



April 8, 2022

VIA ELECTRONIC SUBMISSION

Secretary Xavier Becerra
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: New Jersey FamilyCare Comprehensive Demonstration

Dear Secretary Becerra,

The Center on Budget and Policy Priorities and the Georgetown University Center for Children and Families appreciate the opportunity to comment on New Jersey's extension request for its section 1115 demonstration. The Center on Budget and Policy Priorities (CBPP) is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, CBPP conducts research and analysis to inform public debates and policymakers about a range of budget, tax, and programmatic issues affecting individuals and families with low or moderate incomes. The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes.

Section 1115(a) of the Social Security Act gives the Secretary the power to waive compliance with the requirements of Section 1902 if a proposal "is likely to assist in promoting the objectives" of Medicaid. Section 1115 demonstrations can play an important role in reducing racial disparities and should be consistent with the objectives of Executive Order 13985 (Advancing Racial Equity and Support for Underserved Communities Through the Federal Government).¹ We believe that many of the provisions in the application, including 12-month continuous eligibility for adults and behavioral health coordination services for incarcerated individuals 30 days pre-release, will advance racial equity and promote the objectives of Medicaid. We urge CMS to approve the demonstration extension request and consider the following recommendations when crafting the special terms and conditions with the state.

While we support New Jersey's intent to provide 12 months of coverage postpartum, a State Plan Amendment is a simpler and more secure path forward.

¹ "Request for Action on Pending Section 1115 Demonstrations to Reduce Racial Disparities," Letter to Secretary of Health and Human Services, July 2020, https://ccf.georgetown.edu/wp-content/uploads/2020/12/Medicaid_Supporting-Black-Women-Sign-On-Letter.pdf; Executive Order No. 13985, 86 CFR 7009 (2021), <https://www.federalregister.gov/documents/2021/01/25/2021-01753/advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government>.

In 2021, New Jersey requested the authority to provide 12 months of coverage to Medicaid and CHIP beneficiaries after the end of pregnancy through an amendment to their existing section 1115 demonstration. The intent was to provide this coverage prior to the April 1, 2022 effective date of the State Plan Amendment option included in the American Rescue Plan Act. CMS approved this request in October 2021. In this current extension request, New Jersey seeks to continue the authority to provide 12 months of coverage postpartum and states its intent to operationalize the extension before the PHE-related continuous coverage ends.

Extending postpartum coverage for 12 months would improve maternal health outcomes, especially for women of color. When Medicaid/CHIP pregnancy coverage ends just 60 days after birth, approximately 55 percent of women experience at least one month of uninsurance within the first six months postpartum, putting them at risk for forgoing needed medical care or accumulating medical debt.² Providing a full 12 months of continuous coverage would allow beneficiaries to attend all recommended check-ups and maintain treatment regimens when they are still at risk from postpartum complications. Researchers estimate that approximately 11,000 postpartum individuals per year will benefit from this coverage extension.³

Access to treatment is particularly important in New Jersey, where according to New Jersey's Maternal Mortality Review Committee, 70 percent of pregnancy related deaths occurred within one year of the end of pregnancy. And, non-Hispanic Black women were 7.6 times more likely to die from pregnancy-related causes than non-Hispanic White women.⁴

We commend the state for its commitment to this important policy which will help promote health equity, however we believe the SPA option is the more appropriate pathway to provide this coverage. As noted earlier, the Medicaid and CHIP state plan option created by the American Rescue Plan Act to extend postpartum coverage to 12 months after the end of the pregnancy became available on April 1, 2022. Even though the SPA option is currently scheduled to sunset on March 31, 2027, the guidance issued by CMS on the option made clear that, "CMS will work with states to identify other options to maintain extended postpartum coverage if the statutory authority to extend coverage is not reauthorized."⁵ Placing the authority in a SPA signals that the state is committed to continuing this policy long-term, as opposed to as a temporary experiment. While the SPA option *might* require

² Jamie R. Daw *et al.*, "Women in the United States Experience High Rates of Coverage 'Churn' in the Months Before and After Childbirth," *Health Affairs*, April 2017, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1241>; Sarah Sugar *et al.*, "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic," April 2021, available at https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//199881/medicaid-churning-ib.pdf.

³ Sarah Gordon *et al.*, "Medicaid After Pregnancy: State-Level Implications of Extending Postpartum Coverage," Assistant Secretary for Planning and Evaluation Office of Health Policy, December 7, 2021, <https://aspe.hhs.gov/sites/default/files/documents/cf9a715be16234b80054f14e9c9c0d13/medicaid-postpartum-coverage-ib%20.pdf>.

⁴ Cheryl A.S. McFarland, Carly Worman Ryan, and Kate DiPaola, "Maternal Mortality: New Jersey 2014-2016," New Jersey Maternal Mortality Review Committee; New Jersey Maternal Care Quality Collaborative; New Jersey Maternal Data Center, https://www.nj.gov/health/fhs/maternalchild/documents/NJ%20Maternal%20Mortality_2014-2016_12.14.21_Final.pdf.

⁵ Center for Medicaid & CHIP Services, "SHO #21-007: Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP)," December 7, 2021, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf>.

administrative action in five years, any waiver approval is *certain* to be temporary and will require regular administrative efforts to extend.

Maternal and family health pilot programs will improve health outcomes and yield useful evaluation data.

New Jersey requests expenditure authority to provide medically-indicated meals to pregnant people with diabetes as well as to expand its home visiting pilot statewide. *We are supportive of these proposals aimed at supporting maternal and family health and we urge CMS to approve these requests.*

Providing tailored meals to pregnant individuals with diabetes is an innovative and important part of New Jersey's initiative to improve maternal care and pregnancy outcomes. Diabetes during pregnancy is associated with short- and long-term risks such as preeclampsia, cesarean delivery, and type 2 diabetes for both the pregnant person and the child later in life.⁶ In addition to pharmacological interventions, managing diabetes during pregnancy requires a carefully balanced diet that both promotes optimal gestational weight gain and inhibits further insulin resistance.⁷ We applaud the state for its proposal to provide proper nutritional support to individuals managing diabetes during pregnancy and anticipate that the evaluation of the pilot will be helpful for other states. We particularly commend the state for including an analysis of the health equity impact of the provision in their proposed design.

In the proposal, the state seeks the authority to expand its previously approved home visiting pilot statewide and to increase the number of families served. Home visiting is a long-term investment in the health and well-being of children. Nurse visitations for children through the age of two have been shown to improve language and executive functioning by age four, emotional and behavioral regulation by ages six to nine, and cognitive skills by age 18.⁸ Due to the COVID-19 pandemic, the agency's work on implementing the previously approved pilot program has been slow to start and we are supportive of the state ramping up work on this section of its demonstration. We urge the state to build on any lessons learned during the pandemic, including the potential role that telehealth could play in reaching families in the manner in which they are most comfortable.

Continuous eligibility for adults is likely to promote health equity, improve access to care, and strengthen program efficiency.

New Jersey has provided 12-month continuous eligibility for children since 2006.⁹ New Jersey seeks to align continuous eligibility policy for parents and other MAGI-eligible adults by providing a

⁶ Centers for Disease Control and Prevention, "Diabetes During Pregnancy," June 12, 2018, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/diabetes-during-pregnancy.htm>.

⁷ Louise Rasmussen *et al.*, "Diet and Healthy Lifestyle in the Management of Gestational Diabetes Mellitus," *Nutrients* 12, no. 10, October 2020, <https://www.mdpi.com/2072-6643/12/10/3050>.

⁸ David L. Olds *et al.*, "Effects of Home Visits by Paraprofessionals and by Nurses: Age 4 Follow-Up Results of a Randomized Trial," *Pediatrics* 114, no. 6, December 2004, <https://pubmed.ncbi.nlm.nih.gov/15574615/>; David L. Olds *et al.*, "Effects of Home Visits by Paraprofessionals and by Nurses on Children: Age-Six and Nine Follow-Up of a Randomized Trial," *Pediatrics* 168, no. 2, February 2014, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4217160/>; Harriet Kitzman *et al.*, "Prenatal and Infancy Nurse Home Visiting and 18-Year Outcomes of a Randomized Trial," *Pediatrics* 144, no. 6, December 2019 <https://pubmed.ncbi.nlm.nih.gov/31748254/>.

⁹ Donna Cohen Ross and Laura Cox, "In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families," Center on Budget and Policy Priorities and Kaiser Family Foundation, October 2005,

full 12 months of continuous eligibility. We strongly believe that extending continuous eligibility would promote health equity, improve access to care, and strengthen program efficiency. This proposal will promote the objectives of Medicaid and is the type of request for which 1115 demonstrations should be used. *We strongly urge CMS to approve the request to extend continuous eligibility without a 2.6 percent funding “haircut.”*

Continuous eligibility has the potential to ameliorate disparities in coverage for adults. In 2019, the uninsured rate for Black adults (of any ethnicity) in New Jersey was 12.1 percent compared to 9.4 percent for White adults (of any ethnicity).¹⁰ This disparity could partially be explained by the fact that families of color are more likely to experience income volatility.¹¹ And, according to a recent study from MACPAC, nationally, non-Hispanic Black beneficiaries and Hispanic beneficiaries are more likely to “churn”—that is, be disenrolled and re-enroll within 12 months.¹² Establishing a 12-month eligibility period would help maximize coverage by minimizing the disenrollments that stem from temporary fluctuations in income.

In addition to aligning family renewal periods and lessening the administrative burdens on families, continuous eligibility for parents and other adults would increase family and financial stability. Access to stable coverage for parents and other caregivers would promote increased preventive care, timely access to acute care, and protect against the medical debt that can accrue during gaps in coverage and disproportionately affects Black individuals and families.¹³ In turn, continual access to care and lower levels of financial stress in the home foster a better home environment and healthy parental-child interaction.¹⁴

Evidence also shows that continuous eligibility will improve program efficiency and managed care performance measurement. In New York, implementing a one-year continuous eligibility period for adult beneficiaries led to declines in inpatient hospital admissions and overall per-member per-

<https://www.kff.org/wp-content/uploads/2013/01/in-a-time-of-growing-need-state-choices-influence-health-coverage-access-for-children-and-families-report.pdf>.

¹⁰ Georgetown University Center for Children and Families analysis of U.S. Census Bureau 2019 American Community Survey data, Table C27001.

¹¹ Judith Garber, “Is There a Racial Volatility Gap?” Aspen Institute, August 1, 2016, <https://www.aspeninstitute.org/blog-posts/racial-volatility-gap/>.

¹² Medicaid and CHIP Payment and Access Commission, “An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP,” October 2021, <https://www.macpac.gov/publication/an-updated-look-at-rates-of-churn-and-continuous-coverage-in-medicaid-and-chip-abstract/>

¹³ Sarah Sugar *et al.*, “Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic,” April 2021, available at

https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//199881/medicaid-churning-ib.pdf; Matthew Rae *et al.*, “The Burden of Medical Debt in the United States,” Kaiser Family Foundation, March 10, 2022,

<https://www.kff.org/health-costs/issue-brief/the-burden-of-medical-debt-in-the-united-states/>; The Census Bureau analysis of Survey of Income and Program Participation Survey Year 2020, “Wealth, Asset Ownership, & Debt of Households Detailed Tables: 2019,” October 27, 2021,

<https://www.census.gov/data/tables/2019/demo/wealth/wealth-asset-ownership.html>.

¹⁴ Daniel Brisson *et al.*, “A Systematic Review of the Association between Poverty and Biomarkers of Toxic Stress,” *Journal of Evidence-Based Social Work* 17, no. 6, July 12, 2020,

<https://www.tandfonline.com/doi/abs/10.1080/26408066.2020.1769786>; National Scientific Council on the Developing Child, “Young Children Develop in an Environment of Relationships,” Harvard Center on the Developing Child, January 2004, <https://developingchild.harvard.edu/resources/wp1/>.

month costs.¹⁵ And, after implementing one-year of continuous eligibility for adults, Montana officials reported administrative spending savings and fewer staff hours needed to process individuals moving off and on the program.¹⁶ Finally, most metrics used to measure managed care performance as well as overall program performance (such as those in the Child Core Set) require that a beneficiary be enrolled for a minimum period of time to be included in the baseline.¹⁷ Consequently, as beneficiaries churn off and on coverage, their experience is not reflected in the performance metrics. Given that New Jersey seeks to move more of its services to managed care through this demonstration, it is critical that the measures allow the state to incentivize and reward access and value accurately in their managed care payment methodology.

Extending continuous eligibility has a valid, and commendable, experimental purpose that serves the objectives of the Medicaid program. In addition, the proposed evaluation goes beyond that of New York and Montana. We commend the state for proposing to measure how continuous eligibility affects racial and ethnic disparities in emergency department visits and continuity of care.

While in the past, CMS has required states extending continuous eligibility to take a 2.6 reduction in their matching rate for a share of member months, we recommend that CMS rethink the legal basis for the demonstration authority to avoid the need for such a haircut. For example, CMS could provide authority to waive the age limit on the existing continuous eligibility option or waive the requirement to report and act upon eligibility changes that are part of the standards for reasonable eligibility determinations.¹⁸ The demonstration would still meet budget neutrality requirements, but could take into account savings related to the marketplace, uncompensated care, and/or program administration.

If implemented with an emphasis on community-based organizations, the state's Community Health Worker pilot could promote health equity and provide promising models for Medicaid-CHW partnerships.

New Jersey requests expenditure authority to launch a pilot in which the managed care organizations will design, apply for, and, if selected, implement targeted interventions with community health workers (CHWs). There is compelling evidence that working with community health workers can help improve access to care for people living in underserved communities.¹⁹

¹⁵ Harry H. Liu *et al.*, “New York State 1115 Demonstration Independent Evaluation: Interim Report,” Rand Corporation, 2021, https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/ext_request/docs/2021-08-03_1115_demo_eval.pdf#page=110.

¹⁶ Niranjana Kowlessar *et al.*, “Federal Evaluation of Montana Health and Economic Livelihood Partnership (HELP): Summative Evaluation Report,” Social & Scientific Systems and Urban Institute, November 30, 2020, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/summative-eval-rpt-montana-2020.pdf>.

¹⁷ Center for Medicaid & CHIP Services, “Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP (Child Core Set): Technical Specifications and Resources Manual for Federal Fiscal Year 2021 Reporting,” March 2021, <https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf?t=1649191245>.

¹⁸ Title XIX of the Social Security Act, §1902(e)12 and §1902(a)(17), respectively.

¹⁹ Sonali Saluja *et al.*, “Community-Based Health Care Navigation’s Impact on Access to Primary Care for Low-Income Latinos,” *Journal of the American Board of Family Medicine* 35, no. 1, January/February 2022, <https://www.jabfm.org/content/35/1/44>; Michele Heisler *et al.*, “Impact on Health Care Utilization and Costs of a Medicaid Community Health Worker Program in Detroit, 2018-2020: A Randomized Program Evaluation,” *American Journal of Public Health*, online ed., March 24, 2022, <https://ajph.aphapublications.org/doi/10.2105/AJPH.2021.306700>;

Thus, we believe pilot programs in New Jersey could produce valuable information on how community health workers can work hand-in-hand with Medicaid to improve access to care and advance health equity. *We urge CMS to approve the proposal.* However, the demonstration application does not include much detail about how the state would guide or evaluate the managed care organizations' applications. *We offer the following recommendations for the state and CMS as they develop the details of the program and frame the evaluation design and special terms and conditions.*

It is important for the state to incentivize MCOs to partner with community-based community health workers and prioritize equitable and sustainable compensation. If MCOs choose to hire CHWs directly, instead of working with those embedded in the communities they serve, the state runs the risk of replicating existing top-down care models instead of testing new approaches. In order to combat this phenomenon, Michigan has built financial incentives into its managed care contracts to reward MCOs for contracting with community-based organizations who employ community health workers that are directly connected to the communities they are serving.²⁰ The state should also consider how MCOs can make the reimbursement model sustainable so that community-based organizations can safely invest in recruiting and training CHWs. This can include reducing administrative barriers for CHWs billing for their services and a streamlined credentialing process for CHWs who want to serve patients enrolled in Medicaid.

One valuable contribution from the demonstration would be a CHW intervention designed to support children and/or pregnant women, particularly in primary care contexts. While there are several CHW programs underway around the country, very few focus specifically on pediatric populations, where the right preventive interventions could mitigate costlier care needs as children age.²¹ Evaluations focused on how CHWs could improve EPSDT screening and follow-up or access to mental health services would be a significant contribution to the evidence base for maximizing coverage and access through community health worker-focused interventions.

Increasing Medicaid's role in delivering housing-related supports would improve cross-system coordination and support high-risk populations.

We strongly support New Jersey's plans to expand access to housing-related supports and improve coordination of housing-related benefits. The plan would advance New Jersey's efforts to provide better access and outcomes for people of color and people with disabilities.

MCO Requirements

New Jersey proposes a holistic strategy that would charge Medicaid managed care organizations (MCOs) with assessing enrollees' housing needs, connecting enrollees to available community resources, and reporting and being accountable for key metrics related to housing-related services. New Jersey ranks eighth and tenth in Medicaid managed care penetration rates among seniors and

James Krieger et al., "The Seattle-King County Healthy Homes II Project: A Randomized Controlled Trial of Asthma Self-management Support Comparing Clinic-Based Nurses and In-Home Community Health Workers," *The Archives of Pediatrics & Adolescent Medicine* 163, no. 2, 2009, <https://jamanetwork-com.proxy.library.georgetown.edu/journals/jamapediatrics/fullarticle/380846>.

²⁰ State of Michigan, "Comprehensive Health Care Program for the Michigan Department of Health and Human Services," Contract, 2021, https://www.michigan.gov/documents/contract_7696_7.pdf.

²¹ National Academy for State Health Policy, "State Community Health Worker Models," December 10, 2021, <https://www.nashp.org/state-community-health-worker-models/#tab-id-5>.

people with disabilities and expansion adults, respectively, with 96 percent of these enrollees enrolled in an MCO.²² With such a high proportion of enrollees in managed care, it is appropriate to place MCOs at the center of connecting enrollees to these services, although proper oversight will be critically important. We support the enhanced requirements for MCO housing specialists, the proposal to require MCOs to develop sufficient networks with housing service providers, and the requirement that MCOs participate in multi-agency and stakeholder working groups established by the Medicaid agency's new Housing Unit. While we do not support direct linkages between rental assistance and enrollment in specific health plans, the infrastructure New Jersey describes in its proposal is *not* that; it will leverage Medicaid dollars to facilitate more intentional coordination between MCOs and housing and service providers while maintaining appropriate, non-duplicative roles for stakeholders in the housing and health care sectors.

We also support the required data collection and reporting proposal. We agree that these data will provide valuable insight into whether the new infrastructure and services are having the intended effects, including increased housing stability, reductions in ED visits, increased continuity of care, reductions in racial and ethnic disparities, reductions in Medicaid and Medicare expenditures, and increased multi-sector collaboration.

New Medicaid Housing Unit

We support the state's proposal to create a dedicated Medicaid Housing Unit within the state Medicaid agency to focus on how the state can best provide housing-related services through Medicaid, monitor and enforce the new housing-related requirements for MCOs, and manage connections between the state, MCOs, and housing stakeholders (including service providers or other community-based organizations, housing authorities, housing finance organizations, and more). Partnerships across health and housing sectors are key to helping people with low incomes obtain and maintain housing that they can afford.²³

We are not aware of any other state that has created a dedicated department to manage and coordinate housing-related Medicaid services and believe this demonstration could provide valuable information for other states seeking to provide and better coordinate these services. We also believe the monitoring and accountability role the office will play is of critical importance to ensure that MCOs conduct assessments fairly and ensure timely access to benefits for all enrollees. It is not clear what authority the office would have to hold MCOs that are not complying with requirements accountable. We suggest the CMS request additional information from the state on this.

The proposal for this new Housing Unit would be stronger if it included a specific function related to seeking and incorporating input from people with lived expertise of homelessness or housing instability. These perspectives are often overlooked but are critical to designing integrated health and housing services that meet people's needs and reduce racial and ethnic disparities in access to services and related outcomes. Inviting input from people with lived expertise brings a

²² Kaiser Family Foundation, "Medicaid Managed Care Penetration Rates by Eligibility Group," July 1, 2021, <https://www.kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/>.

²³ Peggy Bailey, "Housing and Health Partners Can Work Together to Close the Housing Affordability Gap," Center on Budget and Policy Priorities, January 17, 2020, <https://www.cbpp.org/research/housing/housing-and-health-partners-can-work-together-to-close-the-housing-affordability>.

critical policy and program design perspective to the discussion based on how health and housing systems actually function.²⁴ CMS should work with the state to ensure the new department will dedicate ongoing time and resources to incorporating input from people eligible for or receiving Medicaid housing-related services.

Expanded Housing-Related Benefits

We support the state’s proposal to offer new housing-related benefits—including housing transition services and tenancy sustaining services—to virtually all enrollees with demonstrated need. This would be one of the most expansive housing-related benefits ever made available through Medicaid, to our knowledge. The state proposes that MCOs include housing-related questions in their initial screen of all new enrollees as well as enrollees experiencing a transition from an institutional to a community-based setting. Anyone with an identified need would receive a more thorough assessment to determine eligibility for housing-related services. Enrollees could also request an assessment at any time. This is an important part of the proposal because it will allow for broad access to these new benefits and create the opportunity for people to access them when they are needed, not just on an annual screening schedule initiated by the MCO. We note that the proposal does not include details about how MCOs would be held accountable for making assessment decisions and whether Medicaid enrollees would have the right to appeal decisions about eligibility for housing-related benefits. We recommend CMS work with the state to establish clear accountability mechanisms and recourse for enrollees who disagree with an assessment for housing-related supports.

The state is considering a requirement that high-risk populations, including people leaving institutions, automatically receive a full assessment. We would support such a requirement; people exiting nursing homes and people exiting jails and prisons face some of the greatest barriers to securing and maintaining affordable housing in community-based settings. As CMS has explained in guidance, housing-related services can help people with disabilities secure adequate housing, advocate for reasonable accommodations, and avoid eviction.²⁵ And stable housing greatly improves people’s chances of staying out of jail and prison. A significant portion of people leaving incarceration report that finding housing is a major challenge, making it difficult to prioritize their health care.²⁶ People who were formerly incarcerated experience homelessness at nearly 10 times the rate of the general public.²⁷ Homelessness is even worse for Black people returning home from jail and prison, reflecting a long history of racial discrimination and structural racism in federal, state,

²⁴ Ann Oliva, “Why Expanding Housing Choice Vouchers Is Essential to Ending Homelessness,” Testimony before the Housing Financial Services Committee, June 9, 2021, <https://www.cbpp.org/research/housing/why-expanding-housing-choice-vouchers-is-essential-to-ending-homelessness>.

²⁵ Centers for Medicaid and CHIP Services, “SHO# 21-001: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH),” January 7, 2021, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>.

²⁶ Kamala Mallik-Kane, Ellen Paddock, and Jesse Jannetta, “Health Care after Incarceration: How Do Formerly Incarcerated Men Choose Where and When to Access Physical and Behavioral Health Services?” Urban Institute, February 2018, https://www.urban.org/sites/default/files/publication/96386/health_care_after_incarceration.pdf.

²⁷ Lucius Couloute, “Nowhere to Go: Homelessness Among Formerly Incarcerated People,” Prison Policy Initiative, August 2018, <https://www.prisonpolicy.org/reports/housing.html>.

and local housing policy.²⁸ Ensuring that people leaving nursing homes and people leaving jails and prisons receive an assessment and are connected to housing supports would ensure the benefits reach those most in need of them.

While we are strongly supportive of this overall effort, its efficacy hinges on implementation. This starts with regular engagement across all involved stakeholders, including people with lived expertise, housing service providers, homelessness Continuums of Care, MCOs, the Medicaid agency, and health care providers. We recommend that CMS work with the state to ensure a robust engagement process. For example, all stakeholders should have the opportunity to contribute to the creation of the assessment instrument. Designing an assessment that accurately and consistently measures need for various housing-related supports is critical to ensuring the people in greatest need of these newly covered services get them. It is also crucial that payment rates for community service providers are developed with provider input and that the state works with service providers to build knowledge of Medicaid and how to bill Medicaid appropriately for services. Lack of provider capacity has often stymied efforts to expand access to new services in Medicaid, including housing services as well as substance use disorder treatment and recovery services.²⁹ CMS should work with the state to ensure the process of determining payment rates for various housing-related services is transparent and fair and that the state has plans in place to grow provider capacity to meet need.

Importantly, the housing-related supports the state proposes are of limited use without reliable access to affordable housing. As the state notes, Medicaid and other health care funding sources cannot fill the vast funding gaps for housing. Only 1 in 4 eligible low-income households receive federal rental assistance due to funding limitations.³⁰ As a result, public housing agencies must generally establish waitlists for applicants. In 2020, the New Jersey Department of Community Affairs had more than 23,000 households on its waitlist for a housing voucher, with an average wait time of 18 months.³¹ We are encouraged by the state's proposal to use American Rescue Plan Act funding for Medicaid home- and community-based services to develop additional subsidized, accessible rental units for Medicaid enrollees, and to ensure this initiative is connected and coordinated with the services described in this demonstration proposal through the new housing office within the Medicaid agency. Ultimately, the state must go further and ensure that this proposal, if approved, is part of a broader strategy to secure access to affordable housing and needed services for all low-income individuals who need it.

²⁸ Margery Austin Turner, Solomon Greene, and Martha M. Galvez, "Facing the Facts About Housing Injustice Will Help Pave the Way to Racial Equity," Urban Institute, January 26, 2021, <https://www.urban.org/urban-wire/facing-facts-about-housing-injustice-will-help-pave-way-racial-equity>.

²⁹ Anna Bailey, Kyle Hayes, Hannah Katch, and Judith Solomon, "Medicaid Is Key to Building a System of Comprehensive Substance Use Care for Low-Income People," Center on Budget and Policy Priorities, March 18, 2021, <https://www.cbpp.org/research/health/medicaid-is-key-to-building-a-system-of-comprehensive-substance-use-care-for-low>.

³⁰ Erik Gartland, "Chart Book: Funding Limitations Create Widespread Unmet Need for Rental Assistance," Center on Budget and Policy Priorities, February 15, 2022, <https://www.cbpp.org/research/housing/funding-limitations-create-widespread-unmet-need-for-rental-assistance>.

³¹ Sonya Acosta and Brianna Guerrero, "Long Waitlists for Housing Vouchers Show Pressing Unmet Need for Assistance," Center on Budget and Policy Priorities, October 6, 2021, <https://www.cbpp.org/research/housing/long-waitlists-for-housing-vouchers-show-pressing-unmet-need-for-assistance>.

Finally, we note that New Jersey has proposed to deliver housing-related services to Medicaid enrollees through its 1115 demonstration rather than the 1915(i) state plan option. State plan coverage is appropriate for these evidence-based services and gives service providers the confidence they need to continue expanding access to eligible enrollees. We encourage CMS to work with New Jersey and other states to eventually transition these important services from demonstration projects to state plan coverage.

Pre-Release services for incarcerated individuals would reduce gaps in coverage and care, supporting successful transitions back to the community.

We strongly support New Jersey's goals to "support continuity of care" for people transitioning out of incarceration and "foster a care relationship between the individual and a community behavioral health provider." New Jersey's request to cover up to four in-reach behavioral health visits delivered by community-based providers during the last 60 days of incarceration is well tailored to meet those goals. *We recommend CMS approve New Jersey's proposal to cover a limited set of pre-release, in-reach services and work with the state to clarify its plan for implementing the services.*

As the state's proposal explains, people in jail and prison have high rates of behavioral health conditions, as well as chronic physical conditions. However, they often return home without adequate access to medications or care coordination. Once home, health care often falls by the wayside as people face competing demands, including securing housing, finding work, filling prescriptions, connecting with family, and fulfilling court-ordered obligations. Gaps in coverage and care contribute to a litany of poor health outcomes and compound the harmful effects of mass incarceration and the over-policing of people of color, particularly for Black and Hispanic people.

While the Medicaid statute generally prohibits federal match for health care services delivered in correctional facilities, Medicaid can play a limited but important role in ensuring that people who are incarcerated get the coverage and care they need when returning to the community. However, Medicaid coverage of services delivered during incarceration should not be used to merely shift the cost of correctional care services from county and state governments to the federal government, but rather should be used to enhance access to care and improve the continuity of care as people transition to community-based care, consistent with the objectives of the Medicaid program.

New Jersey's proposal to cover a limited set of services delivered during the last 60 days of incarceration is clearly designed to enhance continuity of care and connection to community-based care, and therefore has little risk of inappropriately shifting costs from correctional institutions onto the Medicaid program. It also minimizes the risk that Medicaid coverage of the services during confinement would displace the use of community-based services for justice-involved people or incentivize longer-term detainment as a method of delivering behavioral health care. In addition, we strongly endorse the state's plan to use community-based providers to deliver the services. Such "in-reach" services where case managers, clinicians, or peer support professionals visit people in jail or prison is a promising strategy to help people prepare to return home. One benefit is that it builds in time for behavioral health professionals to establish rapport, develop an individualized care plan, and schedule future appointments before someone returns to the community.

We strongly support New Jersey's plan to require the providers to assess enrollees for social needs that may pose barriers to accessing care. People leaving incarceration report that finding work

and housing are among their most urgent needs, making it difficult to prioritize their health care.³² Stable employment and housing greatly improve people's chances of staying out of jail and prison³³ and would support the state's goals of improving health outcomes and addressing barriers to quality care for people experiencing homelessness. Moreover, community-based providers are particularly well-positioned to connect people to community resources because they are often familiar with the resources available.

We recommend that CMS work with New Jersey to more clearly outline the state's strategies for operationalizing the proposed services, including by ensuring that New Jersey:

- **Implements enrollment and suspension practices that ensure eligible people have active Medicaid coverage upon release.** We commend the state's efforts to collaborate with correctional facilities "to help ensure a smooth transition to full Medicaid benefits," including efforts to assist people with applications. However, there is likely room for improvement.³⁴ For instance, is the state increasing its efforts to delay the suspension of benefits for people entering jail to minimize disruptions for people who are incarcerated for short periods, suspending coverage rather than terminating it (New York is the only state to utilize indefinite Medicaid suspension), or doing more to ensure that beneficiaries have enrolled in a Managed Care Organization prior to release?
- **Works with correctional facilities to ensure access to evidence-based, medication-assisted treatment for people with opioid use disorder.**
- **Develops robust monitoring and oversight mechanisms to ensure services delivered during incarceration are high-quality and tracks outcomes.** Key outcomes include access to community-based behavioral health and physical health services, reduced hospitalization and utilization of emergency department services, self-reported wellbeing, and housing stability.
- **Considers the different structures and processes that will need to be in place for people in jail during pretrial detention and people who are in serving a sentence to benefit from the services.** The logistics and barriers to care are different for people who are held in jail during pretrial detention than those serving a sentence. For example, people held in pretrial detention often have much less predictable release dates.
- **Explores how to integrate the proposed pre-release services with other state Medicaid initiatives.** For example, mobile crisis services could help to prevent arrest or incarceration among Medicaid enrollees, contributing to the state's goal of preventing gaps in care and coverage. The state's proposal to incorporate Certified Community Behavioral Health Clinics into the 1115 demonstration includes a requirement that participating clinics provide crisis diversion and mobile outreach services.

³² Kamala Mallik-Kane, Ellen Paddock, and Jesse Jannetta, Op cit.

³³ Lucius Couloute, "Nowhere to Go" Op cit.; Lucius Couloute and Daniel Kopf, "Out of Prison & Out of Work: Unemployment among formerly incarcerated people," Prison Policy Institute, July 2018, <https://www.prisonpolicy.org/reports/outofwork.html>.

³⁴ Gabrielle de la Guéronnière and Deborah A. Reid, "Strengthening Access to Care: Developing Systems that Maximize Medicaid Eligibility, Support Enrollment, and Promote Seamless Coverage in the Criminal Legal System" Legal Action Center, January 2022, <https://www.lac.org/assets/files/january-2022-FINAL-Medicaid-Coverage-CLS-Brief.pdf>.

Conclusion

Our comments include numerous citations to supporting research, including direct links to the research for HHS' benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

Thank you for consideration of our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Judith Solomon (Solomon@cbpp.org).

Sincerely,

Center on Budget and Policy Priorities
Georgetown University Center for Children and Families