August 31, 2022

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

Re: Washington Medicaid Transformation Project Demonstration Extension

Dear Secretary Becerra,

The undersigned organizations appreciate the opportunity to comment on Washington's request for a five-year extension of its "Medicaid Transformation Project" section 1115 demonstration project (MTP 2.0). The state is seeking to build on its existing demonstration to implement a number of new proposals to advance health equity, including proposals to improve access to care, advance whole-person care, and invest in community-driven care and supports. Given the breadth of the state's extension request, we are only providing comments on aspects of the proposal detailed below.

Advancing health equity is central to the state's extension request and we believe Washington's request will promote health equity and the objectives of Medicaid. We strongly support Washington's proposal to provide multiple years of continuous eligibility for children through age six which would improve continuity of care for young kids during the foremost developmental years. We also support other proposals that will advance health equity, including the proposals to provide targeted services to individuals 30 days prior to release from incarcerated settings to support re-entry in the community, extending postpartum coverage an additional ten months for those not eligible through the American Rescue Plan Act's state plan option, and expanding health-related services and community-based workforce. We believe Washington's request will promote health equity and the objectives of Medicaid. We urge you to approve the state's extension and consider the following recommendations when crafting the special terms and conditions with the state.

Multi-year continuous eligibility would promote stable health coverage and improve continuity of care.

Washington currently provides a 12-month continuous eligibility period for children enrolled in Medicaid or CHIP. In this application, the state seeks to maximize coverage and limit administrative burdens by providing continuous eligibility for young children through age six with household income below 215 percent of the federal poverty level ($59,663 per year for a family of four). We 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 exactly the type of proposal for which 1115 demonstrations should be used; there is much to be learned from this approach. *We strongly urge CMS to approve Washington's request to extend continuous eligibility.*

Consistent with the goals of Executive Order 13985 and the strategic vision laid out by CMS Administrator Chiquita Brooks-LaSure and CMCS Director Dan Tsai, lengthening continuous

eligibility for children and adults has the potential to remedy disparities in coverage.[1] Individuals with Medicaid are at risk of moving off and on coverage due to temporary changes in income that affect eligibility, a phenomenon known as "churn." Recent research shows that children are among the eligibility groups most likely to experience churn, and that Asian, Black, and Hispanic children are more likely to be uninsured for part or all of the year than non-Hispanic white children.[2] Continuous eligibility can help mitigate the disproportionate impact of churn and uninsurance. A recent study found that eight percent of children enrolled in Medicaid or CHIP in 2018 disenrolled and re-enrolled in coverage within twelve months; the rate of churn was even higher when looking at children enrolled in separate CHIP (16 percent).[3] Washington's own data shows that coverage disruptions disproportionately affect children of color in the state, with black Hispanic children experiencing almost 1.4 times the number of coverage month disruptions every five years compared to white Hispanic children.[4]

Continuous eligibility can help mitigate the disproportionate impact of churn and uninsurance. From the last quarter of 2020 through the first quarter of 2022, the national child uninsured rate decreased 2.7 percentage points, from 6.7 percent to 3.7 percent.[5] During the entirety of that period, The Families First Coronavirus Response Act (FFCRA) maintenance of effort requirement was in place, which has kept children with Medicaid continuously enrolled in coverage. While the decrease in uninsurance may be the result of multiple factors, the FFCRA protection was likely a major factor. A new report estimates that 5.3 million children will lose coverage once the FFRCA protection ends; of these, 72 percent of children will still be eligible for Medicaid but will lose coverage due to administrative churn.[6] Once the FFCRA continuous enrollment protection is no longer in effect, Washington's proposal will be especially important and will enable the state to evaluate the ongoing benefits of continuous enrollment.

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[1] 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.; Chiquita Brooks-LaSure and Daniel Tsai, "A Strategic Vision for Medicaid and the Children's Health Insurance Program (CHIP)," *Health Affairs Blog,* November 16, 2021, https://www.healthaffairs.org/do/10.1377/forefront.20211115.537685/full/.

[2] Bradley Corallo *et al.*, "Medicaid Enrollment Churn and Implications for Continuous Coverage Policies," Kaiser Family Foundation, December 14, 2021, https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/; Aubrianna Osorio and Joan Alker, "Gaps in Coverage: A Look at Child Health Insurance Trends," Georgetown University Center for Children and Families, https://ccf.georgetown.edu/2021/11/22/gaps-in-coverage-a-look-at-child-health-insurance-trends/.

[3] MACPAC, "An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP," October 2021, https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf.

[4] Washington State Health Care Authority, "Section 1115 Medicaid Demonstration Waiver Renewal Request," August 2022, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medicaid-transformation-pa5.pdf.

[5] Aiden Lee, *et. al.,* "National Uninsured Rate Reaches All-Time Low in Early 2022," HHS Assistant Secretary for Planning and Evaluation (ASPE) Office of Health Policy, August 2022, https://aspe.hhs.gov/sites/default/files/documents/15c1f9899b3f203887deba90e3005f5a/Uninsured-Q1-2022-Data-Point-HP-2022-23-08.pdf.

[6] ASPE Office of Health Policy, "Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches," August 19, 2022, https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf.

Continual access to care is vital for the healthy development of young children. Children with unaddressed conditions such as asthma, vision, hearing impairment, nutritional deficiencies, and mental health challenges are unable to thrive in kindergarten and beyond.[7] To catch early warning signs of these problems, the American Academy of Pediatrics recommends that young children receive at least 15 well-child visits in their first six years of life.[8] Ensuring that children through age six have stable coverage would improve access to the necessary preventive care and developmental screenings that occur during these visits and set the stage for better long-term outcomes.[9]

Finally, continuous eligibility has the potential to free up administrative resources, improve program efficiency, and reduce burdens on families. When beneficiaries churn on and off coverage, states have to go through determining someone ineligible for coverage, complete the termination process, and then process a new application when the individual reapplies. One study found that the cost of disenrolling and then reenrolling in Medicaid was between $400 to $600 per person.[10] The burden is even greater on families who may experience greater out-of-pocket costs or medical debt during gaps in coverage. Multi-year continuous coverage would mitigate these costs for the state and families of young children while decreasing administrative workloads and providing peace of mind for new parents.

Extending continuous eligibility has a valid and commendable experimental purpose that promotes the objectives of the Medicaid program. Washington's proposed evaluation design includes disaggregating all metrics for continuous enrollment for young children by race and ethnicity, which is important in identifying whether the proposal is helping reduce the noted disparities in coverage disruptions. The state's evaluation design would be strengthened if it included measuring service use and cost of care before and after implementation, with a particular focus on EPSDT services. The proposal would test an innovative idea to improve the lives of children that would provide important new information. The full benefits of the policy may take a longer time to manifest compared to the standard section 1115 waiver, but that should not discourage this investment in children, especially given the well-documented, long-term benefits of providing Medicaid to children.[11]

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[7] Delaney Gracy *et al.*, "Health Barriers to Learning: The Prevalence and Educational Consequences in Disadvantaged Children, A Review of the Literature," January 2017, https://www-childrenshealthfund.b-cdn.net/wp-content/uploads/2017/02/HBL-Literature-Review-2-2-2017.pdf.

[8] American Academy of Pediatrics, "Recommendations for Preventive Pediatric Health Care," March 2021, https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

[9] Elisabeth Wright Burak, "Promoting Young Children's Healthy Development in Medicaid and CHIP," Georgetown University Center for Children and Families, https://ccf.georgetown.edu/2018/10/17/promoting-young-childrens-healthy-development-in-medicaid-and-the-childrens-health-insurance-program-chip/.

[10] Katherine Swartz, *et. al.*, "Reducing Medicaid Churning: Extending Eligibility For Twelve Months Or To The End Of Calendar Year Is Most Effective," Health Affairs, July 2015, https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204.

[11] Joan Alker, Genevieve Kenney, and Sara Rosenbaum, "The Biden Administration Should Approve Oregon's Request To Cover Children Until Their Sixth Birthday," Health Affairs Blog, July 13, 2022, https://www.healthaffairs.org/do/10.1377/forefront.20220711.14370; Edwin Park, *et. al,* "Jeopardizing a Sound Investment: Why Short-Term Cuts to Medicaid Coverage During Pregnancy and Childhood Could Result in Long-Term Harm," Commonwealth Fund, December 8, 2020, https://www.commonwealthfund.org/publications/issue-briefs/2020/dec/short-term-cuts-medicaid-long-term-harm.

Extending postpartum coverage to persons not covered by Medicaid during pregnancy will improve maternal health outcomes.

Washington has already adopted the American Rescue Plan Act's state plan option to provide postpartum people an additional ten months of postpartum coverage after the end of pregnancy. The proposal would extend 12 months of postpartum coverage to pregnant people who were not enrolled in Medicaid or CHIP during their pregnancy and those who received coverage through the CHIP "unborn child option," working in tandem with the state plan option to provide all postpartum individuals a full year of coverage.

Extending postpartum coverage reduces the likelihood of individuals becoming uninsured in the year following pregnancy by eliminating the 60-day postpartum cutoff – allowing people to maintain prescribed treatments and recommended check-ups for a longer period after giving birth with little to no disruption of care. For example, extended coverage would ensure access to critical postpartum care needed throughout the first year after the end of pregnancy, such as care for conditions exacerbated by pregnancy, including hypertension or diabetes, as well as access to maternal depression screening and treatment. Additionally, providing coverage through 12 months postpartum would work to reduce maternal and infant mortality and morbidity, both of which disproportionately affect women and infants of color.[12]

Children would benefit from extended postpartum coverage as well. Research has shown that when parents are healthy, they can better support their child's healthy cognitive and social-emotional development and help reduce the effects of adverse childhood experiences on their child's health.[13] Medicaid coverage for parents is also associated with an increased probability of their children receiving annual well-child visits.[14]

We commend Washington for taking up the state plan option to provide Medicaid and CHIP coverage through twelve months postpartum and support the state's efforts to expand the SPA option to extend postpartum coverage to those who are not eligible under this option, with the following recommendations:

- With respect to extending coverage to postpartum individuals who were not enrolled in Medicaid during pregnancy, we recommend CMS waive the relevant provisions of 1902(e)(16) to enable the state to extend postpartum coverage to individuals who were not enrolled in Medicaid during pregnancy but who apply for coverage during the postpartum period and at the time of application meet the state's income eligibility threshold for pregnant people. Section 1115 authorizes waivers of otherwise applicable provisions to test approaches that promote the objectives of the Medicaid program,

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[12] Donna L Hoyert, "Maternal Mortality Rates in the United States," Centers for Disease Control NCHS Health E-Stats, February 2022, https://stacks.cdc.gov/view/cdc/113967; Centers for Disease Control, "Births: Final Data for 2019," National Vital Statistics Report, March 23, 2021, https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-02-tables-508.pdf.

[13] Georgetown University Center for Children and Families, "Healthy Parents and Caregivers are Essential to Children's Healthy Development, December 2016, https://ccf.georgetown.edu/wp-content/uploads/2016/12/Parents-andCaregivers-12-12.pdf.

[14] Maya Venkataramani, Craig Evan Pollock, and Eric Roberts, "Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventative Services," Pediatrics, December 2017, https://pediatrics.aappublications.org/content/140/6/e20170953.

which we believe Washington's proposal does. CMS should waive the applicable provision and evaluate the demonstration. For example, approval of this waiver should be accompanied with a requirement that the state evaluate the characteristics of this "postpartum entry" population, including when in the postpartum period they enroll, what postpartum services they receive, and what health outcomes they experience.

- With respect to extending coverage during the postpartum period to individuals who received pregnancy-related services under the CHIP "unborn child option," we urge CMS to encourage Washington to consider using a portion of the state's allotment from its CHIP administrative funds that can be used to support health services initiatives (or HSIs) to provide postpartum coverage to individuals that received pregnancy care through the "unborn child option," as CMS has approved in other states.[15] Extending postpartum coverage to a population otherwise ineligible to Medicaid is a laudable goal that will support the health of not only pregnant people but also their children.

Pre-release services during the last 30 days of incarceration would reduce gaps in coverage and care, supporting successful transitions back to the community.

We strongly support Washington's goal "to provide transition services" and "support continuity of care" for people exiting incarceration. Washington's proposal to cover a targeted set of services during the last 30 days of incarceration is well tailored to meet those goals. We recommend CMS approve Washington's proposal and require the state to 1) clarify the limited set of pre-release services covered and 2) prioritize the use of community-based providers to deliver 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.[16] 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. In addition, incarceration can harm health, and incarcerating children and young adults can cause serious harm to youth who are separated from their family and community, including long-term adverse impacts on individuals' physical and mental health.[17]

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[15] California State Plan Amendment #CA-21-0032, https://www.medicaid.gov/CHIP/Downloads/CA/CA-21-0032.pdf; Illinois State Plan Amendment #IL-21-0014, https://www.medicaid.gov/CHIP/Downloads/IL/IL-21-0014.pdf.

[16] Kamala Mallik-Kane and Christy A. Visher, Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration, Urban Institute, February 2008, https://www.urban.org/sites/default/files/publication/31491/411617-Health-and-Prisoner-Reentry.PDF.

[17] Cortney Sanders, "State Juvenile Justice Reforms Can Boost Opportunity, Particularly for Communities of Color," Center on Budget and Policy Priorities, July 27, 2021. https://www.cbpp.org/research/state-budget-andtax/statejuvenile-justice-reforms-can-boost-opportunity-particularly-for; Vincent Schiraldi, "Can We Eliminate the Youth Prison? (And What Should We Replace It With)?" Square One Project, June 2020, https://squareonejustice.org/paper/can-we-eliminate-the-youth-prison-and-what-should-we-replaceit-with-by-vincentschiraldi-june-2020/; Christopher Wildeman and Emily Wang, "Mass Incarceration, Public Health, and Widening

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.

Recommendations

To ensure that the covered services advance the objectives of the Medicaid program and prevent unintended consequences, we recommend CMS require the state to:

- **Cover a limited set of services during the last 30 days of incarceration** to avoid covering all or the bulk of Medicaid services. Washington's proposal to cover "a set of targeted Medicaid services" includes relevant health assessments, lab work, case management/ care coordination, and medications (including for treatment of Opioid Use Disorder), which are clearly designed to enhance continuity of care and connection to community-based care. However, the state's proposal notes that the set of services is "not limited to" this list, leaving the door open for the state to cover any number of services. Without defining the set of services, Washington could be at risk of inappropriately shifting costs from correctional institutions onto the Medicaid program. Covering a limited set of services also helps to protect against incentives for facilities to delay care until the last 30 days when Medicaid coverage is available to offset the costs.

- **Maximize the use of community-based providers to deliver covered services**. Covering 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 successfully return to the community. One benefit is that it builds in time for health professionals to establish rapport, develop an individualized care plan, and schedule future appointments before someone returns to the community. Community-based providers are also best positioned to connect individuals to housing, employment, and other community resources that can reduce barriers to care and prevent returning to a carceral setting.

Providing a limited set of re-entry services to support discharge from IMDs could assist transitions, but care coordination is essential.

Washington is also proposing to provide a similar set of targeted services during the 30 days prior to individuals leaving an institution for mental disease (IMD). In addition to the concerns raised above which apply to this population as well, the state should ensure that it includes care

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Inequality in the USA," The Lancet 389, April 2017, https://doi.org/10.1016/S0140-6736(17)30259-3; Michael Massoglia and Brianna Remster, "Linkages Between Incarceration and Health," Public Health Reports, May 1, 2019, https://doi.org/10.1177/0033354919826563.

coordination to facilitate transitions into the community. Care coordination and supports to secure community-based services, including to address unmet social needs, are critical to ensuring people leave IMDs as soon as clinically appropriate and have access to the community-based care and other supports they need to remain in the community. Without appropriate supports, people with serious mental illness often endure a harmful cycle of repeated hospitalization and institutionalization, diminishing their independence, health, and quality of life.

Coverage of a limited set of carefully tailored transition services—including care coordination—may be appropriate during the final weeks of an IMD stay to ensure people return to the community as soon as possible. In contrast, coverage of a broad range of benefits during an IMD psychiatric residential stay that are not tailored to supporting care transitions would not be appropriate. Also, the state should be cautious when defining the specific services that would be made available prior to discharge to prevent undermining the intent of the IMD exclusion to promote access to community-based care.

Piloting access to community health workers in pediatric primary care will prioritize early childhood development, better identify preventive care needs, and inform improved sustainability.

As part of its efforts to grow a culturally responsive, community-based workforce, Washington requests authority to pilot community health workers (CHWs) in pediatric primary care practices as a member of the care team. Pediatric team-based care, through proven models such as Healthy Steps[18], can boost support for early childhood development by using well-child visits to offer greater support to families. Regular check-ups offer the most consistent way to reach the families of Medicaid-eligible children before kindergarten entry. In addition to helping families connect with community-based services, CHWs, with the care team, can help parents and caregivers ensure the safe, stable and nurturing relationships which provide the foundation of social-emotional development, including rapid brain development in the earliest months and years of life.

The proposal would also help to provide data on the services, such as targeted case management or preventive care, that may be reimbursable under existing authority. For example, the pilot program would yield useful information on implementation and sustainability like payment lessons learned for uptake, access for kids in pediatric practices with CHWs, and considerations for scaling the program up beyond the pilot. The program would also help identify any reimbursement challenges or opportunities specific to CHWs that may require new approaches to ensure sufficient growth in the community-based workforce.

Funding for focused health equity initiatives is a central part of the waiver and robust evaluation is critical to show the outcomes of these investments.

We also support Washington's request to fund local, community-based initiatives to advance health equity and to ensure their process of setting health equity goals and standards is inclusive of

[18] Johnson, K., and Bruner, C. (2018), "A Sourcebook on Medicaid's Role in Early Childhood: advancing High performing medical Homes and improving lifelong Health" (Child and Family policy Center, 2018), available at https://www.inckmarks.org/docs/pdfs_for_medicaid_and_EpsDT_page/sourcebookmEDiCaiDYOUNGCHilDRENall.pdf.

organizations led by people of color and of Apple Health enrollees and their families. The state acknowledged that several health measures for enrollees improved during the prior demonstration period, according to the state's December 2020 interim report, but that there are still ongoing racial and ethnic disparities in quality of care and outcomes that the state's proposal seeks to address. We support Washington's goal of ensuring that investment is focused on local needs and that the demonstration advances and centers health equity in Washington's health care system.

Because of long-standing systemic inequities that contribute to disparities, tracking changes in the differences over time would be an effective way to show the impact of the project initiatives. For example, as the evaluation plan is developed, it would be helpful to include analysis of whether the identified disparities narrowed or widened and to gather more information about the barriers enrollees of color are facing to determine best areas of ongoing investment.

Creation of Community Hubs and enhanced access to health-related services are positive investments, but additional clarity is needed.

We are supportive of and commend the state's intention to increase access to health-related services and supports (HRS), including by expanding the services covered under managed care and FFS and by developing and coordinating a community-based network to screen and respond to HRS. While HRS cannot remedy all obstacles that individuals with Medicaid coverage may be experiencing, these supports are a meaningful step forward toward addressing social and economic conditions that affect health, when paired with appropriate guardrails. We believe these investments have the potential to improve health and reduce health care spending in the long-term. At the same time, we urge CMS to set clear standards in the development of this system.

First, we believe the state needs clearer roles and lines of accountability between managed care, ACHs, and now Community Hubs. In terms of financing, it is unclear from the proposal what role, if any, managed care plans play in paying for any of the new services, what roles ACHs play in financing services or Hubs, and what roles Hubs play in paying for services. More importantly for the consumer experience, there is potential for multiple or redundant care management systems (across managed care, ACHs, and now Hubs) that will create confusion and diffuse accountability. CMS should ensure that its approval STCs delineate clear roles and accountability within the new system.

Second, while we are supportive of increasing access to HRS, we believe that CMS should ensure that the expanded set of services are not provided in a way that appears discretionary (whether they are approved under the section 1115 demonstration or as in-lieu-of services through the managed care delivery system). CMS should require standards around the formal identification of available services and how those services can be requested and prescribed, and ensure they are subject to the same due process as traditional state plan services.

Finally, we recommend that CMS treat this as an *investment*, meaning that CMS should not expect or demand instant savings. Specifically, CMS should require that capitation payments for current state plan services remain actuarially sound; funding for the expanded set of services should be *in addition to* the funding needed to support the delivery of current state plan services at the levels needed by beneficiaries. Needed care should not be reduced to finance long-term investments.

Conclusion

Our comments include numerous citations to supporting research, including direct links to the research, for HHS's 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 Allison Orris (aorris@cbpp.org).

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