



January 4, 2021

Alex M. Azar II
Secretary, Department of Health and Human Services
Health Resources and Services Administration
200 Independence Avenue SW
Washington, DC 20201

Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Box 8016, Baltimore, MD 21244-8016

Re: CMS-9912-IFC – Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

Dear Secretary Azar and Administrator Verma:

On behalf of the Partnership for Medicaid—a nonpartisan, nationwide coalition of health care providers, safety net health plans, and counties—the undersigned organizations appreciate the opportunity to respond to the Department of Health and Human Services’ (HHS) interim final rule with comment period regarding Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (IFR). As a source of health insurance coverage for one in five Americans, Medicaid plays a key role in connecting individuals to testing and treatment for COVID-19. The undersigned organizations believe the federal government must do more to enhance states’ capacity to provide meaningful access to care through Medicaid, both during and beyond the COVID-19 public health emergency (PHE). The Partnership is concerned about the impact of the IFR on Medicaid beneficiaries. We urge HHS and the Centers for Medicare and Medicaid Services (CMS) to rescind various policies in the IFR, as outlined in detail below.

COVID-19 Vaccine Coverage for Medicaid and CHIP Beneficiaries

The Partnership is concerned that CMS has chosen to take a limited view of the requirements of Section 6008(b)(4) of the Families First Coronavirus Response Act (FFCRA) with regard to COVID-19 testing and treatment, during and after the PHE, that excludes individuals eligible for limited benefit categories. We disagree with CMS’s interpretation that states can receive the temporary 6.2 percent increase in their Federal Medical Assistance Percentage (FMAP) authorized under FFCRA while denying COVID-19 testing services and treatment to Medicaid beneficiaries based on the scope of their pre-PHE coverage. In the interest of public health, we believe that CMS should interpret the requirements under Section 6008(b)(4) of the FFCRA to cover COVID-19 testing services and treatment for *all* individuals currently enrolled in Medicaid.

In the IFR's preamble, CMS broadly looks to Section 3716 of the CARES Act as a basis for its conclusion that the 6.2 percent FMAP increase per Section 6008 of FFCRA does not require states to cover COVID-19 testing services and treatments for Medicaid recipients with limited benefits. CMS notes that Congress allowed states to include these groups as meeting the definition of "uninsured" and therefore qualify for COVID-19 testing and treatment under Section 3716. The agency appears to conclude that Congress included these limited benefit recipients as "uninsured" because they would otherwise not be able to receive testing and treatment services under 6008(b) of FFCRA. The Partnership does not agree with this conclusion, and instead finds that CMS has the discretion to apply both Sections 3716 and Section 6008(b)(4) of the FFCRA to limited benefit groups, which would allow states to receive 100 percent FMAP for COVID testing and treatment under Section 3716 and their regular FMAP in addition to the 6.2 percent per Section 6008.

Individuals with limited Medicaid coverage should not be penalized for being enrolled in benefit-specific coverage, including limited-scope family planning coverage or tuberculosis coverage. The Partnership urges CMS to consider the circumstances of a global pandemic to provide treatment options with no cost-sharing, like vaccine coverage, to individuals with coverage that does not traditionally cover adult vaccines.

Partnership for Medicaid Recommendation: Clarify that states must cover COVID-19 testing, therapeutics, and vaccination without cost-sharing for all Medicaid enrollees during the PHE, regardless of their benefit category.

Temporary Increase in Federal Medicaid Funding

In this IFR, CMS proposes to reinterpret Section 6008(b)(3) of the FFCRA. Under the reinterpretation, states would be required to make individual beneficiary eligibility changes short of disenrollment from Medicaid entirely. For example, states would be required to make changes to a beneficiary's eligibility to reflect a change in income or a change related to age, pregnancy status, need for long term services and supports, or other eligibility factors. To aid states in this process, CMS created three distinct coverage tiers:

- Tier 1: States can move eligible beneficiaries into different eligibility groups as long as minimum essential coverage (MEC) and access to COVID-19 testing and treatment is maintained for those who had it as of March 18, 2020.
- Tier 2: States are permitted to move beneficiaries into different eligibility groups as long as coverage of COVID-19 testing and treatment is maintained.
- Tier 3: Applies to eligibility groups that do not have MEC or coverage of testing or treatment for COVID-19. If a beneficiary that is eligible for a type of tier 3 coverage becomes ineligible while the MOE requirements are in effect, the state cannot move them into a different tier 3 eligibility group.

In addition, under the enrollment reinterpretation, states claiming the 6.2 percentage point FMAP increase would be permitted to make programmatic changes, such as altering medical necessity criteria or utilization control procedures in determining coverage for benefits; eliminating optional benefits coverage; and increasing cost-sharing responsibilities (except with respect to

testing services and treatments for COVID-19 per Section 6008(b)(4) of the FFCRA). The Partnership has many concerns with the reinterpretation of Section 6008(b)(3) of the FFCRA and the potential impact on Medicaid beneficiaries. These concerns, as well as those related to the elimination of optional benefits and the implementation of patient cost-sharing, are outlined below.

Changing eligibility groups

The coverage tiers proposed by CMS are purportedly designed to help ensure that beneficiaries protected under Section 6008(b)(3) of the FFCRA do not experience a reduction in covered benefits that would be inconsistent with Section 1902(a)(19) of the Act. The Partnership is concerned that CMS' reinterpretation may lead to fewer benefits for some beneficiaries.

For example, a beneficiary that turns 21 and is moved from the child eligibility category to the Medicaid expansion eligibility category will lose access to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. As a result of losing access to EPSDT, this young adult may be unable to access necessary immunizations, such as the human papillomavirus vaccine. In another example, women who – as a result of the COVID-19 PHE – have remained enrolled in pregnancy-related Medicaid and have surpassed the statutorily-mandated 60-day cliff for postpartum coverage may be deemed eligible for coverage under Medicaid expansion. States would now be required to move these women into the adult expansion group for the remainder of the PHE. In some instances, this may result in decreased benefits, such as a reduction in coverage for case management, parenting education, and breastfeeding support.

Similarly, if a postpartum beneficiary residing in a state that offers pregnancy-related Medicaid coverage that is not considered MEC is not eligible for any tier 1 eligibility groups but is eligible for tier 2 coverage, such as through a limited benefit section 1115 demonstration providing non-MEC coverage that includes access to testing services and treatment for COVID-19, the state must move her to that coverage. Under this scenario, a woman could find herself losing critical health care services, including home visits and treatment for substance use disorder (SUD). In turn, she would only be eligible for family planning and family planning-related services and supplies, as well as testing and treatment for COVID-19, should her state provide that coverage under the limited benefit family planning program.

Narrowing the definition of “validly enrolled”

As Medicaid stakeholders, the Partnership acknowledges that states are facing budget constraints driven by the pandemic and increased Medicaid enrollment. Nevertheless, states should not be permitted to resolve budget deficits at the expense of vulnerable populations, like those enrolled in Medicaid. This is especially unconscionable in the middle of a pandemic. The Partnership finds it is unreasonable for CMS to interpret the term “enrolled for benefits” in Section 6008(b)(3) of FFCRA to mean “validly enrolled” for purposes of FFCRA Section 6008. CMS seriously misinterprets the maintenance of enrollment statutory requirement and should not allow states to claim the temporary FMAP increase while reducing or terminating Medicaid recipients' benefits.

The Partnership is also concerned about the implications of this narrow definition for individuals found eligible for Medicaid under presumptive eligibility. Under the IFR, CMS states that individuals deemed eligible via 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.” The Medicaid statute consistently describes presumptive eligibility as (for example, under hospital presumptive eligibility) “determining, on the basis of preliminary information, whether any individual is eligible for medical assistance....”¹ CMS’ attempt to distinguish the presumptively eligible population from other Medicaid populations is therefore inconsistent with the Medicaid statute and should be rescinded.

Elimination of optional benefits

Optional benefits in the Medicaid program are essential to patient health. In the IFR, CMS proposes to give states the flexibility to eliminate optional benefits – including dental, vision, and targeted case management services – in an effort to reduce costs. Experience shows, however, that when optional benefits are cut, the result is an increase in overall associated costs.² For example, cuts to optional dental benefits in Massachusetts in 2002 and 2003 and in California in 2009 resulted in both a decline in provider reimbursements as well as increases in associated costs because health needs went untreated by providers.³⁴ This, in turn, led to increased dependence on emergency departments. The Partnership urges a return to previous guidance that keeps in place states’ benefits packages if accepting an increase in funding as this will cost states less over time than making cuts to essential care.

Moreover, there are areas where cutting optional benefits in the middle of a pandemic would be counterproductive by increasing the risk of infection, as with cuts to Home and Community-Based Services (HCBS). As COVID-19 has exposed, people with disabilities and older adults are particularly vulnerable to the risk of infection and illness, facing high risk of complications and death from the virus. It is critically important that state HCBS programs and benefits be sustained – not rolled back – throughout this crisis.

Increases in cost-sharing

Research demonstrates that requiring financial contributions from patients for health care and related services has an adverse effect on lower-income populations, particularly those who are eligible for Medicaid.⁵ In a review of 65 papers published between 2000 and 2017, the Kaiser Family Foundation found that premiums and other forms of financial contributions in the Medicaid program are a barrier to receiving and maintaining coverage over the long term.⁶ Given the severe economic toll of the COVID-19 pandemic, now is not an appropriate time for states to be shifting more costs onto Medicaid program beneficiaries.

Partnership for Medicaid Recommendation: Abandon the reinterpretation finalized in the IFR and instead issue new guidance reinstating the MOE requirements that were provided to states earlier this year.

State Innovation Waivers Policy and Regulatory Revisions

The IFR will allow states to request that public notice requirements for Section 1332 waiver applications be waived during the PHE if certain conditions are met. It will also allow CMS to waive public notice requirements for approved Section 1332 waivers during the PHE when the application of the public notice procedures would be contrary to the interests of consumers. The public notice and comment period associated with Section 1332 waivers is statutorily required. The Partnership appreciates that under the current process there is adequate notification and opportunity for stakeholders to provide public comment on the implications (both positive and negative) of regulatory changes pursued via Section 1332. Removing the requirements for public notice and comment threatens the validity of these programs and is ill-advised during the COVID-19 PHE.

Further, this proposal is unnecessary. States already have the option to request 1135 waiver authority for the explicit purpose of making rapid changes in the event of a PHE. In fact, the majority of states have used this authority during the COVID-19 pandemic. The Partnership applauds CMS for working with states to ensure that they could quickly respond to this crisis under the authorities provided by 1135 waivers. The Partnership does not, however, support the changes made to the Section 1332 waiver process set forth in this IFR.

Partnership for Medicaid Recommendation: Revoke the changes made to the Section 1332 waiver process.

General Comments on the Use of an Interim Final Rule

CMS should not have implemented these policies – which directly and materially impact access to health care for tens of millions of Medicaid enrollees during a pandemic – as an IFR. The Administrative Procedure Act anticipates that government agencies will implement regulations only after receiving and considering public comment and that IFRs will be used rarely and only of necessity. There is no significant exigency associated with a notice and comment period for the policies 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 before CMS has time to finalize the rule – harms that could have been avoided had CMS solicited public comments before the rule went into effect.

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Thank you for the opportunity to comment on CMS-9912-IFC – Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency. Should you have any questions regarding our comments, please contact Jonathan Westin, First Co-Chair of the Partnership for Medicaid, at Jonathan.Westin@JewishFederations.org.

Sincerely,

American Academy of Family Physicians
American Academy of Pediatrics

American College of Obstetricians and Gynecologists
American Dental Association
American Dental Education Association
America's Essential Hospitals
Association of Clinicians for the Underserved
Association for Community Affiliated Plans
The Catholic Health Association of the United States
The Jewish Federations of North America
National Association of Community Health Centers
National Association of Pediatric Nurse Practitioners
National Health Care for the Homeless Council
National Hispanic Medical Association

¹ 42 CFR §435.1110

² Kaiser Family Foundation. [Few Options for States to Control Medicaid Spending in a Declining Economy](#). April 2008.

³ Health Affairs. [Eliminating Medicaid Adult Dental Coverage In California Led To Increased Dental Emergency Visits And Associated Costs](#). May 2015.

⁴ American Journal of Public Health. [Effects of Cuts in Medicaid on Dental-Related Visits and Costs at a Safety-Net Hospital](#). June 2014.

⁵ National Health Law Program. [Medicaid Premiums and Cost Sharing](#). March 26, 2014.

⁶ Kaiser Family Foundation. [The Effects of Premiums and Cost Sharing On Low-Income Populations](#). June 2017.