LEGAL ACTION CENTER

Recent Medicaid Waiver Activity Important to the Criminal Justice System

If a state wants to try a new approach to offer supplemental or other services to address specific health needs of its Medicaid enrollees, it can design a "waiver" (or demonstration) program to do so. Waivers give states flexibility in how to operate their Medicaid programs, while addressing various unmet health needs of low-income state residents. Medicaid waivers can serve as a critical method of addressing specific unmet health needs of people involved in the criminal justice system and other underserved communities.

This policy brief:

- provides foundational information about how waivers operate as a part of the Medicaid program
- details the attributes of different types of Medicaid waivers, and
- describes and provides links to recently approved Medicaid waivers important to the criminal justice population.

The Fundamentals of the Medicaid Program

States voluntarily work with the federal government, through the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) to create the joint federal and state Medicaid program. This arrangement permits the federal government to pay states at least 50% of the costs to operate their Medicaid programs, while reimbursing a higher percentage to states with lower per capita incomes.

In order to participate in Medicaid, states also must adhere to several federal governing requirements in administering their programs, such as:

- Freedom of Choice - the Medicaid enrollee is allowed to obtain services from any qualified Medicaid provider that providers them;
- Amount, Duration and Scope - services must be sufficient in "amount, duration and scope" to reasonably achieve its purpose;"
- Statewideness - services must be offered throughout the state, and states cannot change the amount, duration, or scope of covered services based on where the enrollee lives within the state; and
- Nominal Cost-sharing - States can impose nominal cost-sharing (e.g., copayments and deductibles) on most non-medical services (excluding family planning services and supplies) for certain groups of enrollees, except for children, pregnant women, and nursing home residents.

States must cover certain "mandatory" services (e.g., inpatient hospital care, physician services, and laboratory and x-ray services, etc.), while they have the flexibility to determine if they will cover "optional" services (e.g., prescription drugs, dental, and rehabilitative, etc.). Mostly all states cover some optional services, such as prescription drugs, in addition to the mandatory services. Each state submits a state plan to the federal government that describes how they will implement their Medicaid programs.

The traditional Medicaid program requires states to determine eligibility criteria to cover certain low-income populations -- individuals and their dependent children, pregnant women, the elderly, and people with disabilities. Financial eligibility criteria can vary from state-to-state under this approach. While the Affordable Care Act ("ACA") added an additional Medicaid eligibility category based on income alone for individuals whose incomes are at and below 133% of the federal poverty level, not all states have expanded their Medicaid eligibility and instead continue to use the traditional criteria. However, it is unclear at this time what new criteria CMS may require for states to operate either their traditional or expansion Medicaid programs.

How Different Types of Medicaid Waivers Work

Under Medicaid law, the Secretary of HHS has the authority to allow states to "waive" or not require compliance with certain federal Medicaid requirements, such as statewideness, etc. Waivers also provide states with federal matching funds for expenses that typically would not be for Medicaid costs. Before states can implement their waiver programs, the waiver applications must first be submitted to HHS for approval.

Generally, the Social Security Act authorizes federal Medicaid funding for three types of federal waivers:

- Section 1115 ("1115 demonstration") waivers
- Section 1915(b) waivers, and
- Section 1915(c) Home and Community Based ("HCBS") waivers.[1]

<u>What are Some Characteristics of 1115 Waivers?</u>

- Must be designed as an experimental, pilot, or demonstration project, and assist in promoting the objectives of the Social Security Act/Medicaid program.
- Can make broad changes in Medicaid eligibility, benefits and cost sharing, and provider payments.
- Can be designed to focus on particular services (e.g., substance use disorder) or certain populations (e.g., people living with HIV).
- Requirement of budget neutrality for the federal government (federal spending for states' waivers must not be more than projected federal spending would have been for the state without the waiver).
- Can be granted up to five years, and then must be renewed.

[1] Kaiser Family Foundation, Issue Brief, *3 Key Questions: 1115 Medicaid Demonstration Waivers*, Feb. 2017, available at http://files.kff.org/attachment/Issue-Brief-3-Key-Questions-Section-1115-Medicaid-Demonstration-Waivers. "As of February 2017, 33 states had 41 approved 1115 waivers in five categories:. . . delivery system reform, alternate ACA Medicaid expansion models, managed long term services and supports (through capitated managed care), behavioral health, and other targeted waivers."

- Section 1115A waivers can be designed to test, evaluate, and expand different service delivery and payment strategies to promote patient-centered care, improve quality, and decrease the cost of Medicare, Medicaid and the Children's Health Insurance Program ("CHIP").

What Are Some Characteristics of 1915(b) Waivers?

- Two-year (or five-years, if the waiver serves enrollees who are dually eligible for Medicaid and Medicare) waiver programs.
- States can require mandatory enrollment in managed care delivery systems on a statewide basis or in specific geographic areas (§ 1915(b)(1) Freedom of Choice waivers).
- States can use primary care case management under these waivers.[2]
- Can identify services for excluded populations.
- Need not offer the waiver program statewide.
- Must not substantially impair enrollee access to medically-necessary services of adequate quality.
- Includes (b)(3) Non-Medicaid Services waivers that use cost savings to provide additional services to enrollees.
- Includes (b)(4) Selective Contracting waivers that limit the providers from whom the enrollee can obtain services.

What are Some Characteristics of § 1915(c) Home and Community Based Waivers?

- Provides long-term care services in community or home settings, instead of in institutions, e.g. for people living with developmental or mental disabilities, the elderly, children born with substance use disorders, or people living with HIV.
- Can implement the waiver program in specific geographic locations within a state (so states would not have to satisfy the federal Medicaid requirement of statewideness).
- Can implement the waiver program with services that are different from the state's Medicaid population (states would not have to satisfy the federal Medicaid requirement of comparability), but the services must be the same for the population served by the waiver.
- Must indicate the maximum number of participants and factors for selection.
- Can include individuals with incomes up to 300% of the federal Supplemental Security Income benefit rate.
- Renewable for five years after the initial three or five year approval.

The Importance of Medicaid Waivers to the Criminal Justice System

Available data indicates that a significant number of individuals who are incarcerated in jails and prisons have low-incomes and are uninsured. In addition, chronic diseases, such as HIV,

[2] Medicaid primary care case management ("PCCM") is a type of health care delivery model that usually requires the enrollee to select a primary care provider ("PCP"). The PCP then becomes responsible for coordinating the enrollee's care, and receives a monthly fee for this service. In addition, the PCP is paid for providing medical services.

mental health conditions, substance use disorders, diabetes, hepatitis B and C, and sexually transmitted diseases, are prevalent among this population.

Many individuals involved in the criminal justice system are, however, eligible for Medicaid, particularly in those states that expanded Medicaid eligibility under the Affordable Care Act. Medicaid waivers can serve as a critical supplemental and sometimes primary method of addressing specific unmet health needs of justice-involved and other underserved communities.

Recently Approved Medicaid Waivers that Could Improve Care Access to People Involved in the Criminal Justice System

1115 Waivers:

1. Virginia Governor's Access Plan and Addiction and Recovery Treatment Services Demonstration

In September 2017, CMS approved Virginia's section 1115 waiver application which is aimed at strengthening access to MH/SUD care.

The goal of the Governor's Access Plan ("GAP") component of the demonstration is to utilize a targeted benefit package to prevent people with a serious mental illness ("SMI") diagnosis from becoming fully and permanently disabled. This portion of the waiver program covers both traditional medical and MH/SUD services, including:

- outpatient hospital coverage
- outpatient medical/home health
- mental health case management
- crisis stabilization
- psychiatric evaluation and outpatient individual, family, and group therapies (MH/SUD)
- peer supports and
- prescription drugs.

This program also features an informal and voluntary network of community providers that provide unreimbursed services that are not part of the Virginia GAP demonstration's benefit package. This network, "Preferred Pathways" is based in the region in which the enrollee resides.

The GAP portion of the demonstration covers individuals aged 21 through 64, who have been diagnosed with SMI and are otherwise ineligible for Medicaid, with household incomes at or below 80% of the FPL modified adjusted gross income ("MAGI") level as of July 1, 2016.[3] GAP program enrollees will have no cost sharing or premium obligations.

[3] *See generally* U.S. Dep't of Health & Human Services, Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services, *MAGI: Medicaid and CHIP's New Eligibility Standards*, Sept. 30, 2013, available at https://www.medicaid.gov/medicaid/program-information/downloads/modified-adjusted-gross-income-and-medicaid-chip.pdf. The ACA provided an easier method of calculating income eligibility for Medicaid, the Children's Health Insurance Program ("CHIP"), and financial assistance through the health insurance marketplace. MAGI uses one set of income eligibility rules for all insurance affordability programs to allow

Secondly, the Addiction and Recovery Treatment Services ("ARTS") portion of the demonstration focuses on how comprehensive and high quality SUD care can improve the health of ARTS enrollees, while reducing the costs of other portions of the health system (e.g., the emergency department and inpatient hospital services). ARTS is a new SUD delivery system for Virginia's Medicaid-eligible enrollees who are living with SUD, that is modeled after the American Society of Addiction Medicine ("ASAM")'s criteria for SUD treatment. ARTS uses policy and program measures to help providers satisfy ASAM criteria for the appropriate standards of care, integrates SUD treatment services into a comprehensive delivery system for its enrollees who receive managed care, and increases reimbursement rates for SUD treatment.

The ARTS provisions of the demonstration were implemented on April 1, 2017. Both ARTS and GAP expire on December 31, 2019.

2. West Virginia's Creating a Continuum of Care for Medicaid Enrollees with Substance Use Disorders

West Virginia's section 1115 waiver, approved in October 2017, seeks to improve care and health care outcomes for West Virginia Medicaid beneficiaries with SUD by expanding SUD coverage and introducing new programs to improve quality of care and care coordination. The waiver specifically aims to combat the opioid epidemic by expanding the SUD benefits package to include coverage for:

- Peer Recovery Support Services: Peer recovery coaches are individuals in recovery who have been certified by the West Virginia Department of Health and Human Services to provide peer support to others in the process of SUD recovery.

- Residential Treatment Services: Treatment services will be delivered to residents in institutional care settings and institutions for mental diseases (IMDs), when determined to be medically necessary and in accordance with individualized services plans. The waiver will accordingly allow for Federal Financial Participation for services provided to Medicaid beneficiaries who are receiving care for in residential SUD treatment facilities larger than 16 beds. Services:
    - Can be provided in centers of any size.
    - Can include: therapeutic treatment, addiction pharmacotherapy and drug screening, motivational enhancement, withdrawal management and treatment, monitoring of medication adherence, recovery support services, counseling services involved the beneficiary's family, and education on and referrals to medication assisted treatment.

- Opioid Treatment Program Services: Physician-supervised daily or multiple times weekly medication and counseling services for those with severe opioid use disorder. Only for individuals in state-licensed methadone clinics.

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people to apply for health coverage with one application, and eliminates the previous income deduction method for calculating Medicaid eligibility (that varies from state-to-state and eligibility group).

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- Covered services: Consultations (psychological, medical, and psychiatric), access to emergency medical and psychiatric care, access to ongoing primary care and evaluation, laboratory and toxicology tests, evaluation and monitoring use of methadone, supervision of administration of methadone, group or individual therapies, medication for other physical and mental illness as needed, optional substance use care coordination, screening for infectious diseases (HIV, hepatitis B and C, tuberculosis).

The demonstration also aims to increase access to care by expanding the SUD provider networks available to Medicaid populations, and decrease use of emergency and hospital services for enrollees with SUD.

Within 150 days of approval of the demonstration, West Virginia must submit a plan that will describe data collected, reporting, and analytic methodologies for performance measures, as well as timeframes for reporting progress. The plan must also identify a baseline, a target to achieve by the end of the demonstration, and an annual goal for achieving this target for each performance measure.

All Medicaid enrollees, in both managed care and fee-for-service programs, all eligible for the demonstration. The waiver provisions to expand coverage of methadone maintenance therapy will be implemented in January 2018. All other services authorized by the waiver will be implemented by July 2018.

3. Nevada Comprehensive Care

The Nevada Comprehensive Care Waiver (NCCW) program is designed to provide care management to high-cost high need Medicaid beneficiaries who receive services on a fee-for-service (FFS) basis, improve the quality and efficiency of that care, and sustain long-lasting reforms and improvements in the quality of health care for Medicaid beneficiaries.

Eligible beneficiaries are those who are not currently eligible for care management services, and have at least one of the following qualifying conditions:

- asthma; chronic obstructive pulmonary disease/chronic bronchitis/emphysema; pregnancy; diabetes mellitus; end stage renal disease/chronic kidney disease; heart disease/coronary artery disease; HIV/AIDS; mental health; neoplasm/tumor/cancer; obesity; substance use disorder; cerebrovascular disease/aneurysm/epilepsy; and musculoskeletal system problems.

Individuals with complex conditions or a history of being a high utilizer of medical services are also eligible for enrollment. All eligible individuals will be mandatorily enrolled, except for American Indians/Alaskan Natives, who can participate on a voluntary basis.

Ineligible individuals include: individuals eligible for Medicare or receiving emergency Medicaid; individuals in the child welfare system (either juvenile justice or foster care programs); individuals enrolled in MCOs; individuals receiving service through one of the states 1915(c) home and community based services waivers, people receiving targeted case management, and residents of Intermediate Care Facilities for individuals with Mental Retardation.

Nevada will operate at least one care management organization (CMO), and beneficiaries must be given a choice of care manager within the CMO. Participants will receive care management services in addition to state plan and Medicaid benefits. The continuing state plan and Medicaid services will still be provided FFS. There are no changes to benefits received under NCCW.

NCCW was implemented on July 1, 2013, and expires on June 30, 2018.

4. New Hampshire's Building Capacity for Transformation

New Hampshire's Building Capacity for Transformation waiver program is designed to reform New Hampshire's state MH/SUD care system, through the Medicaid expansion under the Affordable Care Act. Through a statewide network of regionally based Integrated Delivery Networks (IDN), the waiver program has four main goals:

- integrate physical and behavioral health for "whole person" care
- expand the state's capacity to address MH and SUD issues
- develop new expertise to address current crises in behavioral health
- improve care coordination to reduce gaps in care during patient transitions

This waiver will affect all Medicaid beneficiaries in New Hampshire who need MH/SUD care, with the exception of those who are served under the New Hampshire Health Protection Program Premium Assistance section 1115(a) Medicaid demonstration.

New Hampshire will use the Delivery System Reform Incentive Payments (DSRIP) program, structured by the regional IDNs, to incentivize providers to work together to achieve the goals of Building Capacity for Transformation. All providers are expected to work together to design and implement a series projects to promote integration and coordination across specialties and care settings. These programs will be designed in order to increase the capacity to provide behavioral health services, promote integration of behavioral and physical health, and promote community social service supports.

The waiver program was implemented on January 5, 2016, and expires on December 31, 2020.

5. Maryland's HealthChoice

HealthChoice seeks to improve the health of low income Marylanders by: improving access to health care for the Medicaid population; improving the quality of the health services delivered to that populations; expanding coverage to more low income Marylanders; emphasizing health promotion and disease prevention by providing access to wellness services; and by providing comprehensive coordinated care to each individual.

HealthChoice seeks to strengthen access to SUD care with an evidence-based benefit design covering the full continuum of care, implementing key benchmarks from industry standards of care, reporting specific quality measures, and embarking on a strategy to integrate physical and behavioral health services to improve health outcomes for beneficiaries with SUD. The demonstration allows for Federal Financial Participation (FFP) for Medicaid-covered services provided to Medicaid beneficiaries who are receiving care in

residential SUD treatment facilities that constitute an IMD. Under the demonstration, FFP can apply for up to two non-consecutive IMD stays of thirty days or less annually.

In addition, HealthChoice includes provisions to strengthen access to: expanded dental care for former foster care youth; the Rare and Expensive Care management program, which provides special case management services that are not available under the state Medicaid program to individuals with rare and expensive medical conditions; the Maryland Children's Health Insurance program; a family planning program; and the Primary Adult Care program.

All Medicaid beneficiaries are eligible and enrolled in a Managed Care Organization or a case management program, and participation in HealthChoice is mandatory for all Medicaid beneficiaries. Through demonstration programs such as HealthChoice, Medicaid eligibility has been expanded to include: women of childbearing age with a family income at or below 200 percent FPL; women diagnosed with breast or cervical cancer with incomes between 133-250 percent FPL; and individuals with Substance Use Disorder (SUD).[4]

HealthChoice was originally implemented from July 1997 to June 1998, and was renewed in January 2017 with an expiration date of December 31, 2021.

More information on the waiver can be found here.

Section 1915(b) Waivers

1. *Indiana's Behavioral and Primary Health Care Coordination*

Indiana's Behavioral Healthcare Coordination (BPHC) program is designed to help eligible individuals manage their physical and behavioral health by coordinating healthcare services to more efficiently and effectively manage mental health and addiction healthcare needs of recipients. As part of BPHC, community mental health centers will provide services to help recipients schedule appointments and communicate more effectively with doctors. BPHC includes support programs to help recipients adhere to health regimens, schedule and keep appointments with doctors, and to link recipients with the appropriate services they need. Additionally, BPHC services help assess the service needs of the individual and then aid in developing an individualized integrated care plan, as well as monitor and follow-up with the recipient.

Eligible recipients must be 19 years old or older, and have been diagnosed with a BPHC eligible primary mental health diagnosis. These eligible diagnoses include various alcohol and drug dependencies, bipolar disorders, schizophrenic disorders, and manic affective disorders, among others. The individual must meet the needs-based criteria: they must have a demonstrated need related to management of their behavioral and physical health; a demonstrated impairment in self-management of their behavioral and physical health; a health need which requires assistance and support in coordinating health treatment; and a recommendations for intensive community based care. The individual must also have income below 300 percent FPL, though this can be adjusted on an individual basis.

[4] For more information on programs and eligibility, see https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/md/md-healthchoice-fs.pdf.

More information on the waiver can be found here, and here.

2. California's Medi-Cal Specialty Mental Health Services

CMS approved California's Medi-Cal Specialty Mental Health Services (SMHS) waiver for five years beginning July 1, 2015. SMHS covers services such as mental health assessments, group and individual therapy, group and individual rehabilitation, case management, residential treatment services, psychiatrist and psychologist services, training and counseling for family members, and crisis intervention and stabilization. These services are covered if they meet the following medical necessity requirements:

- there must be a diagnosis of a mental disorder[5];
- there must be an impairment, as a result of that disorder, that affects the individuals ability to function individually or in the community;
- the mental health service provided must be focused on addressing that impairment; and
- the intervention must be a specialty mental health service.

The services are provided through Mental Health Plans (MHPs) through each county's mental health department. The MHPs authorize and pay for the mental health services. Medi-Cal requires each MHP to have services available 24 hours a day, 7 days a week in case of urgent conditions. MHPs must provide emergency services access and are required to maintain a 2-hour toll-free telephone number to provide general information to recipients and providers.

3. Colorado's Community Behavioral Health Sciences Program and Special Connections Substance Abuse Treatment Program

Colorado received CMS approval to renew their section 1915(b) Community Behavioral Sciences Program and Special Connections Substance Abuse Treatment Program in 2015. The program includes: rehabilitative services; targeted case management, school-based mental health services, counseling, psychiatric treatment, physician services, group and family psychotherapy, and medication assisted treatment.

Special Connections is a substance use disorder treatment program jointly administered by the Colorado Department of Human Services (DHS), Office of Behavioral Health (OBH), and the Department's Medicaid Program Division. Special Connections provides treatment and case management services to pregnant and postpartum women with substance use disorders, former foster care children under 26 years of age, and children age 6 through 19 with income between 100 percent and 133 percent FPL. The waiver renewal extends the Special Connections programs from three to twelve month post-partum to support new mothers in their recovery and their babies.

More information on the waiver can be found here.

[5] For a list of disorders covered by Medi-Cal, see https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/CA_Speciality-Mental-Heatlh-Services_CA-17.pdf, at page 21.

4. Minnesota's Consolidated Chemical Dependency Treatment Fund

Minnesota's 1915(b) waiver, the Consolidated Chemical Dependency Treatment Fund, became effective on July 1, 2014. Minnesota's demonstration seeks to ensure that public funds for SUD treatment are used in the most cost-effective way to provide the highest level of care available. The Consolidated Fund combines all state and federal treatment funds into one fund available to all Minnesotans statewide who are eligible, and Counties enter into contracts with providers to establish consistent rates and services. Eligibility is determined by using a statewide criteria that determines what the appropriate level of care for each individual is, based on the specific nature of the individuals substance abuse problems. Eligible clients may have an income up to 215 percent FPL.

The Consolidated Chemical Dependency Treatment Fund incorporates a number of individualized services to promote recovery and avoid relapse, and address the physical, psychological, social, and economic problems that come with substance abuse. Services provided include therapy, family services, mental health services, HIV/AIDS services, educational services, financial services, development of a treatment plan with clinical and case management, and involvement of the individual in self-help and peer-support groups.

More than half of the Consolidated Fund clients are under court jurisdiction at their time of admission, and 45 percent have been arrested or convicted within the last six months.[6] After six months of treatment, 55 percent of Consolidated Funds clients report total abstinence from alcohol or drugs, and there is a 75 percent decline in arrests for clients. Only 20 percent of clients have been readmitted to treatment within two years of ending the program.[7]

More information on the waiver can be found here and here.

5. Utah's Prepaid Mental Health Plan

Utah's renewal 1915(b) waiver application for the state's Prepaid Mental Health Plan became effective on July 1, 2017. The goals of the Prepaid Mental Health Plan (PMHP) are to: promote effective coordination of care; promote preventative care for woman and children; and improve access to and quality of services provided to Medicaid beneficiaries. The Prepaid Ambulatory Health Plan is a part of the PMHP that provides SUD services.

All Medicaid beneficiaries in Utah, including children in foster care, must get mental health services through PMHP, and must get SUD services through PMHP if the individual wishes Medicaid to cover those services. Under the CMS-approved waiver, mental health and substance use disorder services are carved out of the Choice of Health Care Delivery waiver and are provided by specialized mental health and substance use disorder providers. All mental health/substance use disorder clients receive an individualized comprehensive mental health evaluation by a licensed mental health therapist and are prescribed services in a mental health/substance use disorder treatment plan. The provided services include evaluations, psychological testing, medication management, therapy in individual, group, and family settings, rehabilitation services, peer support services, and case management services.

[6] https://www.leg.state.mn.us/docs/2009/other/090616.pdf

[7] https://www.innovations.harvard.edu/consolidated-chemical-dependency-treatment-fund

More information on the waiver can be found here.

Section 1915(c) Home and Community Based ("HCBS") Waivers

A number of states have utilized 1915(c) HCBS waivers to improve care access for people with HIV/AIDS:

- **Illinois's HCBS waiver program for Persons with HIV or AIDS** offers adult day care, homemaker, personal assistant, respite care, home health aide, intermittent nursing, occupational therapy, physical therapy, speech therapy, environmental accessibility adaptations, home delivered meals, in-home shift nursing, Personal Emergency Response System services, and specialized medical equipment for individuals living with HIV or AIDS. There are no age restrictions for eligibility for this waiver.
- **Alabama's HIV/AIDS waiver program** provides for case management, respite care, a homemaker, personal care, companion, and skilled nursing for individuals over the age of 21 living with HIV/AIDS.
- **Florida's Project AIDS Care** provides case management services, homemaker and personal care, skilled nursing care, therapeutic management for substance use issues, home delivered meals, specialized medical equipment and supplies, education and support, environmental accessibility adaptations, and specialized personal care for children in foster care. There are no age restrictions on the Florida Project AIDS Care Waiver.
- **Iowa's AIDS HCBS waiver** provides adult day care, homemaker services, respite, home health aide and nursing, financial management services, home-delivered meals, counseling, both unskilled and skilled consumer-directed attendant care, counseling, self-directed community support and employment, and self-directed personal care. There are no age restrictions on this waiver.
- **Missouri's AIDS waiver program** provides personal care, attendant care, private duty nursing, and specialized medical supplies for individuals with HIV or AIDS who are age 21 or above.
- **South Carolina's HIV/AIDS HCBS waiver** provides case management, personal care, prescription drugs that cannot be obtained through Medicare Part D benefits, attendant and companion care services, home accessibility adaptation, specialized medical equipment and supplies, home delivered meals, and private duty nursing. There are no age restrictions on this waiver.

Other states, including Connecticut and Georgia, have used 1915(c) waivers to improve access to mental health care.

- The **Connecticut Mental Health Waiver** is focused on improving care access to adults with serious mental illness who are being discharged or diverted from nursing home care. Under the waiver, individuals with mental illness age 22 and older are provided with the medical and psychiatric services and supports necessary to live independently in the community. Waiver services are provided face to face, in the participant's home or in other community settings (non-office based). Services include

adult day health, community support, employment support, assisted living and assistive technology, the installment of personal emergency response systems, specialized medical equipment, home accessibility adaptation, non-medical transportation, home delivered meals, transitional case management, brief episode stabilization, overnight recovery assistants, and peer support services. The waiver is operated by the Department of Mental Health and Addiction Services with oversight by the Department of Social Services, Connecticut's Single State Agency for Medicaid.

- **Georgia's Community Based Alternatives for Youth** seeks to improve care access to individuals with mental illness between age 18 and 21, and children between the ages of 4 and 17 with severe emotional disturbance. Covered services include: behavioral assistance, care managements, clinical consultative services, expressive clinical services, family peer support, financial support, youth peer support, supported employment, and community transition services.

Conclusion

Medicaid waivers can be particularly helpful in addressing the needs of people with complex, co-occurring chronic health conditions, including those involved in the criminal justice system. It is important for criminal justice decision-makers to know about the various ways in which Medicaid waivers can be designed and implemented and to understand specific options in their state. It is equally important for health decision-makers, as they make changes to their state Medicaid programs, to understand and to work to address the health care needs of Medicaid enrollees involved in the criminal justice system. Medicaid waivers present an important opportunity to improve both health care and public safety outcomes.

Additional Helpful Resources

- Key Centers for Medicare and Medicaid Services (CMS) websites:
  - Medicaid program website
  - Searchable database of state Medicaid waivers
  - State Medicaid and CHIP Profiles
  - State Resource Center

- Kaiser Family Foundation Resources on State Medicaid Waivers

- National Health Law Program Resources on State Medicaid Waivers

- Legal Action Center materials on health and justice