCs, to qualifying beneficiaries that are different than the services available to all other beneficiaries outside of carceral settings in the same eligibility groups authorized under the State Plan or the Demonstration.</p> <p>To the extent necessary to allow the State to offer the JI HRSN services. To the extent necessary to enable the State to provide HRSN services based on service delivery systems that are not otherwise available to all beneficiaries in the same eligibility group during the phase-in process.</p>
<p>Freedom of Choice Section 1902(a)(23)(A) 42 CFR 431.51</p>	<p>To enable the State to require qualifying beneficiaries to receive pre-release services, as authorized under this Demonstration, through only certain providers.</p>

Waiver Authority	Reason and Use of Waiver Authority Will Enable the State To:
Title XXI Requirements Not Applicable to the Title XXI Expenditure Authority Above Requirements for Providers under the State Plan Section 2107(e)(1)(D)	To enable the State to not require carceral providers to enroll in Connecticut CHIP, in order to provide, order, refer, or prescribe pre-release services as authorized under this Demonstration.

Expenditure Authority

The State requests expenditure authority to provide Medicaid benefits to Demonstration eligible individuals.

Title XIX Expenditure Authority	Expenditures
Expenditures Related to Pre-Release Services	Expenditures for pre-release services, as described in the STCs to be established by CMS, are provided to qualifying Medicaid beneficiaries and beneficiaries who would be eligible to receive Medicaid covered services if not for their incarceration status for up to 90 days immediately prior to the expected date of release from a participating State correctional system facility, including all correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile detention centers.
Expenditures for Allowable Administrative Costs to Support the Implementation of Pre-Release Services	Expenditures for allowable administrative costs to support the implementation of pre-release services as outlined in the April 17, 2023, SMD letter # 23-003 relating to administrative information technology (IT) and transitional, non-service expenditures, including administrative costs under an approved cost allocation plan.
Health-Related Social Needs (HRSN) Services.	Expenditures for approved evidence-based health-related social needs services not otherwise eligible for Medicaid payment furnished to individuals who meet the qualifying JI and HRSN criteria
Health-Related Social Needs Services Infrastructure.	Expenditures for allowable administrative costs and infrastructure not otherwise eligible for Medicaid payment, to the extent such activities are authorized as part of the approved HRSN infrastructure activities.

Title XXI Expenditure Authority	Expenditures
Expenditures Related to Pre-Release Services	Expenditures for pre-release services, as described in the STCs, are provided to qualifying Demonstration beneficiaries who would be eligible for CHIP if not for their incarceration status, for up to 90 days immediately prior to the expected date of release from a participating State correctional system facility, including all correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile detention centers.

Section VII. Demonstration Financing and Budget Neutrality

Refer to Budget Neutrality — Attachment A for the State’s historical and projected expenditures for the requested period of the Demonstration.

Medicaid enrollment is not expected to change as a result of this Demonstration. Separate SPAs, including, but not limited to provisions for provider qualifications and reimbursement methodologies consistent with the services covered under the demonstration will be submitted with a fiscal impact, if needed. This Demonstration will permit Connecticut to provide Medicaid coverage and federal financial participation (FFP) using Medicaid and CHIP matching funds for adults incarcerated in correctional centers (jails and courthouses) and correctional institutions (prisons) and juveniles detained in juvenile detention centers throughout the State receiving a targeted benefit package that would ordinarily not be covered under federal law in the 90-days prior to release. In addition, it will allow the State to provide health related social needs (HRSN) services for individuals being released from correctional centers (jails and courthouses) and correctional institutions (prisons) and juveniles detained in juvenile detention centers. The State is also requesting financial assistance for non-service costs to implement the justice involved (JI) Re-Entry Initiative and for infrastructure costs associated with implementing the HRSN services for JI individuals.

Consistent with the federal guidance regarding the calculation of federal budget neutrality (BN) in JI Re-entry 1115 Demonstration waivers, this Demonstration has been designed in a manner to maintain federal BN consistent with federal requirements based on monthly per capita expenditures per Medicaid eligibility group for the JI Re-Entry population. The State is requesting a hypothetical capped budget neutrality test for the non-services costs to implement the JI re-entry initiative.

The State is requesting a hypothetical capped budget neutrality test for the HRSN and HRSN infrastructure authorities. For this population, the Without Waiver component is used to calculate the budget neutrality expenditure limit. Expenditures are counted against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the Capped Hypothetical Budget Neutrality test cannot be offset by savings because the State has no savings accrued from prior 1115 waiver Demonstrations.

Utilization of Medicaid State Plan-covered services for adults in a correctional centers (jails and courthouses) and correctional institutions (prisons) or youth in detention centers will be authorized only if DSS, or its designee, determines the individual is Medicaid eligible, meets eligibility criteria under the demonstration and generally complies with all other applicable requirements, including medical necessity.

Approximately 20% of the sentenced adults released from Department of Correction (DOC) and youth facilities eligible for the JI pre-release services are estimated to be eligible for the HRSN services. Provision of services under the demonstration for the JI population including HRSN services will be cost effective compared to Medicaid expenditures for inpatient hospitalizations and emergency room visits for the year following Medicaid individual’s release from incarceration and detention.

Budget Neutrality

Mercer was engaged by the State of Connecticut and DSS to develop the response to the BN Form section for the Section 1115 Medicaid Demonstration Waiver Application for Justice Involved services. BN is a comparison of without waiver expenditures to with waiver expenditures. CMS recommends two potential methodologies of demonstrating BN:

1. Per Capita Method: Assessment of the per member per month (PMPM) cost of the Demonstration
2. Aggregate Method: Assessment of both the number of individuals and PMPM cost of the Demonstration

BN for the 1115 waiver Medicaid Eligibility Group (MEG) for Justice Involved Individuals (JI Services) will be demonstrated through the Hypothetical per capita method. For JI Non-Services, JI HRSN, and JI HRSN Infrastructure MEGs, the State has utilized a capped Hypothetical methodology. Any expenditures in excess of the limit from the Hypothetical capped budget neutrality will not be matched by CMS. The BN projections were developed in alignment with CMS BN requirements.

MEG	Expenditure Type	DY03 (JI Services MEG); DY03-DY05 (all other MEGs)	Trend Rate	Test
JI Services	PMPM Cost	\$1,093	5.55%	Hypothetical
JI Non-Services	Total Expenditure	\$300,000,000		Aggregate Capped Hypothetical
JI HRSN	Total Expenditure	\$155,363,010		Aggregate Capped Hypothetical
JI HRSN Infrastructure	Total Expenditure	\$27,417,002		Aggregate Capped Hypothetical

The Justice Involved BN worksheets prepared by Mercer are attached as Attachment A.

Mercer has relied upon certain data and information provided by Connecticut’s state agencies, including the Department of Social Services (DSS), Department of Mental Health and Addition Services (DMHAS), DOC, Judicial Branch Court Support Services Division (JB-CSSD), Department of Developmental Services (DDS), Office of Policy and Management (OPM), and Department of Children and Families (DCF) in the development of the estimates contained in the BN Worksheet. Mercer has relied upon the State agencies for the accuracy of the data and accepted them without audit. To the extent the data provided are not accurate, the results of this analysis may need to be modified to reflect revised information.

Differences between Mercer’s projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the finite assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. It should be emphasized that the values in the BN Form are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this analysis.

Background

Mercer assisted DSS in developing BN estimates to include in the state's JI Re-Entry Demonstration 1115 waiver application, which is anticipated to be effective July 1, 2024 or upon CMS approval, whichever is later.

This document provides a summary to the State of the 1115 BN modeling methodology for JI services in carceral settings for which federal law would prohibit Medicaid FFP absent a section 1115 demonstration waiver. This includes a summary of one year of historical data and modeling assumptions to develop projected JI and HRSN services over the 1115 demonstration period. These estimates were included within the overall BN documentation delivered to the State on December 21, 2023, which includes BN estimates as required by the SUD 1115 BN template provided by CMS.

This document includes appendices summarizing the base data and BN projection outcomes, which will be shared with CMS as part of the formal 1115 waiver application.

Overview

The State, through its 1115 waiver application, seeks to provide a targeted benefit package to adults and youth in carceral settings in the 90 days prior to their release. The State intends to provide these services under the fee-for-service (FFS) delivery system, which is consistent with the FFS delivery model of the Connecticut Medicaid program. As such, the State seeks 1115 waiver authority to allow the State to claim FFP for services provided to Medicaid eligible individuals that utilize targeted services provided in a carceral setting.

Currently, individuals eligible for Medicaid receive services in carceral settings through state-only and non-Medicaid federal block grant funded programs (except for services provided while such individuals are patients in a medical institution, as authorized under section 1905 of the Social Security Act). Current State expenses for individuals in carceral settings do not reflect current Medicaid documentation requirements because of the limited funding available. In addition, the state agencies administering the current non-Medicaid programs do not have consistent utilization data because the programs are contract-funded and DOC and JB-CSSD employees are not required to be compliant with Health Insurance Portability and Accountability Act (HIPAA) because no data is exchanged external to the system. Because the programs are not funded through the FFS delivery system, Mercer relied on the historical utilization in Connecticut state-only and non-Medicaid federal block grant funded correctional programs as the basis for developing the BN baseline, as further detailed below. Connecticut plans to submit a Medicaid SPA adding CHW services for the JI population to the Medicaid State Plan to assist individuals in re-entry, which is anticipated to be for an effective date of on or after July 1, 2024. Other SPAs may also be necessary to include additional provider qualifications for practitioners operating in secure facilities.

These PMPM costs, along with an estimated caseload, non-service costs, HRSN, and HRSN infrastructure estimated costs were relied upon to establish Without Waiver (WoW) and With Waiver (WW) projections utilizing the BN spreadsheets provided by CMS.

Medicaid Eligibility Groups (MEGs)

Mercer acknowledges the complexities of the various State datasets. Mercer utilized the available expenditure data to estimate expenditures for the JI Services MEG. Mercer utilized state-specific utilization data to determine historic PMPM costs limited to the services intended to be covered by the Demonstration. These costs were developed on a per capita basis and further adjusted to represent costs levels aligning with a state fiscal year (SFY) 2023 time period and to only reflect costs expected 90 days prior to release from a carceral setting. Due to the limitations in the available data from Connecticut state-only and non-Medicaid federal block grant funded correctional programs, the State and Mercer are developing BN projections for JI Services under a single FFS MEG for all ages combined, including those who are dually-eligible (i.e., it combines HUSKY A (TANF-related, generally children and caretaker adult coverage groups), HUSKY B (CHIP), HUSKY C (Aged, Blind and Disabled coverage groups), and HUSKY D (Adult expansion population coverage groups)). The State expects that the majority of eligible individuals under the demonstration will be in its HUSKY D population group. 90% of all adults are expected to be in the HUSKY D eligibility category. 10% of adults are expected to be in the HUSKY A or HUSKY C eligibility categories. Out of the 26,017 individuals, 750 youth are expected to be split between HUSKY A and C eligibility categories, with very few children are anticipated to be in the HUSKY C eligibility categories. A non-material number of youth are expected to be in HUSKY B (CHIP).

Recently, 14,720 adults and 649 youth under age 18 in secure youth correctional settings were released from DOC and juvenile carceral settings in the State of Connecticut. In addition, Connecticut will phase in additional staff secure and residential detention facilities for juveniles over time including an additional 101 youth who will be released annually. Of those individuals, 96% of adults are assumed to be eligible for Medicaid with 85% anticipated to meet the chronic condition requirements for the demonstration. All youth are assumed to be eligible for the demonstration (e.g., no chronic condition requirements) and additional releases are assumed for facilities anticipated to be phased-in under the demonstration. Member months were determined based on an assumed demonstration eligible duration of 3 months for sentenced adults and 45 days, or 1.5 months, for adults who are incarcerated (either in a DOC facility or in court lock-up) but not yet sentenced. It is anticipated that Connecticut will submit a SPA in response to section 5121 of the Consolidated Appropriations Act, 2023, to cover at least 30 days of juvenile pre-release coverage resulting in the assumption that juveniles to be released will have 2 months of eligibility under the demonstration and in response to section 5122 of the Consolidated Appropriations Act, 2023, to cover juveniles in detention pending disposition of the charges resulting in the assumption that certain juveniles will be covered under the State Plan pending disposition of their charges.

	Adults in DOC Facilities Sentenced	Adults in DOC Facilities Pre-Sentenced	Adults in Court Lock-up	Youth in Juvenile Facilities
Annual number of releases	9,568	5,152	80,000	750
Number meeting Demonstration Eligibility conditions	7,807	4,204	13,256	750
Average months of eligibility	3.0	1.5	1.5	2.0

Total annual member months	23,421	6,306	19,884	1,500
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The baseline member months were then trended forward from the mid-point of the base year to the mid-point of the first Demonstration year for the program using a 1% trend rate, consistent with the caseload growth in the approved SUD Demonstration.

The JI Non-Services MEG reflects assumed capped hypothetical of \$300 million across the three years remaining in the demonstration.

For the JI HRSN population, it is estimated that 20% of incarcerated individuals released from DOC and JB-CSSD youth facilities will require some assistance with HRSN, which forms the enrollment basis of the capped hypothetical costs reflected in the JI HRSN MEG along with an expected cost of \$17,000 per eligible individual spread over a 12-month time period.

	JI HRSN
Number meeting Demonstration Eligibility conditions requiring HRSN (20% of individuals released from DOC and JB-CSSD youth facilities)	2,552
Average months of utilization	12.0
Total annual member months	30,626

Per CMS' feedback, JI HRSN Infrastructure MEG costs are capped to 15% of the total cost of JI HRSN services and infrastructure costs.

Modeling Assumptions

The SFY2023 (base year) per capita costs as outlined above were projected forward 21 months from the midpoint of SFY2023 (January 2023) to October 2024, which represents the midpoint of demonstration year (DY) 03 of the State's current SUD 1115 waiver. Note that the State is requesting an effective date for its JI Waiver amendment of July 1, 2024 or upon CMS approval, whichever is later. Beyond DY03, PMPMs are trended forward on an annual basis using a blend of the already approved SUD Demonstration trend rates for the mix of populations in the JI Population MEG as shown below:

MEG	Approved Trend from CT SUD 1115
HUSKY A	4.50%
HUSKY C	3.90%
HUSKY D	5.70%

**Weighted Average CT JI
Demonstration Trend Rate**

5.55%

In accordance with CMS guidance for JI Re-Entry 1115 demonstration waivers, the WoW and WW projections have identical assumptions, which results in the projected per capita and total spending being equivalent (i.e., no assumed waiver savings exist within this 1115 projection), consistent with CMS guidance for treatment of hypothetical MEGs.

Results

Across the remaining three-year waiver period (DY03-DY05), the State cost projections range from \$56.8 million to \$64.6 million resulting in total cost estimates of \$182.1 million for the JI Services MEG. This includes the estimated costs for the Targeted Benefit Package for individuals who utilize services pre-release. Costs for the aggregated hypothetical MEGs are \$300 million for the JI Non-Services, \$155.4 million for the JI HRSN, and \$27.4 million for JI HRSN Infrastructure MEGs. The caseload, aggregate capped expenditure and per capita estimates by DY for both the WoW and WW projections are provided in Attachment A and are broken out separately in the projections for each MEG.

Caveats and Limitations

In preparing these projection estimates, Mercer relied on readily available State-specific information and guidance from the State. Mercer reviewed the data and information for internal consistency and reasonableness but did not audit them. These projection estimates are being provided to CMS to facilitate review in advance of the State's 1115 waiver effective date. Through ongoing discussions with the State and CMS, additional information may become known that would necessitate modification of these projections. If changes become necessary, Mercer will revise these projections and update the enclosed appendices, accordingly.

The suppliers of data are solely responsible for its validity and completeness. Mercer reviewed the data and information for internal consistency and reasonableness, but Mercer did not audit it. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events, and actual experience will vary from estimates.

The assumptions outlined throughout this narrative are based upon Mercer's understanding of the services and provisions to be included in the State's waiver. To the extent changes are made to the planned services or to the program design, these projections may be impacted and need to be updated accordingly. Further, Mercer acknowledges that CMS review may necessitate changes to the proposed projections. As such, the information included in this report should be considered draft and subject to change.

This methodology document assumes the reader is familiar with the State's 1115 waiver application and budget neutrality projection techniques. It is intended for the State and should not be relied upon by third parties. Other readers should seek advice of qualified professionals to understand the technical nature of these results. This document should only be reviewed in its entirety. **This document is not intended for broad distribution beyond Mercer, the State of Connecticut, its stakeholders (including the public notice and comment processes and related stakeholder engagement) and CMS.** Mercer expressly disclaims responsibility, liability or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

Reinvestment: To the extent that the Re-entry Demonstration Initiative covers services that are the responsibility of and were previously provided or paid by the carceral facility or carceral authority with custody of qualifying beneficiaries, the State will reinvest all new federal dollars, equivalent to the amount of FFP projected to be received for such services, as further defined in the Re-entry Demonstration Initiative Reinvestment Plan submitted consistent with the terms and conditions of the Demonstration. The Reinvestment Plan will define the amount of reinvestment required over the term of the Demonstration, based on an assessment of the amount of projected expenditures for which reinvestment is required. FFP projected to be expended for new services covered under the Re-entry Demonstration Initiative, defined as services not previously provided or paid by the carceral facility or carceral authority with custody of qualifying beneficiaries before the individual facility implemented the Re-entry Demonstration Initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the Re-entry Demonstration Initiative, with respect to the relevant increase in expenditures, as described in the Re-entry Demonstration Initiative Reinvestment Plan), is not required to be reinvested.

Within 120 days of approval, the State will submit a Re-entry Demonstration Initiative Reinvestment Plan, as part of the required implementation plan for CMS approval, that memorializes the State's reinvestment approach. The Reinvestment Plan will also identify the types of expected reinvestments that will be made over the Demonstration period. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, will be made throughout the Demonstration period. Allowable reinvestments include, but are not limited to:

1. The state share of funding associated with new services covered under the Re-entry Demonstration Initiative;
2. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the HRSN of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;
3. Improved access to and/or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the Re-entry Demonstration Initiative opportunity;
4. Improved health information technology and data sharing;
5. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, JI individuals or individuals at risk of justice involvement;
6. Expanded or enhanced community-based services and supports, including services and supports to meet the HRSN of the JI population; and
7. Any other investments that aim to support re-entry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the JI population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

Demonstration Hypotheses and Evaluation

With the help of an independent evaluator, the State will amend the approved SUD evaluation plan for evaluating the hypotheses indicated below. Connecticut will calculate and report all performance measures under the Demonstration. The State will submit the updated SUD evaluation plan to CMS for approval.

The State will conduct ongoing monitoring of this Demonstration related to the five Re-Entry milestones as required in CMS guidance as well as the three required HRSN tests identified below, and will provide information regarding monitoring activities in the required quarterly and annual monitoring reports.

By providing Medicaid coverage prior to an individual's release from incarceration, the State will be able to bridge relationships between community-based Medicaid providers and JI populations prior to release, thereby improving the likelihood that individuals with a history of behavioral health conditions and/or chronic diseases will receive stable and continuous care. The following hypotheses and goals will be tested during the approval period:

Hypotheses: The full 90-day timeline will enable the State to support pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs) which could reduce post-release acute care utilization.

By allowing early interventions to occur in the full 90-day period immediately prior to expected release, such as for certain behavioral health conditions and including stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs, Connecticut expects that it will be able to reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release.

Questions: The State will test, and comprehensively evaluate through robust hypotheses testing, the effectiveness of the extended full 90-day coverage period before the beneficiary's expected date of release on achieving the articulated goals of the initiative:

1. Increase coverage, continuity of coverage, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release;
2. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during re-entry;
3. Improve coordination and communication between correctional systems, Medicaid systems, administrative services organizations, and community-based providers;
4. Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful re-entry post-release;
5. Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and HRSN;
6. Reduce all-cause deaths in the near-term post-release; and

7. Reduce the number of ED visits and inpatient hospitalizations among recently released Medicaid beneficiaries through increased receipt of preventive and routine physical and behavioral health care.

Additionally, the State will test, and comprehensively evaluate through robust hypotheses testing, the effectiveness of HRSN services in achieving the articulated goals of the initiative:

1. Address unmet HRSN,
2. Reduce potentially avoidable, high-cost services (e.g., ED visits, institutional care), and/or
3. Improve physical and mental health outcomes for beneficiaries.

Data Source: Claims/encounter data.

Evaluation Design: Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons and interrupted time series analysis.

Section VIII. Compliance with Public Notice and Tribal Consultation

Summary of Public Comments

A summary of feedback from commenters received during the public comment period has been provided in attachment 3 following the public comment period.

Public Notice Process

Public Notice: There were two public notices published in the Connecticut Law Journal on January 9 and January 30, 2024. Copies of the public notice can be found in Attachment 2. In addition, the brief public notice was used by all State agencies to notify stakeholders via their listserves.

Below are links to access the public notice posting, including links to the public notice webpage, JI Demonstration application draft, and the full public notice.

[1115 Justice-Involved Demonstration Waiver--Public Hearings and Public Comments \(ct.gov\)](#)

[CT-JI-1115-Amendment---Waiver-Application---Draft---01-02-24.pdf](#)

[CT-JI-1115-Amendment---Full-Pub-Notice---01-26--24.pdf](#)

Additional information regarding the public notice process, including public hearings, are included below. There were three public hearings:

Public Hearings: There were three electronic public hearings (accessible by electronic device and telephone). Links and call-in information are included below.

1. **Public Hearing hosted by the Medical Assistance Program Oversight Council (MAPOC) on Friday, January 12, 2024, at 1:00pm**, link and call-in as follows:

<https://zoom.us/j/95808481439?pwd=VFpMaGxkNGx5RGxaS3ZZQ0hmdjNCdz09>

Meeting ID: 958 0848 1439

Passcode: 435459

Phone: 1-305-522-1968

One tap mobile

+13052241968,,95808481439#,,,,*435459# US

2. **Public Hearing hosted by DSS, on Thursday, January 25, 2024, from 10:00 to 12:00 p.m.**, link and call-in as follows:

<https://us06web.zoom.us/j/86974493855?pwd=OvurwCDqP0iqJcfTu0AA8diAETHfgb.1>

Meeting ID: 869 7449 3855
Passcode: 350389
Phone: 1-305-224-1968
One tap mobile
+13052241968,,86974493855#,,,,*350389# US

3. **1115 Justice-Involved Demonstration Waiver Public Hearing hosted on Feb 6, 2024 at 01:00 PM Eastern Time (US and Canada)**

<https://us06web.zoom.us/j/86297504386?pwd=sNaZxl7zdPZmVBqe8YZShQTabmL Eqa.1>

Meeting ID: 862 9750 4386
Passcode: 597612
Phone: 1-309-205-3325
One tap mobile
+13092053325,,86297504386#,,,,*597612# US

Tribal Consultation

Connecticut has two federally recognized tribes, the Mashantucket Pequot Tribal Nation and the Mohegan Tribe. The State has solicited feedback from both tribes by sending emails to the tribal representatives with a copy of the public notice, plus a copy of the budget neutrality, and waiver application (as well as a link to the DSS website with the relevant documents). This process follows the State's approved tribal consultation State Plan Amendment. No comments were received.

Section IX. Demonstration Amendment Contact

Name and Title: William Halsey, LCSW, MBA, Deputy Director of
Medicaid and Division of Health Services, Department of Social
Services

Telephone Number: 860-424-5077

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ATTACHMENT 1



CT JI 1115
Amendment - Budget

Compliance with Budget Neutrality Requirements

State of Connecticut

Attachment A

Draft and subject to change based on CMS review

Weighted Average Trend Using Approved SUD 1115 Trend Rates

MEG	Approved Trend from CT SUD 1115	Proportion of population	Weighted Trend
HUSKY A	4.50%	5.00%	0.23%
HUSKY C	3.90%	5.00%	0.20%
HUSKY D	5.70%	90.00%	5.13%
Weighted Average CT JI Demonstration Trend Rate for Initial Projections			5.55%
			5.55%

State of Connecticut

Attachment A

Draft and subject to change based on CMS review

Member Months Estimated in Demonstration					
Population	JI Services				JI HRSN
	Adults in DOC Facilities Sentenced*	Adults in DOC Facilities Pre-Sentenced**	Adults in Court Lock-up**	Youth in Juvenile Facilities***	20% of DOC and Youth Releases Estimated to require HRSN Services
Annual number of releases	9,588	5,152	80,000	750	
Number of releases meeting Demonstration Eligibility conditions	7,807	4,204	13,256	750	2,552
Average months of eligibility	3.0	1.5	1.5	2.0	12.0
Total annual member months	23,421	6,306	19,884	1,500	30,626

Annual Member Months	
JI Services	51,111
JI HRSN	30,626

*average months of eligibility under the Demonstration for Sentenced Adults in DOC Facilities is 3 months or the full 90-day period prior to release.

**average months of eligibility under the Demonstration for Pre-Sentenced Adults in DOC Facilities and Court Lock-up 45 days or 1.5 months.

***average months of eligibility under the Demonstration for Youth in Juvenile Facilities is >3 months but has been reduced by 1 month to account for the forthcoming SPA pursuant to the Consolidated Appropriations Act.

JI Member Months/Caseloads				Demonstration Years		
Medicaid Eligibility Group (MEG)	Trend Rate	SFY2023 Member Months	Months of Trend	DY03	DY04	DY05
JI Services	1%	51,111	21	52,009	52,529	53,054
JI HRSN	1%	30,626	21	31,164	31,476	31,791

JI and HRSN Historical
 Representative Data Year:
 Type of State Year:

2023
State Fiscal Year

JI Services	SFY2023
Total Expenditures	\$ 50,843,700
Eligible User Months	51,111
PMPM Costs	\$ 994.77

JI HRSN	SFY2023
Total Expenditures	\$ 43,387,400
Eligible User Months	30,626
PMPM Costs	\$ 1,416.69

Adjusted SFY2023 Baseline

Medicaid Eligibility Group (MEG)	Estimated Total Expenditures for Targeted JI Medical Assistance provided 90-days Pre-Release and HRSN Services	Estimated Total Expenditures for All Other Title XIX State Plan Medical Assistance	Estimated Eligible Member Months for Targeted JI Benefit Package	Revised Baseline PMPM Cost	Trend Rate Used Based on Approved SUD Trend Rates
JI Services	\$ 50,843,700	\$ -	51,111	\$ 994.77	5.55%
JI Non-Services	\$ 300,000,000	\$ -	N/A	N/A	
JI HRSN	\$ 43,387,400	\$ -	30,626	\$ 1,416.69	5.55%
JI HRSN Infrastructure*	\$ 7,656,600	\$ -	N/A	N/A	

*15% of the total of HRSN spend including administration

Without-Waiver Projections

ELIGIBILITY GROUP	MEG Type	BN Component	Base Year SFY2023	Trend Rate	DEMONSTRATION YEARS (DY)			TOTAL WOW
					DY 03	DY 04	DY 05	
JI Services	Hypothetical Costs on a PMPM Basis	Eligible User Months	51,111	1.00%	52,009	52,529	53,054	
JI Services		PMPM Cost	\$ 994.77	5.55%	\$ 1,093.00	\$ 1,154.00	\$ 1,218.00	
JI Services		Total Expenditure	\$ 50,843,700		\$ 56,845,837	\$ 60,618,466	\$ 64,619,772	\$ 182,084,075
JI Non-Services	Capped Hypothetical Costs	Total Expenditure			\$ 120,000,000	\$ 105,000,000	\$ 75,000,000	\$ 300,000,000
JI HRSN	Capped Hypothetical Costs	Eligible User Months	30,626	1.00%	31,164	31,476	31,791	
JI HRSN		PMPM Cost	\$ 1,416.69	5.55%	\$ 1,557.00	\$ 1,643.00	\$ 1,734.00	
JI HRSN		Total Expenditure	\$ 43,387,400		\$ 48,522,348	\$ 51,715,068	\$ 55,125,594	\$ 155,363,010
JI HRSN Infrastructure*	Capped Hypothetical Costs	Total Expenditure			\$ 8,562,767	\$ 9,126,188	\$ 9,728,046	\$ 27,417,002

*Capped at 15% of the total of HRSN spend including administration

With-Waiver Projections

ELIGIBILITY GROUP	MEG Type	BN Component	Base Year SFY2023	Trend Rate	DEMONSTRATION YEARS (DY)			TOTAL WW
					DY 03	DY 04	DY 05	
JI Services	Hypothetical Costs on a PMPM Basis	Eligible User Months	51,111	1.00%	52,009	52,529	53,054	
JI Services		PMPM Cost	\$ 994.77	5.55%	\$ 1,093.00	\$ 1,154.00	\$ 1,218.00	
JI Services		Total Expenditure	\$ 50,843,700		\$ 56,845,837	\$ 60,618,466	\$ 64,619,772	\$ 182,084,075
JI Non-Services	Capped Hypothetical Costs	Total Expenditure			\$ 120,000,000	\$ 105,000,000	\$ 75,000,000	\$ 300,000,000
JI HRSN	Capped Hypothetical Costs	Eligible User Months	30,626	1.00%	31,164	31,476	31,791	
JI HRSN		PMPM Cost	\$ 1,416.69	5.55%	\$ 1,557.00	\$ 1,643.00	\$ 1,734.00	
JI HRSN		Total Expenditure	\$ 43,387,400		\$ 48,522,348	\$ 51,715,068	\$ 55,125,594	\$ 155,363,010
JI HRSN Infrastructure*	Capped Hypothetical Costs	Total Expenditure			\$ 8,562,767	\$ 9,126,188	\$ 9,728,046	\$ 27,417,002
Net Overspend					\$ -	\$ -	\$ -	\$ -

*Capped at 15% of the total of HRSN spend including administration

ATTACHMENT 2

Public Notice Requirements

Public notice was published in the Connecticut Law Journal on January 9 and January 30, 2024. Three public hearings were held:

1. Public Hearing hosted by the Medical Assistance Program Oversight Council (MAPOC) on Friday, January 12, 2024, at 1:00pm
2. Public Hearing hosted by DSS, on Thursday, January 25, 2024, from 10:00 to 12:00 p.m.
3. 1115 Justice-Involved Demonstration Waiver Public Hearing hosted on Feb 6, 2024 at 01:00 PM Eastern Time (US and Canada)



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CT-JI-1115-Amendm
ent---Full-Pub-Notice

January 9, 2024 Connecticut Law Journal

NOTICE OF CONNECTICUT STATE AGENCIES

DEPARTMENT OF SOCIAL SERVICES

Abbreviated Notice of Proposed Medicaid and Children's Health Insurance Program

Re-entry Initiative Demonstration Waiver Amendment Pursuant to Section 1115 of the Social Security Act

This abbreviated public notice provides information regarding the proposed amendment request to the U.S. Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services for a "Re-entry Initiative" to better support individuals' re-entry from incarceration to the community. Specifically, the State of Connecticut's Department of Social Services (DSS) proposes to amend its Medicaid Substance Use Disorder (SUD) Demonstration Waiver pursuant to section 1115 of the Social Security Act, effective on or after July 1, 2024, for Medicaid Coverage for Justice-Involved Population Re-entry (Re-entry Initiative).

The Re-entry Initiative will enable Medicaid coverage and federal financial participation (FFP) using Medicaid and Children's Health Insurance Program (CHIP) matching funds for adults incarcerated in correctional centers (jails and courthouses) and correctional institutions (prisons), and youth detained in juvenile and community residential centers throughout the State receiving a targeted benefit package that would ordinarily not be covered under federal law. This Re-entry Initiative will ensure a continuum of care strategy that enables robust coordination, service provision, and community connections after release.

Where the Demonstration is Posted

All information and materials pertaining to the Amendment, including the full public notice, public hearing dates and times, public comment submission instructions, and a copy of DSS's full demonstration draft amendment are posted to the DSS website at this link: <https://portal.ct.gov/DSS/Health-And-Home-Care/1115-Justice-Involved-Demonstration-Waiver>. Please check this website regularly for updates.

The proposed Demonstration and related materials may also be obtained upon request from DSS, at any DSS field office, or the Town of Vernon Social Services Department.

Where and When to Submit Written Comments

To send comments about the Demonstration, please email: **CT-Justice-Involved-Waiver@ct.gov** or write to the Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. In any correspondence, please reference "Re-entry Initiative 1115 Demonstration". **The public comment period will be open for 30 days from January 9, 2024 to February 8, 2024.** All written comments in response to this public notice must be received by DSS within that time period.

Public Hearings

In addition to the opportunity for anyone to send DSS written comments as noted above, there will also be two electronically convened public hearings to afford anyone the opportunity to provide DSS with verbal comments. Members of the public will be invited to make comments via the telephone or the virtual platform, Zoom, as follows:

Public Hearing Convened by the Connecticut General Assembly Medical Assistance Program Oversight Council (MAPOC)

January 12, 2024 at 1:00 PM: Join Zoom Meeting:

<https://zoom.us/j/95808481439?pwd=VFpMaGxkNGx5RGxaS3ZZQ0hmdjNCdz09>
+1 646 931 3860 US, Meeting ID: 958 0848 1439, Passcode: 435459

Public Hearing Webinar Hosted by DSS

January 25, 2024 — 10:00 AM–12:00 PM: Join Zoom Meeting: <https://us06web.zoom.us/j/81205056493?pwd=HyyAHqZ7NAHXBUxbMKxDalh0ytbrUl.1>

+1 646 931 3860 US; Meeting ID: 812 0505 6493, Passcode: 800524

Summary of Re-Entry Initiative

Connecticut is requesting this authority to design and implement a “Re-entry Initiative” that provides:

1. **Medicaid Coverage** for eligible inmates in the State’s correctional system, including all correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile and community residential centers throughout the State. Eligible inmates include those with behavioral health needs, including mental health disorders, and substance use disorder (SUD), certain other health conditions and detained youth.
2. A **Targeted Benefit Package** for these individuals to include case management services, medication-assisted treatment for SUD, a 30-day supply of medications upon release, and certain other supportive services.
3. A **Coverage Period of Up to 90 Days** immediately prior to the release of the eligible individual from the correctional system.
4. **Services to Address Health Related Social Needs (HRSN)** for the justice-involved (JI) population transitioning from correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile and community residential centers throughout the State.

Connecticut’s specific goals for the Re-entry Initiative are to:

1. Increase coverage, continuity of coverage, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release;
2. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during re-entry;
3. Improve coordination and communication between correctional systems, Medicaid systems, administrative services organizations, and community-based providers;

4. Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful re-entry post-release;
5. Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and HRSN;
6. Reduce all-cause deaths in the near-term post-release; and
7. Reduce the number of emergency department (ED) visits and inpatient hospitalizations among recently incarcerated Medicaid beneficiaries through increased receipt of preventive and routine physical and behavioral health care.

The State also intends to help address unmet needs related to a lack of adequate housing support. These conditions contribute to poor health for individuals transitioning from correctional centers (jails and courthouses), correctional institutions (prisons), and juvenile and community residential centers throughout the State and addressing them is key to successful re-entry. Connecticut requests authority to claim FFP in HRSN infrastructure investments in order to support the development and implementation of JI HRSN services, not to exceed 15% of the total JI HRSN spend.

To receive services under the Re-entry Initiative, a beneficiary will need to meet all of the following qualifying criteria:

- Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a State correctional system, including all correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile and community residential centers; and
- Be enrolled in Medicaid or otherwise eligible for CHIP if not for their incarceration status; and
- Identified as expected to be released in the next 90 days and identified for participation in the Demonstration; AND
- One of the following conditions:
 - Is an individual incarcerated in a juvenile and/or community residential center; or
 - Is an adult and meets one of the following diagnosis or population requirements:
 - Mental illness (MI);
 - SUD;
 - Co-occurring MI/SUD;
 - Chronic condition or significant non-chronic clinical condition;
 - Intellectual disability;
 - Acquired brain injury, including traumatic brain injury;
 - Positive test or diagnosis of HIV/AIDS; or
 - Currently pregnant or within a 12-month postpartum period.

This Re-entry Initiative will not change the underlying Medicaid program or CHIP; in particular, it will not change the current Connecticut fee-for-service delivery system, eligibility requirements, covered services, or cost-sharing. This Re-entry Initiative will allow for the provision of certain approved services within carceral settings in the 90 days prior to release and designate new entities able to coordinate and provide those services. Cost-sharing requirements will not differ from those provided under the State Plan for either Medicaid or CHIP. DSS will determine when each applicable facility is ready to participate in the Re-entry Initiative based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement.

The pre-release services authorized under the Re-entry Initiative include the provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth. All facilities must implement service level one with the minimum CMS benefits. Service level one is structured as the CMS-required minimum benefit package for pre-release coverage:

- Re-entry transitional case management services to assess and address physical and behavioral health needs and HRSN;
- Medication-Assisted Treatment (MAT), for all Food and Drug Administration approved medications, including coverage for counseling; and
- Covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid and CHIP State Plans) provided to the individual immediately upon release from the correctional facility.

The State may define additional service level categories in its implementation plan. Additional service levels may include the following services currently covered under the Connecticut Medicaid and CHIP State Plans:

- Physical and behavioral health clinical consultation services provided through telehealth or in-person, as needed, to diagnose health conditions, provide treatment, as appropriate, and support pre-release case managers' development of a post-release treatment plan and discharge planning;
- Laboratory and radiology services;
- Medications and medication administration;
- Services by community health workers to the extent covered under the Medicaid State Plan, including those with lived experience;
- Family planning services;
- Screening for common health conditions within the incarcerated population, such as blood pressure, diabetes, hepatitis C, and HIV/AIDS;
- Rehabilitative or preventive services to the extent covered under the Medicaid State Plan, including those provided by community health workers, as applicable;
- Treatment for hepatitis C; and
- Provision of durable medical equipment and/or supplies.

In addition to the pre-release services, qualifying beneficiaries may also receive durable medical equipment upon release, consistent with approved State Plan coverage authority and policy.

Allowable HRSN services for the JI population include:

- Rent/temporary housing for up to six months, specifically for individuals transitioning from correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile and community residential centers throughout the State;
- Utility costs including activation expenses and back payments to secure utilities, are limited to individuals receiving rent/temporary housing as described above;
- Pre-tenancy and tenancy sustaining services, including tenant rights education and eviction prevention;
- Housing transition navigation services;
- One-time transition and moving costs (e.g., security deposit, first month's rent, movers, relocation expenses, pest eradication, pantry stocking, and the purchase of household goods and furniture);
- Housing deposits to secure housing, including application and inspection fees and fees to secure needed identification;
- Medically necessary air conditioners, heaters, humidifiers, air filtration devices, generators, and refrigeration units as wanted for medical treatment and prevention; and
- Medically necessary home accessibility modifications and remediation services such as ventilation system repairs/improvements and mold/pest remediation.

Administrative FFP will be available for the following activities related to JI infrastructure: development for technology, development of business or operational practices, workforce development, outreach, education and stakeholder convening.

NOTICE OF CONNECTICUT STATE AGENCIES

***Updated Public Notice: Third Public Hearing has been added.**

All other information remains the same.

Third Public Hearing Webinar to be held on February 6, 2024 – 1PM to 2 PM

Link is provided below

DEPARTMENT OF SOCIAL SERVICES

Abbreviated Notice of Proposed Medicaid and Children’s Health Insurance Program

Re-entry Initiative Demonstration Waiver Amendment Pursuant to Section 1115 of the Social Security Act

This abbreviated public notice provides information regarding the proposed amendment request to the U.S. Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services for a “Re-entry Initiative” to better support individuals’ re-entry from incarceration to the community. Specifically, the State of Connecticut’s Department of Social Services (DSS) proposes to amend its Medicaid Substance Use Disorder (SUD) Demonstration Waiver pursuant to section 1115 of the Social Security Act, effective on or after July 1, 2024, for Medicaid Coverage for Justice-Involved Population Re-entry (Re-entry Initiative).

The Re-entry Initiative will enable Medicaid coverage and federal financial participation (FFP) using Medicaid and Children’s Health Insurance Program (CHIP) matching funds for adults incarcerated in correctional centers (jails and courthouses) and correctional institutions (prisons), and youth detained in juvenile and community residential centers throughout the State receiving a targeted benefit package that would ordinarily not be covered under federal law. This Re-entry Initiative will ensure a continuum of care strategy that enables robust coordination, service provision, and community connections after release.

Where the Demonstration is Posted

All information and materials pertaining to the Amendment, including the full public notice, public hearing dates and times, public comment submission instructions, and a copy of DSS’s full demonstration draft amendment are posted to the DSS website at this link: <https://portal.ct.gov/DSS/Health-And-Home-Care/1115-Justice-Involved-Demonstration-Waiver>. Please check this website regularly for updates.

The proposed Demonstration and related materials may also be obtained upon request from DSS, at any DSS field office, or the Town of Vernon Social Services Department.

Where and When to Submit Written Comments

To send comments about the Demonstration, please email: CT-Justice-Involved-Waiver@ct.gov or write to the Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. In any correspondence, please reference “Re-entry Initiative 1115 Demonstration”. **The public**

comment period will be open for 30 days from January 9, 2024 to February 8, 2024. All written comments in response to this public notice must be received by DSS within that time period.

Public Hearings

In addition to the opportunity for anyone to send DSS written comments as noted above, there will also be two electronically convened public hearings to afford anyone the opportunity to provide DSS with verbal comments. Members of the public will be invited to make comments via the telephone or the virtual platform, Zoom, as follows:

Public Hearing Convened by the Connecticut General Assembly Medical Assistance Program Oversight Council (MAPOC)

January 12, 2024 at 1:00 PM: Join Zoom Meeting:

<https://zoom.us/j/95808481439?pwd=VFpMaGxkNGx5RGxaS3ZZQ0hmdjNCdz09>

+1 646 931 3860 US, Meeting ID: 958 0848 1439, Passcode: 435459

Public Hearing Webinar Hosted by DSS

January 25, 2024 — 10:00 AM–12:00 PM: Join Zoom Meeting:

<https://us06web.zoom.us/j/81205056493?pwd=HyyAHqZ7NAHXBUxbMKxDalhOytbrUl.1>

+1 646 931 3860 US; Meeting ID: 812 0505 6493, Passcode: 800524

***February 6, 2024 – 1:00 PM - 2:00 PM: Join Zoom Meeting**

<https://us06web.zoom.us/j/86297504386?pwd=sNaZxI7zdPZmVBqe8YZShQTabmLEqa.1>

+1 646 931 3860 US; Meeting ID: 862 9750 4386, Passcode: 597612

Summary of Re-Entry Initiative

Connecticut is requesting this authority to design and implement a “Re-entry Initiative” that provides:

1. **Medicaid Coverage** for eligible inmates in the State’s correctional system, including all correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile and community residential centers throughout the State. Eligible inmates include those with behavioral health needs, including mental health disorders, and substance use disorder (SUD), certain other health conditions and detained youth.
2. A **Targeted Benefit Package** for these individuals to include case management services, medication-assisted treatment for SUD, a 30-day supply of medications upon release, and certain other supportive services.
3. A **Coverage Period of Up to 90 Days** immediately prior to the release of the eligible individual from the correctional system.
4. **Services to Address Health Related Social Needs (HRSN)** for the justice-involved (JI) population transitioning from correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile and community residential centers throughout the State.

Connecticut's specific goals for the Re-entry Initiative are to:

1. Increase coverage, continuity of coverage, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release;
2. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during re-entry;
3. Improve coordination and communication between correctional systems, Medicaid systems, administrative services organizations, and community-based providers;
4. Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful re-entry post-release;
5. Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and HRSN;
6. Reduce all-cause deaths in the near-term post-release; and
7. Reduce the number of emergency department (ED) visits and inpatient hospitalizations among recently incarcerated Medicaid beneficiaries through increased receipt of preventive and routine physical and behavioral health care.

The State also intends to help address unmet needs related to a lack of adequate housing support. These conditions contribute to poor health for individuals transitioning from correctional centers (jails and courthouses), correctional institutions (prisons), and juvenile and community residential centers throughout the State and addressing them is key to successful re-entry. Connecticut requests authority to claim FFP in HRSN infrastructure investments in order to support the development and implementation of JI HRSN services, not to exceed 15% of the total JI HRSN spend.

To receive services under the Re-entry Initiative, a beneficiary will need to meet all of the following qualifying criteria:

- Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a State correctional system, including all correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile and community residential centers; and
- Be enrolled in Medicaid or otherwise eligible for CHIP if not for their incarceration status; and
- Identified as expected to be released in the next 90 days and identified for participation in the Demonstration; AND
- One of the following conditions:
 - Is an individual incarcerated in a juvenile and/or community residential center; or
 - Is an adult and meets one of the following diagnosis or population requirements:
 - Mental illness (MI);
 - SUD;
 - Co-occurring MI/SUD;

- Chronic condition or significant non-chronic clinical condition;
- Intellectual disability;
- Acquired brain injury, including traumatic brain injury;
- Positive test or diagnosis of HIV/AIDS; or
- Currently pregnant or within a 12-month postpartum period.

This Re-entry Initiative will not change the underlying Medicaid program or CHIP; in particular, it will not change the current Connecticut fee-for-service delivery system, eligibility requirements, covered services, or cost-sharing. This Re-entry Initiative will allow for the provision of certain approved services within carceral settings in the 90 days prior to release and designate new entities able to coordinate and provide those services. Cost-sharing requirements will not differ from those provided under the State Plan for either Medicaid or CHIP. DSS will determine when each applicable facility is ready to participate in the Re-entry Initiative based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement.

The pre-release services authorized under the Re-entry Initiative include the provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth. All facilities must implement service level one with the minimum CMS benefits. Service level one is structured as the CMS-required minimum benefit package for pre-release coverage:

- Re-entry transitional case management services to assess and address physical and behavioral health needs and HRSN;
- Medication-Assisted Treatment (MAT), for all Food and Drug Administration approved medications, including coverage for counseling; and
- Covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid and CHIP State Plans) provided to the individual immediately upon release from the correctional facility.

The State may define additional service level categories in its implementation plan. Additional service levels may include the following services currently covered under the Connecticut Medicaid and CHIP State Plans:

- Physical and behavioral health clinical consultation services provided through telehealth or in-person, as needed, to diagnose health conditions, provide treatment, as appropriate, and support pre-release case managers' development of a post-release treatment plan and discharge planning;
- Laboratory and radiology services;
- Medications and medication administration;
- Services by community health workers to the extent covered under the Medicaid State Plan, including those with lived experience;
- Family planning services;
- Screening for common health conditions within the incarcerated population, such as blood pressure, diabetes, hepatitis C, and HIV/AIDS;

- Rehabilitative or preventive services to the extent covered under the Medicaid State Plan, including those provided by community health workers, as applicable;
- Treatment for hepatitis C; and
- Provision of durable medical equipment and/or supplies.

In addition to the pre-release services, qualifying beneficiaries may also receive durable medical equipment upon release, consistent with approved State Plan coverage authority and policy.

Allowable HRSN services for the JI population include:

- Rent/temporary housing for up to six months, specifically for individuals transitioning from correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile and community residential centers throughout the State;
- Utility costs including activation expenses and back payments to secure utilities, are limited to individuals receiving rent/temporary housing as described above;
- Pre-tenancy and tenancy sustaining services, including tenant rights education and eviction prevention;
- Housing transition navigation services;
- One-time transition and moving costs (e.g., security deposit, first month's rent, movers, relocation expenses, pest eradication, pantry stocking, and the purchase of household goods and furniture);
- Housing deposits to secure housing, including application and inspection fees and fees to secure needed identification;
- Medically necessary air conditioners, heaters, humidifiers, air filtration devices, generators, and refrigeration units as wanted for medical treatment and prevention; and
- Medically necessary home accessibility modifications and remediation services such as ventilation system repairs/improvements and mold/pest remediation.

Administrative FFP will be available for the following activities related to JI infrastructure: development for technology, development of business or operational practices, workforce development, outreach, education and stakeholder convening.

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 24-H: Increase to the Rate for Select Long-Acting Reversible Contraceptive and Changes to Select Manually Priced Codes

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS). Public comment information is at the bottom of this document.

ATTACHMENT 3

Public Notice Comments

Connecticut received 38 comments from ten separate parties between the three public hearings and written comments from the public.

1. **Representative Anne Hughes:** We are very excited to see this Demonstration submitted to help individuals gaining access to health care right before release and to address and to decrease post release deaths.

Response: Thank you.

2. **Matthew Barrett (Connecticut Association of Health Care Facilities/Connecticut Center for Assisted Living):** This is a strong endorsement for the Demonstration. Connecticut has been a leader in the CHES housing program. I strongly believe that Medicaid should begin in advance of discharge. I am happy to see public hearings on this topic.

Response: Thank you. Please note that not every medical service will be transferred to Medicaid, only transitional services approved by CMS.

3. **Anthony DiLauro (Executive Director of the Human Services Council):** On page 10 of the Demonstration application, there are estimates of the total number of individuals who are incarcerated. How many individuals are estimated to be eligible annually?

Response: We expect 12,000 individuals will be eligible annually.

4. **Representative Susan Johnson (House Deputy Majority Leader):** How will seniors be transitioned from correctional facilities into nursing facilities?

Response: The Demonstration will cover all transitions to nursing facilities for eligible incarcerated individuals, including transitional case management services pre-release.

5. **Yale Transitions Clinic-SEICHE Center on behalf of the Transitions Clinic Connecticut which is based out of the SEICHE Center for Health and Justice at Yale School of Medicine:** We are in full support of the Justice-Involved Demonstration Waiver and laud state efforts to submit this application and actualize the changes proposed by this waiver.

Transitions Clinic Connecticut is comprised of a collection of clinical programs at federally qualified health centers in New Haven, Bridgeport, and Hartford, that are focused on addressing the health needs of people returning to the community after incarceration in Connecticut. They are part of the Transitions Clinic Network (TCN), a national network focused on transforming the health system to better meet the health needs of individuals returning from incarceration. Started 17 years ago, and currently adopted in 48 health centers in 12 states, the model provides tailored, immediate, and patient-centered medical

care for people returning to the community from incarceration, addressing the medical needs and health-related social needs of men and women with chronic health conditions and substance use disorders. Core to the model are community health workers with a history of incarceration who are embedded in community clinics. These community health workers help people leaving prison navigate the health system, while also connecting them to services to address their health-related social needs such as housing, food, and employment through collaborations with community agencies.

Studies of the impact of this model, both nationally and specifically in Connecticut, have shown that it is effective in accomplishing the very goals of the 1115 Demonstration Waiver application, specifically, it improves access to services and care coordination, improves connections between carceral settings and community services and decreases emergency department utilization, hospitalization for preventable conditions, and return to incarceration for technical violations of probation or parole. This model is also **cost saving** to the state, with \$2.55 saved for every dollar invested.

As mentioned above, we are in **full support** of DSS's application for a Medicaid 1115 Justice-Involved Demonstration Waiver.

Response: Thank you.

5A Yale Transitions Clinic-SEICHE Center: As written, this demonstration project is comprehensive, but despite the promise, there are some areas we would like to highlight as benefiting from further clarification.

Past [research](#) studying Medicaid expansion under the Affordable Care Act shows that insurance is necessary but not sufficient for engagement in care. States that are applying for waivers are largely incorporating staff that will assist in the transition of care, and our state proposal refers frequently to [case management](#), but where these staff work, their past experiences with incarceration, and their funding have bearing to how efficacious these programs will be and how smooth the transitions will be. For instance, our research indicates that care management by a community health worker with a personal history of incarceration leads to [decreased visits to the emergency department](#) among people recently released from incarceration and less future contact with the criminal justice system. Meeting with a community health worker prior to release from jail has been shown to [more than double the attendance at the first medical appointment following release](#). And yet many health systems do not allow people with criminal records to work in community systems and getting the DOC to allow those with criminal records to enter correctional facilities in Connecticut can be very challenging as well. For the work that this waiver allows to be successful, our state will need to take active steps to address these concerns and open the doors to the DOC to people who themselves have been incarcerated, with a system to allow for adequate permissions.

Response: Connecticut intends to incorporate community health workers with lived experience in incarcerated systems to engage with individuals prior to release and support follow-up care after release. This is envisioned to be a fundamental part of the Re-Entry Transitional Case Management Service Level One as well as the community health worker benefit proposed in later levels.

5B Yale Transitions Clinic-SEICHE Center: A major factor in the success of this waiver will be the funding mechanisms that DSS puts in place that allow for

reimbursement for the work of community health workers and case managers. Adequate funding will need to be allotted to compensate community agencies for coming into the DOC to do some of this very critical transitional work, and without it, they are unlikely to get involved.

Response: Connecticut intends to work with community agencies to develop adequate and sustainable funding for community agencies who will be providing transitional case management and community health worker services.

5C Yale Transitions Clinic-SEICHE Center:

The re-entry demonstration amendment briefly mentions the planned evaluation to assess outcomes. Constant assessment of outcomes is of critical importance, but we highlight here that the state should also develop a plan for process measures as well. Who benefits from this demonstration, is the benefit distributed equitably, what percent of the transitional work is done by community partners vs correctional workers? We point the state to a recent [white paper](#) we have put together with colleagues and input from formerly incarcerated community health workers, and informed by key experts, to envision process and quality measures that would be realistic, informative and meaningful.

Response: Although not directly mentioned, CMS is developing required process and outcome measures that Connecticut anticipates will mirror the information in the white paper listed. Connecticut publicly reports similar metrics quarterly and annually under the Substance Use Disorder 1115 waiver and anticipates that it will also report the selected CMS Justice-Involved Re-entry metrics on a quarterly and annual basis. These reports will be available publicly in addition to the Demonstration's mid-point assessment, interim evaluation, and summative evaluations provided by the State's independent evaluator.

- 6. The CT Community Nonprofit Alliance (The Alliance):** The Alliance is the statewide advocacy organization representing the nonprofit sector. Connecticut's community nonprofits employ more than 118,000 people, over 8% of the state's workforce, and serve more than 500,000 people each year, improving the quality of life in communities across the State.

We would like to express our appreciation to DSS, for their ongoing efforts to lead the collaborative process which has focused on this important initiative. The involvement of each state agency, as well as representation of all stakeholder groups, has been an essential and appreciated aspect of the process.

Members of The Alliance are uniquely qualified to provide perspective regarding both the implementation process and impact of the proposed waiver. Community Justice providers support justice-involved individuals and their families, as well as supporting survivors of crime. Along with providers of services related to behavioral health and substance use, they provide critical support related to prevention, as well as reentry. These programs, funded by the Department of Correction (DOC), the Court Support Services Division of the Judicial Branch (JB/CSSD), as well as the Department of Mental Health and Addiction Services (DMHAS), continue to play an essential role in the ongoing success related to criminal justice reform in Connecticut.

From the perspective of The Alliance, this is an incredible and long-overdue opportunity

for the justice-involved population. There is a long-standing prohibition in Medicaid that precludes Medicaid reimbursement for services provided to incarcerated individuals. This is known as the "inmate exclusion." As noted in the 1115 Medicaid Waiver presentation, currently, 16 states have submitted applications to CMS for exclusions. California and Washington have received approvals, and our collective goal would be for Connecticut to follow suit.

Members of The Alliance are in full support of the goals of the 1115 Justice-Involved Demonstration Waiver, as outlined in the April 17, 2023, State Medicaid Directors' letter,

We envision this process as a critical opportunity to not only achieve change in terms of enhanced support for the justice involved population, but also – an opportunity to affect change with regard to adjusting the system to achieve sustainability moving forward. As the State moves forward with the process, we once again present our willingness to assist in each of the areas which are critical to achieving the success which we all foresee as our collective goals.

Among the issues which the proposed Waiver would address, are the increasingly complex needs of the justice involved population. These issues are substantiated in the State of Reentry Report, released on February 21, 2024. The report provides a critical overview and statistics related to the state of criminal justice reform in Connecticut. The opportunity to receive critical support as provided by the proposed 1115 Waiver would greatly enhance the potential for positive outcomes and long-term improvement to the quality of life for these individuals and families.

Questions, Concerns and Recommendations of the Alliance are below:

6A The Alliance: Rate Setting: Members of The Alliance are uniquely qualified to provide perspective regarding both the implementation process and impact of the proposed waiver and subsequent rates. We stand ready to assist in the rate development process, as a resource and collaborative partner.

Response: Thank you for your offer. As noted above, Connecticut intends to work with community providers to develop sustainable funding for those community providers that will be providing transitional services.

6B The Alliance: Rate Setting: For services provided within the prison system - Will the final waiver recognize that providing services inside prisons and jails is more complicated and expensive than in the community? It is critical that the rates reflect these aspects of services.

Response: We acknowledge that there are additional costs to the provision of services within prisons and jails and anticipate recognizing those reasonable costs in the calculation of rates. *Please note that not all services provided in the prisons, jails, and juvenile centers will be under the Demonstration, only those transitional costs approved by CMS.*

6C The Alliance: Rate Setting: The volume of services is not controlled by providers but rather by the Department of Corrections. How will that be taken into account when developing a rate?

Response: We acknowledge that there are unique aspects to providing services within prisons, jails, and juvenile centers that will need to be accounted for in rate setting, including factors such as utilization. *Please note that not all services provided in the prisons, jails, and juvenile centers will be under the Demonstration, only those transitional costs approved by CMS.*

6D The Alliance: Ongoing Stakeholder Input: We understand that the State is in the preliminary development stages of this initiative. For this reason, we anticipate that questions, concerns and recommendations will likely be an ongoing process. Please share your recommendations to ensure the ability to receive stakeholder input moving forward.

Response: Thank you for your offer. We anticipate holding multiple meetings with stakeholders to understand the unique delivery of services in carceral settings as implementation planning continues.

6E The Alliance: System of Care – Definition: The waiver proposes to build a “more robust system of care.” Please provide additional information, in terms of the anticipated system/definition as it applies to the waiver.

Response: The system of care references the system of transitional care between carceral settings and community providers. Connecticut plans to implement a screening process for all individuals to screen for the qualifying criteria and determine eligibility for the Demonstration benefit package, as clinically appropriate. In the implementation plan, Connecticut will describe how it will implement processes to ensure all pre-release service providers, as appropriate for the provider type, have the necessary experience and training, and case managers have knowledge of (or means to obtain information about) community-based providers in the communities where individuals will be returning upon release. Further, as applicable, the State will establish requirements for carceral health providers who are not currently participating in the Medicaid program or Children’s Health Insurance Program (CHIP) that are similar to Medicaid provider standards, as well as program integrity standards to ensure appropriate billing.

The system of care will include post-release case management and the process to help ensure the scheduling and receipt of needed services, as well as other services needed to address HRSN and long-term services and supports. The system of care will include the operational steps and timeline to provide or facilitate timely access to post-release medical supplies, equipment, medication, additional exams, or other post-release services to address the physical and behavioral health care needs identified during the case management assessment and the development of the person-centered care plan. It will also include processes for promoting and ensuring collaboration between case managers, providers of pre-release services and providers of post-release services, to ensure that appropriate care coordination is taking place.

The system of care will connect individuals to services available post-release to meet the needs of the reentering population. Connecticut will work with its extensive network of behavioral health and substance use disorder providers to

implement a system to monitor the delivery of post-release services and ensure that such services are delivered within the appropriate timeframe.

The correctional system will facilitate incarcerated beneficiaries' access to community health care providers, including case managers, either in person or via telehealth, including establishing communication and engagement between correctional systems, community supervision entities, health care organizations, the State Medicaid agency, and supported employment and housing organizations. Connecticut has already developed plans to connect its carceral electronic health records to the Connecticut Health Information Exchange (Connie). The State will utilize these systems to monitor individuals' health care needs, HRSN, and their access to and receipt of health care services pre- and post-release, and identify anticipated challenges and potential solutions.

6F The Alliance: Currently Existing Programs: How will the waiver work with programs currently located in the prisons treating substance use, particularly opioid dependence? There are Medication-assisted treatment (MAT) programs operating now that are funded with state and federal resources.

Response: The Demonstration will only affect services and individuals within 90 days of release. DSS, DOC, and DMHAS are working together to develop options for maintaining current providers and programs in all carceral settings. While we cannot guarantee that there will not be some changes, the goal is to preserve current programs that are already providing key elements that will be moved under the Demonstration for the transitional period.

6G The Alliance: Transitional Case Management Services: What types of providers will be able to operate the transitional case management services?

Response: At this time, because no final decision has been made, the State is soliciting suggestions and feedback regarding the suggested qualifications of practitioners and the types of provider entities that will be utilized for transitional case management services.

6H The Alliance: Support for Existing Treatment System: The existing treatment system for Behavioral Health is currently underfunded and experiencing severe staffing shortages. What will be done to shore up this system to be able to accept additional clients, many of whom are at a higher risk than those currently served?

Response: As noted above, Connecticut intends to work with community providers to develop sustainable funding for those community providers that will be providing transitional services.

6I The Alliance: Local Mental Health Authority System: How will these services be integrated into the existing Local Mental Health Authority system?

Response: For adults who have Severe Mental Illness (SMI) or youth with Severe Emotional Disturbance (SED), DSS and DOC are working with DMHAS and DCF to ensure linkages to existing behavioral health providers, including LMHAs.

6J The Alliance: Existing Certified Community Behavioral Health Clinics (CCBHC): How will these services be integrated into the CCBHCs that exist in the state?

Response: There is a natural synergy between the CCBHCs that currently exist in this state and this Demonstration. CCBHCs enrolled as behavioral health clinics are already qualified to provide mental health and substance use disorder services. As noted above, DSS and DOC are working with DMHAS and DCF to ensure linkages to existing behavioral health providers, including behavioral health clinics.

6K The Alliance: Credentials: What will be the requirements for credentials of staff providing these services?

Response: At this time, because no final decision has been made, the State is soliciting suggestions and feedback regarding the suggested qualifications of practitioners and the types of provider entities that will be utilized for transitional behavioral health services.

6L The Alliance: Behavioral Health Services: Many providers serving justice-involved individuals for substance use disorders (SUD) do not currently provide other behavioral health services. Will they be able to develop those services?

Response: At this time, because no final decision has been made, the State is soliciting suggestions and feedback regarding the suggested qualifications of practitioners and the types of provider entities that will be utilized for SUD services.

- 7. Representative Anne Hughes (written comments):** As a licensed Master Social Worker as well as a Connecticut policymaker, I am keenly aware that investing Medicaid resources in Case Management, behavioral and medical healthcare, as well as transitional housing supports at ANY stage of a person's journey with the mass incarceration system results in exponential savings in severe distress, trauma, instability, economic mobility and state and federal dollars in the future.

CT's cost of incarceration, one of the highest rates in the country, is upwards of \$249 per day, or \$90,000 per year, which is passed along to the inmate and their families for recouping after release, to the General Fund of our budget, an egregious practice known as 'pay-to-stay'. It is ridiculously costly to incarcerate individuals, deny adequate mental, medical health and addiction treatment, then release these family members into the community without adequate wrap-around, transitional support to address the lack of determinants of health that contributed to becoming incarcerated in the first place.

This public safety evidenced-based initiative to expand Medicaid services prior to and upon release will save costs to healthcare systems, reduce recidivism, and invest in family and community well-being to break the cycle of mass incarceration that has plagued Connecticut for decades, costs us billions, and made us all less safe while damaging entire generations who have lost stable futures and economic resilience. Better late than never to invest Medicaid services and dollars on the returning end 😊 to our communities and their loved ones.

Response: Thank you.

- 8. Martha Stone-Center of Children’s Advocacy:** I am currently a member of the Legislature’s Juvenile Justice Policy Oversight Council (JJPOC), and co-chair of its Re-entry Subcommittee. I fully support the State’s application for this waiver. It has the capacity to substantially enhance the landscape of reentry services for youth in a positive way.

I have three questions/concerns.

8A Martha Stone-Center: I want to be sure that the application includes pre-trial youth in addition to sentenced youth. The pretrial population incarcerated in the state’s detention centers need this case management and connection to community based services as soon as possible.

Response: It is anticipated that pre-trial youth will be covered under the Demonstration as well as under a separate Medicaid State Plan Amendment effective January 1, 2025.

8B Martha Stone-Center: I want to ensure that the Health-related Social Needs, which can include transition and moving costs, as identified in the application, will be available to the youth under 18 AND their families, since the youth themselves will not be able to sign for any leases, distribute security deposits, etc.

Response: It is anticipated that HRSN for transition and moving costs will be available to the youth under 18 and their families for the benefit of the child who is eligible for Medicaid.

8C Martha Stone-Center: I am hopeful that you have seen “The Connecticut Reentry Success Plan: Recommended Strategies for 2024-2027” as approved by the JJPOC Reentry Subcommittee and submitted to the JJPOC in January, 2024, and that your waiver application will be consonant with and can incorporate the recommendations of this Report.

Response: We are familiar with the report and will utilize it in the creation of the State’s Implementation Plan which will be developed and submitted to CMS after waiver submittal.

https://www.cga.ct.gov/app/tfs/20141215_Juvenile%20Justice%20Policy%20and%20Oversight%20Committee/20231214/CONNECTICUT%20REENTRY%20SUCCESS%20PLAN.pdf

- 9. Healthcare Company (ViiV):** ViiV Healthcare Company (ViiV) appreciates the opportunity to submit comments to the Connecticut Department of Social Services (DSS) regarding its proposed amendment to its §1115 Demonstration Amendment to offer reentry health care services to incarcerated individuals with substance use disorders (SUD) and/or HIV who are Medicaid-eligible.

ViiV is the only independent, global specialist company devoted exclusively to delivering advancements in human immunodeficiency virus (HIV) treatment and prevention to support the needs of people with HIV and those vulnerable to HIV. From its inception in 2009, ViiV has had a singular focus to improve the health and quality of life of people affected by this disease and has worked to address significant gaps and

unmet needs in HIV care. In collaboration with the HIV community, ViiV remains committed to developing meaningful treatment advances, improving access to its HIV medicines, and supporting the HIV community to facilitate enhanced care and treatment.

ViiV is proud to be part of the nation's success in reducing the number of new HIV cases and increasing viral suppression rates. We recognize our important role as a research-based pharmaceutical company is limited without the ongoing collaboration among public health officials such as those in Connecticut.

In the United States, an estimated 1.1 million people are living with HIV, at least 13 percent of whom are unaware that they have the virus. Despite groundbreaking treatments that have slowed the progression and burden of the disease, surveillance and retention remain a challenge. In 2020, at least one in five new HIV cases in the United States were diagnosed in late stages of the disease. Only half of all people with HIV are retained in treatment.

In Connecticut, there were 10,638 people with HIV in 2021 with only 72 percent achieving viral suppression.

In 2019, the U.S. Department of Health and Human Services (HHS) launched *Ending the HIV Epidemic in the U.S.* (EHE), which has set a goal to reduce new cases of HIV by 90 percent by 2030. The plan proposes to use scientific advances in antiretroviral therapy to treat people with HIV and expand proven models of effective HIV care and prevention. The EHE includes four pillars—*Diagnose, Treat, Prevent, and Respond*—and coordinates efforts across government agencies to stop the HIV epidemic with a focus on state and local areas.

Connecticut has a significant role in achieving these goals. The state of Connecticut initiated its End the Syndemic (ETS) Initiative with the goal to provide *all* people living with HIV and SUD in the state “access to the prevention and care services they need.” ETS includes expanding access to routine testing services, improving access to treatment, and improving access to HIV pre-exposure prophylaxis (PrEP) and PrEP education.

ViiV supports DSS's effort to provide targeted Medicaid services for people experiencing incarceration with SUD and people with HIV (PWH) and encourages DSS to further align the amendment with the national EHE and Connecticut's ETS initiatives by:

- **Including HIV testing in the pre-release health assessments**
- **Providing HIV treatment and linkage to care upon release to people with HIV.**
- **Providing access to PrEP prior to release for people with SUD.**
- **Case management services should include those with HIV.**

People with HIV are disproportionately involved in the criminal justice system with seropositive rates more than three times that of the general population; often they face complex medical, mental health, and substance abuse needs. In 2006, an estimated 14 percent, or more than 150,000 PWH, passed through a correctional facility, while the proportion was closer to 20 percent for Black and Hispanic PWH. Fortunately, the population of state and federal prisoners living with HIV has been falling steadily since

1998. Connecticut's sero- positive rate for PWH in the custody of state and federal correction authorities mirrors the national average rate of 1.1 percent.

People experiencing incarceration are more likely to engage in behaviors that increase their risk for HIV transmission, including having multiple sexual partners, condomless sex, and injection drug use. In 2021, HIV prevalence in federal and state prisons in Connecticut was 3 times higher than the general population

Substance use can increase risky behaviors for HIV transmission, and injection drug use in a population can fuel transmission of blood-borne infectious diseases such as HIV. People who inject drugs intravenously in their lifetime are more than 30 times as likely to be diagnosed with HIV. In 2021, people who inject drugs accounted for 7 percent of new HIV infections.

9A Healthcare Company (ViiV): Include HIV testing in the pre-release comprehensive assessments

ViiV recommends that the proposed service level one that all facilities would have to implement include HIV testing for individuals diagnosed with SUD consistent with guidelines from the Centers for Disease Control and Prevention (CDC), the American Society of Addiction Medicine (ASAM), and the US Preventive Services Task Force (USPSTF).

In 2021, injection drug use in Connecticut caused 7.1 percent of new HIV infections among men and 12.0 percent of new infections among women. Despite the link between the HIV and opioid epidemics, HIV testing is an often-overlooked part of SUD treatment efforts, and HIV infections among people with SUD may be missed without routine HIV testing. Many people may not be aware of how substance use can increase their HIV risk.

The CDC recommends opt-out HIV screening for all individuals entering a correctional facility and additional screening for people who inject drugs. The CDC, ASAM, and USPSTF all recommend routine HIV testing for people who inject drugs or are being assessed for opioid use disorder. The amendment proposal suggested HIV screening could be included in additional service level categories, but screening for HIV in SUD programs for people experiencing incarceration is critical for identifying HIV status and linking people with HIV to care.

In an analysis across six major American cities, targeted on-site HIV testing for patients receiving medication for opioid use disorder was projected to be cost saving or highly cost- effective.

Response: There will be a screening process in place that will address known diagnoses and will permit individuals to have RTCM. Additional testing will be phased in with physical and behavioral health clinical consultation as defined in the implementation plan. Connecticut wants to ensure each facility is able to provide the minimum benefit package as soon as possible, in alignment with the phase-in plan by facility type. The implementation plan will address facility progression to subsequent service levels, including the possibility of offering multiple service levels initially based on the applicable readiness determination.

9B Healthcare Company (ViiV): Provide HIV treatment and linkage to care upon

release to people with HIV

ViiV supports the state's proposal to provide a 30-day supply of clinically necessary prescribed medications upon release, including antiretrovirals (ARV) to treat HIV. For people with HIV, ViiV urges the state to provide long term treatment that a thirty-day supply plus at least two refills.

For PWH, adherence to treatment is vitally important. The HHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV emphasize the importance of adherence in treatment selection, stating that, "Regimens should be tailored for the individual patient to enhance adherence and support long-term treatment success." High adherence is necessary for HIV treatments to be effective. When people with HIV are not able to adhere to antiretroviral (ARV) treatment, the virus can damage the immune system. Non-adherence can also increase the risk of treatment resistance. If taken as prescribed, antiretrovirals have the potential to reduce the amount of HIV in the blood to a very low level – below what can be measured by a lab test – which promotes a long and healthy life for a person with HIV. Effective ARV treatment that reduces the amount of HIV in the blood to undetectable levels has a secondary public health benefit of preventing new transmission of HIV to others. This is commonly referred to as Treatment as Prevention, or Undetectable = Untransmissible (U=U). It is estimated people with HIV who are not retained in medical care may transmit the virus to an average of 5.3 additional people per 100- person years.

Advancements in ARV treatment often enables PWH to be treated successfully while incarcerated, resulting in viral suppression. Upon release, however, PWH often face multiple challenges to maintaining their continuity of care. For these reasons, ViiV urges DSS to include transitional services that maintain continued access to ARV treatment and other prescribed medications, such as linkages to care, including scheduling a first appointment with an HIV specialist.

Response: It is anticipated that the 30-day supply of medications, will be provided as clinically appropriate based on the medication dispensed and the indication. We will continue discussions on the implementation of that guidance. Regarding care transitions, re-entry transitional case management services will assist with linkages to care upon release, and Connecticut intends to incorporate community health workers with lived experience in incarcerated settings to engage with individuals prior to release and support follow-up care after release.

9C Healthcare Company (ViiV): Provide access to PrEP for SUD populations prior to release

ViiV recommends that any reentry plan include testing for HIV prior to release, especially for individuals with SUD, and that the amendment's proposed service level one include counseling on HIV pre-exposure prophylaxis (PrEP) and PrEP prescriptions in accordance with CDC guidelines on PrEP. For people who can benefit from PrEP, ViiV urges the state to dispense or administration of long-acting (LA) PrEP prior to release.

For the majority who will not test positive for HIV, ViiV urges DSS to include education on remaining HIV negative, including information and potential initiation of PrEP as part of its reentry protocol. In 2023, the USPSTF assigned a "Grade A" rating to PrEP as a highly effective preventive intervention. PrEP has been shown to reduce the risk of

acquiring HIV from sex by 99 percent and from injection drug use by 74 percent. The CDC recommends that for soon-to-be-released individuals who engage in behaviors that increase their risk for HIV infection, such as injection drug use, “starting HIV PrEP (or providing linkage to a community clinic for HIV PrEP) for HIV prevention should be considered.” Connecticut falls behind 13 other states and the District of Columbia in its PrEP coverage. Nearly 7 in 10 people in Connecticut who could benefit from PrEP are not prescribed it.

PrEP is available in either a daily oral option or an LA injectable option with dosing every 2 months, or as few as 6 times per year. LA PrEP offers an important prevention option for vulnerable populations like those individuals recently released from incarceration who are experiencing transitions in housing, employment, community, and health care. LA PrEP also may benefit those who fear disclosure of taking PrEP to avoid stigma associated with daily oral pills.

Providing people experiencing incarceration with better access to PrEP could improve racial disparities in HIV incidence. People experiencing incarceration in Connecticut are disproportionately Black. In Connecticut, Black individuals account for 36.1 percent of new HIV diagnoses but only 8.9 percent of PrEP users.

Response: As mentioned above, screening and testing will be outlined within the service levels to be defined in the implementation plan. Similarly, medications and medication administration will be defined in the appropriate service level within the implementation plan. The State does not anticipate any barriers to medication administration for eligible individuals during the pre-release period once a facility implements the appropriate service level.

9D Healthcare Company (ViiV): Case management services should include those with HIV

ViiV supports the state’s proposal to provide transitional case management services for people with HIV and/or SUD.

One study published in the American Journal of Public Health found that people with HIV who were provided a transitional care plan and connections to health care providers upon their release from New York City Jails were more likely to have better treatment adherence six months after their release, as compared to individuals without those services.

Targeted interventions for HIV and SUD can complement each other and benefit from coordination between correctional and community health systems.

Studies demonstrate that medical case management can improve care engagement and treatment adherence.

Case management services can also smooth reentry for people with HIV by helping them navigate the complex US healthcare system.

Response: Re-entry transitional case management activities will include any diagnoses that the individual has from the screening conducted for eligibility, which may include HIV.

Conclusion

ViiV urges DSS to align the efforts of this proposed amendment request with national EHE and state ETS efforts to improve health outcomes for soon-to-be-released individuals with SUD, people who could benefit from PrEP, and people with HIV. Thank you for considering ViiV's recommendations. Please feel free to contact me directly if you have any questions.

Verbal Comments From January 12, 20/24 MAPOC Hearing

- 10. Representative Toni Walker** asked if we spend \$10 million in the Department of Correction for health care right now, is it correct that \$9 million of that \$10 million is reimbursable under this waiver.

Response: DSS explained that the scenario presented was an example to demonstrate budget neutrality. DSS is reviewing the current services to determine what will be reimbursable across all state agencies. DSS discussed additional scenarios and explained that "budget neutrality" for the purposes of federal Medicaid 1115 waivers is a term of art that has its own very technical definition. DSS added that CMS requires that any new federal reimbursement generated under this project must go back into the system.

- 11A. Ellen Andrews (Executive Director of the Connecticut Health Policy Project)** inquired as to what is meant by "into the system" and whether this meant the reimbursements must go back into the specific services from which they were generated. She also asked to see the complete package sent to the Appropriations Chairs to better understand the funds and how we make sure the reimbursements are used appropriately.

Response: DSS explained that it can't be used to build prisons; the new federal reimbursement is for the purpose of improving transition services for the inmate population. The complete package is on the DSS website.

- 11B. Ellen Andrews** asked who will be the provider for housing, how would we ensure the housing is appropriate and safe, and how would we pay rent to a landlord through Medicaid. She also asked if this budget neutrality approach could be extended to other services beyond justice-involved 1115s.

Response: DSS responded that we have two waivers in place where we had to establish budget neutrality, the Substance Use Disorder and Covered CT. This waiver will be the third one. Each is required to be budget neutral to the federal government and is subject to review and approval by CMS. CMS has made it easier for states to demonstrate budget neutrality in limited areas (such as justice-involved) but they have not extended this to all areas. Regarding the provider question, DSS is working with state agency partners as to what may be reimbursable right now and what the future state might look like and plans to leverage existing community-based providers and their expertise in the discussion.

- 12. Representative Anne Hughes** asked about the description of reducing post-release all cause deaths and can we also include pre-release all cause deaths with the goal of

reducing those numbers as part of this waiver.

Response: DSS noted that the focus of this intervention is the transition period from 90-days pre-release to post release to the community and shared the thoughts behind CMS selecting post-release cause of death as a metric. In the 2023 State Medicaid Director letter, CMS cited 2021 county-level analysis that identified a strong association between jail incarceration and increases in premature death rates from infectious diseases, chronic lower respiratory disease, drug use, and suicide as the reasoning behind that metric.¹³

13. Matthew Barrett (Connecticut Association of Health Care Facilities/Connecticut Center for Assisted Living) commented that housing instability is directly related to our healthcare programs and noted that this waiver has a significant housing component to it. He also commented that Medicaid eligibility and service provision should occur in advance of re-entry to facilitate the transition. He asked for additional information on the federal match and the use of MAPOC for the purposes of meeting one of the public hearing requirements.

Response: DSS confirmed that this briefing counts as the first formal public hearing on the 1115 Justice-Involved Waiver and was included in the public notice. Regarding the federal match, Connecticut does not end Medicaid eligibility on incarceration, but rather suspends eligibility until the individual is released. This makes it easier to establish eligibility for the narrow set of health-related services that will be made available 90 days before release and eligible for federal match.

14. Anthony DiLauro (Executive Director of the Human Services Council) asked about page 10 of the presentation questioning if the 12,000 adults released annually represents just Connecticut and, if so, what is the total population.

Response: The daily adult incarcerated population is about 10,500 individuals; however, that number is very dynamic as individuals enter and exit the system with approximately 14,000 adults discharging in a year with 12,000 of them estimated to be eligible for the demonstration.

15. Representative Susan Johnson inquired about the services that would be covered for seniors who are transitioning, perhaps to a nursing facility, and do the services exclude persons with behavioral health issues as we do now with nursing facility admissions.

Response: DSS shared that if there are transition-based services prior to release, and the senior met the eligibility criteria, then those transition- services would be reimbursable.

Legislative Hearing: Committees of Cognizance March 19th 2024

After the public notice period closed, the State of Connecticut Legislature held a hearing on March 19, 2024 on the submittal of this Demonstration amendment. Topics discussed included

¹³ <https://www.publichealth.columbia.edu/public-health-now/news/incarceration-strongly-linked-premature-death-us>.

concern about the timing of the completion of the implementation plan and development of a final budget impact document. After discussion, the Committee of Cognizance for DSS voted to submit the waiver amendment.

ATTACHMENT 4

Tribal Consultation

There are two federally-recognized Indian tribes in Connecticut, the Mashantucket Pequot Tribal Nation and the Mohegan Tribe. In accordance with the State's approved tribal consultation process in the Medicaid State Plan, the State sent an email to tribal representatives of each tribe on January 12, 2024, a copy of the Connecticut Law Journal Notice, a copy of the draft waiver application, and a copy of the draft budget neutrality demonstration (as well as a link to the DSS Demonstration webpage referenced above). The tribal representatives did not send any comments to the State about this Demonstration. This Demonstration does not have a unique or particular impact, nor a direct effect on tribal members, tribes, or tribal health programs or organizations.

From: Mahoney, Ginny L.

Sent: Friday, January 12, 2024 9:01 AM

To: Reels, Shanna <sreels@mptn-nsn.gov>; Vital, Jennifer <JVital@mptn-nsn.gov>; Connie Hilbert <chilbert@moheganmail.com>; Carrie Janus <cjanus@moheganmail.com>; Teri McHale <TMcHale@moheganmail.com>; Susie Jacobs <sjacobs@moheganmail.com>; bmacdonald@moheganmail.com; Mars, Heather A <HAMars@prxn.com>

Cc: Norwood, Joel C. <Joel.Norwood@ct.gov>; Henderson, Claudia <Claudia.Henderson@ct.gov>; Holt, Catherine <Catherine.Holt@ct.gov>; Robinson-Rush, Dana <Dana.Robinson-Rush@ct.gov>; Cartier, Cynthia <Cynthia.Cartier@ct.gov>; Slitt, Michael <Michael.Slitt@ct.gov>; Mohammed, Alexis <Alexis.Mohammed@ct.gov>

Subject: Tribal Notification - 1115 Justice-Involved Demonstration Waiver Amendment [not-secure]

Good morning,

The Department of Social Services in collaboration with the Department of Correction, the CT Judicial Branch, the Department of Mental Health and Addiction Services, the Office of Policy Management, the Department of Developmental Services, and the Department of Children and Families, proposes an amendment for the Medicaid and Children's Health Insurance Program (CHIP) Substance Use Disorder (SUD) Demonstration Waiver (Demonstration) under Section 1115 of the Social Security Act to the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) for Medicaid Coverage for Justice-Involved Population Re-entry Initiative.

The Re-entry Initiative will enable Medicaid coverage and federal financial participation (FFP) using Medicaid and Children's Health Insurance Program (CHIP) matching funds for adults incarcerated in correctional centers (jails and courthouses) and correctional institutions (prisons), and youth detained in juvenile and community residential centers throughout the State receiving a targeted benefit package that would ordinarily not be covered under federal law. This Re-entry Initiative will ensure a continuum of care strategy that enables robust coordination, service provision, and community connections after release.

Attached please find a copy of the Connecticut Law Journal Notice, followed by the draft waiver application, and draft budget neutrality demonstration (please note a full public notice can be found at the link below).

Additionally, there will be two electronic public hearings. More information can be found on the following DSS web site: <https://portal.ct.gov/DSS/Health-And-Home-Care/1115-Justice-Involved-Demonstration-Waiver/Public-Hearings-and-Public-Comments>

Please let us know if you have any questions.

Thank you,
Ginny

Ginny Mahoney

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