January 4, 2021

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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

Dear Administrator Verma:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) interim final rule with comment (IFC), Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 85 Fed. Reg. 71142 (November 6, 2020).

MACPAC is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide range of topics related to Medicaid and the State Children's Health Insurance Program (CHIP). As described in its authorizing statute, MACPAC is required to review and make recommendations regarding policies affecting access to covered items and services (§ 1900(b)(1) of the Social Security Act). The comments provided below stem from this obligation.

Background

With the IFC, CMS is adopting a new interpretation of the maintenance of effort and continuous coverage requirements that states must meet to qualify for the 6.2 percentage point increase in federal medical assistance percentage (FMAP) established by § 6008(b) of the Families First Coronavirus Response Act (FFCRA, P.L. 116-127). The IFC also describes the requirements for Medicaid coverage of COVID-19 vaccines and their administration under § 6008(b)(4) of the FFCRA, consistent with previously issued guidance.

Under CMS's new interpretation of the continuous coverage requirement, if a state determines that beneficiaries have become eligible under a different

eligibility group, states are required to transition them and provide the applicable amount, duration, and scope of benefits of the new group, if certain conditions are met. First, states must maintain Medicaid coverage for validly enrolled beneficiaries enrolled under a state plan or waiver as of or after March 18, 2020 through the end of the month in which the public health emergency (PHE) ends. Individuals are considered validly enrolled if they have had an eligibility determination, including during the retroactive period, unless the determination was erroneous due to agency error or beneficiary fraud or abuse. Individuals in a presumptive eligibility period are not considered validly enrolled. Second, transitions between eligibility groups are generally allowed if the new group provides the same or higher tier of coverage as the beneficiary's current eligibility group. The IFC establishes three tiers of coverage based on whether the coverage is considered minimum essential coverage and provides coverage for COVID-19 testing and treatment services.

The IFC also permits states to disenroll beneficiaries who have not been validly enrolled as well as certain validly enrolled beneficiaries. Before coverage for an individual who is not validly enrolled is terminated, states must follow redetermination requirements in 42 CFR 435.916 and notice and state fair hearing requirements in 42 CFR 431 Subpart E. States may also terminate coverage for beneficiaries identified through a Public Assistance Reporting Information System match as enrolled in Medicaid in more than one state and whose residency cannot be verified. States must take all reasonable measures to verify the beneficiary's residence. In addition, the rule requires states that have elected to cover lawfully residing immigrant children under age 21 and pregnant women for up to 60 days postpartum to limit Medicaid coverage to emergency medical services, once those individuals no longer meet the definitions of § 1903(v)(4)(A) of the Social Security Act.[1]

The IFC also allows states to make certain programmatic changes and remain eligible for the FMAP increase. Such changes include modifying covered benefits, increasing cost sharing, and increasing beneficiary liability under post-eligibility treatment of income rules, all within existing federal rules. Existing requirements for advance notice under 42 CFR 431.211 and for sufficient amount, duration, and scope of benefits in 42 CFR 440.230 apply.

MACPAC Comments

MACPAC recognizes that the IFC seeks to balance ensuring beneficiary coverage during the PHE with providing states flexibility to manage their Medicaid programs at a time when the economic effects of the pandemic are creating substantial resource constraints. While the rule is final and took effect November 2, the Commission has concerns about the potential effect of the IFC on beneficiary access to care and urges CMS to establish and deploy mechanisms to closely monitor coverage and access as the PHE continues. Any indications of substantial loss of coverage or reduced utilization of services should be addressed promptly.

Potential loss of coverage and benefits for certain individuals

MACPAC is concerned that under the IFC, certain vulnerable populations will lose coverage or benefits during the pandemic. These populations include individuals disproportionately likely to be in a period of presumptive eligibility (e.g., pregnant women, children, and beneficiaries in the breast and cervical cancer program) who, under the IFC, could lose coverage, and certain immigrant children under age 21 and pregnant women that would be eligible only for emergency services if they no longer meet the definition of lawfully residing. These policies could result in missed prenatal care or other services that may exacerbate troubling racial and ethnic disparities in maternal morbidity and mortality; erosion in pediatric preventive services, including routine vaccines; and loss of access to lifesaving cancer treatments.

The Commission acknowledges that these IFC policies are consistent with the guidance shared with states in the early months of the pandemic. We also acknowledge that presumptive eligibility is intended to provide temporary coverage while individuals complete the full Medicaid application process. However, during the PHE, some individuals may face exceptional challenges completing the full Medicaid application. For example, individuals who have lost housing may not be receiving mail in a timely manner or may not have ready access to needed documents. As such, states and CMS should ensure that presumptive eligibility agencies redouble their efforts to assist individuals in completing their applications during the presumptive eligibility period. In addition, states should also reach out to enrollees in a presumptive eligibility period to provide them assistance in completing the application process.

The IFC policy on limiting Medicaid services for the treatment of emergency medical conditions for lawfully residing immigrant children under 21 and pregnant women who no longer meet the definition of lawfully residing reflects the statutory and regulatory rules at §§ 1902(v)(2) and (v)(3) and 42 CFR 435.406(b). Nonetheless, the Commission is concerned about potential health consequences for these beneficiaries if they lose their coverage in the midst of the pandemic.

Lack of access to the COVID-19 vaccine during the PHE

Under the IFC, some beneficiaries whose Medicaid coverage is terminated or who are enrolled in Tier 3 coverage will not have coverage for the COVID-19 vaccine and its administration during the PHE. This is troubling for two reasons. First, individuals lacking coverage may be less likely to receive the vaccine, leaving themselves at risk for infection and severe health consequences. Second, lack of access to vaccines for some could lead to ongoing community spread. It is also important to note that if individuals with limited Medicaid coverage (Tier 3) or those who were disenrolled from Medicaid are not vaccinated and become infected with the COVID-19 virus, state and federal governments may ultimately bear the costs of any treatment. Moreover, barriers to vaccine coverage could exacerbate racial and ethnic disparities in COVID-19-related infections, hospitalizations, and deaths, which have disproportionately affected certain communities of color including non-Hispanic Black, Hispanic or Latino, and non-Hispanic American Indian or Alaska Native populations (CDC 2020).

The IFC notes two alternatives for covering the cost of the COVID-19 vaccine and its administration, but it is unclear how effective either will be in ensuring access to the vaccine for those without such coverage under Medicaid. One option requires providers administering the COVID-19 vaccine to uninsured individuals to request payment through the Health Resources and Services Administration's COVID-19 Claims Reimbursement Program. Medicaid beneficiaries enrolled in limited benefits coverage programs are considered uninsured for purposes of the HRSA program. However, patients and providers may be unaware of the program, or find program eligibility rules confusing (Appleby 2020). In addition, some providers have expressed concern with certain program and billing requirements for treatment services under the program, and it is unknown whether similar issues will arise with respect to the vaccine (ACEP 2020). The IFC also notes that states may request or modify a Section 1115 demonstration waiver to cover COVID-19 vaccines for eligibility groups that would otherwise not be entitled to such coverage. However, submitting or amending a demonstration waiver may be both burdensome and slow.

Changes to benefits and cost sharing may pose barriers to beneficiaries

MACPAC agrees that states require tools and flexibility to manage Medicaid program costs as they contend with the ongoing economic challenges of the pandemic. The IFC is responsive to concerns of state officials and may help mitigate provider rate cuts, which also could limit access to care and threaten provider solvency. At the same time, we are concerned that changes to benefits and cost sharing could still result in access barriers. Prior research shows that an increase in cost sharing can result in individuals delaying or forgoing needed care (MACPAC 2015). Other coverage changes such as eliminating optional benefits or reducing coverage limits may also limit access to services. If reduced use of services due to state cost savings measures now permitted under the IFC results in poor health outcomes, including future illness or exacerbations of ongoing health conditions, state Medicaid programs may ultimately bear the cost of that care in spite of their immediate cost containment efforts.

CMS and states should monitor the effects of the programmatic changes permitted under the IFC to ensure that these changes do not negatively affect beneficiary access to care.

Other comments

While states have current concerns regarding their ability to manage programs during the PHE, they are also looking ahead to its eventual end and how to plan for it. Although the Secretary ultimately decides whether to extend the PHE, presumably accounting for a range of factors, this decision has direct bearing on state Medicaid program budgets because the 6.2 percentage point increase in FMAP ends in the quarter during which the PHE ends. As we stated in our August 25 letter to Secretary Azar, for budget planning purposes, state Medicaid officials need to know well in advance when they will lose the enhanced FMAP (MACPAC 2020). While we appreciate that the Secretary announced his intention to renew the current PHE three weeks prior to the effective date in October, providing states substantially more notice than the previous renewals, states would benefit from a longer notice period.

Finally, we are appreciative that CMS has responded to the call of MACPAC and others by issuing guidance to states on planning for the resumption of normal Medicaid, CHIP, and Basic Health Program operations upon conclusion of the COVID-19 PHE. We will be reviewing the guidance to better understand the expectations set forth. We look forward to continued dialogue with the agency on this important matter, and urge CMS to continue working with states as they plan for an efficient and smooth return to routine operations that minimizes disruptions for beneficiaries, providers, and plans.

Sincerely,

Melanie Bella, MBA
Chair

Endnotes

[1] MACPAC uses the term pregnant women as this is the term used in the statute and regulations. However, the term birthing people is being used increasingly, as it is more inclusive and recognizes that not all individuals who become pregnant and give birth identify as women.

References

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