May 16, 2024

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

Re: Colorado Expanding the Substance Use Disorder Continuum of Care 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 Colorado's proposed amendment to its "Expanding the Substance Use Disorder Continuum of Care" 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.

Colorado is seeking to increase coordination of and access to care for people leaving carceral settings by providing services in the 90 days prior to transitioning into the community. We support this proposed initiative which would promote health equity and help minimize negative health outcomes that may occur in the period immediately following reentry. We also strongly support the state's request to expand continuous eligibility policies by providing multiple years of continuous eligibility for children up to age three and one year of continuous eligibility for people leaving incarceration. We believe these policies promote coverage, consistent with the objectives of Medicaid as required for section 1115 demonstrations, and would improve access to care. We urge CMS to approve the proposal, subject to the recommendations below.

Multi-year continuous eligibility would reduce gaps in coverage and improve continuity of care for children in Colorado.

Colorado is requesting authority to provide continuous eligibility to children up to age three who are enrolled in Medicaid or CHIP (the state's current eligibility level for children in Medicaid is

[1] Colorado Department of Health Care Policy and Financing, "Colorado Medicaid Coverage for Justice-Involved Population Reentry, Severe Mental Illness, and Continuous Eligibility: Substance Use Disorder Amendment Request," April 1, 2024, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/co-continuum-care-pa.pdf.

147 percent FPL and 265 percent for children in CHIP, or $37,955 and $68,423 per year for a family of three respectively). The policy would improve continuity and access to care, increase 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 Colorado grew by over 82,000 during the time the continuous enrollment condition was in place; these coverage gains have now been wiped out, as almost 160,000 children in the state have lost coverage since the beginning of its unwinding period.[4] The proposed continuous eligibility policy would help the state reestablish some of the benefits realized through the FFCRA protection on a longer-term scale and would help minimize disruptions to receiving needed care during a crucial developmental time for children newly enrolling, reenrolling, or maintaining enrollment in Medicaid and CHIP.

We commend the state for taking this important step to improve children's coverage, especially during the period children are recommended to have the most well-child visits.[5] However, the state's proposal is limited to children up to age three, leaving many young children without this important protection. In contrast, other states with approved or pending requests with CMS have included children up to age six in their multi-year continuous eligibility proposals.[6] The state recognizes the potential to expand the policy to include more young children, as the underlying state legislation for the proposal also directs the Medicaid agency to conduct a "feasibility" study of providing multi-year continuous eligibility to children under age six.[7] CMS should encourage the state to extend the policy to children up to age six 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/2024/04/CBPP-CCF-Minnesota-CE-Comments-FINAL-.pdf (Minnesota Prepaid Medical Assistance Project Plus Amendment 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," Accessed April 25, 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 April 25, 2024, https://ccf.georgetown.edu/unwinding-enrollment-data/.

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

[6] New Mexico, Oregon, and Washington have been approved to provide multi-year continuous eligibility to children under six. Four other states (Hawaii, Minnesota, North Carolina, and Pennsylvania) have submitted requests to CMS to adopt the policy for the same age group.

[7] SHB 23-100, Reg. Sess. 2023, available at https://leg.colorado.gov/sites/default/files/2023a_1300_signed.pdf.

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 a state Department of Corrections facility, 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.[8] 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.

Colorado 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 participating county jails. We support Colorado's desire to provide pre-release supports for incarcerated individuals with substance use disorders, serious mental illness, chronic conditions, or other risk factors, 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.[9]

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. As the state says in its application, in the first two weeks following release from incarceration, individuals are 129 times more likely to die from an overdose than their peers in the community.[10] 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

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

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

[10] Binswanger IA, Stern MF, Deyo RA, Heagerty PJ, Cheadle A, Elmore JG, Koepsell TD. Release from prison--a high risk of death for former inmates. N Engl J Med. 2007 Jan 11;356(2):157-65. doi: 10.1056/NEJMsa064115. Erratum in: N Engl J Med. 2007 Feb 1;356(5):536. PMID: 17215533; PMCID: PMC2836121.

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.[11]

Colorado's application demonstrates thoughtful consideration of both CMS's guidance and how to translate the guidance into practice in Colorado's Medicaid delivery system, including by phasing-in the proposed demonstration at the State's correctional facilities.[12] We believe covering a targeted set of services (including transitional case management, MAT, and a 30-day supply of medications (including MAT)), during the last 90 days of incarceration for a defined high-needs population is appropriate.

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 are concerned that Colorado's application appears to rely more heavily on carceral providers than do other states that have recently requested similar reentry waivers. Although the state's application notes that all participating providers (community-based or carceral providers) will have "necessary experience and receive appropriate training" (p.39), we urge CMS to work with the state to prioritize reliance on community-based case managers. The application also suggests that corrections staff will be required to meet state requirements that are similar to Medicaid provider requirements (p.22) and requests waivers of provider enrollment requirements in Medicaid and CHIP (p.42). We urge CMS to disapprove these particular waiver requests. Instead, we recommend that CMS require all providers under the demonstration to be enrolled as Medicaid providers and, again, find ways to maximize the use of community-based providers to deliver pre-release services, including case management services that can more seamlessly bridge to post-release services.

As Colorado notes in its application, 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 along with Colorado's intent to "prioritize programs and services that improve health care outcomes for the incarcerated population the State is seeking to support" in its proposed demonstration.

Finally, we appreciate that the state is also considering how to address health related social needs (HRSN) that people leaving carceral settings may have and support the state's intent to evaluate HRSN services for potential inclusion in a later phase as part of enrollees' post-release benefits.

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[11] 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.

[12] 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.

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