January 4, 2021

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

RE: **Comments on 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

Dear Administrator Verma:

The Consortium for Citizens with Disabilities (CCD) Health and Long Term Services and Supports Task Forces appreciate the opportunity to submit comments on the Centers for Medicare and Medicaid Services (CMS) Interim Final Rule "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency." The Consortium for Citizens with Disabilities (CCD) is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society. CCD members represent a broad range of stakeholders – people with disabilities and their families, older adults, disability service providers and workers, healthcare professionals, and state systems that provide disability services – who advocate on behalf of adults and children with all types of disabilities, including people with physical, intellectual, developmental, and mental health disabilities, chronic health conditions, and older adults.

The Families First Coronavirus Response Act (FFCRA), signed into law on March 18, includes an option for states to receive enhanced federal Medicaid funding. In exchange for the additional funds, states must agree to comply with maintenance of effort (MOE) protections. These protections help ensure individuals are able to get and stay covered

during the crisis and receive needed services. The FFCRA includes an explicit requirement to preserve enrollee's existing benefits – both their enrollment in Medicaid overall, and the services for which they have been eligible. At a time of such turmoil, Congress chose to protect enrollees and ensure access to services by maintaining the "status quo."

We are writing to express our deep concern about several provisions of this Interim Final Rule (IFR). In a reversal of CMS's stated policy from March to October 2020, this IFR would now allow states to impose numerous types of coverage restrictions for individuals who are enrolled in Medicaid, including reduced benefits; reduced amount, duration, and scope of services; increased cost-sharing; and reduced post-eligibility income. The IFR will also result in terminations for some individuals who should not be terminated. We oppose these revisions to the MOE, which are inconsistent with the FFCRA and will result in harm for Medicaid enrollees. We also oppose allowing states to circumvent required transparency procedures for 1332 waivers and receive enhanced funding despite refusing to cover COVID-19 vaccination for some Medicaid enrollees. We recommend that CMS withdraw these provisions.

Reduction of Optional Benefits

This rule gives states sweeping authority to reduce optional Medicaid benefits; cut the amount, duration and scope of benefits; increase utilization management; increase cost-sharing; and reduce post-eligibility income – all with no consequences for their enhanced matching funds under the FFCRA. These changes contravene the letter and intent of the statute, and will result in significant harm for people with disabilities and older adults.

"Optional" Medicaid benefits are hardly optional for people with disabilities who rely on those services to stay healthy, safe, and active in their communities. These services include physical and occupational therapy, dental and vision services, home and community-based services, and most behavioral health services. After the previous economic downturn in 2008, many states made significant cuts to each of these services.

This IFR is particularly concerning to CCD because it permits cuts to crucial home and community-based services in the middle of a horrendous pandemic. HCBS provide people with disabilities and older adults a range of services, including in-home assistance with activities of daily living like bathing and eating, employment and day program services, and residential and housing-related supports. However, these services are optional and expensive, and can be capped via HCBS waivers. These

services are also key to ensuring that people with disabilities are able to avoid institutional settings—which should be the utmost priority during a pandemic where nearly 40% of deaths have been in congregate settings.[1]

We are extremely concerned that states facing budgetary concerns will cut HCBS services in an attempt to save money in the short-term, devastating community-based systems that have taken decades to build, and placing the lives of people with disabilities at risk. Many providers of HCBS are facing financial strain due to the pandemic, and cutting optional services may put them out of business. Among HCBS providers serving individuals with intellectual and developmental disabilities, 77% have had to close one or more programs, and 16% do not anticipate these programs reopening. Likewise, a survey of state mental health authorities found that 73% of respondents reported community providers have reduced staff or services, and 20% have had mental health providers close.

Weakening the MOE will also harm other important services for older adults and people with disabilities, such as vision and dental services. Untreated vision and dental issues contribute to poor overall health. Medicaid participants without access to vision services reported more functional limitations.[2] Elimination of Medicaid dental benefits has been found to increase emergency department use for dental complaints – a health care inefficiency particularly concerning during the pandemic, when the risk of COVID-19 transmission is a major concern. COVID-19 itself can negatively affect oral health by weakening the circulatory system and causing inflammation. In addition, dental spending has fallen during the pandemic by far more than other provider types.

Reductions in the Amount, Duration and Scope of Services

The IFR would allow states to change the amount, duration, and scope of services. For example, when states faced budget constraints after the Great Recession, some states placed numerical caps on benefits like physician visits and hospital days. While these capped services may have been adequate for some enrollees, in many cases they were likely not sufficient for other populations, such as some people with chronic illnesses and disabilities.

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[1] Kaiser Family Found., COVID-19: Long-Term Care Facilities, https://www.kff.org/coronavirus-covid-19/issue-brief/state-covid-19-data-and-policy-actions/#longtermcare, (Last visited Dec. 22, 2020).

[2] Brandy J. Lipton and Sandra L. Decker, The Effect of Health Insurance Coverage on Medical Care Utilization and Health Outcomes: Evidence from Medicaid Adult Vision Benefits, 44 J HEALTH ECON. 320 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6767617/.

Further, during the Great Recession, many states targeted reductions to services used almost exclusively by people with disabilities and older adults. For example, Colorado and Nebraska limited incontinence supplies; Idaho limited psychosocial rehabilitation services; South Carolina limited home health visits; and Virginia, Vermont, and Indiana reduced speech, occupational, and physical therapy, to name just a few. This IFR would allow states to take a page from the old playbook, and limit access to services for individuals with disabilities and older adults.

Prior Authorization and Utilization Management Requirements

The IFR would also allow states to impose new prior authorizations and other utilization management requirements. These can harm Medicaid enrollees and providers in typical times, and these issues are likely to be significantly exacerbated during COVID-19. Presently, many providers are overwhelmed caring for COVID-19 patients. Increased prior authorizations will divert them from that essential work. Moreover, overloaded clinician offices and limited in-person visits make it more likely patients will "fall through the cracks" and not get their medications or other services when a prior authorization is needed. This concern is backed up by survey research, which reports that of the 52% of people whose families skipped or postponed care during the previous three months due to coronavirus, 82% did so because the doctor's office was closed or had limited appointments. A survey of certain Medicaid-enrolled providers in Texas found that they saw prior authorizations as a significant burden. They agreed that prior authorizations take time away from patients, and reduce the pool of providers that will see Medicaid patients due to administrative burden.

Research has found that individuals are more likely to discontinue needed medications when prior authorizations are required. For some adults with psychiatric disabilities, prior authorization requirements have been associated with medication discontinuation, reduction in visits to community mental health centers, and increases in emergency room visits. Similarly, caps on the number of prescriptions per month without generous overrides have been associated with high levels of untreated mental health needs for individuals with bipolar disorder, and moves to more generous prescription drug coverage are associated with increases in treatment. These restrictions in coverage particularly harm individuals with disabilities, who typically have greater need for prescription drugs and have well-documented health disparities.

Post-Enrollment Income Verification

The IFR also permits states to modify their post-eligibility treatment of income (PETI) rules. This could leave enrollees with disabilities who are institutionalized or using a home and community-based services (HCBS) waiver program with less money to meet

their basic needs, which could cause significant harm. For example, if states don't allow HCBS waiver enrollees to keep 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 starkly disproportionate impact of COVID-19 on people in congregate settings.

Coverage Tiers

CMS should abandon the coverage tiers system in the IFR. The IFR would allow 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 FFRCA, which requires preserving individuals' benefits, and can cause substantial harm. This harm will disproportionately fall on people with disabilities and older adults.

- Under the IFR, some individuals enrolled in 1915(c) home and community-based service waivers could be moved to Medicaid expansion coverage, which can come with increased cost sharing requirements and fewer benefits, leading them to not get needed services. Some of these individuals have likely been found to no longer be eligible for 1915(c) waiver enrollment because they received inadequate remote functional assessments during the pandemic.

- Individuals becoming eligible for Medicare could be moved into Medicare Savings Programs (MSPs), on the theory that MSPs will include Medicare and thus a source of minimum essential coverage. This is prohibited by the statute. Moreover, such transitions would lead to significant benefit losses and cost increases for consumers. In many cases individuals will no longer qualify for full-scope Medicaid benefits, lose access to critical services such as transportation, and will be subject to Medicare's substantial deductibles and coinsurance – even for services like COVID-19 treatment.

We are also concerned that states will need to spend significant effort implementing these changes to their eligibility system. This effort would be far better spent doing other work, such as bolstering their ex parte renewal processes and updating addresses to better prepare for conducting redeterminations at the end of the public health emergency. Moreover, such massive changes to each states' eligibility system will likely generate errors.

Increased Cost-Sharing

The IFR would allow states to increase cost-sharing, which would also harm Medicaid enrollees. Research over the last four decades 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. Further, the pandemic has increased the barriers cost-sharing imposes. 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.

Further, increased cost-sharing could further disadvantage people with disabilities and older adults. As noted above, people with disabilities and older adults utilize more services that are commonly subject to cost sharing, such as outpatient prescription drugs, or physical, occupational, and speech therapy, at a higher rate than nondisabled people. They also have disproportionately lower or fixed incomes, meaning the relative impact of cost-sharing on their ability to fill prescriptions would be greater. It is well established that discontinuing, rationing, or not initiating a needed medication correlates with more emergency department visits, increased non-elective hospitalizations, and other negative health outcomes.[3]

General Eligibility Exceptions

Additionally, the IFR authorizes states to terminate coverage for individuals that should be protected under the FFRCA. This violates Congress' intent and should be rescinded.

Under Medicaid's Immigrant Children's Health Improvement Act (ICHIA) option, states can cover lawfully present immigrant children and pregnant women without a 5 year wait. However, once these children turn 21 and these women finish their 60-day postpartum period, the IFR requires states to restrict their eligibility to the limited emergency Medicaid eligibility group. Essentially, with no statutory basis, CMS asserts that the MOE does not apply to this population – a particularly troubling exclusion because immigrant communities, including immigrants with disabilities, have experienced higher exposure risk to COVID-19. Depending on the state, COVID-19 testing and treatment may not be covered under emergency Medicaid. Furthermore, individuals will not have coverage for the management of chronic conditions, worsening health outcomes and potentially increasing the risk of death from COVID-19.

[3] John Hsu et al., Unintended Consequences of Caps on Medicare Drug Benefits, 354 NEW ENG. J. MED. 2349–59 (2006); Amitabh Chandra, Jonathan Gruber & Robin McKnight, Patient Cost-Sharing and Hospitalization Offsets in the Elderly, 100 AMER. ECON. REV. 193 (2010); Amal N. Trivedi, Husein Moloo & Vincent Mor, Increased Ambulatory Care Copayments and Hospitalizations among the Elderly, 362 NEW ENG. J. MED. 320 (2010).

CMS newly interprets the statute to allow states to terminate individuals who have not responded to requests to verify residency if the Public Assistance Reporting Information System (PARIS) system shows the individual as eligible in two or more states. However, this policy does not arise from the statute, and has a critical flaw: that many individuals will be terminated by the state they truly reside in. Before the pandemic, many individuals who were eligible for Medicaid lost coverage during redeterminations due to barriers associated with Medicaid mailings. During the PHE, these barriers worsened. Many individuals may not respond due to COVID-related health problems, caretaking responsibilities, and displacement. People with disabilities were already more likely to experience homelessness prior to the pandemic, a concern only heightened during the pandemic. Already, state Medicaid agencies are seeing an increase in returned mail due to the pandemic. Acknowledging these exceptional circumstances arising from the pandemic, Congress enacted the FFCRA's continuous coverage provision. Instead of permitting terminations for non-responsiveness, CMS should instead require states to communicate with each other until one state is able to confirm residence.

The IFR allows states to effectuate "voluntary terminations" or "transitions" of individuals who wish to drop their coverage or move to an eligibility group that would otherwise violate the IFR's tiering policy. However, without clear and prescriptive protections, these policies may lead to abuses. For example, CMS should clarify that a lack of response to a state-initiated communication may never constitute grounds for a voluntary termination or transition.

Valid Enrollment

Under the IFR, CMS narrows the definition of "valid enrollment" to exclude some enrollees who should be considered properly enrolled and covered by the protections of the FFRCA.

CMS 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 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…" (emphasis added).[4] CMS's attempt to distinguish presumptively eligible populations is therefore inconsistent with the Medicaid statute. Moreover, pandemic-related circumstances are making it

[4] 42 U.S.C. § 1396(a)(47)(B)

extremely difficult for many people to complete a full Medicaid application before their presumptive eligibility period ends.

Individuals determined presumptively eligible during a hospital visit might have trouble completing paperwork or gather the necessary documentation for a full application. The process may be particularly difficult for individuals whose conditions require them to completely isolate due to increased risk of COVID-19, or for homeless individuals, individuals with developmental and psychiatric disabilities, and individuals with limited English proficiency. In other times, they may rely on community or social services agencies to assist with the application, but are unlikely to be able to access that kind of in-person support during the pandemic. These individuals are not "ineligible" for Medicaid—they simply face increased barriers to applying. CMS should allow these individuals to continue on Medicaid until the end of the public health emergency.

Determinations of Ineligibility

The IFR writes that "if a state determines that a validly enrolled beneficiary is no longer eligible for Medicaid, including on a procedural basis", the state meets the MOE requirements by "continuing to provide the same Medicaid coverage that the beneficiary would have received absent the determination of ineligibility." This language needs clarification or correction. We note two important considerations.

First, CMS should preserve the requirement that the MOE provision apply to *procedural* problems. For example, an individual who is delayed in responding to state outreach or requests for information may be dealing with serious health, economic, or housing problems related to the COVID-19 crisis. Such procedural breakdowns cannot be a basis to discontinue eligibility in violation of the FFCRA.

Second, however, CMS must correct or clarify the use of the terms "determines" and "determination" in the regulation. No one protected by the MOE can be "determined" ineligible, as that would be contrary to the FFCRA's requirement that during the PHE these enrollees be "treated as eligible". We suggest CMS use a term such a "nonactionable finding of ineligibility" instead of "determination of ineligibility."

Moreover, CMS should make clear that any such nonactionable finding of ineligibility during the public health emergency is not sufficient or even relevant to terminate someone at the end of the PHE. CMS should clarify that *after* the PHE ends, individuals must receive a full redetermination, based on *current, point-in-time* information (current income, household composition, etc.).[5] Such a review must consider all bases of

[5] *See e.g.,* 42 U.S.C. § 1396a(e)(14)(H); 42 C.F.R. § 435.603(h)(2).

eligibility, and give enrollees at least 30 days to respond to a request for information (for those eligible using modified adjusted gross income).[6] After the MOE ends and a full redetermination occurs, if an individual is found ineligible they are entitled to due process protections, such as a notice of termination that includes the effective date of the action and appeal rights.[7]

1332 Waiver Changes

Under the IFR, CMS also proposes to allow the "modification" of public notice, comment, and hearing requirements for Section 1332 waiver requests pursuant to the Affordable Care Act, as well as post-award public hearings. These exceptions conflict with 1332 statutory requirements, and are overbroad and unnecessary.

The IFR conflicts with the Affordable Care Act in that, through "modification," they might allow the *elimination* of required transparency provisions. The IFR would also allow public notice and comment periods to be effectuated *after* the state files the application (in the case of state comment periods) or CMS conducts federal review (in the case of federal comment period). This will result in state proposals and CMS approvals that have no meaningful stakeholder input, violating the statute and congressional intent.

In addition to being required by statute, the transparency process creates a minimal delay, in exchange for substantial benefit. As CMS has previously noted, the public notice and comment process on 1332 waivers "promotes transparency, facilitates public involvement and input, and encourages sound decision-making at all levels of government".[8] This process is essential to ensure that consumers have input into proposed waivers.

Availability of COVID-19 Vaccines

As of December 21, 2020, more than 319,000 people in the United States have died due to COVID-19, with over 18 million confirmed cases. Public health experts agree that widespread use of a safe and effective preventive vaccine will be essential to curb this deadly pandemic.

Two vaccines have now received FDA emergency use authorization and distribution has begun. In March 2020, Congress recognized the vital importance of coverage and access to COVID-19 vaccines when it enacted the FFCRA. Congress provided that

[6] 42 C.F.R. §§ 435.916(a)(3)(i)(B), (f)(1)
[7] *See e.g.,* 42 C.F.R. §§ 435.917(b)(2), 431.210
[8] 76 Fed. Reg. 13556 (Mar. 14, 2011).

state Medicaid programs receive enhanced federal funding if they cover approved COVID-19 vaccines, and provide access without cost sharing, during the period of the public health emergency.

However, CMS is inexplicably seeking to limit access to COVID-19 vaccines, allowing states to exclude coverage of vaccinations for people enrolled in Medicaid limited benefit eligibility groups. These Medicaid limited benefit programs include programs focused on the treatment of breast and cervical cancer and tuberculosis, family planning programs, and some programs provided under § 1115 waiver authority.[9] Further, CMS provides no explanation or analysis on how it would determine which of the existing 57 § 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. The obvious intent of the provision was to ensure widespread access to COVID-19 vaccination. CMS should not invent an ambiguity and then interpret it contrary to the statute's overriding intent. Congress is well familiar with limited scope benefits categories and would have carved out exceptions to FFRCA 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. This misguided interpretation will harm people with disabilities and older adults, including tens of thousands covered by 1115 programs or in limited benefit categories. Even if they are not directly excluded from vaccine coverage, their health ultimately depends on their community achieving herd immunity through mass vaccination. For people with certain conditions, such as individuals with suppressed immune responses, the risk of receiving a vaccine may outweigh the benefits. Those individuals depend on making sure that anyone who can receive the vaccine, does. Restricting Medicaid coverage of the vaccine 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. It should be withdrawn.

Use of an Interim Final Rule

We do not believe CMS should have implemented these policies – which directly and materially access to health care for tens of millions of enrollees during a pandemic – as an interim final rule. The Administrative Procedure Act anticipates that that government

[9] *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).

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 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 policies described in this IFR. But reducing health care eligibility, decreasing benefits, and increasing costs during a pandemic without an opportunity contravenes the public interest. These policies will cause substantial harms before CMS can finalize the rule – harms that could have been avoided had CMS solicited public comments, like ours, before the rule went into effect.

Conclusion

This is an unprecedented pandemic, and Congress took unprecedented measures under the Families First Coronavirus Response Act to make sure Medicaid enrollees can access the services they need. The aforementioned provisions of the Interim Final Rule fly in the face of the law, and rip health care away from people at a time when health care is more important than ever. We strongly oppose these provisions of the Interim Final Rule, and urge HHS to withdraw them immediately.

Finally, we have included citations and direct links to research and other materials. 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 for purposes of the Administrative Procedures Act. If HHS is not planning to consider these citations part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies into the record.

Thank you for the opportunity to comment on this important issue. If you have further questions, please contact Jennifer Lav (lav@healthlaw.org) or David Machledt (machledt@healthlaw.org).

Sincerely,

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