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October 27, 2022

VIA ELECTRONIC SUBMISSION

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-9912-N, Mail Stop C4-26-05
7500 Security Boulevard, Baltimore, MD 21244-1850

Re: 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 (CMS-9912-N)

Dear Administrator Brooks-LaSure:

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the **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**. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable and equitable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over three million people with Medicare, family caregivers, and professionals.

We were deeply troubled by the promulgation of CMS-9912-IFC,[1] the fourth COVID-19 interim final rule (IFR), which was finalized in January of 2021. This rule was both a stark reversal of CMS's stated policy from March to October 2020 and in direct conflict with the Families First Coronavirus Response Act

[1] 85 FR 71142.

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(FFCRA) text and congressional intent. We strongly opposed those revisions and applaud CMS for reconsidering its interpretation of the statute's vital Medicaid maintenance-of-effort (MOE) provisions.[2]

Background

Around 12 million people are enrolled in both Medicare and Medicaid, but some forms of Medicaid are statutorily barred from such dual enrollment.[3] Adult Group Medicaid—commonly called expansion Medicaid—is one such form. It is available only to individuals who are 19-64 and not eligible for Medicare. When individuals in the Adult Group become eligible for Medicare, they must transition out of this coverage. Some, but not all, are then eligible for a form of comprehensive Medicaid that can be combined with Medicare, such as Aged and Disabled programs.[4] Those who are not are faced with the higher costs and less robust benefits of Medicare without the wraparound coverage of Medicaid. People in this situation may be eligible for a Medicare Savings Program (MSP), Medicaid-funded financial assistance that can help low-income beneficiaries better afford their Medicare.[5] But only one of the four MSPs, the Qualified Medicare Beneficiary program, covers Medicare cost sharing and none grant access to benefits Medicaid covers that Medicare doesn't, such as dental and long-term care.

The FFCRA, signed into law on March 18, 2020, allows states to temporarily receive enhanced federal Medicaid funding if they comply with certain MOE protections. These policies are intended to ensure individuals can access coverage and care during the COVID-19 public health emergency (PHE).[6] Specifically, Section 6008b(3) of the FFCRA requires states to preserve then-current Medicaid enrollments and benefits through the end of the PHE: "[A]n individual who is enrolled for benefits under such plan (or waiver) as of the date of enactment shall be treated as eligible for such benefits through the end of the month in which such emergency period ends."[7]

In April 2020, CMS released guidance and a FAQ on these MOE requirements and dedicated a specific question and answer to the topic of what should happen if a person enrolled in the Adult Group became eligible for Medicare during the PHE.[8] CMS noted that moving such an individual to an MSP would be out of compliance, because it would "not provide the full benefit package available to adult group

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[2] Medicare Rights Center, "Comments on the Fourth COVID Interim Final Rule" (January 4, 2021), https://www.medicarerights.org/policy-documents/comments-on-4th-covid-ifr.

[3] Centers for Medicare & Medicaid Services, "People Dually Eligible for Medicare and Medicaid" (March 2020), https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf.

[4] *See, e.g.*, Julie Carter, "Toward Seamless Coverage: Identifying Enrollment Gaps and Opportunities in Medicare Transitions for People with Expansion Medicaid" (October 2017), https://www.ncoa.org/article/expansion-medicaid-to-medicare-transitions-toward-seamless-coverage.

[5] Medicare.gov, "Medicare Savings Programs" (last accessed October 3, 2022), https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs.

[6] Families First Coronavirus Response Act, 134 STAT. 208, Pub. Law 116-127 Sec. 6008, (March 18, 2020).

[7] FFRCA Sec. 6008b(3).

[8] Centers for Medicare & Medicaid Services, "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies," p. 52 (last accessed October 3, 2022), https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf ("NOTE: This FAQ is applicable only prior to the effective date of the IFC…").

beneficiaries."[9] As a result, states were not permitted to shift enrollees out of the Adult Group into Medicare and an MSP and still claim the enhanced federal funding.

Coverage Changes

Later in 2020, CMS changed course and claimed such transitions do meet the FFRCA's MOE obligation.[10] This has allowed states to transition enrollees out of the Adult Group and into Medicare plus an MSP, despite the loss of benefits. This was troubling, as the statutory language clearly requires enrollees be "treated as eligible for such benefits." And the revised interpretation led to a nonsensical result: Individuals with very low incomes and assets could retain comprehensive coverage by transitioning into Aged and Disabled Medicaid plus Medicare; individuals barely over the income limits or with a few too many assets to qualify for Aged and Disabled Medicaid or an MSP would get to maintain comprehensive Adult Group coverage; but individuals with resources between those two categories would be forced to transition to the MSP[11]—with fewer benefits and higher out-of-pocket expenses than either of the other groups—during a pandemic that disproportionately impacts the health of older adults and people with disabilities.

The new interpretation was also legally troubling. Permitting states to move beneficiaries from one Medicaid eligibility category to another, less comprehensive one is not a reasonable interpretation of the plain language of the statute. Section 6008b(3) is not about whether the person is enrolled in Medicaid, but about whether their enrollment, guaranteed by 6008b(1), must include eligibility for the same benefits. CMS's attempted conflation of these two concepts was impermissible.

To justify this change, CMS claimed that "[s]tates made clear to CMS that this [original] interpretation, coupled with the prohibition on adopting more restrictive eligibility standards, methodologies, or procedures under section 6008(b)(1) of the FFCRA, would impede the routine, orderly transition of beneficiaries between eligibility groups, and could lead to significant backlogs in redeterminations and appeals after the PHE for COVID-19 ends. States also noted that our existing interpretation severely limits state flexibility to control program costs in the face of growing budgetary constraints and developing fiscal challenges during the emergency period."[12] But growing budgetary constraints cannot rewrite a statute, and concerns about post-COVID backlogs must not take precedence over beneficiary access to necessary care during a pandemic.

In addition to permission to move beneficiaries to less comprehensive coverage, thus cutting their benefits, CMS began to allow states to impose additional coverage restrictions, including reduced optional benefits; reduced amount, duration, and scope of services; increased cost-sharing; and reduced post-eligibility income—entirely at odds with the language and intent of FFRCA. We opposed each of these revisions as harmful to Medicaid enrollees and public health.

[9] *Ibid*.
[10] 85 Fed. Reg. 71142, 71160.
[11] *Ibid* at 71198.
[12] *Ibid* at 71161.

Current Proposals

CMS now proposes to revert to its original interpretation of Medicaid MOE for purposes of enhanced federal Medicaid funding. We strongly support this proposal and urge CMS to move forward as quickly as possible.

In addition, CMS is contemplating requiring states to offer Medicaid beneficiaries whose coverage was changed as a result of the previous interpretation an opportunity to re-enroll in, or to have their enrollment changed back to, their prior coverage, as of the final rule's effective date. We strongly support this potential action as well and urge CMS to move quickly. While it does not undo previous harm, it mitigates future damage for people who were unjustifiably disenrolled from the full scope of Medicaid due to a flawed interpretation.

Conclusion

Thank you again for the opportunity to provide comment. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Counsel for Federal Policy at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

Fred Riccardi

Fred Riccardi
President
Medicare Rights Center