Center on Budget and Policy Priorities

Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

December 20, 2023

VIA ELECTRONIC SUBMISSION

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

Re: North Carolina Medicaid Reform Demonstration Renewal

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 North Carolina's Medicaid Reform Section 1115 Demonstration renewal request.

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.

North Carolina's Medicaid Reform Section 1115 Demonstration included key delivery system innovations as well as novel approaches to address unmet social needs among the Medicaid population. *We support extending the demonstration with the changes requested by the state, subject to recommendations detailed below*, which will improve access to high quality care for Medicaid enrollees in North Carolina. The proposed extension also takes important steps to continue advancing health equity by addressing unmet social needs across the population and by testing strategies to help improve health outcomes for individuals leaving prisons and select county and tribal-operated jails and youth correctional facilities.

Multi-year continuous enrollment would reduce gaps in coverage and improve continuity of care for North Carolina children.

North Carolina has requested authority to implement two multi-year continuous enrollment policies for children. First, the state is requesting authority to continuously enroll children from birth until they turn six years old. Second, the state proposes to provide two years of continuous eligibility for children from age six through eighteen. The continuous enrollment policies would improve continuity and access to care, increase family and financial stability, and strengthen program efficiency. *We strongly recommend that the Centers for Medicare and Medicaid Services (CMS) approve both of*

these policies – they promote coverage, consistent with the objectives of Medicaid as required for section 1115 demonstrations, as noted by CMS in its approval of a similar policy in Oregon.[1]

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 the continuous eligibility period for children has the potential to reduce disparities in coverage.[2] Individuals with Medicaid are at risk of moving off and on coverage due to temporary income changes that affect eligibility, a phenomenon known as "churn." Recent research shows that children are among the eligibility groups most likely to experience churn. In addition, Asian, Black, and Hispanic children are more likely to be uninsured for part or all of the year than non-Hispanic white children.[3] Non-white children in North Carolina experience higher rates of churn, with Latinx children almost twice as likely to churn as white children.[4]

Continuous eligibility can help mitigate the harmful 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.[5] North Carolina data shows that more than 1 in 4 children who lose Medicaid coverage reenroll within one year.[6]

From the last quarter of 2020 through the first quarter of 2022, the national child uninsured rate decreased 2.7 percentage points, from 6.4 percent to 3.7 percent.[7] During the entirety of that period, The Families First Coronavirus Response Act (FFCRA) continuous coverage requirement was in place, which kept children with Medicaid continuously enrolled in coverage. While the decrease in uninsurance may result from multiple factors, the FFCRA protection likely played a major role. A report from the Department of Health and Human Services' (HHS) Assistant Secretary for Planning and Evaluation (ASPE) estimates that 5.3 million children will lose coverage once the FFCRA protection ends; of these, 72 percent of children will still be eligible for Medicaid but will lose

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[1] Oregon Health Plan Approval Letter, September 28, 2002, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-health-plan-09282022-ca.pdf.

[2] 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/.

[3] 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/.

[4] Duke Margolis Center for Health Policy, "Churn Patterns Among Youth Medicaid Beneficiaries in North Carolina: 2016-2018," 2021., https://healthpolicy.duke.edu/publications/fact-sheet-churn-patterns-among-youth-medicaid-beneficiaries-north-carolina-2016-2018.

[5] 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.

[6] Duke University. Churn Patterns Among Youth Medicaid Beneficiaries in North Carolina: 2016-2018. 2021., https://healthpolicy.duke.edu/publications/fact-sheet-churn-patterns-among-youth-medicaid-beneficiaries-north-carolina-2016-2018.

[7] 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.

coverage due to administrative churn.[8] So far, the unwinding data suggests results may exceed ASPE's prediction: about half-way through the unwinding *net* enrollment for children has already declined by more than 3 million.[9]

Continuous access to care is vital for the healthy development of young children, whose brains are developing most rapidly in the months and years following a birth. Children with preventable, unaddressed conditions such as asthma, vision, hearing impairment, nutritional deficiencies, and mental health challenges may miss important developmental milestones critical to kindergarten readiness and long-term success.[10] To track developmental milestones, the American Academy of Pediatrics recommends that young children receive at least 15 well-child visits in their first six years of life.[11] 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.[12]

Finally, continuous eligibility has the potential to free up administrative resources, improve program efficiency, and reduce burdens on families. When beneficiaries churn off and on coverage, states have to determine 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.[13] 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-month costs.[14] And, after implementing one-year of continuous eligibility for adults, Montana officials reported potential administrative spending savings and fewer staff hours needed to process individuals moving off and on the program.[15] 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

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[8] HHS 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.

[9] Georgetown University Center for Children and Families, "How Many Children are Losing Medicaid?", December 2023, https://ccf.georgetown.edu/2023/09/27/how-many-children-are-losing-medicaid.

[10] 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.

[11] American Academy of Pediatrics, "Recommendations for Preventive Pediatric Health Care," April 2023, https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

[12] 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/.

[13] 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.

[14] 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

[15] 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.

for the state and families of young children while decreasing administrative workloads and providing peace of mind for new parents.

As North Carolina formalizes its evaluation design, the state should disaggregate all metrics for continuous enrollment for children by race and ethnicity (as per the state commitment to report stratified data in evaluation design changes submitted September 29, 2022). These data will be important in identifying the proposal's role in closing coverage disparities due to churn. The evaluation should also measure service use and cost of care before and after implementation, with a particular focus on Early Periodic Screening Diagnostic and Treatment (EPSDT) services, Medicaid's required benefit for children. The proposal would test an innovative idea to improve the lives of children, providing valuable new information on policy changes that could reduce disparities in access to care. While the full financial benefits of the policy may be realized over a longer timeframe compared to many section 1115 waivers, this investment in children should not be discouraged, especially given the well-documented, long-term benefits of providing Medicaid to children.[16]

The eligibility expansion and continuous enrollment for former foster youth will reduce gaps in coverage and improve continuity of care.

Though the application is unclear, North Carolina's demonstration extension appears to request authority to implement two policies supporting coverage for former foster care youth (FFCY). First, the state proposes to cover FFCY in North Carolina who aged out of foster care in another state prior to January 1, 2023 (to bring their coverage into alignment with other FFCY who are already covered). Second, the state proposes to implement continuous enrollment for FFCY. These requests will improve eligibility and continuity of coverage and care for FFCY as well as strengthen program efficiency. *We strongly recommend that CMS approve both of these policies.*

Pursuant to the SUPPORT Act of 2018, states must cover FFCY who aged out of foster care in another state until the age of 26, but only if the FFCY aged out on or after January 1, 2023. This means there is no coverage category for FFCY who aged out of coverage in another state prior to January 1, 2023. A number of states have received 1115 authority to cover this group of FFCY as suggested by CMS in guidance.[17] North Carolina's extension would add this coverage group as has been done in the other states, creating uniform coverage for FFCY in the state until age 26 regardless of when and where the individual aged out of foster care.

North Carolina also requests authority to provide continuous enrollment for FFCY. This would ensure that FFCY have stable coverage until they are 26 years old. We believe this is the first request of its kind in the nation.

We recommend that CMS approve these requests for all of the reasons described above regarding continuous eligibility for children – improved continuity of coverage and care, reduced health disparities, and reduced administrative barriers. Continuity of coverage and care are particularly important for FFCY, who have higher prevalence of health conditions and other

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[16] 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.
[17] CMS Dear State Health Official letter #22-003, Coverage of Youth Formerly in Foster Care in Medicaid, December 16, 2022, https://www.medicaid.gov/federal-policy-guidance/downloads/sho22003.pdf.

challenges, such as housing instability, compared to other young adults.[18] FFCY are also disproportionately people of color, and thus the policy will also benefit health disparities.[19]

We urge CMS to clarify the approved section 1115 authorities for FFCY in the demonstration extension approval. Specifically, the list of waiver and expenditure authorities should include approvals of authority for both (1) the addition of a coverage category for FFCY who aged out in another state prior to January 1, 2023, and (2) the provision of continuous enrollment to all FFCY. While the state application's table of requested authorities includes a broad request for continuous enrollment that could be inclusive of FFCY, there is no authority requested to create categorical eligibility for FFCY who aged out in another state prior to January 1, 2023. Finally, we urge CMS to also clarify that this authority includes permission to enroll these same FFCY without screening for other categories of eligibility, as authorized by the SUPPORT Act for children who aged out in another state after January 1, 2023.

CMS should require more standards and oversight for managed care plan implementation.

North Carolina's demonstration would continue implementation of the state's Medicaid managed care redesign. The state's plan includes three types of plans, "Standard" plans that were implemented in 2021, and "Tailored" and "Specialty" plans that are not yet implemented due to problems that have delayed implementation. In particular, network adequacy has been a major concern for the Tailored and Specialty plans, both of which would cover populations with heightened needs. Tailored plans would cover individuals with serious mental illness (SMI), serious emotional disturbance (SED), severe substance use disorder (SUD), intellectual/developmental disabilities (I/DD), and/or traumatic brain injuries (TBI). Specialty plans would cover groups involved with the foster care system. Both of these plan types would offer additional, specialized services targeted to the needs of the population. However, if the networks are inadequate, individuals might, for example, be forced between choosing to remain in a Standard plan without the additional targeted services *or* transition to a Tailored plan where they could get the targeted services but lose their longstanding care providers.

CMS should ensure that any approval for on-going implementation of Tailored and Specialty plans includes assurances from the state that networks will be adequate prior to implementation and that protections will be put in place to preserve the longstanding provider relationships of individuals with special health care needs. The state should ensure the networks include the range of specialized providers needed to care for the population and are inclusive of local community-based providers with expertise in treating individuals with special health care needs. In addition, the state should create out-of-network exceptions processes that preserve existing provider relationships. CMS should also specifically require the state to submit an equivalent report for Specialty plans as was required for Tailored plans, "detailing the total percentage of members who experienced a disruption in primary care across all primary care providers."[20]

Finally, we recommend that CMS review and carefully scrutinize the requested managed care authorities (including those currently approved) for compliance with statutory requirements and

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[18] Youth.Gov, "Young Adults Formerly in Foster Care: Challenges and Solutions," https://youth.gov/youth-briefs/foster-care-youth-brief/challenges.
[19] HHS Children's Bureau, Foster Care Statistics 2019, https://www.childwelfare.gov/pubpdfs/foster.pdf.
[20] CMS Approval of Medicaid Reform Demonstration amendment, July 7, 2023, page 2, https://www.medicaid.gov/sites/default/files/2023-07/nc-medicaid-reform-demo-ca.pdf.

limitations for managed care. In particular, we note that section 1115 waiver authority was not intended to circumvent standards in sections 1903 and 1932. CMS should review, first, whether the demonstration improperly restricts choice of plan in regions of the state where there is only one plan option, and second, whether the mandatory enrollment policies are permissible. Under the design of section 1932, some special needs children and Medicare/Medicaid dual eligibles may not be mandatorily enrolled and all individuals have enumerated enrollment protections. In the context of a managed care transition plagued by network adequacy concerns, CMS should review whether granting expenditure authority to circumvent these standards is legal and sound health policy.

Building on the Healthy Opportunities Pilot (HOP) infrastructure and experience will expand health-related social needs services.

North Carolina has been a leader in advancing efforts to use Medicaid to address health-related social needs (HRSN). *We support the expansion of North Carolina's Healthy Opportunities Pilot (HOP) to provide important services statewide and reach more people through expanded eligibility criteria*, consistent with CMS's recent policy guidance on HRSN. Throughout the previous demonstration period, North Carolina forged important relationships across health and human services agencies, managed care entities, and community-based Human Service Organizations (HSOs) to help address non-medical drivers of health. We agree with the state's approach to scale pilot services to new regions of the state based on service effectiveness, regional readiness to participate, and community-based HSO capacity. Ensuring that the renewed demonstration continues to require and strengthen coordination with community-based providers is key.

North Carolina also is requesting to expand upon the 29 pilot services offered during the previous demonstration period by adding a "firearm safety" service that provides, at a minimum, locks and/or safes to support firearm safety and a new targeted "childcare support" service to provide affordable childcare and related services to qualifying, high-needs children and families. These proposals address important non-medical needs of the Medicaid population and, as novel HRSN interventions, are an appropriate use of Section 1115 demonstration authority to test and evaluate these approaches.

North Carolina also is requesting authority to include up to three meals per day (including Healthy Food Boxes, Healthy Meals and Medically Tailored Meals) and to adapt an existing HOP housing service to provide up to six months of rental or mortgage assistance (including payment of arrears) for high-needs enrollees. We support these requests in principle, but note that the application does not include much detail about how the services will be delivered and how eligibility criteria will be established. We urge CMS to work with North Carolina to delineate additional details. CMS has recently approved nutrition and housing services in other states and we urge CMS to apply its new conditions and guardrails to North Carolina as well.[21]

[21] For example, CMS has limited such temporary housing assistance to people facing certain transition points, such as people leaving institutional care, exiting homelessness, or transitioning out of the child welfare system. Centers for Medicare & Medicaid Services (CMS), All-State Medicaid and CHIP Call, "Addressing Health-Related Social Needs in Section 1115 Demonstrations," December 6, 2022, https://www.medicaid.gov/sites/default/files/2023-01/addrss-hlth-soc-needs-1115-demo-all-st-call-12062022.pdf; CMS, CMCS Informational Bulletin, "Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and the Children's Health Insurance Program," November 16, 2023, https://www.medicaid.gov/sites/default/files/2023-11/cib11162023.pdf; CMS, "Coverage of Health-Related

For example, CMS should also require the state to elaborate on how it will ensure the six months of housing assistance (herein called "temporary housing assistance") is designed and implemented as a steppingstone toward long-term housing stability. The state already has some experience with using the Lead Pilot Entity/ Network Lead structure to contract and deliver other housing-related services under the pilot, such as housing navigation, support, and sustaining services. However, delivering temporary housing assistance likely requires additional or qualitatively different partnerships with community-based housing and homelessness services providers. Whereas many other services to address HRSNs operate similarly to case management services or other Medicaid-covered services or are one-time in nature (such as security deposits or home modifications), temporary housing assistance is singular and requires thoughtful design and additional infrastructure to support repeated financial transactions with landlords or mortgage lenders. Like all states, North Carolina is facing a longstanding affordable housing crisis, forcing 668,100 people in 320,100 low-income North Carolina households pay more than half their income for rent, often forgoing necessities, like food or medicine, to keep a roof over their heads.[22] Temporary housing assistance will require strong collaborations across state and local housing agencies to coordinate housing and other resources administered by state and local entities and ensure that enrollees who receive transitional housing assistance maintain housing stability beyond the six-month time limit.

Close coordination is also needed to ensure temporary housing assistance is aligned with housing navigation, support and sustaining services and other housing-related services provided in the state's Healthy Opportunity Pilot. Many Medicaid enrollees in greatest need of temporary housing assistance will also need these services to help them navigate the housing market, apply for housing units, secure long-term rental subsidies, and avoid eviction and maintain stable housing. Thus, the temporary housing assistance will be most effective when offered as part of a package of housing-related services. We also encourage CMS to work with North Carolina and other states to prepare to transition key housing navigation and housing support and sustaining services (often called tenancy support services) from demonstration projects to state plan coverage, such as through 1915(i) state plan amendments. While temporary housing assistance is an appropriate service to test through a 1115 demonstration, and in fact, cannot be covered through any other Medicaid authority, state plan coverage of tenancy support services could strengthen the state's demonstration of transitional rent and other experimental housing-related services. State plan coverage (through rehabilitation services, case management, or 1915(i) options) would give service providers more certainty and predictability so they can more confidently engage in Medicaid and invest in needed partnerships and infrastructure to and expand and sustain access of tenancy supports to eligible enrollees.

As part of its approval, CMS should ensure that these and other HRSN interventions fit within the overall 3 percent of total Medicaid spending standard established by the agency, that infrastructure costs do not exceed 15 percent 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 North Carolina, 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

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Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP)," November 2023, https://www.medicaid.gov/sites/default/files/2023-11/hrsn-coverage-table.pdf.

[22] Center on Budget and Policy Priorities, "North Carolina Federal Rental Assistance Fact Sheet," January 19, 2022, https://www.cbpp.org/sites/default/files/atoms/files/12-10-19hous-factsheet-nc.pdf.

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.

Providing targeted pre-release Medicaid services for justice-involved individuals will improve health outcomes and support reentry into the community.

North Carolina is requesting authority for federal Medicaid matching funds to provide a set of targeted Medicaid services to eligible justice-involved populations within the 90-day period prior to release, and to provide $315 million total computable in capacity building funding to support service delivery. These services will be available to individuals incarcerated in the State's prisons as well as to individuals incarcerated in select county- and tribal-operated jails and youth correctional facilities.

As the state's proposal explains, people in jail and prison have high rates of behavioral health conditions, as well as chronic physical conditions.[23] 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.[24] We support North Carolina's proposal to cover targeted pre-release services for justice-involved individuals and agree that the proposal is an important step to address the health impacts of the stark racial disparities in the state's justice-involved population.

North Carolina appears to have designed its request to be consistent with CMS' recent guidance on reentry waivers and we urge CMS to approve the state's request. We support continued evaluation of whether providing case management, medication-assisted treatment (MAT), and a 30-day supply of prescription medication to individuals in the 90-days prior to their release from prison helps improve health outcomes and ease community transitions. Understanding that pre-release services are difficult to launch and that it will take time to develop both the infrastructure and community-based provider network necessary to make the demonstration success, we support the state's plan to phase in additional pre-release services, including physical and behavioral health clinical consultations, laboratory and radiology services, medications and medication administration, tobacco cessation, and durable medical equipment (DME) upon release. *As with the state's HRSN*

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[23] 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.

[24] 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.

requests, we urge CMS to approve North Carolina's request consistent with its guidance and to work with the state to assure that implementation plans are sufficiently detailed and robust to provide a clear roadmap to implementation of this important intervention.

As it has done in other recent approvals, 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; 2) prioritize the use of community-based providers to deliver the services; and 3) develop a Reentry Initiative Reinvestment Plan to ensure that Medicaid funding doesn't simply replace other current funding sources.

Expanding access to critical supports offered under the 1915(i) authority will help address important needs for home and community-based services.

We also support the state's request to ensure that key populations can continue to receive important home and community-based services (HCBS) that are not permitted under Section 1915(i). We agree that there is value in allowing Medicaid enrollees with income over 150 percent of the federal poverty level (FPL) to continue to be eligible for 1915(i) services and in paying for one-time transitional costs for individuals to move from an institution for mental diseases (IMD) into their own private residence in the community or to divert an enrollee from entering an adult care home. CMS's recently released framework for coverage of HRSN services[25] indicates that Section 1915(i) can cover one-time transition costs only under a community transition services that aligns with criteria for such services established in State Medicaid Director Letter #02-008.[26] *We encourage CMS to work with North Carolina to confirm whether the state's policy goals could be achieved via Section 1915(i); otherwise, we support using the demonstration renewal to authorize these important services.*

CMS should fund improvements for behavioral health, I/DD, and TBI services.

We recommend that CMS approve two other components of the North Carolina extension request: (1) health information technology support for behavioral health, I/DD, and TBI providers, including schools, to improve access to behavioral health and care integration; and (2) health information technology support for behavioral health, I/DD, and TBI providers serving a high volume of Medicaid patients.

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 the 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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[25] CMS, "Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP)," November 2023, https://www.medicaid.gov/sites/default/files/2023-11/hrsn-coverage-table.pdf.
[26] CMS, SMDL #02-008, May 9, 2002, https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/smd050902a.pdf.