Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

October 27, 2022

VIA ELECTRONIC SUBMISSION

Department of Health and Human Services
Centers for Medicare & Medicaid Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-9912-N
Medicaid Program; Temporary Increase in Federal Medical Assistance Percentage (FMAP) in Response to the COVID-19 Public Health Emergency (PHE); Reopening of Public Comment Period

Dear Sir/Madam:

Thank you for the opportunity to comment on CMS-9912-N, RIN 0938-AU35, "Medicaid Program; Temporary Increase in Federal Medical Assistance Percentage (FMAP) in Response to the COVID-19 Public Health Emergency (PHE); Reopening of Public Comment Period" (hereinafter referred to as "the reopened IFR"). The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005. As part of the McCourt School of Public Policy, CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, especially those with low and moderate incomes.

The reopened IFR references the November 2020 issuance of a rule entitled, "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency," hereinafter referred to as "the original IFR." The original IFR covered a wide range of topics, which we commented on in December 2020. The reopened IFR is limited to 42 CFR §433.400, and as such, this letter simply responds to the two questions raised by the Centers for Medicare & Medicaid Services (CMS): (1) whether 42 CFR §433.400 should be rescinded and (2) if so, whether it should be replaced with a provision implementing CMS' initial interpretation of §6008(b)(3) of the Families First Coronavirus Response Act (FFCRA) issued in guidance.

Rescind 42 CFR §433.400

The FFCRA provided a temporary 6.2 percentage point increase in the federal Medicaid matching rate (FMAP) through the end of the calendar year quarter in which the current public health emergency (PHE) expires. As a condition of receiving the increased FMAP, state Medicaid programs must adhere to four statutory rules: (1) maintain the same eligibility standards, methodologies and procedures (FFCRA §6008(b)(1)); (2) prevent any

premium increases (FFCRA §6008(b)(2)); (3) cover COVID-19 testing and treatment without cost-sharing (FFCRA §6008(b)(4)); and (4) maintain coverage for any beneficiaries who were enrolled as of March 18, 2020 (or newly enrolled beneficiaries after such date) through the end of the month in which the PHE ends (FFCRA §6008(b)(3)).

This last "continuous coverage" requirement is critical to ensuring that low-income individuals and families have access to health coverage and needed care during the pandemic. The statute requires states to continue to provide beneficiaries with *such benefits* as they received at the time of enrollment through the end of the month in which the PHE ends as a condition of receiving the higher federal match. States may disenroll beneficiaries only if the beneficiary requests a voluntary termination or ceases to be a state resident.

The regulatory provision at 42 CFR §433.400 implementing the continuous coverage requirement should be rescinded. Under 42 CFR §433.400, state Medicaid programs are permitted to reduce the amount, duration, and scope of covered benefits for individuals enrolled, even as they continue to collect an additional 6.2 percentage points of federal matching funds. The regulatory provision violates the plain reading of the statute.

CMS Must Limit Disenrollment to Title XIX Statutory Bases

The Secretary of HHS does not have the authority to provide states with the enhanced federal matching funds unless the state complies with the continuous coverage requirements under FFCRA. The Secretary cannot make exceptions outside of those defined by the statute. Therefore, the Secretary should limit any allowable disenrollment to only those beneficiaries who request a voluntary termination, cease to be a state resident (including by dying), or have been convicted of or pleaded guilty to fraudulent enrollment, consistent with Medicaid program integrity rules.

- Remove references to "valid" enrollment. 42 CFR §433.400(c) limits the continuous coverage requirement to only those who are "validly enrolled" (the eligibility determination was not erroneous or the result of fraud and abuse). Medicaid law already provides for appropriate legal action, including disenrollment, in the case of fraud (as defined by 42 CFR §455.2). The references to "valid" enrollment at 42 CFR §435.400 are confusing and unnecessary.
- Require states to maintain coverage for lawfully residing children and pregnant women. 42 CFR §433.400(d)(2), *requires* states that have opted to cover lawfully residing children and pregnant women to limit their coverage to emergency services if individuals are found to no longer meet the definition of such children and pregnant women. The FFCRA provisions requiring continuous coverage are inclusive of all beneficiaries enrolled as of March 18, 2020, and those who have enrolled since that date, and there is no distinction made for beneficiaries enrolled under the state option at §1903(v)(4).[1]
- Prevent states from terminating coverage based on discrepant data matches. 42 CFR §433.400(d)(3)(ii) allows states to terminate coverage for Medicaid beneficiaries if

they do not respond to requests to verify residency following a data match indicating simultaneous Medicaid enrollment in two or more states. A discrepant data match is simply not grounds for terminating coverage while receiving the enhanced federal funding under FFCRA.

States must provide access to "such benefits" as a condition of receipt of the additional federal Medicaid funding

The FFCRA requires states to continue to provide beneficiaries with *such benefits* as they received at the time of enrollment through the end of the month in which the PHE ends as a condition of receiving the higher federal match.

However, under 42 CFR §433.400(c), state Medicaid programs are mistakenly permitted to eliminate optional benefits; reduce the amount, duration and scope of covered benefits; transfer beneficiaries from one category to another, even if it may reduce the benefits available to them; and increase beneficiary cost sharing compared to what was covered on March 18, 2020, even as they continue to collect an additional 6.2 percentage points of federal matching funds. The reopened IFR acknowledges that commenters to the original IFR cautioned that allowing states to reduce benefits not only violated the statute but also risked causing serious harm to beneficiaries (87 Fed. Reg. 58457). The original IFR was implemented anyway, and as the commenters warned, beneficiaries lost access to critical benefits, resulting in at least one lawsuit so far.

In the lawsuit, Connecticut Medicaid enrollees who were receiving full Medicaid coverage in March 2020, and thus protected by FFCRA, saw their full benefits terminated due to eligibility for a Medicaid "Medicare Savings Program" without the same benefits. These individuals live with serious medical conditions, including Freidrich's Ataxia, severe circulatory abnormalities and Multiple Sclerosis, and without full coverage had reduced access to medical, dental, and transportation services, risking worsened illness, new health problems, financial hardship, institutionalization, and even death.[2]

Simply put, any reduction in benefits clearly violates the statutory standard that, as a condition of receiving the 6.2 percentage point FMAP increase, beneficiaries continue to receive *such benefits* as they received in January – March 2020 (or, if enrolled after March 18, 2020, the benefits received at the time of enrollment) through the end of the month in which the PHE ends.

Importantly for young people, the FFCRA provision guarantees ongoing coverage including the comprehensive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit as they turn 21. The pandemic has caused major disruptions in the lives of children, teens, and young adults, including school closures and loss of social connections.[3] Allowing states to end EPSDT services for youth during the pandemic could expose them to increased risk of unmet needs and further exacerbate mental stressors. Reduced or eliminated benefits have particularly harmful consequences for beneficiaries living with disabilities, managing a chronic condition, or in the middle of a course of treatment.

Even small increases in cost-sharing imposed on low-income populations are associated with reduced use of care, including necessary services.[4] Allowing states to continue to receive the enhanced federal funding while imposing higher cost sharing not only violates the plain reading of the statute, it exacerbates the health and economic problems faced by families during the PHE.

Replace 42 CFR §433.400 with the policies outlined in CMS Frequently Asked Questions Documents that pre-dated the original IFR, with one notable exception

We urge CMS to replace 42 CFR §433.400 with provisions that adhere to the FFCRA requirements. In order to draw down the additional 6.2 percentage point match, states must be required to maintain continuous coverage for *all* beneficiaries enrolled on or after March 18, 2020 until the end of the month in which the PHE ends. All beneficiaries must continue to receive at least *such benefits* as they received in January – March 2020 (or, if enrolled after March 18, 2020, the benefits received at the time of enrollment) throughout the entire period. States may not reduce the amount, scope, or duration of benefits. States may not impose higher cost sharing.

For the most part, CMS accurately interpreted and implemented FFCRA §6008(b)(3) in subregulatory guidance issued prior to the original IFR. These earlier interpretations, along with erroneous modifications, can be found in the compiled document entitled, "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program Agencies," in Section II: Eligibility and Enrollment, Subsection I: Continuous Coverage under Section 6008 of the Families First Coronavirus Response Act.[5] CMS should return to these initial, accurate interpretations with respect to disenrollment and maintenance of benefits and cost sharing.

- Disenrollment. "… states must provide continuous coverage… to all Medicaid beneficiaries who were enrolled in Medicaid on or after March 18, 2020, **regardless of any changes in circumstances or redeterminations at scheduled renewals that otherwise would result in termination**. States may terminate coverage for individuals who request a voluntary termination of eligibility, or who are no longer considered to be residents of the state." (See FAQ I.1. at page 44, emphasis added)
- Benefits. "… states must continue to provide coverage to such beneficiaries in the eligibility group in which the beneficiary is enrolled if transitioning the beneficiary to another eligibility group would result in a reduction in benefits. If there is a separate eligibility group for which the individual is eligible and which provides the same amount, duration and scope of benefits, then a state may shift the individual to that group; **what is critical for ensuring eligibility for the temporary FMAP increase is that the same amount, duration and scope of medical assistance be maintained**." (See FAQ I.20. at page 52, emphasis added)
- Cost sharing. "A state is not eligible for the temporary FMAP increase authorized by section 6008 of the FFCRA if it reduces the medical assistance for which a beneficiary is eligible.... Such a reduction in medical assistance would be inconsistent with the requirement at section 6008(b)(3) of the FFCRA that the state

> ensure that beneficiaries be treated as eligible for the benefits in which they were enrolled…. **Because an increase in cost-sharing reduces the amount of medical assistance for which an individual is eligible, a state is not eligible for the enhanced FMAP if it increases cost sharing for individuals enrolled as of or after March 18, 2020.**" (See FAQ I.13. at page 48, emphasis added)

However, with respect to enrollment under §1903(v)(4), CMS erred in its interpretation of FFCRA even in the FAQs that predated the original IFR. (See FAQ 1.6. at page 45) As noted, the statute applies the continuous coverage provision to all Medicaid beneficiaries and CMS cannot create an exception for certain subgroups. Therefore, we recommend that CMS correct this interpretation in the next regulatory or subregulatory update, requiring states to maintain coverage for *all* Medicaid beneficiaries enrolled on or after March 18, 2020 through the end of the month in which the PHE ends in exchange for the additional federal funding as the statute requires.

Changed Circumstances

The original IFR incorrectly interpreted the continuous coverage requirement in violation of the plain reading of the statute. Even assuming the statute was ambiguous, the rationale used to justify the original IFR has not passed the test of time and is not reasonable. In the reopened IFR, CMS correctly acknowledges that circumstances have changed since the issuance of the original IFR in November 2020, invalidating the rationale used. As noted above, beneficiaries have been harmed by the unlawful reduction in benefits, contradicting Congress's unmistakable overarching intent to *protect* beneficiaries with a continuous coverage requirement and resulting in at least one lawsuit so far. CMS' initial interpretation in guidance provided beneficiaries with access to medical assistance during the COVID-19 pandemic consistent with the text and intent of the statute. The pending litigation is just one example of the harms that have followed the implementation of the original IFR. CMS also notes that predictions of dire state budgetary concerns that were a basis for the original IFR interpretation have not borne out, rendering that interpretation groundless. Congress has continued to provide states with fiscal relief throughout the COVID-19 pandemic, which combined with higher-than-expected tax revenues, has resulted in record-high state budget surpluses.[6]

Given these changed circumstances, the only permissible interpretation of FFRCA §6008 requires rescinding 42 CFR §433.400 and implementing the policy of the initial guidance. CMS must correct their interpretation of the statute and enforce the continuous coverage requirement in exchange for the additional federal funding.

Conclusion

The statutory requirements are clear: states must continue to provide all Medicaid beneficiaries with *such benefits* as they received at the time of enrollment through the end of the month in which the PHE ends as a condition of receiving the higher federal match. After months of implementing these policies through subregulatory guidance that generally adhered to the statute, CMS issued the original IFR in plain violation of the statutory

requirements. Commenters warned of the harms that would follow, and sadly, those predictions have come true. The reopened IFR gives CMS an opportunity to correct its interpretation and restore access to medical assistance as the statute requires. We urge CMS to rescind 42 CFR §433.400 and replace it with the policies outlined in subregulatory guidance in 2020, with one notable exception. CMS must require states to maintain continuous coverage for *all* beneficiaries enrolled on or after March 18, 2020, including those enrolled under §1903(v)(4) in exchange for the higher match.

We urge CMS to require states to immediately and automatically restore beneficiaries to their previous coverage, retroactive to the date coverage was terminated, and provide enrollees notice of such action. We further urge CMS to make the rule effective upon finalization, to minimize the wait for enrollees to get relief from their health and financial losses. CMS should also clarify that this retroactive period of coverage during the full duration of the PHE as required by FFRCA should be reinstated regardless of when the PHE ends or a state ceases to accept enhanced FFRCA funding. For example, if the PHE ends (or a state rejects enhanced funding) prior to the finalization of the rule, it should not dimmish a state's obligation to provide coverage for the duration of time that the PHE *was* in effect (and the state *was* accepting enhanced funding).

Our comments include numerous citations to supporting research for the benefit of the CMS. We direct CMS to each of the studies cited and made available 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 formal administrative record on this IFC for purposes of the Administrative Procedures Act.

If you have questions regarding our comments, you may contact us at (202) 784-3138.

Sincerely,

Kelly Whitener
Associate Professor of the Practice

[1] Under SSA §1903(v)(4), states have the option to provide coverage to lawfully residing immigrant children and pregnant women during their first five years in the U.S. As of January 2022, 35 of 51 states and DC have adopted this option for children in Medicaid, 24 of 35 have adopted this option for children in separate CHIP programs, 25 of 51 have adopted this option for pregnant women in Medicaid, and 4 of 7 have adopted this option for pregnant women in CHIP. See T. Brooks, et al, "Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings from a 50-State Survey," table 3, (Georgetown CCF and the Kaiser Family Foundation, March 2022), available at https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey/.

[2] Complaint, Carr v. Becerra (D. Conn. 2022) (No. 3:2022cv00988), available at https://healthlaw.org/wp-content/uploads/2022/08/U.S.-District-Court-in-Connecticut-Complaint_Aug-5.pdf.

[3] E. Williams and P. Drake, "Headed Back to School: A Look at the Ongoing Effects of COVID-19 on Child Health and Well-Being," (Kaiser Family Foundation, August 2022), available at https://www.kff.org/coronavirus-covid-19/issue-brief/headed-back-to-school-a-look-at-the-ongoing-effects-of-covid-19-on-childrens-health-and-well-being/.

[4] S. Artiga, et al, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of the Research Findings," (Kaiser Family Foundation, June 2017), available at https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[5] Centers for Medicare & Medicaid Services COVID-19 Frequently Asked Questions for State Medicaid and Children's Health Insurance Programs, last updated January 6, 2021, available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.

[6] B. Sigritz, "Strong Growth in Fiscal 2022 Revenues, Record-High Surpluses for Many States," (National Association of State Budget Officers, July 2022), available at https://budgetblog.nasbo.org/budgetblogs/blogs/brian-sigritz/2022/07/29/strong-growth-in-fiscal-2022-revenues-leads-to-rec.