March 1, 2024

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

Re: Minnesota Prepaid Medical Assistance Project Plus 1115 Demonstration 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 Minnesota's proposed amendment to its "Prepaid Medical Assistance Project Plus" section 1115 demonstration.[1] Our comments detail our support for the state's proposal to provide multi-year continuous eligibility to children enrolled in coverage through Medicaid and CHIP during the first six years of life as well as 12-month continuous eligibility to 19-and 20-year-olds.

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.

Minnesota is requesting authority to implement two continuous eligibility policies, one for young children and one for young adults. First, the state is seeking approval to continuously enroll children up to age six in Medicaid and CHIP. The state also proposes extending 12-month continuous eligibility, which is currently provided to children under 19, to 19-and 20-year-olds. The continuous eligibility policies would improve continuity and access to care, increase family and financial stability, and strengthen program efficiency. 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.[2] *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, extending and expanding the

[1] Minnesota Department of Human Services, Minnesota Prepaid Medical Assistance Project Plus (PMAP+), Section 1115 Waiver No. 11-W-0039/5 Continuous Eligibility, January 25, 2024, https://www.medicaid.gov/sites/default/files/2024-02/mn-pmap-cont-eligib-amndmnt-pa.pdf.
[2] Oregon Health Plan Approval Letter, September 28, 2002, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-health-plan-09282022-ca.pdf.

length of continuous eligibility for children has the potential to reduce disparities in coverage.[3] 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.[4] 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.[5] According to state data, almost two-thirds of Black children (64 percent) as well as over 50 percent of American Indian/Alaskan Native and Hispanic children (54 and 52 percent, respectively) are covered by Medicaid.[6] As a result, the proposal would have an outsized benefit on children of color, which would help advance health equity.

Continuous eligibility can help mitigate the harmful impact of churn and uninsurance. A MACPAC study found that almost 44 percent of children who were disenrolled from Medicaid in 2018 reenrolled within 12 months.[7] Unlike other states that have requested similar waivers, Minnesota does not include state-level data on historical rates of churn among children in its application; the state should provide this data to establish a baseline from which to analyze the effect of the proposed policies on churn rates in the future.

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, The Families First Coronavirus Response Act (FFCRA) continuous coverage requirement was in place, which kept individuals with Medicaid continuously enrolled in coverage. While the decrease in uninsurance may be attributable to multiple factors, the FFCRA protection likely played a major role. The number of children enrolled in Medicaid and CHIP in Minnesota grew by almost 120,000 during the time the continuous enrollment condition was in place; these coverage gains are now at risk, as over 62,000 children in the state have lost coverage since the beginning of its unwinding period.[9] The proposed continuous eligibility policies would help the state retain some of the benefit realized through the FFCRA protection on a longer-term scale.

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[3] 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/.

[4] 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/.

[5] 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/.

[6] Minnesota Department of Human Services, "Building Racial Equity into the Walls of Minnesota Medicaid: A focus on U.S.-born Black Minnesotans," February 2022, https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8209A-ENG.

[7] 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.

[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.

[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-

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.[10] 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.[11] 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.[12]

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.[13] 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, especially multi-year continuous eligibility, would mitigate these costs for the state and families while decreasing administrative workload and providing parents peace of mind.

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.[14] 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.[15] Ensuring that children through age six have stable coverage before kindergarten can improve access to the screenings, preventative services, and treatment needed to

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9d06-db29c692a360/data; Georgetown University Center for Children and Families, "What is the impact of unwinding on Medicaid enrollment?" Accessed February 14, 2024, https://ccf.georgetown.edu/unwinding-enrollment-data/.

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

[11] 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

[12] 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.

[13] 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/.

[14] 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.

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

address delays or prevent conditions, setting the stage for better outcomes in the short and long term.[16]

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 the 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.[17] 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 measuring whether expanding continuous eligibility increased the use of recommended well-child visits and preventative care for children enrolled in Medicaid and CHIP. These data will be important in identifying the role of multi-year continuous eligibility not only in improving coverage retention, but also in reducing disparities in access to care. In addition, the evaluation should also include cost of care before and after implementation.

Minnesota did not provide 12-month continuous eligibility in Medicaid or CHIP prior to January 1, 2024 (when all states were required by the Consolidated Appropriations Act of 2023 to begin providing continuous eligibility to all children in the programs). Between the ongoing unwinding process and the implementation of 12-month continuous eligibility, the state is faced with significant demands on its system, which is further complicated by the use of county-based eligibility operations. The proposed policies in this application necessitate additional system changes that must be applied at the county level. 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.

In its application, the state indicates that infants age zero to one would be excluded from the amendment since they would presumably be protected by the existing 12-month continuous eligibility policy. While the state's intention is to "expand continuous eligibility up to age six," we are concerned that this exclusion might create an additional and unnecessary administrative layer that could have unintended consequences; for example, it might result in some children losing coverage after their first year of coverage. Given the existing 12-month continuous eligibility policy, inclusion of infants under age one should not affect budget neutrality calculations and would help ensure that no child would be subject to a renewal before the multi-year continuous eligibility period begins or become lost in the administrative complexity. We strongly encourage CMS to work with the state to include infants age zero to one as part of the demonstration population.

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[16] 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.

[17] 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.

Additionally, we are concerned the application does not list the specific waiver and expenditure authorities being requested, a foundational prerequisite to providing informed comments. We believe that the current standard terms and conditions (STC), at 3.7.b., would require such critical information for any amendment.[18] We recommend that CMS update its STC template to make this more explicit.

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 your consideration of our comments. If you need additional information, please contact Joan Alker (jca25@georgetown.edu) or Allison Orris (aorris@cbpp.org).

[18] Center for Medicaid and CHIP Services, Minnesota Prepaid Medical Assistance Project Plus (PMAP+) Section 1115 Demonstration Approval letter, January 2, 2024, https://www.medicaid.gov/sites/default/files/2024-01/mn-pmap-dmnstn-extnsn-aprvl-01022024.pdf.