December 21, 2020

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:

TakeAction Minnesota and our partners 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,” issued on November 6 and related to the Families First Coronavirus Response Act (FFCRA).

TakeAction Minnesota is a multi-racial people’s organization building power for a government and economy that works for all of us. We and our partners have been on the frontlines of fighting to grow and sustain access to comprehensive, equitable health care in Minnesota, and we led the grassroots campaign to expand Medicaid and establish the country’s first Basic Health Plan. We believe everyone should have access to quality, affordable, culturally appropriate health care, no exceptions.

Medical Assistance, Minnesota’s Medicaid program, provides essential health and economic security to over one million Minnesotans. As recent enrollment growth indicates, Medicaid is providing a lifeline during the health and jobs crisis resulting from COVID 19. As our state navigates the remaining months of the pandemic, access to secure, comprehensive, and affordable Medical Assistance coverage will remain critical to the health and wellbeing of Minnesotans.

During this precarious time for our state’s health, we are writing to express our deep concern about several provisions of the Interim Final Rule (IFR). 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 enrollees’ existing benefits – both their enrollment in Medicaid overall, and the services for which they

have been eligible. At a time of such turmoil and uncertainty, Congress specifically chose to protect enrollees and ensure access to services by maintaining the “status quo.”

In a reversal of CMS’s stated policy from March to October 2020, the November 6 IFR would upend MOE protections by allowing states to impose numerous types of coverage restrictions for individuals who are enrolled in Medicaid. Such restrictions include reduced benefits; reduced amount, duration, and scope of services; increased cost-sharing; and reduced post-eligibility income. The IFR will also result in coverage terminations for some individuals who should not be terminated.

Restricting health services to Medicaid enrollees or imposing additional cost burdens is harmful at any time, but is particularly damaging during COVID 19. We oppose these revisions to the MOE, which are inconsistent with the FFCRA and will undermine the health and economic stability of Medicaid enrollees. We also oppose allowing states to circumvent required transparency procedures for 1332 waivers. Finally, we oppose allowing states to 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 enrollees.

Minnesota provides several benefits within Medical Assistance that are optional under the federal law but essential to the health of tens of thousands of Minnesota enrollees. Home and community-based services, for example, comprise one of the largest and most important parts of Minnesota’s Medicaid system. The diverse array of services is critical for keeping individuals out of institutions while living safely integrated in a variety of community-based settings. For enrollees in these programs, such services are not “optional,” they often need a nursing level of care, and the home and community-based services (HCBS) services they receive are vital to helping them remain in their own homes. Removing enrollees from these programs, especially during a pandemic, would jeopardize their own health while further destabilizing our already overburdened institutions such as hospitals, nursing homes, and other institutional settings.

Numerous other services that are optional under federal law are essential to the health of Medicaid enrollees in Minnesota. These services include: dental and vision services, physical and occupational therapy, and rehabilitative services for substance use and mental health. Reduction of these and other optional benefits would be devastating to individual enrollees, their families, and fragile provider networks struggling in the pandemic. Consequences of such reductions would include the following:

- Untreated vision and dental issues that will contribute to poor overall health. Lack of Medicaid coverage for vision services makes it more likely that a person will have functional limitations.
- Elimination of Medicaid dental benefits increases the use of emergency department services for dental complaints and further strains our already overtaxed emergency departments. Increased strain on emergency departments is particularly concerning during the pandemic, as the risk of COVID-19 transmission is a major concern in emergency departments.
- Cuts to optional services may put some providers out of business, as many providers of optional benefits are already under financial strain due to the pandemic. For example, 77 percent of HCBS providers serving individuals with intellectual and developmental disabilities have had to close one or more programs, and 16 percent do not anticipate these programs reopening. In Minnesota, older adults and persons with disabilities depend on day-service providers, including job supports. Those programs were closed through earlier parts of the pandemic and it is unclear how many will ultimately survive.

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.

Prior Authorization and Utilization Management Requirements

The IFR would also allow states to impose new prior authorizations and other utilization management requirements. These mechanisms 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 percent of people whose families skipped or postponed care during the previous three months due to coronavirus, 82 percent did so because the doctor's office was closed or had limited appointments. Research has also found that patients are more likely to discontinue needed medications when prior authorizations are required.

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 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.

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 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 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 certain groups, including people with disabilities and older adults.

Under the IFR, some individuals enrolled in 1915(c) HCBS 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.

Narrowed Definition of 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.

Presumptive Eligibility

- 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).[1] CMS's attempt to distinguish presumptively eligible populations is therefore inconsistent with the Medicaid statute. Moreover, pandemic-related circumstances are making it extremely

[1] 42 U.S.C. § 1396(a)(47)(B)

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

Agency Error, Fraud and Abuse

- CMS would allow states to terminate individuals for “agency error,” fraud or abuse. The IFR states that if the state investigates and finds there was “agency error,” fraud or abuse that was “material to the determination of eligibility”, then the individual is not “validly enrolled”, and the state may have to terminate their Medicaid. However, the applicable regulations give states a range of options to resolve an abuse investigation, and do not necessarily require an individual be disenrolled.[2] CMS should not impose outcomes that supplant or skip the state processes already in place and specified by regulations.

1332 Waiver Process Transparency 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”.[3] This process is essential to ensure that consumers have input into proposed waivers.

Availability of COVID-19 Vaccines

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 programs. 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

[2] *See* 42 C.F.R. § 455.16
[3] 76 Fed. Reg. 13556 (Mar. 14, 2011).

§ 1115 waiver authority.[4] Further, CMS does not provide any 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 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. 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 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 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 before CMS has time to 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.

Sincerely,

TakeAction Minnesota

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[4] *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).

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