

July 27, 2023

VIA ELECTRONIC SUBMISSION

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

Re: Illinois Healthcare Transformation Section 1115 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 the proposed extension of Illinois' Behavioral Health Transformation Section 1115 demonstration, renamed the Healthcare Transformation Section 1115 Demonstration (Project No. 11-W-00316-5). The state is requesting a five-year extension of its demonstration, which would continue most of the state's currently approved authorities and add important new initiatives to address health related social needs (HRSN). Our comments are limited to the aspects of the state's proposal detailed below; we recommend that CMS approve the extension subject to the comments here.

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 commend the state for learning from its experience during the prior demonstration period and making changes to prioritize the delivery of services to address HRSN. The state's proposals will support the objectives of the Medicaid program by improving coverage for enrollees and we also support the state's important goal of advancing equity. We believe the demonstration is an appropriate use of section 1115 authority as it will provide an opportunity for CMS and the state to evaluate the efficacy of different types of interventions. As with all Section 1115 demonstrations, robust monitoring and evaluation will be essential.

We also appreciate that Illinois is transitioning some elements of its waiver to state plan authority, including section 1915(i) authority. While section 1115 demonstrations serve an important purpose, we commend the state for testing strategies during the current demonstration period and transitioning successful interventions into more permanent authorities under the state plan. We also commend Illinois for learning from its early implementation challenges and taking steps to ensure that data related to HRSN benefits be captured, tracked, and available for reporting.

Accurate, reliable reporting is essential not just for budget neutrality purposes but also to ensure that enrollees are receiving services as part of care coordination and to facilitate overall demonstration monitoring and evaluation.

We provide the following additional comments on several specific proposals:

Proposed services to address unmet HRSN should be approved consistent with CMS's recent guidance.

Unmet social needs are common among Medicaid enrollees, especially people of color. Over half of Medicaid enrollees had unaffordable or inadequate housing prior to the pandemic.¹ And roughly one-fifth of enrollees reported food insufficiency in a given week in 2020, most of whom still struggled with it four months later.² Addressing a person's HRSN is likely to improve their health. The state intends to "direct community-based investments to provide or facilitate the provision of HRSN services in geographic areas with the highest rates of social vulnerability and a presence of significant economic, environmental, and socio-cultural healthcare access barriers to achieving and maintaining good health." We support this goal and the state's approach of developing targeted pilots to test the delivery of these services, including housing supports, medical respite, food and nutrition services, and other services. The state's application clearly specifies eligible populations, eligibility needs criteria, and benefits that will be provided through the new and updated pilots.

Over the last several years, CMS has shared extensive guidance with states regarding the delivery and financing of services to address HRSN, and we support approval of Illinois' proposals to adopt new services consistent with CMS guidance.³ For example, Illinois' application acknowledges the state's intent to limit HRSN spending to a specified percentage of total waiver spending and to increase selected provider payment rates as part of the approval of HRSN related authorities.

We recommend that CMS work with the state to assure that the demonstration support the use of community-based providers to deliver services. While managed care organizations (MCOs) will be responsible for connecting enrollees to services, the demonstration provides an important opportunity to bolster the capacity of community-based providers to deliver HRSN services. Many MCOs have limited experience partnering with small, community-based providers and lack a network or experience contracting with these providers, such as developing appropriate rates for non-clinical services. Similarly, small community-based providers often lack the capacity or infrastructure to partner with large health plans, such as the ability to effectively negotiate rates or

¹ Bradley Corallo, "Housing Affordability, Adequacy, and Access to the Internet in Homes of Medicaid Enrollees," KFF, September, 22, 2021, <https://www.kff.org/medicaid/issue-brief/housing-affordability-adequacy-and-access-to-the-internet-in-homes-of-medicaid-enrollees/>.

² Cornelia Hall *et al.*, "Food Insecurity and Health: Addressing Food Needs for Medicaid Enrollees as Part of COVID-19 Response Efforts," KFF, August 14, 2020, <https://www.kff.org/medicaid/issue-brief/food-insecurity-and-health-addressing-food-needs-for-medicaid-enrollees-as-part-of-covid-19-response-efforts/#:~:text=Recent%20data%20indicates%20that%20access,week%20ending%20July%2021%2C%202020.>

³ CMS, SHO# 21-001 RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH), Centers for Medicare and Medicaid Services, January 7, 2021, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>; CMS, All-State Medicaid and CHIP Call, December 6, 2022, <https://www.medicaid.gov/resources-for-states/downloads/covid19allstatecall12062022.pdf>.

the systems required to collect and report data. CMS should work with the state to ensure that Illinois has plans in place to develop networks to deliver services that address HRSN effectively.

We also recommend that CMS continue to build policy to protect Medicaid access and program integrity within HRSN expansions. First, CMS should explicitly require the state and its contractors to comply with due process requirements for HRSN services as they would apply for other managed care and state plan services. Second, while we appreciate the state's clarity with respect to eligibility criteria and available services in the application, we recommend that CMS develop explicit requirements for outreach and policies to ensure that prescribers and patients have a way to know these services are available and how they can be accessed. Third, CMS should develop and/or explicitly identify mechanisms to ensure that capitation payments and rates dedicated to HRSN expansions are actually distributed by managed care plans in the form of service payments, and that HRSN providers in turn are using payments to deliver services (or that capitation payments be adjusted to account for low utilization). This is particularly important in early years when it will be difficult to predict the utilization and cost of the HRSN services.

Finally, we note that commenters at the state level expressed concern that HRSN services will only be available to individuals who receive Medicaid through MCOs.⁴ We agree that all Medicaid enrollees – including those with I/DD who may not be enrolled in MCOs – could benefit from HRSN services. We appreciate the state's response to public comments indicating that “HFS will consider this as part of our implementation planning with stakeholders.”⁵ Indeed, some of the proposed HRSN could be covered under a 1915(i) state plan amendment that could be inclusive of more Medicaid enrollees who need these services, including the bulk of pre-tenancy and tenancy sustaining support services.

The Housing Supports Services Pilot can help address housing insecurity in Illinois.

We strongly support Illinois' request to continue addressing housing insecurity by providing housing support services. There is growing evidence that for people with complex health needs, housing support services such as help locating and applying 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.

We agree that if implemented well, extending the amended pilot could “not only create opportunities for stable housing, but also will improve health outcomes among Medicaid enrolled individuals and their families, reducing the burden of chronic health conditions, as well as reducing costs related to emergency departments (ED)/, hospital, and institutional care.”⁶ We support the inclusion of pre-tenancy supports and tenancy sustaining supports that help people find and maintain housing, thereby providing them with the stability they need to care for their health and engage in treatment services after exiting homelessness or institutional care. Coverage of these

⁴ Letter from Laura J. Miller, Senior Counsel, Equip for Equality, to Kelly Cunningham, Medicaid Administrator, Division of Medical Programs, Illinois Department of Healthcare and Family Services, June 12, 2023, https://1115publiccomments.medicaid.gov/jfe/file/F_39o13519hm6mKl3.

⁵ Illinois Behavioral Health Transformation 1115 Demonstration, Application for Extension, June 23, 2023, at page 60, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/il-behave-health-transform-pa-06232023.pdf>.

⁶ *Ibid*, page 34.

services is consistent with CMS' State Health Official letter, Opportunities in Medicaid and CHIP to Address Social Determinants of Health.⁷

The state generally outlines an appropriate list of pre-tenancy and tenancy sustaining supports. However, to avoid confusion, we recommend that the state clarify that covering rent or temporary housing of up to six months is a distinct service from pre-tenancy supports, consistent with CMS guidance. States have long been able to cover pre-tenancy and tenancy sustaining services under state plan authorities because it does not constitute room and board. In contrast, rent and transitional housing up to 6 months is only available via 1115 demonstrations. While the state may choose to limit eligibility for rent/temporary housing to those receiving pre-tenancy or tenancy sustaining services, it is important to identify it as a separate service and avoid conflating these distinct services to maintain clarity about which services states may and may not cover using various authorities. Finally, the state requests broad expenditure authority for "housing support" but fails to request waiver authority for rent, which would be necessary.⁸

The state's proposal sets out reasonable eligibility criteria. It will be important that the state take measures to ensure consistent, reliable access to services for all eligible enrollees across the state, including by establishing a strong provider network, developing robust provider networks that include existing tenancy support services providers, and 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. Such details will be important for the state to consider and include in the implementation plan. Some promising strategies include Washington's state's approach of selecting a single third-party administrator to operate housing-related services statewide, and New Jersey's approach of developing a new housing unit within the Medicaid agency.

Targeted pre-release services during the last 90 days of incarceration would reduce gaps in coverage and care, supporting successful transitions back to the community.

We support Illinois' desire to provide outreach and pre-release supports for individuals who are incarcerated and support approval of Illinois' request, consistent with the standards that CMS set forth in its recent letter to State Medicaid Directors, which outlined standards for approval of pre-release services.⁹

As the state's proposal explains, people in jail and prison have high rates of untreated, chronic conditions as well as a high incidence of substance use disorder and mental illness. However, they often return home without adequate access to medications or care coordination. Once home, health

⁷ State Health Official letter, "Opportunities in Medicaid and CHIP to Address Social Determinants of Health," Centers for Medicare & Medicaid Services, January 7, 2021, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>.

⁸ We note that in its response to public comments, the state includes the following response: "Some comments suggested broadening the housing benefit to permit "room and board" services that are similar to those CMS has articulated in other state 1115 HRSN approvals as being excluded 1115 HRSN demonstration services. HFS did not accept these suggestions accordingly." (page 59 of the June 23, 2023 application) We are uncertain about the distinction that the state is making in this comment but reiterate our comment that a "room and board" waiver would be needed if the state intends to provide up to 6 months of rent as part of its housing services pilot.

⁹ State Medicaid Directors Letter, "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated, SMD 23-003, CMS, April 17, 2023, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf>.

care may fall 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, 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.¹⁰

Illinois' request appears to be consistent with CMS guidance, focusing on a targeted set of services for people preparing to leave prison or jail. Recognizing that transitions take time, we support the state's request to provide services in the 90-days prior to release. We also strongly support the state's commitment that covered reentry services include "any HRSN that may create barriers to receiving necessary healthcare services" as addressing housing, employment, and other social needs is critical to successful reintegration into the community.

As with other recent demonstration approvals, we urge CMS to 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 recommend that CMS require all providers under the demonstration to be enrolled as Medicaid providers. 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 90 days of incarceration for a defined high-needs population is appropriate. We also anticipate that CMS will require a Reentry Initiative Reinvestment Plan to ensure that Medicaid funding doesn't simply replace other current funding sources; we support this important new requirement. Finally, we recommend that CMS ensure that the state's correctional system have the caseworker capacity and training necessary to ensure access to Medicaid (both enrollment and services).

Community Reinvestment Pool

We support the state's proposed Community Reinvestment Pool, which would be spent on implementing HRSN initiatives in communities that have historically been underserved. However, the reallocation of DSH funding requires comprehensive monitoring and evaluation. The proposed Community Investment Pool, if properly implemented and managed, has the potential to fund important investments to improve health much more than DSH payments based on uncompensated care.

As a starting point, CMS should require that the state seek input from its Medicaid Advisory Committee (MAC) as it develops strategies and interventions that will be supported by the Community Reinvestment Pool, and that the MAC be consulted prior to deployment of any such

¹⁰ 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-replace-it-with-by-vincent-schiraldi-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](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>.

strategies. CMS should also require careful and public reporting about how the money is spent, collection of data and metrics on services provided and outcomes, and evaluations of the impact of the funding pool. Finally, CMS should require the state to evaluate the impact of re-allocating funding on access to care (when uncompensated care funding is reduced) and the state's safety-net infrastructure.

CMS should carefully evaluate the Continuum of Care Facility Licensure proposal.

Illinois is requesting a waiver to implement Continuum of Care Facility Licensure to enable a new license for organizations that provide services to people with I/DD. We have concerns that this proposal does not support the objectives of Medicaid because it would create a more institutional environment, moving in the opposite direction of recent steps to support home and community-based services (HCBS), including CMS rules on HCBS settings. The “continuum of care” concept in the proposal is rooted in two improper assumptions. First, it implies that individuals generally will need a campus-like setting and/or “progress” to an institutional setting. Second, it implies that individuals with the highest needs can only be served in an institutional setting. The reality is that the entire continuum of care can be provided in home settings, and it is the lack of home supports that makes transitions necessary across the continuum. In evaluating this proposal, we urge CMS to carefully weigh feedback from enrollees with disabilities and organizations that support them¹¹ and to consider the impact on HCBS infrastructure development if the pilot is approved. We are concerned that approving the proposed continuum model could decrease incentives to build robust HCBS supports, which are essential to enabling people to receive the care they need in their homes and communities.

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 Allison Orris (aorris@cbpp.org) or Joan Alker (jca25@georgetown.edu).

¹¹ See, e.g. Letter from Laura J. Miller, Equip for Equality, *op cit*.