LEGAL ACTION CENTER
Breaking Barriers. Defending Dignity.

Laura Goodman
Medicaid Office of Innovation, Research and Development
Maryland Department of Health
201 West Preston Street, Room 224
Baltimore, MD 21201

February 12, 2024

RE: Maryland HealthChoice §1115 Reentry Demonstration Waiver Amendment Application

Dear Ms. Goodman,

Thank you for the opportunity to submit comments on Maryland's amendment to the HealthChoice §1115 Demonstration (Project Number: 11-W-00099/3) for the addition of a Reentry Demonstration. These comments are submitted by the Legal Action Center, along with the 10 undersigned organizations. The Legal Action Center a law and policy organization that has worked for 50 years to fight discrimination, build health equity, and restore opportunities for individuals with substance use disorders, arrest and conviction records, and HIV or AIDs. In Maryland, we convene the Maryland Parity Coalition and work with our partners to ensure non-discriminatory access to mental health (MH) and substance use disorder (SUD) services through enforcement of the federal Mental Health Parity and Addiction Equity Act (Parity Act) in both public and private insurance. The Legal Action Center also works to expand support for alternatives to incarceration and reentry programs across the country and improve access to health care for those involved with, or with a history of involvement with, the criminal legal system, and has engaged on Medicaid reentry at the state and federal level.[1]

We applaud the Maryland Department of Health (MDH) for working to expand access to a targeted set of Medicaid services to certain eligible people who will soon be released from state prison or jail. By improving access to Medicaid coverage and needed health care services as people prepare to return to the community from prison and jail, this demonstration would strengthen reentry outcomes, improve individual and public health, and promote greater racial justice and equity. People reentering the community are 129% more likely to die from a drug overdose and are at significantly higher risk to die by suicide. Untreated MH and SUDs are a significant driver of the overrepresentation of Black and brown people in jails and prisons. Strengthening people's access to quality community-based health care upon reentry would foster racial justice and equity by improving Black and brown people's health outcomes and reducing rates of re-involvement with the criminal legal system. Allowing for Medicaid coverage just prior to release also would reduce the use and cost of emergency department care, hospitalizations, and other medical expenses connected to health care needs upon reentry.

While we recognize that MDH intends to expand this demonstration in future years, we are concerned

[1] Legal Action Center, "HHS Releases Guidance Encouraging States Nationwide to Apply for Medicaid Reentry Waivers (First Conceived of by LAC) to Bridge Dangerous Health Care Gap for People Leaving Incarceration" (Apr. 18, 2023), https://www.lac.org/news/hhs-releases-guidance-encouraging-states-nationwide-to-apply-for-medicaid-reentry-waivers-first-conceived-of-by-lac-to-bridge-dangerous-health-care-gap-for-people-leaving-incarceration.

by the limited number of carceral settings that will be included in this initial phase of the waiver. Failure to cover all local detention centers will miss an important opportunity to provide treatment and reduce incarceration associated with untreated SUD and MH conditions. **We strongly recommend MDH consider expanding the initial demonstration to help improve community transitions and health outcomes for all Maryland individuals who are being released from carceral settings**. At a minimum, MDH should work with the Maryland Department of Public Safety and Correctional Services to build capacity to provide greater access to these life-saving services across all correctional settings in the state and to Medicaid coverage upon release.

Additionally, **we recommend MDH provide greater detail on its plans to engage people with lived experience in the development and execution of this demonstration and how it plans to regularly elicit patient feedback from participants throughout the demonstration**, as "strongly encourage[d]" by the Centers for Medicare and Medicaid Services (CMS).[2] We also recommend MDH work with CMS to ensure this waiver is designed, implemented, and evaluated in a way that is consistent with CMS's principles of health equity.[3] In addition, **MDH should detail its plans to inform people participating in this demonstration about their rights and benefits as Medicaid beneficiaries**.

Moreover, Maryland should use this opportunity to identify how existing state funding for carceral health services – especially insofar as Medicaid coverage will now cover some services that are already being provided – will continue to support access to necessary care and achievement of positive health outcomes for the justice-involved population. For example, to the extent that not all carceral settings have medication units that provide all FDA-approved medications for SUD, Maryland should build capacity in these settings to ensure that all those who are incarcerated with SUD have access to these life-saving medications, including naloxone and other harm reduction services. **In addition to reinvesting savings from this demonstration into SUD and MH care, both in carceral settings and the community, we recommend Maryland ensure those reentering the community have uninterrupted access to Medicaid coverage, including requiring continuous Medicaid coverage for at least one year after release.**

Furthermore, we offer the following recommendations:

A. MDH should extend eligibility to all individuals with a SUD or MH diagnosis, not just serious mental illness, and provide regular and comprehensive screenings in jails and prisons by licensed community-based providers to identify eligible participants for the demonstration.
B. MDH should prioritize and facilitate having culturally and linguistically effective community-based providers deliver demonstration services.
C. MDH should clarify and expand the covered benefits under this demonstration to facilitate successful transitions into the community and improve health outcomes, including transportation, ongoing case management in the community, housing and employment supports, sexual and reproductive health screening and treatment, and HIV/HCV screening and treatment.

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[2] Centers for Medicare & Medicaid Services, "SMD #23-003 RE: Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated" (Apr. 17, 2023), https://www.medicaid.gov/sites/default/files/2023-04/smd23003.pdf [hereinafter "SMD #23-003"].
[3] *See id.* at 38.

A. MDH Should Extend Eligibility to All Individuals with a SUD or MH Diagnosis and Provide Regular and Comprehensive Screenings in Jails and Prisons by Licensed Community-Based Providers to Identify Eligible Participants for the Demonstration.

We support MDH's proposal to provide Medicaid coverage for individuals with SUD and/or severe mental illness (SMI) for up to 90 days prior to release from jail or prison. However, we urge MDH to cover all individuals with MH conditions, rather than just individuals with SMI, which would be more consistent with California's approved demonstration waiver.[4] Many individuals in Maryland's jails and prisons may meet the criteria for a mental illness under the DSM-5 and have a critical need for treatment and care coordination, even if their MH condition does not rise to the level of SMI. Expanding this waiver application to include individuals with any MH condition, if not other chronic health conditions frequently associated with MH and SUDs, is also consistent with CMS's guidance to states in which, "CMS encourages states interested in the Reentry Section 1115 Demonstration Opportunity to propose *a broadly defined* demonstration population that includes otherwise eligible, soon-to-be former incarcerated individuals." (emphasis added).[5]

Additionally, in the proposal, MDH has indicated that it would identify people who have a qualifying diagnosis that constitutes SMI and that the entire institution populations will be assessed for SUD using a recognized assessment tool. To ensure that eligible individuals are appropriately identified for this demonstration, we recommend MDH provide greater clarity on who will be conducting the SUD evaluations and the frequency at which such assessments will occur, and align this proposal with evidence-based practices for screening and assessment. We recommend MDH require a full SUD evaluation be administered by a community-based clinician who is licensed to evaluate, diagnose, and treat SUDs when an individual is initially incarcerated, and a clinical update and SUD screening should be administered at least annually thereafter and at the point when MDH is identifying individuals who are eligible for this demonstration (around 120 days prior to release or shortly before that). This model would both improve access to care within the carceral setting and ensure individuals are appropriately identified for the demonstration. We also recommend MDH extend the proposal for comprehensive assessment of the institution's population to MH conditions, to ensure that both those who are incarcerated and those who are soon to be released from incarceration receive the treatment and linkages to care they need.

In summary, we offer the following recommendations with respect to the populations eligible for this demonstration and the assessments of MH and SUDs:

1. MDH should extend eligibility to all individuals who have a SUD and/or MH condition (*not just SMI*) for the 90-day period prior to their release from incarceration.
2. MDH should require a community-based provider who is licensed to evaluate, diagnose, and treat SUDs to administer a full SUD evaluation for all individuals when they are initially incarcerated, with a clinical update and additional screenings on an annual basis thereafter, to ensure that all individuals who are incarcerated receive the appropriate SUD treatment they need throughout their incarceration and effective reentry planning can occur as early as possible. To

[4] Medicaid Reentry Waiver Approval Letter from CMS to California Department of Health Care Services, Attachment W (Jan. 26, 2023), https://www.medicaid.gov/sites/default/files/2023-01/ca-calaim-ca1.pdf.
[5] *See* "SMD #23-003" *supra* note 2, at 13.

ensure that all eligible individuals for the demonstration are identified, MDH should screen all individuals again 120 days prior to their release from incarceration, or shortly before, at the point when MDH intends to submit Medicaid enrollment applications for those individuals.

3. MDH should also identify an appropriate evaluation tool that assesses for all MH conditions, and provide this assessment to all individuals upon their initial incarceration, with additional screenings on an annual basis thereafter, and at the time when MDH would need to submit a Medicaid application for someone who would be eligible for this demonstration. As with SUD, this would ensure that individuals receive the appropriate MH treatment they need throughout their incarceration and are identified for this demonstration.

B. MDH Should Prioritize and Facilitate Having Culturally and Linguistically Effective Community-Based Providers Deliver Demonstration Services.

Recognizing the goal of this demonstration to facilitate successful reentry into the community, and to provide the best possible health care that is consistent with Medicaid funding requirements, we strongly encourage MDH to ensure that all of the services under this demonstration be provided and supervised by community-based providers rather than carceral health providers. This country has a long history of extremely poor quality jail- and prison-based health care, and there have been numerous lawsuits demonstrating that individuals who are incarcerated are unable to get the appropriate treatment they need, especially for SUDs.[6] Culturally and linguistically effective community-based providers should be the primary source of care delivery for this demonstration, and MDH should leverage other benefits in Medicaid – such as transportation and telehealth – to ensure that those soon to be released from incarceration have access to the highest quality care and build the capacity of our state's MH and SUD workforce. Having community providers deliver services for the demonstration will allow participants to develop relationships with these providers, which will increase the likelihood that they continue with their treatment upon reentry. These community-based providers can also help identify and treat co-morbid medical conditions, which full further improve health outcomes for this population.

We support MDH's proposal to use Community Health Workers and Certified Peer Recovery Specialists to help deliver services for this demonstration. We urge MDH to clarify that these individuals should be people "with lived experience." We also request greater clarification as to who will be delivering the majority of the services, as well as the roles and activities of Community Health Workers and Certified Peer Recovery Specialists. For example, MDH has identified Community Health Workers as part of the case management team, but has not identified their role or activities for the case management benefit or the other individuals who will work on this team. MDH has identified Certified Peer Recovery Specialists as being included in the provision of Medication Assisted Treatment, but does not identify their role in relationship to those who administer medications and deliver the range of therapeutic services provided by certified and licensed SUD and MH counselors. Certified Peer Recovery Specialists have a critical role in the interdisciplinary treatment team and provide essential support the target population. We recommend MDH clarify in this application. We also recommend MDH identify the other types of providers who will be delivering and supervising the services to provide clearer explanation or plans to CMS and to the carceral settings on how Maryland Medicaid

[6] ACLU, "Over-Jailed and Un-Treated: How the Failure to Provide Treatment for Substance Use in Prisons and Jails Fuels the Overdose Epidemic" 12 (2021), https://www.aclu.org/wp-content/uploads/legal-documents/20210625-mat-prison_1.pdf.

intends to administer this demonstration and ensure it most effectively meets the needs of participants.

In summary, we offer the following recommendations with respect to the providers for this demonstration:

1. MDH should clearly identify that culturally and linguistically effective community-based providers will be the primary providers of demonstration services, and carceral health providers will be used only for activities in which no community-based service is available.
2. MDH should clarify the type and credential of providers (i.e., licenses or certifications) who will be delivering each of the services (i.e., who is part of the "case management team," prescribing the medications and delivering counseling services based on diagnosis), and should also clarify that Certified Peer Recovery Specialists should be involved in all services under this demonstration that they are authorized to perform by the state.
3. MDH should clarify that Community Health Workers and Certified Peer Recovery Specialists should be people "with lived experience." Additionally, recognizing that Community Health Workers and Certified Peer Recovery Specialists generally are unable to bill Medicaid directly for their services, MDH should also ensure that these individuals are supervised by community-based Medicaid providers and programs, and ideally by Registered Peer Supervisors, rather than carceral health providers.
4. MDH has identified telehealth as a delivery method for these demonstration services. We fully support telehealth service delivery to connect individuals with appropriate services and providers to the extent practitioners are not otherwise available on site and an individual's health needs can be addressed effectively via telehealth. As discussed further in the following section, MDH should also incorporate Medicaid transportation benefits into this waiver application to help individuals in the demonstration access community-based providers and services in a way that best facilitates their transition back into the community.

C. MDH Should Clarify and Expand the Covered Benefits Under This Demonstration to Facilitate Successful Transitions into the Community and Improve Health Outcomes.

We support MDH's proposal to cover case management (to also address physical and behavioral health needs); medication-assisted treatment (hereinafter referred to as "medications for SUDs"); and a 30-day medication supply upon release. We request clarification regarding these benefits and offer recommendations to best achieve MDH's goals. Additionally, we note that MDH has only proposed to include the bare minimum of services that CMS has required for such waivers, when, in fact, "CMS expects that state proposals for benefit designs will be *sufficiently robust* to be likely to improve care transitions as contemplated in section 5032 of the SUPPORT Act." (emphasis added).[7] A much broader range of Medicaid services have been proposed in other states' demonstration waiver applications, and inclusion of those services are necessary to achieve the objectives laid out by MDH. We urge the state to incorporate additional benefits into this demonstration, as described below.

With respect to the case management benefit, MDH has proposed providing services in a manner similar to the current "Targeted Case Management" benefit offered to people with SMI. We appreciate the clarification that this benefit will follow CMS guidelines laid out in the April 2023 State Medicaid

[7] *See* "SMD #23-003" *supra* note 2, at 16.

Director Letter on Reentry Strategies, although we believe MDH needs to elaborate further on how this benefit will be tailored to meet the needs of Marylanders who are incarcerated with MH and SUD. SAMHSA's Treatment Improvement Protocol (TIP) 27, "Comprehensive Case Management for Substance Abuse Treatment," offers a detailed exploration on case management principles and strategies, including specific considerations for clients in criminal justice settings,[8] which we urge MDH to incorporate into this demonstration.

Two critically important aspects of case management, as identified by SAMHSA, are establishing appropriate housing that will facilitate recovery and developing job-seeking skills.[9] We strongly recommend MDH explicitly list these two aspects of case management in the waiver application and ensure that the case management team is appropriately trained and qualified to perform these tasks. MDH should strengthen this application even further by adding supportive housing and supported employment as additional benefits that should be covered under the demonstration, which would not only improve the transition into the community but also improve health outcomes. Furthermore, given MDH's plan to enroll individuals in managed care plans upon their release from incarceration, the case management team should also be explicitly required to help individuals in the demonstration identify and enroll in a plan that will best meet their needs. Recognizing the importance of telehealth and the need to communicate with providers, the case management team should also help individuals in the demonstration apply for and access cell phones through the Affordable Connectivity Program.

We further encourage MDH to consider how to ensure case management remains available to formerly incarcerated individuals with MH and SUD upon reentry into the community, as well as all Maryland Medicaid enrollees with MH and SUD. Legal Action Center has previously noted that MDH does not cover case management services as a benefit in the fee-for-service carve-out of MH and SUD treatment, as compared to the case management that is available for special needs populations through managed care. COMAR 10.67.04.04.[10] Individuals with SUDs were eligible for case management as a special needs population prior to the carve-out of SUD services. While a subset of individuals with MH and SUDs is eligible for case management through the health home program, those services are available only in certain care settings. People with these conditions need access to the navigation services, assistance with health related social needs (HRSN), and advocacy that improve health outcomes. It is critical that MDH ensure that case management services continue to be available to all Medicaid enrollees with MH and SUD who are in the community, as many of the issues that are identified during the 90-day period prior to release from incarceration will not be resolved in this timeframe.

With respect to the medications for SUD benefit, we urge MDH to clarify that all FDA-approved medications for opioid use disorder and alcohol use disorder will be covered in this demonstration, consistent with CMS's guidance to states.[11] We note that "CMS encourages states to cover the full array

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[8] Substance Abuse and Mental Health Services Administration (SAMHSA), "TIP 27: Comprehensive Case Management for Substance Abuse Treatment" 57 (2015), https://store.samhsa.gov/sites/default/files/sma15-4215.pdf.
[9] *Id.* at 58.
[10] *See, e.g.*, Letter from the Legal Action Center to Maryland Department of Health, Legal Action Center 3 (Dec. 22, 2022), https://www.lac.org/assets/files/LAC-Comment-Letter_Maryland-Medicaid-Parity-Compliance-Report-12.22.22.pdf.
[11] "Medicaid coverage is available for all U.S. Food and Drug Administration (FDA) approved medications for opioid use disorder (MOUD), including buprenorphine, methadone, and naltrexone as well as acamprosate and naltrexone for alcohol use disorder." "SMD #23-003" *supra* note 2, at 23.

of FDA-approved medications, including buprenorphine and methadone. States should encourage providers, including those practicing in correctional facilities, to utilize the medication that is most appropriate for each individual, with a focus on MAT induction, stabilization, and maintenance of treatment, including post-release."[12] We also recommend that MDH explicitly identify naloxone, both as a medication that should be available to individuals who are incarcerated, as well as a medication that should be provided upon release to prevent overdose deaths once people are back in the community. To the extent that other harm reduction services may be covered by Medicaid, MDH should incorporate those into this demonstration as well. MDH should also clarify that medications for SMI and other MH conditions should be covered benefits under this demonstration, which is particularly important for individuals with co-occurring diagnoses for whom medications for SUD alone may not be sufficient.

We appreciate MDH's inclusion of counseling under the medications for SUD benefit, although we encourage MDH to identify counseling and behavioral therapies as a separate benefit for demonstration participants. While counseling can be helpful to some individuals who receive medications for SUD, it is not a necessary component of this treatment. On the other hand, many individuals with MH and SUDs who do not receive medication would benefit greatly from counseling and psychotherapy, particularly as they approach this transition into the community.

Furthermore, we strongly encourage MDH to add HIV/HCV screening and treatment, as well as sexual and reproductive health counseling and treatment, to the list of benefits for this demonstration to improve linkages to care and health outcomes for this population. SAMHSA has noted that SUDs are more prevalent amount people with HIV than the general population, and that for people experiencing these co-occurring conditions, effective SUD treatment improves both HIV- and SUD-related health outcomes.[13] The National Institute on Drug Abuse (NIDA) has also identified the importance of linking people with have HIV and a history of substance use to community HIV and SUD services, and other wrap-around services, upon their release from incarceration:

> Testing for and treating HIV in criminal justice settings benefits both the health of inmates and overall public health. People with HIV infection are overrepresented in prisons; in 2010, there were 20,093 inmates with HIV/AIDS in state and federal prisons. Most incarcerated individuals with HIV acquired it in the community prior to incarceration. Individuals with HIV often begin treatment while incarcerated, but they experience a disruption of care when they return to the community, in addition to facing challenges coping with substance use and mental health problems. Therefore it is particularly important to link people who have HIV and a history of substance use to community HIV services, substance abuse treatment, mental health services, and other wrap around services in their community to reduce recidivism, improve their health, reduce the spread of the infection to others, and prevent relapse to substance abuse.[14]

Finally, not all services or medications for SUD and MH may be available at all Maryland jails and prisons that will participate in this demonstration. CMS has noted, "In cases where MAT benefits may

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[12] *Id.* at 23-24.
[13] SAMHSA, "Treating Substance Use Disorders Among People with HIV" 1 (2020), https://store.samhsa.gov/sites/default/files/pep20-06-04-007.pdf.
[14] National Institute on Drug Abuse (NIDA), "The Connection Between Substance Use Disorders and HIV" (April 2020), https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-3-connection-between-substance-use-disorders-hiv.

be limited or not easily accessible, such as when provided by a state-only program or by the carceral system directly, demonstration coverage may be used to enhance the benefit to help ensure robust coverage and access to MAT services for beneficiaries for whom they are appropriate."[15] As such, we also recommend that MDH include Medicaid-covered transportation benefits to enable individuals to access appropriate services and providers – including all medications for SUD in the case where they are not available at the carceral setting – and identify strategies to remove barriers to methadone for individuals in this demonstration upon their release when a 30-day prescription is not available, such as mobile vans, delivery, and unsupervised dosing flexibilities.

In summary, we recommend:

1. MDH should clearly identify and tailor the case management benefit to include services that are necessary for individuals with MH and SUD who have involvement with the criminal legal system, based on models that are consistent with guidance from SAMHSA.
    a. MDH should ensure that all Medicaid enrollees with a MH or SUD have equitable access to this benefit in the community, and that those who were enrolled in this demonstration continue to have access to case management services upon their reentry.
2. As part of the case management benefit, or separately if appropriate, we also recommend MDH explicitly identify:
    a. Helping individuals identify and access appropriate **housing and employment** that will facilitate their recovery.
    b. Helping individuals identify an appropriate **managed care plan** and enroll upon their release, to ensure that their ongoing coverage meets their needs once in the community.
    c. Helping individuals in the demonstration apply for and access **cell phones** through the Affordable Connectivity Program, to ensure they have the ability to continue to use telehealth services upon their release and connect with their providers in the community.
3. MDH should clarify that the medication for SUD benefit includes:
    a. **All FDA-approved medications for SUDs** and should be available for all types of SUD as clinically appropriate, utilizing the medication that is most appropriate for each individual;[16]
    b. **Naloxone and other harm reduction services**, both through this demonstration and more broadly throughout Maryland's carceral system. Naloxone should also be provided to individuals upon their release, along with the other medications for which they are prescribed for 30 days; and
    c. **Medications for MH conditions**.
4. MDH should further clarify that counseling services and behavioral therapies should be a separate benefit that is covered for all individuals under the demonstration, not just those who are receiving medications for SUD, and that not all individuals who receive medications for SUD need counseling services.
5. Consistent with CMS's recommendations,[17] MDH should also clarify that the 30-day supply of all prescription medications includes medications for SUD, as clinically appropriate, including

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[15] *See "*SMD #23-003" *supra* note 2, at 22-23.
[16] *See supra* notes 11-12, and accompanying text.
[17] "CMS expects the Reentry Section 1115 Demonstration Opportunity to facilitate the provision of a 30-day supply of any prescription medication(s) (as clinically appropriate based on the medication dispensed and the indication) for physical and behavioral health conditions, including MAT prescription(s), at the point of release." *Id.* at 24.

naloxone, and consider benefit expansion to enable individuals who are receiving methadone to continue to access their medication – such as mobile vans, delivery to the individual upon release, or unsupervised methadone dosing flexibilities, as permitted under HHS's final rule on Medications for Treatment of Opioid Use Disorder.[18]

6. MDH should also consider incorporating additional benefits that are necessary for the treatment of SUD and MH conditions, and other physical health conditions, and that would help facilitate the transition into the community for this population:
    a. MDH should cover **transportation services** to appointments in the community that provide the services under this demonstration to enable individuals to travel to culturally and linguistically effective community-based providers who can best meet their needs and ideally continue providing treatment upon their release.
    b. Recognizing the high rate of homelessness upon release, MDH should propose covering **housing supports, including recovery housing**, for individuals in the demonstration upon release.[19] MDH should also consider other HRSN for which Medicaid coverage may be available, such as **food, employment, utilities, and transportation support**.
    c. Recognizing the high correlation between SUD and HIV/AIDS, as well as other conditions that may be transferred through drug use, MDH should also propose covering **sexual and reproductive health information and connectivity** (as New York as proposed) and **HIV/HCV screening and treatment** (as West Virginia has proposed).[20]

Thank you for considering our comments. We look forward to working with you to improve access to care and health outcomes for Marylanders reentering the community. Please contact Deborah Steinberg, Senior Health Policy Attorney at the Legal Action Center, dsteinberg@lac.org, with any questions.

Sincerely,

Legal Action Center
AHEC West
Community Behavioral Health Association
James' Place Inc.
Maryland Coalition of Families
Maryland-DC Society of Addiction Medicine
Maryland Psychiatric Society
MATOD
Montgomery Goes Purple
NAMI Maryland
Institutes for Behavior Resources, Inc.

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[18] U.S. Dep't. Health & Human Services, "Medications for the Treatment of Opioid Use Disorder," 89 Fed. Reg. 7528, 7531 (Feb. 2, 2024).
[19] For example, Kentucky has proposed covering recovery residence supports for up to 90 days for adults with an SUD diagnosis upon release and participating in the Behavioral Health Conditional Dismissal Program. *See* KFF, "Medicaid Waiver Tracker: Approved and Pending Waivers by State" (Jan. 23, 2024), https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.
[20] *See id.*