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January 4, 2020

VIA ELECTRONIC SUBMISSION

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Attn: CMS-9912-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

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

Dear Administrator Verma:

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (CMS-9912-IFC) interim final rule. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable 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 nearly three million people with Medicare, family caregivers, and professionals.

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 these additional funds, states must comply with certain maintenance of effort (MOE) protections. These policies are intended to help ensure individuals can access coverage and care during the COVID-19 public health emergency (PHE).¹ Specifically, Section 6008b(3) of the FFCRA requires states to preserve then-current enrollments and

¹ Families First Coronavirus Response Act, 134 STAT. 208, Pub. Law 116-127 Sec. 6008, (March 18, 2020).

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benefits through the end of the PHE: “an 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.”²

We are deeply troubled that the Interim Final Rule (IFR) seeks to undermine these critical enrollee protections. In a stark reversal of CMS’s stated policy from March to October 2020, and in direct conflict with the statute and congressional intent, the IFR would allow states to restrict coverage and terminate benefits for current Medicaid enrollees. We strongly oppose these revisions, as well as those allowing states to bypass the 1332 waiver process and to refuse to cover COVID-19 vaccinations for all enrollees. We urge CMS to immediately withdraw these harmful provisions.

Coverage Changes

Under the IFR’s new coverage tier system, states would be allowed to move some people with Medicaid from one eligibility category to another, even if doing so resulted in a loss of benefits. This clearly violates the FFRCA and could cause some Medicare-eligible individuals to lose access to affordable coverage.

Around 12 million people are enrolled in both Medicare and Medicaid, but some forms of Medicaid are statutorily barred from such dual enrollment. 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 the adult group. Many are eligible for a form of comprehensive Medicaid that can be combined with Medicare such as Aged and Disabled programs. Unfortunately, not everyone transitioning out of the adult group has the option of enrolling in comprehensive Medicaid.³ Such individuals 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 help from Medicare Savings Programs (MSPs)—Medicaid-funded programs that can help beneficiaries afford their Medicare.⁴ But only one of the four MSPs—the Qualified Medicare Beneficiary program—covers Medicare cost sharing and none of the programs grant access to Medicaid-only benefits such as dental coverage or long-term care.

In April, CMS released guidance and a FAQ on the MOE requirements of FFRCA 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.⁵ CMS noted that moving such an individual from adult group

² FFRCA Sec. 6008b(3).

³ 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/wp-content/uploads/Toward-Seamless-Coverage.pdf>.

⁴ Medicare.gov, “Medicare Savings Programs” (last accessed December 22, 2020), <https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs>.

⁵ Centers for Medicare & Medicaid Services, “Families First Coronavirus Response Act (FFCRA), Public Law No. 116-127, Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136: Frequently Asked Questions (FAQs)” (April 13, 2020), <https://www.medicare.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf>.

Medicaid to an MSP would be moving such a beneficiary to a program that does “not provide the full benefit package available to adult group beneficiaries.”⁶ 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 funding support.

However, CMS now seeks to reinterpret the FFRCA’s requirement of 6008b(3) to claim that it is ambiguous. The agency now allows states to transition enrollees out of the adult group into Medicare plus an MSP, despite the loss of benefits, claiming that such enrollment eligibility is sufficient to meet the MOE obligation. As a result, states have begun to move adult group enrollees into Medicare and an MSP rather than keeping them in the adult group with its full suite of benefits. But, as shown above, the language of the statute requires enrollees to be “treated as eligible for such benefits.” Reducing benefits cannot be interpreted as maintaining eligibility for benefits. Permitting states to move beneficiaries from one Medicaid eligibility category to another where they no longer have eligibility for previous benefits 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 is impermissible.

To justify this change, CMS claims 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.”⁷ But growing budgetary constraints cannot rewrite an unambiguous statute, and concerns about post-COVID backlogs must not take precedence over beneficiary access to necessary care during a pandemic.

Even if the agency’s new interpretation were valid, states have, in turn, misinterpreted the rule by taking the permission to transition enrollees as a requirement to transition enrollees. The rule is clear that “a beneficiary enrolled in the adult group as of or after March 18, 2020, **may be** transitioned to a Medicare Savings Program eligibility group” (emphasis added).⁸ However, we have received reports from advocates that states are treating the invalid permission to disenroll individuals from the adult group as an obligation to shift enrollees onto MSPs, leading to people losing benefits and access to comprehensive Medicaid coverage.

This defiance of the plain language of the statute also leads to a non-sensical result: Individuals with very low incomes and assets would transition into Aged and Disabled Medicaid plus Medicare, which would mean comprehensive coverage; 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 adult group coverage;

⁶ *Ibid.*

⁷ 85 Fed. Reg. 71142, 71161.

⁸ 85 Fed. Reg. 71142, 71165.

but individuals with resources between those two categories would be forced to transition to the MSP— 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.

In addition to permission to move beneficiaries to less comprehensive coverage, thus cutting their benefits, CMS has also begun allowing 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. The rule will also result in terminations for some individuals who should not be terminated, which is entirely at odds with the language and intent of FFRCA. We oppose each of these revisions to the MOE, as they would harm Medicaid enrollees and public health.

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, Senior Federal Policy Associate at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

A handwritten signature in cursive script that reads "Fred Riccardi".

Fred Riccardi
President
Medicare Rights Center