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January 4, 2021

Seema Verma, Administrator
Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-9912-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

RE: **Comments on CMS-9912-IFC**
Centers for Medicare and Medicaid Services Interim Final Rule: Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

Dear Administrator Verma:

Families USA appreciates the opportunity to provide comments on this Interim Final Rule "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency." Families USA is a national, non-partisan health care policy and advocacy organization that supports policies and programs at the state and federal levels to ensure the best health and health care are equally accessible and affordable to all, with a particular focus on actions that affect lower-income individuals. Please note that in addition to my current role at Families USA, I was formerly the Health Division Director at the bipartisan National Governors Association's Center for Best Practices, where I worked with governors of both parties to improve their Medicaid programs.

This Interim Final Rule (IFR) is substantively bad policy and legally bad procedure. The IFR includes multiple elements that will hurt consumers and that countermand the stated will of Congress – including the weakening of protections for millions of Medicaid beneficiaries during the COVID-19 pandemic and a lack of a public comment process before implementing this rule. **We urge CMS to withdraw this regulation in its totality to ensure that Medicaid coverage remains stable and strong throughout the COVID-19 pandemic.**

Introduction

The Families First Coronavirus Response Act (FFCRA) (PL-116-127) passed by Congress on March 18, 2020, provided temporary enhanced federal funding to state Medicaid programs. Each qualifying state and territory receives a 6.2 percentage point increase in its Federal Medical Assistance Percentage (FMAP) effective January 1, 2020 through the last day of the last calendar quarter of the public health emergency. As with Medicaid match increases in earlier recessions, to qualify for this funding a state must abide by a Maintenance of Effort (MOE) provision that prohibits it from imposing more restrictive eligibility standards, methodologies, or procedures than those that were in place as of January 1, 2020. These requirements also include a continuous coverage provision, meaning individuals (except under limited circumstances) are to remain covered during the crisis in order to receive the services they need. At a time of such public health and economic turmoil, Congress chose to protect enrollees by maintaining the "status quo" to ensure that beneficiaries do not face interruptions in their access to services.

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These provisions of the FFCRA are important. Congress included an explicit requirement to preserve enrollee's existing benefits in Section 6008 of FFCRA – both their enrollment in Medicaid overall, and the services for which they have been eligible. Consistent with this statutory language, CMS issued-sub-regulatory guidance last spring that correctly told the public that in order to receive the enhanced FMAP, that "states may not reduce benefits"[1] and "states must maintain the eligibility, and benefits, of all individuals who are enrolled."[2] Additionally, the sub-regulatory guidance released by CMS stated that a state would be ineligible for the enhanced FMAP if it increased cost-sharing on individuals since that action "reduces the amount of medical assistance for which an individual is eligible." [3] This sub-regulatory guidance by CMS correctly implemented the FFCRA's MOE provisions. Stakeholders across the country have relied upon this CMS guidance in order to access health care. Unfortunately, the statutory implementation described above was reversed when this IFR was published in the Federal Register on November 6, 2020 (effective November 2, 2020), without any opportunity for public comment.

The IFR opens up numerous types of coverage restrictions for Medicaid enrollees despite Congress's stated intent to maintain coverage and benefits for them, including: cuts to optional benefits; reductions in amount, duration, and scope of services; increases in cost-sharing; and reductions in post-eligibility income. The IFR will also result in terminations for some individuals who should not be terminated, such as lawfully present immigrant pregnant women. This ostensible reinterpretation of the MOE is inconsistent with the FFCRA and will harm Medicaid enrollees. We also oppose the provisions of this rule that allow states to receive enhanced funding despite refusing to cover COVID-19 vaccination for some Medicaid enrollees.

The reversal of this guidance pulled the rug out right from under 70 million Medicaid beneficiaries. The lack of notice or a comment period before this regulation took effect meant that the public did not have an opportunity to participate in the rule making process. Interim final rules are supposed to be used rarely and only out of necessity. In this circumstance, the use of the interim final rule process will lead to immediate harms and is clearly contrary to the public interest. These policies will cause substantial harms – harms that could have been avoided had CMS solicited public comments before the rule went into effect.

This IFR is substantively and procedurally indefensible, and we recommend that CMS withdraw this regulation. Below are Families USA"s <u>comments on specific provisions in the IFR:</u>

1. ***Cuts to Optional Benefits:*** In addition to mandatory benefits under federal Medicaid law, states can cover a number of optional benefits for their Medicaid enrollees. Optional benefits are a critical part of comprehensive insurance coverage and typically include adult oral health services, substance use treatment, other behavioral health services, and most home- and community-based long-term care services. This IFR gives states sweeping authority to make cuts in the amount, duration and scope of

[1] Families First Coronavirus Response Act – Increased FMAP FAQs, (April 13, 2020), https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf
[2] COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies, (June 30, 2020), https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf
[3] COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies, (June 30, 2020), https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

optional Medicaid benefits, including benefit cuts; increases in utilization management; increases in cost-sharing; and reduced post-eligibility income – while allowing states to retain their enhanced matching funds under the FFCRA. The IFR runs directly counter to Congressional intent to maintain eligibility and bnefits during the COVID-19 crisis. Medicaid cuts will disproportionately affect communities of color, older adults, and people with disabilities. It is a sad irony that the very populations who are most likely to get sick and to lose jobs during the pandemic are the same communities who will suffer most from reduced Medicaid coverage.[4]

Historically, states have been all too quick to cut adult dental benefits in Medicaid during times of economic stress. In response to fiscal challenges in the early 2000s, many states reduced or eliminated Medicaid dental coverage over the course of a decade,[5] with a concurrent 10 percent decline in oral health care utilization among low-income adults.[6] Cutting Medicaid adult dental benefits would not only cause serious harm to the very communities hit hardest by the pandemic it would also hinder economic recovery in the states. These harms can be long-lasting even if the cuts are reversed. In 2008, due to a recession, California eliminated coverage for adult dental services in Medicaid. Even though the state restored this coverage in 2014, access to care remains considerably worse than it was before the state cut dental services. If California had simply maintained 2008 levels of access to dental benefits to the present day, almost 800,000 additional people would be getting the oral health care they need to stay healthy.[7] Further, oral health care has a likely direct link to COVID-19 outcomes. Among people who become infected by COVID-19, those with poor oral health tend to get sicker and are more likely to die.[8] Finally, cutting optional oral health benefits will cause tremendous harm to Medicaid beneficiaries across the country, as indicated by the data:

- Low-income adults suffer a disproportionate share of dental disease, and are nearly 40 percent less likely to have a dental visit in the past 12 months, compared to those with higher-incomes.[9]

- Forty-four percent of low-income adults ages 20 to 64 have untreated tooth decay, and five percent of adults have lost all of their teeth.[10]

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[4] Melissa Burroughs, "California's Proposed Oral Health Cuts Would Cost the State Billions, Further Harm Those Hardest Hit by COVID-19," Families USA, May 2020, https://www.familiesusa.org/wp-content/uploads/2020/05/OH_Oral-Health-Medicaid-Budget-Cut-Fact-Sheet_5-28-20.pdf

[5] National Conference of State Legislatures. "Health Cost Containment and Efficiencies: NCSL Briefs for State Legislators." 2014. Available at: http://www.ncsl.org/documents/health/IntroandBriefsCC-16.pdf

[6] M. Vujicic. Dental Care Utilization Declined among Low-income Adults, Increased among Low-Income Children in Most States from 2000 to 2010. Health Policy Institute, American Dental Association, February 2013. Available at http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0213_3.ashx

[7] Melissa Burroughs, "The Long Term Consequences Of Cutting Adult Dental: California's Access Problems Persist," Families USA, January 2020, https://familiesusa.org/resources/the-long-term-consequences-of-cutting-adult-dental-californias-access-problems-persist/

[8] Victoria Sampson, "Could there be a link between oral hygiene and the severity of SARS-CoV-2 infections?,"British Dental Journal, June 26, 2020, https://www.nature.com/articles/s41415-020-1747-8

[9] Centers for Disease Control and Prevention. "Oral and Dental Health: Table 78." May 2017. Available at: https://www.cdc.gov/nchs/fastats/dental.htm

[10] National Institute of Dental and Craniofacial Research. "Dental Caries (Tooth Decay) in Adults (Age 20 to 64)." July 2018. Available at: https://www.nidcr.nih.gov/research/data-statistics/dental-caries/adults.

- Adults who are disabled, homebound, or institutionalized have an even greater risk of dental disease.[11]

- When California Medicaid eliminated its adult dental coverage in 2009, the policy change led to a significant and immediate increase in dental ED use, amounting to more than 1,800 additional dental ED visits per year. Young adults, members of racial/ethnic minority groups, and urban residents were disproportionately affected. Average yearly costs associated with dental ED visits increased by 68 percent.[12]

Consistent with the straightforward protection of benefits in section 6008 of the FFCRA, CMS should continue to prohibit states from cutting optional benefits during the public health emergency. States that cut optional benefits should not be eligible to receive the enhanced FMAP as provided by Congress.

2. ***Increased Cost-Sharing:*** Cost-sharing plays an important role in determining whether or not Medicaid beneficiaires are able to access to Medicaid benefits. Consequently, given that Congress's stated intent was for beneficiaries to be able to maintain Medicaid benefits as a condition of states being able to receive the enhanced 6.2 percentage point increase in federal Medicaid matching funds, CMS guidance originally and correctly stipulated that states could not increase cost-sharing during the public health emergency. With this IFR, CMS is reversing its own guidance and now allows states to increase cost-sharing while still receiving the enhanced match. This reversal will lead to poor health outcomes and harm individuals across the country. Research has consistently concluded that the imposition of cost-sharing on low-income populations reduces both necessary and unnecessary care and correlates with increased risk of poor health outcomes.[13] These studies highlight that reductions in care means that delays in high-value, low-cost services such as ambulatory care can lead to more costly care and poor outcomes down the road.[14, 15, 16] Further, the economic crisis increases the harm caused by cost-sharing. The pandemic has significantly increased financial hardship among low-income families and families of color, making it less likely that they will be able to afford to pay additional cost-sharing.[17]

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[11] The Institute of Medicine. "Improving Access to Oral Health Care for Vulnerable and Underserved Populations." 2011. Available at: http://www.hrsa.gov/publichealth/clinical/oralhealth/improvingaccess.pdf

[12] Astha Singhal, Daniel J. Caplan, Michael P. Jones, Elizabeth T. Momany, Raymond A. Kuthy, Christopher T. Buresh, Robert Isman, and Peter C. Damiano, "Eliminating Medicaid Adult Dental Coverage In California Led To Increased Dental Emergency Visits And Associated Costs," Health Affairs, May 2015, https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1358

[13] David Machledt and Jane Perkins, "Medicaid Premiums and Cost Sharing," National Health Law Program, March 2014, https://healthlaw.org/resource/medicaid-premiums-and-cost-sharing/

[14] Powell V, Saloner B, Sabik LM. Cost sharing in Medicaid: Assumptions, evidence, and future directions. Med. Care Res. Rev. 2016;73(4):383-409.

[15] Snyder L, Rudowitz R. "Premiums and cost-sharing in Medicaid: A review of research findings." Kaiser Commission on Medicaid and the Uninsured; 2013. https://www.kff.org/wp-content/uploads/2013/02/8417-premiums-and-cost-sharing-in-medicaid.pdf

[16] MACPAC. The effect of premiums and cost sharing on access and outcomes for low-income children. [Issue Brief]. 2015; https://www.macpac.gov/wp-content/uploads/2015/07/Effect-of-Cost-Sharing-on-Low-Income-Children.pdf

[17] Kim Parker, Rachel Minkin, Jesse Bennett, "Economic Fallout From COVID-19 Continues To Hit Lower-Income Americans the Hardest," Pew Research Center, September, 2020,

Consistent with their original interpretation of FFCRA, CMS should prohibit states from increasing cost-sharing during the public health emergency if they are to receive the enhanced FMAP.

3. ***Reductions in the Amount, Duration and Scope of Services:*** Another core aspect of Medicaid benefit levels protected by section 6008 of the FFCRA is the amount, duration and scope of covered benefits. Some states – particularly when facing tight budget sessions – may move to limit the amount, duration and scope of a service, a reduction in coverage that can apply to either mandatory or optional benefits. For example, after the Great Recession, some states placed numerical caps on benefits like physician visits and hospital days.[18] These capped services were in many cases not sufficient for vulnerable populations, such as some people with chronic illnesses and disabilities. As a condition of the enhanced 6.2 percentage point increase in federal Medicaid match, CMS guidance originally stipulated that could not "reduce benefits for any beneficiary enrolled in Medicaid" during the public health emergency.[19] This IFR reverses that guidance and allows states to change the amount, duration, and scope of services. This means that state legislatures and/or Medicaid agencies could cap the number of times an individual could see a provider as a way to cut services to millions of children, families, elderly, disabled individuals, and other low-income adults who rely on Medicaid despite clear Congressional intent to maintain all Medicaid beneficiaries' coverage and benefits for the duration of the emergency.

   This IFR would also allow states to impose new prior authorization requirements and other utilization management requirements. These policies can harm Medicaid enrollees and providers in typical times, but will pose significantly greater risks during COVID-19. Behavioral health problems are skyrocketing for low-income people, and maintaining access to medications and to telehealth benefits is a critical public health priority. Many acute care providers are overwhelmed caring for COVID-19 patients and increased administrative work via prior authorizations will divert them from that essential work.

   Consistent with the original CMS interpretation of FFCRA, CMS should prohibit states from making reductions in amount, duration, and scope of services during the public health emergency if there are to receive the enhanced FMAP.

4. ***Reduced Coverage within New Tiers:*** Medicaid benefit packages can vary based on an individual's eligibility group. As a condition of the enhanced 6.2 percentage point federal match, FFCRA explicitly mandates that states may not disenroll beneficiaries from their Medicaid coverage. CMS originally informed states that they are not permitted to move an individual into a new eligibility group that would result in a reduction of benefits. This IFR creates three new, unprecedented and confusing

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https://www.pewsocialtrends.org/2020/09/24/economic-fallout-from-covid-19-continues-to-hit-lower-income-americans-the-hardest/

[18] Snyder L, Rudowitz R. "Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends," Kaiser Commission on Medicaid and the Uninsured; 2011. https://www.kff.org/wp-content/uploads/2013/01/8248.pdf#page=93

[19] Families First Coronavirus Response Act – Increased FMAP FAQs, (April 13, 2020), https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf

coverage "tiers" for Medicaid enrollees that have the effect of allowing states to move people from one eligibility category to another in certain circumstances, even when that would result in an individual receiving fewer benefits. This system violates the FFCRA, which requires preserving individuals' benefits, and can cause substantial harm. This harm will disproportionately fall on the most vulnerable groups of beneficiaries, including people with disabilities and older adults.

Consistent with their original interpretation of FFCRA, CMS should abandon the coverage tiers system.

5. ***Limited Coverage for Vaccines:*** As of December 21, 2020, more than 317,000 people in the United States have died as a result of COVID-19, with over 17 million confirmed cases.[20] Widespread public health measures, including the availability and distribution of a safe and effective preventive vaccine will be essential to curb this deadly pandemic. FFCRA provided that state Medicaid programs receive enhanced federal funding only if they cover approved COVID-19 vaccines and provide access without cost sharing during the period of the public health emergency. However, this IFR would reverse this clear stipulation from Congress and would limit access to COVID-19 vaccines, allowing states to exclude coverage of vaccinations for people enrolled in Medicaid "limited benefit" programs. These Medicaid limited benefit programs include programs focused on the treatment of breast and cervical cancer and tuberculosis, family planning programs, and some 1115-waiver programs.[21] For example, this could significantly impact the ability of pregnant immigrant women who are insured through the Children's Health Improvement Program (CHIP) to obtain the COVID vaccine. CMS does not provide any explanation or analysis on how it would determine which of the existing 1115 waiver programs would be subject to the IFR limits on vaccine coverage. The FFCRA makes no distinction between full and limited benefit Medicaid categories and specifically applies vaccination requirements to waiver programs.

   Congress's intent was to ensure widespread access to COVID-19 vaccination. CMS should not invent an ambiguity and then interpret it contrary to the statute's clear intent. Congress is surely familiar with limited scope benefits Medicaid eligibility categories and would have carved out exceptions to FFCRA if it wanted to carve out such exceptions. Barring access to lifesaving COVID-19 vaccines would hamper efforts to combat the pandemic, and would harm tens of thousands of individuals who rely on Medicaid limited benefit programs. The IFR is inconsistent with the FFCRA statutory language and intent, relies on misreading of the Medicaid statute, and is harmful as a matter of health policy.

   CMS should not limit vaccine coverage for people enrolled in Medicaid limited benefit under this IFR.

6. ***"Validly Enrolled":*** FFCRA prohibited states from terminating Medicaid eligibility for any beneficiary, except in two instances: (1) voluntary termination by the beneficiary; or (2) when an individual is no

[20] Johns Hopkins Coronavirus Resource Center, Accessed December 21, 2020, https://coronavirus.jhu.edu/region/united-states

[21] *See* 42 U.S.C. § 1396a(aa) (Breast and Cervical Cancer Program); 42 U.S.C. § 1396a(z) (Tuberculosis); 42 U.S.C. § 1396a(ii) (Family Planning); 42 U.S.C. § 1315 (Section 1115 demonstration projects).

longer a resident of the state. This IFR expands permissible coverage terminations to include individuals "not validly enrolled" during the public health emergency, allowing states to terminate coverage for an enrollee who was initially determined eligible and received coverage but has since been determined ineligible due to agency error, fraud, or abuse. While "fraud" (evidenced by a fraud conviction) or "abuse" (determined following an investigation) is defined in the rule, CMS did not define "agency error". We are concerned that the absence of a definition of "agency error" will give states broad discretion that could lead to widespread terminations. Additionally, the IFR states that if the state conducts an abuse investigation under the applicable Medicaid regulations and finds there was abuse "material to the determination of eligibility", the individual is not "validly enrolled", and the state may terminate their Medicaid. However, the applicable regulations give states a range of options to resolve an abuse investigation that do not necessarily require disenrollment.[22] CMS should not impose outcomes that supplant or skip state processes already in place and specified by regulations.

Additionally, under the IFR, CMS narrows the definition of "valid enrollment" to exclude some enrollees who should covered by the protections of the FFCRA. For example, the IFR states that individuals eligible by presumptive eligibility are not "validly enrolled" for the purposes of the continuous coverage provision, on the theory that these individuals "have not received a determination of eligibility under the state plan." However, the Medicaid statute describes presumptive eligibility as "determining, on the basis of preliminary information, whether any individual is eligible for medical assistance."[23] CMS's attempt to distinguish presumptively eligible populations from other Medicaid enrollees is therefore inconsistent with the Medicaid statute. Moreover, presumptive eligibility has been an important tool during COVID-19, used by many states and benefitting many individuals across the country. The pandemic has made it difficult for many people to complete a full Medicaid application, sometimes due to reduced staffing at state agencies, before their presumptive eligibility period ends.

CMS should not reinterpret FFCRA's statutory "enrolled for benefits" to mean "validly enrolled" for benefits under this IFR.

7. ***Post-Enrollment Treatment Income (PETI) Rules:*** Post-eligibility treatment of income (PETI) rules are used to calculate an institutionalized member's contribution to their cost of care. In the June 30 guidance, CMS explained—consistent with the intent of FFCRA to maintain Medicaid beneficiary eligibility--that states could not modify their PETI rules in a way that would increase an institutionalized individual's patient liability during the emergency period and still receive the enhanced FMAP.[24] CMS explained that, like a cost-sharing increase, an increase to a beneficiary's liability would reduce "the amount of medical assistance for which an individual is eligible" and is therefore inconsistent with section 6008(b)(3) of the FFCRA. The IFR reversed this guidance and permits states to modify their PETI rules. This could leave enrollees with disabilities who are institutionalized or using a home and community-based services (HCBS) waiver program with less

[22] 42 C.F.R. § 455.16
[23] 42 U.S.C. § 1396(a)(47)(B)
[24] COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies, (June 30, 2020), https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

money to meet their basic needs, which could cause significant harm. For example, if home-based individuals enrolled in an HCBS waiver do not have enough money each month to cover their living expenses, they may be forced into institutions. This prospect is particularly frightening during the pandemic, given the disproportionate health impact of COVID-19, including heightened risk of death, on people in congregate settings.

CMS should not permit states to modify their PETI rules under this IFR.

8. ***Administrative Procedure Act*:** By implementing this IFR without first opening a public comment period, CMS is deliberately avoiding procedures designed to give the public an opportunity to understand and influence decisions that affect it. The Administrative Procedure Act (APA) anticipates that that government agencies will implement regulations only after receiving and considering public comment and that interim final rules will be used rarely and only of necessity. For example, interim final rules could be used when a comment period would be "contrary to the public interest." There is no significant exigency associated with a notice and comment period for the policy contained in this IFR, whereas reducing health care eligibility, decreasing benefits, and increasing costs during a pandemic without an opportunity to comment will lead to immediate harms and is clearly contrary to the public interest. These policies will cause substantial harms. We believe CMS violated the APA in issuing this rules as an interim final rule.

   CMS should not have published this rule as an interim final rule and it should be withdrawn.

Conclusion

Overall, the aforementioned provisions of the Interim Final Rule are not only illegal, they also have the potential to cause serious harm to millions of Americans who rely on Medicaid for their health coverage. That the IFR comes amid an unprecedented pandemic when coverage is more important than ever is even more troubling. In its previous interpretation of FFCRA's MOE protections, CMS recognized that robust Medicaid coverage is integral to keeping our communities safe and healthy during the COVID-19 pandemic. This IFR is a dramatic departure from that previous interpretation. In fact, CMS recognizes in this same IFR that its reinterpretation of FFCRA could "undermine states' COVID-19 response efforts during the public health emergency."[25] **Therefore, we strongly oppose the provisions of the IFR detailed in this comment letter, and we urge CMS to withdraw the rule in its totality immediately.**

We request that the full text of material cited, along with the full text of our comment, be considered part of the formal administrative record. Please contact Joe Weissfeld, Families USA's Director of Medicaid Iniatives, at jweissfeld@familiesusa.org for further information.

Respectfully submitted,

Frederick Isasi, JD, MPH
Executive Director, Families USA

[25] Federal Register, "CMS-9912-IFC, Center for Medicare and Medicaid Services Interim Final Rule: Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency November 6, 2020, https://beta.regulations.gov/document/CMS-2020-0129-0001