March 15, 2024

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

Re: Bridges to Success: Keystones of Health for Pennsylvania Section 1115 Request

Dear Secretary Becerra,

The Center on Budget and Policy Priorities and Georgetown University Center for Children and Families appreciate the opportunity to comment on Pennsylvania's application for the Bridges to Success Section 1115 demonstration.[1]

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.

Pennsylvania is requesting a new demonstration to address health related social needs (HRSN), such as homelessness and food insecurity, and is seeking authority to help stem the overdose crisis by improving coordination of care for people leaving incarceration by providing services in the 90 days prior to reentry to the community. We support these proposed initiatives subject to the recommendations below. We also strongly support Pennsylvania's request to expand continuous eligibility policies by providing multiple years of continuous eligibility for children up to age six and one year of continuous eligibility for people leaving incarceration.

We believe Pennsylvania's request would improve access to care for Medicaid enrollees and promote the objectives of the program. The application includes robust hypotheses which, if approved, will enable the state and CMS to build the evidence base for these important initiatives. 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 Pennsylvania.

Pennsylvania is requesting authority to provide continuous eligibility to children up to age six who are enrolled in Medicaid (the state's current eligibility level for children under one in Medicaid is 220 percent FPL and is 162 percent for children under six or $56,804 and $41,828 per year for a family of three respectively). The policy would improve continuity and access to care, increase

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[1] https://www.medicaid.gov/sites/default/files/2024-02/pa-keystones-of-health-01262024-pa_0.pdf.

family and financial stability, and strengthen program efficiency. We strongly support the state's proposal, for all the reasons detailed in our prior comments on similar policies,[2] and *urge CMS to swiftly approve the request.*

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.[3] 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 Pennsylvania grew by around 178,000 during the time the continuous enrollment condition was in place; these coverage gains are now at risk, as almost 157,000 children in the state have lost coverage since the beginning of its unwinding period.[4] The proposed continuous eligibility policies would help the state replicate some of the benefits realized through the FFCRA protection on a longer-term scale.

The state's proposal is limited to children enrolled in Medicaid. Given Pennsylvania's income eligibility limit for its separate CHIP program (319 percent FPL or $82,366 per year for a family of three), providing multi-year continuous eligibility only to children in Medicaid would leave thousands of children without this important protection. Additionally, the exclusion of children enrolled in CHIP from the extended continuous eligibility period will make outreach and education efforts to stakeholders and families as part of the implementation more difficult, requiring more nuanced communication about who would be eligible for the policy. A key virtue of continuous eligibility policies is making life easier for parents with simplified communications and less red tape. CMS should encourage the state to extend the policy to all young children in Medicaid and CHIP as all other states with approved or pending requests with CMS have done,[5] to maximize children's access to necessary screenings, preventative services, and needed treatment for healthy development and ensure stable health coverage throughout this critical period.

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[2] We request that our previous comments and all supporting research be included in the administrative record for this proposal. The comments are available at https://ccf.georgetown.edu/wp-content/uploads/2017/10/Washington_Extension_SignOnLetter_FINAL.pdf (Washington Medicaid Transformation Project Extension Application Comments) and https://ccf.georgetown.edu/wp-content/uploads/2023/07/New-Mexico-Extension-FINAL-Comments_CCF_CBPP.pdf (New Mexico Centennial Care 2.0 Extension Application Comments).

[3] 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.

[4] 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; 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/.

[5] Hawaii, North Carolina, and New Mexico use Title XXI funding to operate a CHIP-funded Medicaid expansion program (M-CHIP), so all Medicaid and CHIP eligible children under age six are included in their proposal. Oregon's approval to provide multi-year continuous eligibility includes children in both Medicaid and CHIP. Washington's initial application and approval for multi-year continuous eligibility included only children in Medicaid but subsequently submitted an application to cover children in its separate CHIP program as well.

Twelve months of continuous enrollment for people leaving incarceration would support continuity of care.

We strongly support the state's proposal to extend 12 months of continuous eligibility to enrollees following reentry from correctional settings, regardless of changes in circumstances that would otherwise cause a loss of eligibility. The Affordable Care Act greatly expanded access to health coverage for people who have a history of incarceration or conviction. However, people who have been impacted by the criminal legal system face additional barriers to maintaining health coverage, which can disrupt access to care. For example, formerly incarcerated people experience homelessness at nearly ten times the rate of the general public.[6] Homelessness or frequent moves caused by housing instability can interfere with a person's ability to complete paperwork on time, which can cause eligible people to lose coverage.

We encourage CMS to work with the state to ensure the Medicaid agency has ease of access to the data from county and state correctional facilities and that enrollees and their service providers are aware of the duration of the coverage period. This will facilitate effective implementation of continuous coverage for people exiting incarceration and yield useful insights about strategies for enrolling and coordinating care for this population.

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.

Pennsylvania is requesting approval to provide targeted pre-release benefits to high-risk adults who would be eligible for Medicaid but for their incarceration in state prisons and participation county jails. We support Pennsylvania's desire to provide outreach and pre-release supports for individuals with substance use disorders, serious mental illness, chronic conditions, or other risk factors who are incarcerated, and we therefore 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.[7]

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 harm to youth who are separated from their family and community, including long-term adverse impacts on individuals' physical and mental health.[8]

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[6] Lucius Couloute, "Nowhere to Go: Homelessness Among Formerly Incarcerated People," Prison Policy Initiative, August 2018, https://www.prisonpolicy.org/reports/housing.html.

[7] 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.

[8] 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

Pennsylvania's request appears to be consistent with CMS guidance, focusing on a targeted set of services for people preparing to leave carceral settings.[9] Recognizing that transitions take time, we support the state's request to provide services in the 90-days prior to release. Engaging case managers to help people leaving incarceration select managed care organizations and engaging community case managers post-release to facilitate warm handoffs to community providers will 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 Pennsylvania's plans to use the first year of the demonstration as an implementation year and to phase-in reentry services thereafter based on the results of a readiness assessment.

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

We also support Pennsylvania's proposal to address health related social needs (HRSN) such as homelessness and food insecurity, which both jeopardize health and lead to costly, but avoidable, health care use. 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.[10] And roughly one-fifth of enrollees reported food insufficiency in a given week in 2020, most of whom still struggled with it 4 months later.[11] Addressing a person's HRSN is likely to improve their health.

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.

[9] 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.

[10] 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/.

[11] 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.

We support this goal and the state's interest in evaluating the effects of providing an expanded array of services to help address HRSN statewide, including expanded housing supports for people experiencing homelessness or transitioning from corrections facilities and at risk of homelessness (including pre-tenancy and transition navigation and case management; one-time transition start-up services; up to six months of rental assistance for certain individuals; and tenancy sustaining services) and food and nutrition services (such as medically tailored meals/groceries; grocery delivery/food boxes, including for pregnant people; and nutrition assistance navigation and application support).

The state's application generally specifies eligible populations, eligibility needs criteria, and benefits that would be provided, providing a robust sense of the strategies that Pennsylvania wishes to test in this demonstration. For example, we support Pennsylvania's plans to deliver housing supports to people experiencing homelessness who have serious mental illness, substance use disorder, and people reentering society from correctional institutions who are at risk of homelessness. We note, however, that the state does not intend to make these services available to people who are transitioning out of other institutional settings and may also be at risk of homelessness; we suggest that CMS encourage the state to expand the eligibility criteria to encompass this group. We also urge CMS to ensure that temporary rental assistance is only available for people leaving incarceration (or other key transitional circumstances that CMS outlines in its guidance) who meet certain clinical criteria.

We are also gratified to see Pennsylvania focusing on the nutritional needs of pregnant people during their pregnancy and in the two months postpartum, which is an important period to assure healthy parents and babies.[12] We also support Pennsylvania's explicit acknowledgement that short-term nutritional supports will be linked to long-term supports through programs such as WIC and SNAP. As it negotiates both the demonstration approval and implementation plans, we urge CMS to encourage Pennsylvania to ensure a strong collaboration between the Medicaid, SNAP and WIC programs to better connect people with the nutritional supports for which they are eligible. There is a unique opportunity to increase take up in WIC as participants in Medicaid and SNAP are automatically eligible for WIC. Nationally, 36 percent of WIC-eligible Medicaid participants and 46 percent of WIC-eligible SNAP participants were not enrolled in WIC in 2021. In Pennsylvania, for every 10 births covered by Medicaid in 2022, only 3 pregnant people participated in WIC.[13]

Over the last several years, CMS has shared extensive guidance with states regarding the delivery and financing of services to address HRSN.[14] The state's proposals are in line with both

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[12] Sonya Schwartz et al., "State Medicaid Agencies Can Partner with WIC Agencies to Improve the Health of Pregnant and Postpartum People, Infants, and Young Children," Center on Budget and Policy Priorities and Georgetown Center for Children and Families, December 20, 2023, https://www.cbpp.org/sites/default/files/12-20-23fa.pdf.

[13] Center on Budget and Policy Priorities, "State Fact Sheets: Trends in WIC Coverage and Participation," February 20, 2024, https://www.cbpp.org/research/food-assistance/resource-lists/trends-in-wic-coverage-and-participation.

[14] 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.

CMS guidance and recent Section 1115 demonstration approvals; therefore, we recommend approval of Pennsylvania's request so long as CMS issues detailed special terms and conditions consistent with this guidance. As CMS negotiates demonstration terms and conditions with the state, 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 explore implementation parameters during negotiations and to work with the state to solidify plans that will appropriately include community-based providers in delivering HRSN, even as most services will be provided through Pennsylvania's existing managed care program. We support Pennsylvania's plans to contract with a third-party administrator to support connections between community based organizations and MCOs during the initial launch of these services and would welcome additional detail about the role of the third-party administrator in future years of the demonstration.[15]

We also support Pennsylvania's request for infrastructure funding to support 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 by year two of the demonstration, as Pennsylvania plans. Therefore, we support this funding so long as such funding is limited, Pennsylvania is subject to the same supplement-not-supplant condition as other recently approved demonstrations, and the state makes 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).

[15] For example, Washington's use of a third-party administrator to launch its Housing Related Services initiative has been cited as a promising practice. CSH, "Using Medicaid's Housing Related Services (HRS) to Create New Supportive Housing," https://www.csh.org/wp-content/uploads/2023/07/CSH-Medicaid-Housing-Related-Services-June-2023.pdf.