Center on Budget and Policy Priorities

Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

February 3, 2023

VIA ELECTRONIC SUBMISSION

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

Re: Rhode Island Comprehensive Demonstration Extension Request

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 the Rhode Island Comprehensive Demonstration section 1115 extension application. The state is requesting a five-year extension of its demonstration, which would continue most of the state's currently approved authorities. The proposal also seeks to expand several existing programs as well as implement a number of new provisions that aim to reduce health inequities and improve access to care. The state's application is extensive, so our comments are limited to the aspects detailed below.

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.

We support Rhode Island's request to ensure all pregnant people in the state with Medicaid and CHIP coverage have coverage through the first year after delivery by extending postpartum coverage to 12 months for the populations that gain eligibility through the demonstration. We also applaud the state's emphasis on equity, including the proposed expansion to housing stabilization services and supports and the goals of the proposal to provide outreach and pre-release services to justice-involved populations. However, the proposal to expand housing supports should require the state to develop a process for determining that services are medically appropriate to help address health related social needs and CMS should carefully monitor supports that are tangentially related to health.

While we support the state's goal of advancing health equity and many of the provisions in its extension application, we strongly oppose continuing to eliminate three-month retroactive coverage for almost all non-pregnant adult enrollees. The waiver of retroactive coverage is not even explicitly acknowledged in the state's application and more importantly, does not promote the objectives of Medicaid. We urge CMS to approve Rhode Island's demonstration extension request, without the

inclusion of the waiver of retroactive coverage, and consider the recommendations that follow when crafting the special terms and conditions.

The proposal to provide 12 months of postpartum coverage would ensure all Medicaid-eligible people in the state receive services during a critical time, but use of other federal authorities should be explored.

Rhode Island has already adopted the state plan option to provide postpartum people an additional ten months of postpartum coverage so that they are covered for a full year after the end of pregnancy. The state is requesting "identical authority for all eligible categories under the waiver including Budget Population 3, 6a, and 6b," which, according to the existing STC's, are pregnant people covered only through the demonstration with incomes between 185% and 250% FPL and pregnant people with incomes up to 185% FPL who are not otherwise eligible for Medicaid.[1]

The state's proposal would ensure that pregnant people who are covered through the demonstration have the same coverage throughout the postpartum period as those covered through state plan authority, meeting the standards of the federally authorized option for extended postpartum coverage. Providing 12 months of postpartum coverage reduces the likelihood of mothers becoming uninsured in the first year following delivery and enables these individuals to maintain prescribed treatments 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 reduce maternal and infant mortality and morbidity, both of which disproportionately affect women and infants of color.[2]

We commend Rhode Island for taking up the Medicaid state plan option to provide extended coverage through 12 months postpartum and support the state's efforts to provide similar extended coverage to pregnant people who are covered through the demonstration. We recognize that the design of Rhode Island's current eligibility pathways for pregnant women may necessitate a section 1115 waiver for the state to adopt 12 months postpartum coverage for some covered groups. As CMS works to negotiate the demonstration extension, it should explore with the state whether there are Budget Population 6 sub-populations that could have their pregnancies covered through permanent CHIP state plan authority (i.e., pregnant people with incomes between 185% FPL and 250% FPL that could be CHIP eligible). This would be preferable to temporary demonstration eligibility, and postpartum coverage could then be extended using a state plan amendment.

Finally, to best effectuate Rhode Island's goal to create equivalent access to extended postpartum coverage across programs and coverage groups, we encourage CMS and the state to consider using a portion of the state's allotment from its CHIP administrative funds to support health service initiatives (or HSIs) to provide postpartum coverage to individuals receiving pregnancy coverage

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[1] Rhode Island Comprehensive Demonstration Approval, July 28, 2020, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-ca.pdf.

[2] 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.

through CHIP, as CMS has approved in other states.[3] Extending postpartum coverage to a population otherwise ineligible for Medicaid is a laudable goal that will support the health of not only pregnant people, but also their children.

Home stabilization expansion proposals will help address health related social needs (HRSN) and should be approved consistent with new CMS policy on HRSN.

There is growing evidence that for people with complex health needs, housing support services such as help locating and apply for housing assistance, coaching on tenant rights and responsibilities, developing a support plan and connecting residents to community-based supports help people maintain housing, access care, and improve their health. Rhode Island has a demonstrated record of commitment to providing housing supports and is seeking to make a number of changes (which we support in part) to expand access to services to a broader population that may require housing services by eliminating the current health needs-based eligibility criteria. Below we discuss our perspective in more detail, including recommendations to refine the state's proposal.

We strongly support the state's commitment to expanding eligibility for existing "home find" and "home tenancy" services to a larger group of Medicaid enrollees who need housing-related services and making it simple for providers to establish eligibility for people who need those services. However, the state must establish a mechanism for determining that all housing-related services are medically appropriate, ideally one that does not create excessive administrative burden on providers that may lead to eligible people being denied the services they need. To prevent unnecessary limitations on eligibility for important tenancy support services, we recommend the state adopt health-based criteria that are inclusive of a broad range of health conditions — including mental health and substance use disorders — and do not require conditions to be chronic or disabling. This approach would be consistent with recent approvals in other states that require the state to develop a process for determining the services are medically appropriate. We also recommend the state maintain a requirement for assessment tools to be state-approved; this is important for limiting inequities and promoting consistent implementation across the state.

The state is also seeking to add both non-recurring set-up expenses for individuals to transition to a living arrangement in a private residence and additional support for individuals to maintain tenancy and avoid eviction. The one-time investments that Rhode Island is proposing to help Home Find and Home Tenancy recipients and authorization of up to 6 months of rent payments are consistent with CMS's recent policy clarifications regarding funding health related social needs, but only if the 6 months of temporary housing support is limited to people transitioning out of institutional care or congregate settings, individuals who are experiencing or at risk homelessness, and youth transitioning out of the child welfare system.[4] We also encourage Rhode Island to elaborate about how it will partner with state and local housing agencies to support beneficiaries in maintaining housing stability following the 6-month period; many people with low incomes need ongoing rental assistance to afford rent and maintain stable housing. We support these changes, insomuch as they are consistent with CMS' policy, and believe they provide an opportunity to test

[3] 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.

[4] Addressing Health-Related Social Needs in Section 1115 Demonstrations, CMCS All-State Medicaid and CHIP Call, December 6, 2022, https://www.medicaid.gov/resources-for-states/downloads/covid19allstatecall12062022.pdf.

Rhode Island's hypotheses about the potential to improve health outcomes for Medicaid beneficiaries by supporting unmet housing needs.

The state is also requesting flexibility to enable it to more efficiently administer its housing support programs, including modifications to the education requirement for service providers and flexibility in assessment tools. Removing education requirements that are necessary to ensure a competent staff may expand pathways for people with lived experience of homelessness, institutionalization, or chronic illness to lend their expertise as providers. We support these changes, subject to robust monitoring and evaluation protocols that will help CMS and the state evaluate the efficacy of these changes, and make adjustments, as necessary.

As part of its approval, CMS should also ensure that these and other HRSN interventions, including the recuperative care pilot discussed below, fit within the overall 3% of total Medicaid spending standard established by the agency, that infrastructure costs do not exceed 15% of total HRSN spend, and that spending on HRSN does not supplant spending on other Medicaid services. Finally, given the scope of investments in HRSN proposed by Rhode Island, should CMS approve the state's requests, we also encourage CMS to apply its new policy to ensure that provider rates are sufficient to ensure access to basic Medicaid services and that the state is concurrently working to improve Medicaid provider payment rates. It is critical that CMS apply its new policy consistently so that states have clarity as they design their HRSN proposals and as CMS and stakeholders monitor the outcomes and evaluations of these groundbreaking demonstrations.

The restorative and recuperative care pilot offers an important opportunity to test interventions to address unmet social needs, but it should be narrowed.

Rhode Island also is seeking authority to launch a Recuperative Care Center Pilot Program, which will "provide services to individuals experiencing homelessness to prepare for, undergo, and recover from medical treatment, injuries, and illness." While we support the goals of this pilot and believe that Section 1115 demonstration authority is an appropriate vehicle to test the efficacy of providing medical respite services for people with unmet social needs, we are concerned that the state is proposing a length of stay as long as 36 months. According to the Health Care for the Homeless Council, the "median stay is 30 days, but program averages range from a few days to 1 year (though this is an extreme outlier)"[5]; CMS should work with Rhode Island to refine the proposal. We are also concerned that the project is not sufficiently focused on helping to develop connections to social services that can reduce hospital readmissions and facilitate connections to permanent housing.

Instead, we encourage CMS to approve the pilot proposal consistent with our recommendations below and with CMS' recently articulated approach to using Section 1115 demonstrations to address HRSN on a time-limited basis.[6] CMS should ensure that the medical respite pilot (1) remains short-term (e.g., an average stay of 60 or 90 days with an absolute maximum of 6 months) so it remains focused on helping people transition out of acute care and does not become a secondary long-term care facility, and (2) includes close partnerships with the local

[5] Medical Respite Care: Financing Approaches, National Health Care for the Homeless Council, June 2017, https://nhchc.org/wp-content/uploads/2019/08/policy-brief-respite-financing.pdf.
[6] Addressing Health-Related Social Needs in Section 1115 Demonstrations, CMCS All-State Medicaid and CHIP Call, December 6, 2022, https://www.medicaid.gov/resources-for-states/downloads/covid19allstatecall12062022.pdf.

homelessness services Continuum(s) of Care and public housing agencies, which is necessary to help people transition to stable housing and minimize discharges into homelessness.[7]

As noted above, CMS should assure that this pilot – and other HRSN interventions proposed by Rhode Island – are authorized consistent with CMS's recently announced policy on HRSN.

Targeted 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 support Rhode Island's desire to provide outreach and pre-release supports for individuals who are incarcerated and the states' goal to achieve "an increase individuals enrolling in Medicaid following incarceration and accessing primary care and other necessary services during their transition back into the community." However, we are concerned that Rhode Island's proposal is potentially too broad and could result in Medicaid supplanting other sources of coverage for incarcerated individuals. Rhode Island is requesting "30 days of pre-release coverage to allow for managed care enrollment and access to the full set of Medicaid covered benefits, excluding services provided by DOC providers." We agree with Rhode Island's intent to assure that benefits that could be covered by the DOC system are not simply refinanced by Medicaid, but the scope of services that Medicaid *would* cover is not clear and we are concerned that covering the "full set of Medicaid covered benefits" indicates a potentially broader intent for this demonstration than we would recommend. We also urge CMS to ensure that Medicaid does not supplant Depart of Correction (DOC) funding, which is a more appropriate sources of funding for most care needed in a correctional institutional.

As part of the approval, CMS should 1) establish a clear, limited set of covered pre-release services that are tailored to the goal of improving continuity of care as people return to the community and 2) prioritize the use of community-based providers to deliver the services, in addition to the proposed use of MCOs to coordinate care. We believe covering a targeted set of services (including enhanced care management and coordination, MAT, and a 30-day supply of medications (including MAT) and DME), during the last 30 days of incarceration for a defined high-needs population is appropriate. Therefore, we recommend CMS work with Rhode Island to narrow its proposal, consistent with forthcoming CMS guidance, which we anticipate will establish uniform programmatic and evaluation parameters to test the efficacy of this important intervention. We also recommend that CMS require Rhode Island to develop a Reentry Initiative Reinvestment Plan to ensure that Medicaid funding doesn't simply replace other current funding sources.

As the state's proposal explains, people in jail and prison have high rates of behavioral health conditions, as well as chronic physical conditions.[8] 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

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[7] Expanding Options for Health Care Within Homelessness Services: CoC Partnerships with Medical Respite Care Programs, The Framework for an Equitable Homelessness Response, 2022, https://endhomelessness.org/wp-content/uploads/2022/01/CoC-Partnerships-Medical-Respite-Care-programs_1-5-22.pdf.

[8] 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.

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.[9]

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 that are tailored to the goal of improving continuity of care as people return to the community** to avoid covering all or the bulk of Medicaid services. Rhode Island's proposal to cover the "full set of Medicaid covered benefits, excluding services provided by DOC providers" appears to be overly broad and should be clarified as it is unclear how MCOs and DOC providers would coordinate coverage. The demonstration terms and conditions should not leave the door open for the state to cover an unlimited number of services. 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. We do support Rhode Island's intent to require the MCOs to provide "intentional care coordination during this period to support reintegration and improve access to care and support services upon release." Such care coordination services are an important component of pre-release services aimed at facilitating transitions back to the community.

- **Maximize the use of community-based providers to deliver covered services**. Covering "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. The demonstration approval should require Rhode Island to require its managed care contractors to leverage community-based providers to provide in-reach services. There may be some circumstances in which it is difficult for community-based providers to deliver covered pre-release services, such as for people held in prisons located in remote locations or areas where few community-based providers operate, or in facilities that refuse to accept the terms and conditions required by state Medicaid agencies to reimburse for services. These challenges

[9] 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 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.

should not deter CMS from requiring Rhode Island to use community-based providers. CMS should encourage Rhode Island to invest in expanding provider capacity to deliver in-reach services, such as by utilizing telehealth to connect Medicaid enrollees to community-based providers in the region where they will live after release. We also urge CMS to work with the state to ensure aggressive coordination and record sharing between DOC and managed care, so that managed care can truly effectuate the warm hand-off to the community.

In addition, the demonstration approval should not include the waiver of program integrity requirements for carceral providers contained in the recently approved amendment to California's demonstration. It is essential to the success of this demonstration that *any* provider furnishing pre-release services paid for with Medicaid funds under this demonstration (1) be screened and enrolled in Medicaid and (2) keep records on pre-release services furnished to individuals under this demonstration, including claims for payment for such services, and make this information available to the Secretary on request.

- **Develop a Reentry Initiative Reinvestment Plan to ensure that Medicaid funding doesn't simply replace other current funding sources.** 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. Requiring the state to provide an explanation about how the state will operationalize coverage and provision of pre-release services and how existing state funding for carceral health services will continue to support access to necessary care and achievement of positive health outcomes for the justice-involved population is an important element of any forthcoming approval.

Eliminating retroactive coverage does not promote the objectives of Medicaid and is no longer an experiment.

Rhode Island is requesting to "maintain all existing waiver and expenditure authorities" except three authorities the state seeks to remove, none of which are the state's waiver of three-month retroactive coverage. The state's implicit request to extend its retroactive coverage waiver for almost all non-pregnant adults (to our best understanding; more on this below) exposes these enrollees to medical debt and financial harm and does not promote the objectives of Medicaid. The request is also inconsistent with the state's focus on meeting the health needs of people experiencing or at risk of homelessness.

Under the law, Medicaid payments are available for medical expenses for a full three months prior to the month of application, if the beneficiary was eligible during for Medicaid during this period. The purpose of retroactive coverage is the same today as it was 50 years ago when the benefit was first established: to protect low-income Medicaid beneficiaries from the financial burden of medical debt resulting from the costs of care they need during the three months prior to applying

for Medicaid, and to ensure the health system is not damaged by uncompensated care. Data from Indiana show how important retroactive coverage is for low-income parents in that state – a group that wouldn't be expected to have large medical costs, but in fact incurred significant medical costs prior to enrollment. In a one-year pilot to test whether retroactive coverage filled gaps in coverage, Medicaid paid $1,561 on average on behalf of parents in Indiana who incurred medical costs prior to enrolling in Medicaid.[10] Eliminating retroactive coverage also does not align with Rhode Island's purported goal of advancing health equity as the waiver is more likely to affect people of color who have greater levels of medical debt.[11] Waiving retroactive coverage does not promote the central objective of the Medicaid program – to provide coverage – and in fact, by definition takes coverage away from these enrollees.

Furthermore, Rhode Island does not explicitly mention it is seeking to continue to eliminate retroactive coverage, making it nearly impossible for the public to provide meaningful comments on the issue without prior knowledge of what is authorized in the state's existing demonstration. In fact, there is *no mention* of the waiver anywhere in the state's extension application, including the evaluation. And even if there is knowledge of the existing waiver of retroactive coverage, it is unclear who is impacted by the policy. The current demonstration's standard terms and conditions indicate the waiver "does not apply to individuals under Section 1902(l)(4)(A) of the Act or the ABD population." This exclusion citation is far too obscure for most commenters to understand, and in any case does not explain who the waiver *does* apply to. The public should have a clear understanding of the retroactive coverage waiver hidden in this extension.

The state has had a waiver of retroactive coverage (with the associated, unclear exemptions) as part of its demonstration for almost a *decade and a half*. The purpose of a section 1115 demonstration is to test *new* approaches to delivering services that have the potential to improve Medicaid coverage for beneficiaries. The state does not provide a research hypothesis or an experimental purpose for waiving retroactive coverage in its application nor did it include it in its interim evaluation of the current demonstration period. While we do not believe that there was ever a legitimate research purpose for waiving three-month retroactive coverage, Rhode Island's waiver is well past the point of being an experiment.

Finally, CMS should reconsider allowing Rhode Island to continue eliminating retroactive coverage in light of the impending unwinding of the Medicaid continuous enrollment protection. As a recent report from the Assistant Secretary for Planning and Evaluation (ASPE) outlined, unwinding the continuous coverage protection will likely lead to a high volume of procedural disenrollments – estimating that 6.8 million enrollees will lose coverage despite still being eligible.[12]

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[10] July 29, 2016 letter from the Centers of Medicare and Medicaid Services to the state of Indiana, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf.

[11] Leonardo Cuello, "Retroactive Coverage Waivers: Coverage Lost and Nothing Learned" Georgetown University Center for Children and Families, October 4, 2021, https://ccf.georgetown.edu/2021/10/04/retroactive-coverage-waivers-coverage-lost-and-nothing-learned/.

[12] HHS Assistant Secretary for Planning and Evaluation (ASPE), "Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches," August 19, 2022, https://aspe.hhs.gov/sites/default/files/documents/60f0ac74ee06eb578d30b0f39ac94323/aspe-end-mcaid-continuous-coverage.pdf.

Without retroactive coverage, the state puts beneficiaries at an unnecessary risk for costly periods of uninsurance. *We urge you to deny the state's request.*

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).