KENTUCKY VOICES FOR HEALTH

Building a healthy Kentucky together

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SUD Incarceration Amendment Comment
c/o DMS Commissioner's Office
275 E. Main St. 6W-A
Frankfort, KY 40621

To Whom It May Concern:

Comments re: §1115 Waiver Amendment – SUD Incarceration Services
Submitted via Email to: DMS.ISSUES@ky.gov

Thank you for the opportunity to comment on the Kentucky Department of Medicaid Services' (DMS) Section 1115 SUD Demonstration Proposed Amendment: Continuity of Care for Incarcerated Members. Kentucky Voices for Health (KVH) is a nonpartisan 501(c)(3) coalition of consumer advocates that represents more than 200 individual and organizational members from across the commonwealth working to address the underlying causes of poor health through policy advocacy. KVH is deeply supportive of increasing Kentuckians' access to quality healthcare, and therefore this amendment to Kentucky's existing Section 1115 demonstration project that expands substance use disorder services (SUD) for Medicaid beneficiaries.

Kentucky Voices for Health appreciates that DMS has chosen to address SUD from pre-trial to release, making this the most comprehensive demonstration of its kind. This demonstration bridges healthcare access for justice-involved Kentuckians by providing evidence-based treatment and supports for reentry, with the goals of improving outcomes for people with SUD and Severe Mental Illness (SMI); overcoming barriers to care; decreasing recidivism; and clarifying the role of Managed Care Organizations (MCOs) responsible for the provision of Medicaid services. KVH supports these stated goals with one addition. There is great potential for preventing incarceration through the provision of community-based services, which should be the ultimate goal of this project.

BACKGROUND

One of the most dramatic changes in the healthcare landscape in Kentucky was the implementation of the Patient Protection and Affordable Care Act (ACA), with the expansion of Medicaid in 2014 and the inclusion of SUD services for Kentuckians experiencing addiction and recovery from addiction. As a result of the ACA's requirement for pay parity and the inclusion of SUD treatment under Medicaid

expansion, services increased by more than 700 percent[1] over the first 30 months of implementation. In the years since Medicaid expansion, drug-related deaths have decreased in Kentucky[2], although this positive trend is at risk of being reversed by the current COVID-19 pandemic and economic recession.

Even with expanded coverage, Kentuckians are still struggling with a substance use crisis that has been decades in the making. There are still too many Kentuckians who need medical care for addiction and recovery services.[3],[4] Many of those individuals are currently or recently incarcerated. The SUD services available vary greatly by region and MCO, with many having no access or limited access to the more comprehensive and evidence-based services provided under this demonstration.

CURRENT LANDSCAPE

As we consider the design and implementation of this proposed demonstration project, it is important to recognize that Kentucky is currently experiencing an incarceration crisis. Since 1970, the jail population in Kentucky has increased 740 percent.[5] Since 1983, the population of people in prisons in Kentucky has increased 168 percent.[6] Neither our physical buildings[7] nor programming for rehabilitation have kept up. Our jails are overcrowded and Kentuckians are too often leaving jails without secure connection to needed healthcare - including medication assisted treatment (MAT) and mental health services - to support recovery and prevent a return to incarceration.[8]

Careful planning and policies must be included with implementation of this demonstration project to assure that this experiment does not contribute to an increase in the number of Kentuckians who are incarcerated, nor the length of incarceration. One simple and common sense modification to this proposal would be to strike the words "jail based" on page 12 to reflect that a community-based six-month treatment program may serve as an alternative to a felony conviction. If the intent of this portion of the demonstration project was residential six-month treatment program, adding the word *residential* would still allow for a community based treatment and not the clear preference for incarceration.

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[1] Substance Use and the ACA in Kentucky: Study of the Impact of the ACA Implementation in KY: SHADAC, December 2016. https://www.shadac.org/sites/default/files/publications/SubstanceUseandtheACAIssueBrief.pdf

[2] KY-ODCP and KY-ASAP Annual Report, 2019. https://odcp.ky.gov/Reports/2019%20annual%20report%20final.pdf

[3] Hill I, Wilkinson M, Holahan J. The Launch of the Affordable Care Act in Selected States: The Problem of Provider Capacity. Washington: Urban Institute; 2014. http:// www.urban.org/research/publication/launch-affordable-care-act-eight-statesproblem-provider-capacity. Published March 5, 2014.

[4] Wishner, Jane B, Burton, Rachel A. How Have Providers Responded to the Increased Demand for Health Care Under the Affordable Care Act? Urban Institute; 2017. https://www.urban.org/sites/default/files/publication/94396/2001576-how-have-providers-responded-to-the-increased-demand-for-health-care-under-the-affordble-care-act_0.pdf

[5] https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-kentucky.pdf

[6] Id.

[7] Kentucky county jails are at average packed at 121% of their capacity.https://www.kentucky.com/news/local/watchdog/article231443768.html

[8] https://www.kentucky.com/news/local/watchdog/article233573557.html

> "Upon an agreement between the judge, the commonwealth attorney, the client in question, and their attorney, successful completion of a ~~jail based~~ six month treatment program may serve as an alternative to a felony conviction."

This project should never be used to justify incarceration, initial or ongoing. To further prevent that unintended consequence, the Department of Corrections (DOC) and the Administrative Office of the Courts (AOC) should provide regular reports on lengths of incarceration for our fellow Kentuckians participating in this project, as well as the number of individuals who are incarcerated with a self-reported or diagnosed SUD.

All communication to stakeholders and potential participants, including professionals in our justice system like judges and attorneys, must be clear that this demonstration project is intended to expand access to healthcare, improve outcomes, and support reentry by removing barriers in transitioning from incarceration to community. Without affirmative and ongoing outreach, education, along with regular monitoring, it is possible that this purpose will not be clear to all stakeholders. For example, prosecutors and judges may see the project as an argument supporting incarceration as the place with the most resources available to a defendant, pre- or post-trial. That must be avoided by prioritizing access to comparable community-based treatment whenever possible.

RECOMMENDATIONS TO INCREASE COMMUNITY-BASED TREATMENT AND REDUCE INCARCERATION

We would like to thank DMS for finding opportunities to collaborate with other agencies to improve Kentuckians access to comprehensive, evidence-based SUD services at every stage of interaction with the justice system and Department of Corrections (DOC). Other states have restricted demonstration projects to periods of time unrelated to the needs of the individual. KVH appreciates that this demonstration project takes a more patient-centered approach of finding ways to improve access pre-trial and post.

As we mentioned before, this demonstration project has the potential to *prevent* incarceration from ever occurring, which can and should be the ultimate goal. This can be done by guaranteeing access to comprehensive, evidence-based treatment in the community for Medicaid-eligible individuals as a diversion alternative available to prosecutors and judges.

To be sure that evidence-based, medically appropriate treatment is available in the community, we also ask that clear guidance is sent to community providers that Medicaid can pay for court ordered and medically appropriate: SUD residential rehabilitation, outpatient services including case management, psychiatric evaluation, psychiatric testing, psychological testing, individual therapy, group therapy, family therapy, intensive outpatient, outpatient detoxification, methadone maintenance, Suboxone treatment, and medication evaluation, prescription, and management.[9]

There have been robust conversations amongst providers in NKY, including SUN and Transitions, rationally opposing a judge being given the power of an appropriate health care provider, but also legal

[9] Musumeci, Marybeth, Chidambaram, Priya, Orgera, Kendal. State Options for Medicaid Coverage of Inpatient Behavioral Health Services (2019). https://www.kff.org/report-section/state-options-for-medicaid-coverage-of-inpatient-behavioral-health-services-report/

fears about Medicaid reimbursement. Those agencies, and all others, should have clear guidance that Medicaid can be a payer for medically appropriate and billable healthcare that also fulfills court orders. In ensuring that this demonstration does not allow space for incarceration to supplant community based treatment, Kentuckians who are involved with the justice system must be protected from discrimination by providers. Unfortunately, there are healthcare providers in Kentucky who will not admit otherwise eligible and medically in need Kentuckians if they believe they will not be able to complete the program because of potential upcoming incarceration or otherwise are involved with our justice system. DMS, DOI, and MCOs can work together to change that. We suggest clear communication and requirements from all appropriate state agencies and ongoing education from our MCOs. We also suggest ongoing communication with judicial training to educate judges about requiring evaluations and medically appropriate treatment only to further prevent the conflict.

To integrate the experience of Kentuckians who are moving out of incarceration with community-based healthcare, as designed in this proposal, KVH recommends that DMS work with AOC to adjust diversion and sentencing forms to include acknowledgment of the availability of community based treatment for SUD. Every case deserves clear resource analysis, from the cost of incarceration, and for cases including SUD, the availability of appropriate healthcare services. For the long term success of our community members who need SUD treatment, we must ensure services are provided in the least restrictive setting, prioritizing community treatment over incarceration whenever possible.

This demonstration project also creates an opportunity for Kentucky's contracted MCOs to work with our Department of Insurance (DOI) and with AOC and DOC to be sure that Kentuckians they insure have ready access to quality, evidence based residential, intensive inpatient, outpatient, and all medically appropriate care for their members with SUD or co-occurring SUD and SMI. MCOs, and all health insurance plans, must have truly adequate networks of evidence-based residential treatment options for their members, when residential treatment is the appropriate level of care, jails and prison must never be considered part of those networks or calculations. Currently, networks are not providing enough evidence-based SUD treatment programs with available beds to serve all of the justice-involved Kentuckians who need treatment. Some regions in Kentucky have sufficient beds available and some do not.

The success of this project is strongly dependent on MCOs having an appropriate and adequate network in the community providing the full spectrum of SUD treatment and recovery programs, ranging from fully to partially residential programs, intensive outpatient programs, outpatient therapy to 12-step programs, peer support, targeted case management, care coordination, and medication-assisted treatment programs. These community programs need to be of high quality, evidence-based and very accessible to individuals both as an alternative to incarceration for some and immediately upon release from incarceration for others. Reimbursement for these services must be at parity with similar physical health services in order to support an adequate network of quality services.

Furthermore, "prior authorization" is a tool too often used by MCOs to deny care. It is common practice for MCOs to deny needed behavioral health services based on an improper application of "medical necessity" criteria.[10] To prevent this misuse and ensure access to needed services in community-based

[10] Wit et al. v. United Behavioral Health. and Alexander et al. v. United Behavioral Health

settings, DMS should make permanent the suspension of prior authorization for all behavioral health services, which is currently in place due to the COVID-19 pandemic. This suspension should apply to all SUD and mental health services and treatments, including targeted case management. If the suspension of prior authorization is lifted, DMS should have clear rules in place to prevent misuse along with strong enforcement.

RECOMMENDATIONS TO STRENGTHEN INTEGRATED CARE

Kentucky Voices for Health applauds the inclusion of Severe Mental Illness (SMI) services in this project. Kentucky incarcerates more individuals with severe mental illness than we hospitalize.[11] This demonstration has the potential to greatly improve the delivery of appropriate care for our neighbors with SMI.

KVH would, however, urge a revision to not exclude Kentuckians arbitrarily based on the point in time or otherwise ranking of diagnoses. If an individual has a substance use disorder, they should be eligible to participate in the recovery paths provided by this demonstration project. We recommend deleting the word "primary" in the last paragraph on page 11:

> "Individuals will be Medicaid eligible incarcerated members who have a ~~primary~~ diagnosis of SUD."

A diagnosis of SUD should suffice for eligibility, whether or not there are co-occurring disorders discovered before or after the SUD diagnosis. Requiring the diagnosis be primary is an unnecessary and unsupported tempering of the purpose of this demonstration to address SUD for Kentuckians who are at risk of incarceration or currently incarcerated.

KVH strongly supports the inclusion of coordinated enrollment pre-release. Pre-release Medicaid and MCO enrollment are a necessary foundation for successful case management and care delivery. Research is clear that poor health and healthcare needs make it harder for formerly incarcerated people to successfully reintegrate into their communities.[12] Research suggests that intensive case management[13] improves outcomes for people returning from incarceration, particularly by helping them address mental health needs.[14] This demonstration is targeted the right way in connecting individuals to their MCO prior to release and aligning resources for the individual to support success reentry and recovery.

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[11] https://www.treatmentadvocacycenter.org/browse-by-state/kentucky

[12] Mallik-Kane, Kamala, Wishner, Jane B. New Medicaid guidance could help people get much-needed healthcare after prison or jail. 2016. https://www.urban.org/urban-wire/new-medicaid-guidance-could-help-people-get-much-needed-health-care-after-prison-or-jail

[13] Case management has been defined as "a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs" (https://ccmcertification.org/about-us/about-case-management/definition-and-philosophy-casemanagement). It can take a variety of forms and levels of intensity. Here we use the term case management to include intensive in-person case management as well as less intensive case management such as the care coordination provided by health plans.

[14] See Theurer and Lovell (2008) and Burke and Keaton (2004).

We also strongly support the expansion of Substance Abuse Medication Assisted Treatment (SAMAT) and Medication Assisted Recovery (MAR), which is extremely important to support and maintain recovery. Kentuckians with addiction are suffering and KVH is grateful this proposal acknowledges that reality and promotes a full range of treatment, particularly the language on page 14, "Treatment options include: member, family and group therapy, peer support services and MAT of their choice that is determined clinically and medically appropriate." The patient-centered approach is always the right one. To that same point, on page 19, where the objectives of the amendment are described, we suggest clarifying that same patient centered commitment and improved likelihood by replacing the word allow withe word require:

> "First, to provide SUD treatment to eligible incarcerated individuals in order to ensure this high risk population receives needed treatment before release, and to strengthen follow up care with a Medicaid provider after release by paying for SUD treatment while incarcerated; and to ~~allow~~ **[require]** the recipient's chosen MCO to coordinate aftercare with a Medicaid provider 30 days before release.

We share the Kentucky Mental Health Coalition's request to more clearly outline the providers, services, and treatment options available for those individuals who have co-occurring SUD and SMI. We also agree that ongoing problems that currently exist in Kentucky's behavioral health community vis-à-vis MCOs with regard to network adequacy, prior authorizations, and definitions and applications of medical necessity criteria are issues that should be addressed in this waiver proposal so that they do not become barriers to successful implementation.

Finally, we cannot emphasize enough that access to a full and robust continuum of community-based SUD and SMI treatment and recovery programs is critical to preventing incarceration and enabling justice-involved Kentuckians to achieve and maintain recovery.

Thank you again for the opportunity to provide comments on this 1115 SUD Waiver. We appreciate the broad scope of this proposed demonstration and support the stated goals with the addition of preventing incarceration as the primary goal. For this demonstration to be truly successful at improving outcomes for justice-involved individuals, we must ensure Kentuckians are not penalized by being incarcerated instead of accessing diversion programs or Drug Court or are held in incarceration for completion of treatment programs that should be available in the community.

Kentucky Voices for Health appreciates the careful consideration given to this proposal and requests any response prepared to these comments and others be sent to cara@kyvoicesforhealth.org.

SIncerely,

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