March 1, 2024

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

Re: Hawai'i "QUEST Integration" 1115 Demonstration Extension and Amendment

Dear Secretary Becerra,

The Center on Budget and Policy Priorities and Georgetown University Center for Children and Families appreciate the opportunity to comment on Hawai'i's application to extend and amend its "QUEST Integration" section 1115 demonstration.

The Center on Budget and Policy Priorities (CBPP) is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, CBPP conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes. 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.

The state is requesting a five-year extension of its demonstration, which would continue, and in several cases modify, the state's currently approved authorities. The proposal would also build on the existing demonstration to implement several new authorities that would improve health outcomes and support families and communities with complex health needs. We strongly support Hawai'i's request to extend continuous eligibility policies by providing multiple years of continuous eligibility for children up to age six and two-year continuous eligibility for children ages six to nineteen. We also support the state's request to align coverage for out-of-state former foster care youth and other proposals that will promote health equity, including providing targeted services to individuals in carceral settings up to 90 days prior to reentry in the community and expanding the health-related social needs services offered to individuals with high needs. The state indicates it may seek to increase its child income eligibility threshold to 400 percent of the federal poverty level through a state plan amendment; though this is not part of the state's 1115 proposal, we strongly support this policy which could further improve children's health coverage.

We believe Hawai'i's request would improve access to care for Medicaid enrollees and promote the objectives of the program. We urge you to approve the state's extension with the changes requested by the state, subject to the recommendations detailed below.

Multi-year continuous enrollment would reduce gaps in coverage and improve continuity of care for children in Hawai'i.

Hawai'i 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 to nineteen. These policies promote coverage, consistent with the objectives of Medicaid as required for section 1115 demonstrations, as CMS noted in its approval of a similar policy in Oregon.[1] *We strongly support the state's request and urge CMS to approve the proposal.*

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 ages 20 and under are among the eligibility groups most likely to experience churn.[3] Among children under 19, children of color are more likely to be uninsured for part or all of the year than non-Hispanic white children.[4] The state's proposal would have an outsized benefit on children of color, who represent over 90 percent of the children enrolled in Medicaid and CHIP in Hawai'i,[5] which would promote health equity.

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.[6] Despite Hawai'i's relatively low child uninsured rate (2.8 in 2019), 25 percent of children who were disenrolled from Medicaid or CHIP in the state prior to the COVID-19 pandemic reenrolled within three months.[7]

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.[8] During the entirety of that period,

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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/.
[4] 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/.
[5] SHADAC, "State Health Compare," Accessed February 21, 2024, https://statehealthcompare.shadac.org/table/29/health-insurance-coverage-type-by-race-ethnicity?clean=False#13/8/37/57,58.
[6] 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.
[7] Georgetown University Center for Children and Families, "Children's Health Care Report Card: Hawaii," https://kidshealthcarereport.ccf.georgetown.edu/states/hawaii; Hawai'i Department of Human Services MedQuest Division, "QUEST Integration Section 1115 Demonstration," https://www.medicaid.gov/sites/default/files/2024-02/hi-quest-pa-01172024.pdf#page=37.
[8] 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.

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. The number of children enrolled in Medicaid and CHIP in Hawai'i grew by almost twenty percent (or over 25,000 children) during the time the continuous enrollment condition was in place.[9] Though data shows only a small number of children have lost coverage as of October 2023,[10] the state recently resumed terminating coverage for procedural reasons, so the coverage gains made as a result of the continuous enrollment condition may now be at risk.[11] The proposed continuous eligibility policies would help the state retain some of benefit realized through the FFCRA protection on a longer-term scale.

Additionally, continuous eligibility has the potential to free up administrative resources, improve operational 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 administrative cost of disenrolling and then reenrolling in Medicaid was between $400 to $600 per person.[12] In New York, implementing a one-year continuous eligibility period for adult enrollees led to declines in inpatient hospital admissions and overall per-member-per-month costs.[13] And, after implementing one-year of continuous eligibility for adults, Montana officials reported potential administrative savings and fewer staff hours needed to process individuals moving off and on the program.[14]

The burden is even greater on families who may experience higher out-of-pocket costs or medical debt during gaps in coverage. Focus groups conducted across three states of individuals who lost Medicaid coverage as part of the unwinding highlighted that many who had been disenrolled could not get needed medication or care because it was too expensive.[15] Several moms interviewed also described having to delay medical appointments or important therapies for their children because of the disruptions to coverage. Continuous coverage policies would mitigate these costs for the state and families while decreasing administrative workload and providing parents peace of mind.

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[9] Centers for Medicare and Medicaid Services (CMS), "State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data," January 31, 2024, https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360/data

[10] Georgetown University Center for Children and Families, "What is the impact of unwinding on Medicaid enrollment?" Accessed February 21, 2024, https://ccf.georgetown.edu/unwinding-enrollment-data/.

[11] State of Hawai'i Department of Human Services, "Stay Well Stay Covered Toolkit," Accessed February 21, 2024, https://medquest.hawaii.gov/en/members-applicants/already-covered/Stay_Well_Stay_Covered_Toolkit.html.

[12] 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.

[13] 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

[14] 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.

[15] Amaya Diana, *et. al.,* "Navigating the Unwinding of Medicaid Continuous Enrollment: A Look at Enrollee Experiences," Kaiser Family Foundation, November 9, 2023, https://www.kff.org/medicaid/report/navigating-the-unwinding-of-medicaid-continuous-enrollment-a-look-at-enrollee-experiences/.

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 birth. Children with preventable, unaddressed conditions such as asthma, vision or hearing impairment, nutritional deficiencies, and/or mental health challenges may miss important developmental milestones critical to kindergarten readiness and long-term success.[16] Because early development is most rapid, the American Academy of Pediatrics recommends that young children receive at least 15 well-child visits in their first six years of life.[17] Ensuring that children through age six have stable coverage before kindergarten can improve access to the necessary screenings, preventative services, and needed treatment to address delays or prevent conditions, setting the stage for better outcomes in the short and long term.[18]

Approval of continuous coverage for young children also provides a more accurate picture of children's access to care, specifically required screenings, diagnostic and treatment services under Medicaid's required Early Periodic Screening Diagnostic and Treatment (EPSDT) benefit. As currently reported, children who experience more than 45 days without coverage during a reporting year are excluded from the calculated well-child visit measures under the annual Child Core Set analysis.[19] Continuous coverage through age six would allow for a more complete picture of the access and quality of care that children in Medicaid and CHIP receive before they enter school.

The state's proposed evaluation design includes disaggregating data on gaps in coverage among children by race and ethnicity. These data will be important in identifying the proposal's role in closing coverage disparities due to churn. As Hawai'i formalizes its evaluation design, *the state should include metrics to identify whether expanding continuous eligibility increased the use of recommended well-child visits and preventative care for children enrolled in Medicaid and CHIP, with a particular focus on EPSDT services*. These data will be important in identifying the role of multi-year continuous eligibility not only in improving coverage retention, but reducing disparities in access to care. In addition, the evaluation should also include cost of care before and after implementation.

Hawai'i began providing 12-month continuous eligibility in Medicaid or CHIP within the past year (the state plan amendment was effective as of July 1, 2023). With the ongoing unwinding process and fixing the problem of *ex parte* renewals being conducted at the household instead of individual level, the state is facing significant demands on its system. The proposed policies in this application necessitate additional system changes that the state is seeking to implement as soon as

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[16] 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.

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

[18] 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/; 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," The Commonwealth Fund, December 8, 2020, https://www.commonwealthfund.org/publications/issue-briefs/2020/dec/short-term-cuts-medicaid-long-term-harm.

[19] Centers for Medicare and Medicaid Services, "Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)," January 2024, https://www.medicaid.gov/sites/default/files/2024-01/medicaid-and-chip-child-core-set-manual.pdf.

possible. We urge CMS to work with the state to assess whether additional funding to support implementation of multi-year continuous eligibility is needed, and if so, to approve such funding.

Expanding eligibility for former foster care youth will reduce gaps in coverage and eliminate disparities in existing policy.

Hawai'i is seeking to provide Medicaid coverage to former foster care youth (FFCY) living in the state who aged out of foster care in another state prior to January 1, 2023. This would align coverage for these individuals with other FFCY who are already covered under the SUPPORT Act of 2018. The SUPPORT Act requires states to cover FFCY who aged out of foster care in another state *on or after* January 1, 2023 until age 26, leaving those who turned eighteen prior to this date without coverage. Almost a dozen states have received approval through section 1115 authority to cover the proposed group in their state, as suggested by CMS guidance.[20] We strongly recommend that CMS approve Hawai'i's proposal.

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

Hawai'i is requesting approval to provide targeted pre-release benefits to adults who would be eligible for Medicaid but for their incarceration in a state prison, county jail, or state-operated Youth Correctional Facilities. We support Hawai'i's desire to provide outreach and pre-release supports for individuals who are incarcerated and support approval of the state's request, consistent with CMS's recent letter to State Medicaid Directors, which outlined standards for approval of pre-release services.[21]

As the state's application explains, the "proposed eligibility group is comprised primarily of low-income adults who are disproportionately from racial or ethnic minority populations (particularly Native Hawaiians), have considerable health and health-related social needs, and often have no or limited access to care and needed medications upon release from the carceral system." 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 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. In addition, incarcerating children and young adults can cause serious

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[20] Tricia Brooks, "Implementing Changes to Medicaid Coverage for Former Foster Youth Could Be a Long, Bumpy Path but States Have Easier Option Available," Georgetown University Center for Children and Families, January 12, 2023, https://ccf.georgetown.edu/2023/01/12/implementing-changes-to-coverage-for-former-foster-youth-in-medicaid-could-be-a-long-bumpy-path-but-states-have-easier-option-available/; Center for Medicaid and CHIP Services State Health Officials letter #22-003, Coverage of Youth Formerly in Foster Care in Medicaid, December 16, 2022, https://www.medicaid.gov/sites/default/files/2022-12/sho22003_0.pdf.

[21] 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.

harm to youth who are separated from their family and community, including long-term adverse impacts on individuals' physical and mental health.[22]

Hawai'i's request appears to be consistent with CMS guidance, focusing on a targeted set of services for people preparing to leave carceral settings.[23] Recognizing that transitions take time, we support the state's request to provide services in the 90-days prior to release and we particularly support the state's intention to facilitate in-reach services by community-based providers, which can help promote continuity of care when people leave carceral settings.

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. 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 case 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, given the challenges of launching these new services, we appreciate that Hawai'i may phase implementation – beginning with a pilot program on its three biggest islands. We recommend that CMS work with the state to ensure MAT provider network capacity and to ensure that the state's correctional system has the caseworker capacity and training necessary to ensure access to Medicaid (both enrollment and services).

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

We also support Hawai'i's proposal to address health related social needs (HRSN) by building on its existing CIS program to provide an expanded continuum of housing-related services and to add nutrition supports to the demonstration. 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.[24] And roughly one-fifth of enrollees reported food insufficiency in a

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[22] 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.

[23] CMS, "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated," State Medicaid Director Letter (SMDL) #23-03, April 17, 2023, https://www.medicaid.gov/sites/default/files/2023-12/smd23003.pdf.

[24] 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/.

given week in 2020, most of whom still struggled with it 4 months later.[25] Addressing a person's HRSN is likely to improve their health.

We support this goal and the state's interest in evaluating the effects of providing new services, including expanded housing supports (including up to six months of rental assistance for certain individuals), medical respite (both recuperative care and short-term post-hospitalization housing), and food and nutrition services (such as nutrition counseling and education, fruit and vegetable prescriptions and/or protein boxes, meals or pantry restocking, and medically tailored meals or groceries). The state's application generally specifies eligible populations, eligibility needs criteria, and benefits that would be provided but also acknowledges the need to work with CMS to establish additional medical appropriateness criteria for certain services. We support the inclusion of additional criteria to ensure that Medicaid resources are directed to individuals who meet appropriate clinical standards to receive services that Medicaid does not otherwise provide. We also urge CMS to ensure that temporary rental assistance is only available for people in the key transitional circumstances that CMS outlines in its guidance (e.g., leaving homelessness or congregate care settings, or existing foster care).

Over the last several years, CMS has shared extensive guidance with states regarding the delivery and financing of services to address HRSN.[26] The state's proposals are in line with both CMS guidance and recent Section 1115 demonstration approvals; therefore, we recommend approval of Hawai'i's request so long as CMS issues detailed special terms and conditions consistent with this guidance. For example, we urge CMS to ensure that temporary rental assistance is only available for people leaving homelessness or other key transitional circumstances that CMS outlines in its guidance. We also urge CMS to explore implementation parameters during negotiations and work with the state to solidify plans that will appropriately include community-based providers in delivering HRSN.

We also support Hawai'i's request for infrastructure funding to support the development and implementation of these requests, again consistent with CMS guidance and recent approvals. We recognize the intense level of effort necessary to launch HRSN initiatives and the imperative to develop new systems and processes to ensure that community-based providers can work with the Medicaid agency to deliver services to people who meet medical appropriateness criteria. Approving new funding for infrastructure is important to ensure that HRSN can be implemented effectively and we support this funding so long as such funding is limited, Hawai'i is subject to the same supplement-not-supplant condition as other recently approved demonstrations, and the state makes

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[25] 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.

[26] 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, "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 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.

a commitment to ensure that provider payment rates for certain traditional Medicaid services meet agreed upon standards.

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).