January 4, 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

submitted via www.regulations.gov

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:

Ohio Consumers for Health Coverage (OCHC) appreciates 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".

OCHC is a coalition of over 20 organizations, both statewide and local, that has worked since 2007 to unite the consumer voice with the goal of achieving affordable, high quality health care for all. Its organizational membership is diverse, representing both those with illness and those in good health, both insured and uninsured, those with resources, and those of limited means. For the past several years, OCHC's highest priorities have been to preserve Medicaid and increase health equity through education and advocacy among policymakers.

The significance of Medicaid for Ohioans cannot be overstated. Over 3 million of Ohio's 11.7 million residents, roughly 1 in 4, including 1.2 million children, rely on Medicaid benefits to provide an avenue for accessing health care services. Medicaid enrollment has grown by roughly 300,000 since March 2020, the beginning of the public health emergency. As COVID-19 envelopes Ohio, which has a current positivity rate over 17%, the need for consistent access to health care for routine and chronic care, as well as acute care, is obvious.

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 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 enrollee's existing benefits – both their enrollment in Medicaid overall, and the services for which they have been eligible. At a time of such turmoil, Congress chose to protect enrollees and ensure access to services by maintaining the "status quo."

We are writing to express our deep concern about several provisions of this Interim Final Rule (IFR). In a reversal of CMS's stated policy from March to October 2020, this IFR would now allow states to impose numerous types of coverage restrictions for individuals who are enrolled in Medicaid, including reduced benefits; increased cost-sharing; and reduced post-eligibility income. The IFR will also result in terminations for some individuals who should not be terminated. We oppose these revisions to the MOE, which are inconsistent with the FFCRA and will result in harm for Medicaid enrollees. We also oppose allowing states to circumvent required transparency procedures for 1332 waivers and receive enhanced funding despite refusing to cover COVID-19 vaccination for some Medicaid enrollees. We recommend that CMS withdraw these provisions. Our specific concerns are described below.

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.

Optional Medicaid benefits include essential services like physical and occupational therapy, dental and vision services, and home and community-based services. After the previous economic downturn in 2008, many states made significant cuts to each of these services. Cuts to these services will cause significant harm.

If states are permitted to eliminate, for example, dental benefits from Medicaid coverage, the struggle Ohioans already face in accessing consistent and comprehensive dental services may be exacerbated. Over 1.8 million residents live in areas where there is a shortage of dental care.[1] The problem disproportionately affects children of low-income families, people of color, the working poor and the elderly. Many safety net dental clinics provide services in these areas. Without coverage through Medicaid, the viability of those clinics is jeopardized.

The COVID-19 pandemic has further complicated the problem of dental access. Ohioans, as others across the country, have delayed routine and preventive dental care. Oral infections can compromise one's overall health and have been associated with poor pregnancy outcomes,

[1] Kaiser Family Foundation - Dental Health Care Professional Shortage Areas - as of September 2020 (accessed January 4, 2021).

diabetes and cardiovascular disease. Undetected or late detected cancers of the mouth can be fatal. These comorbidities put people at greater risk for poor COVID outcomes, disproportionately affecting people of color.

The requirement of FFCRA to protect all people who rely on Medicaid from any reduction in benefits ensures that Ohioans will not lose any of the tools they have to stay healthy during the public health emergency. CMS' reinterpretation of the MOE provisions undermines both the spirit and the language of those provisions and should be rejected.

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.[2] 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.[3]

The pandemic has been a crushing economic force in Ohio, increasing unemployment, hunger, and shelter insecurity. Over 115,000 more Ohioans are unemployed than a year ago.[4] According to a Feeding America analysis, Ohio is among the top ten states with the highest projected food insecurity in the country, with a projected 2 million people living in food insecure households.[5] As described by the Ohio Housing Financing Agency in its 2021 Housing Needs Assessment, over 70% of Ohioans with income at or below 30% of the area median income spend *more than 50%* of their income on housing costs.[6] All of these economic blows have fallen more heavily on families of color than on white families, highlighting the inequitable way these burdens are borne. To ask low-income Ohioans who rely on Medicaid to pay additional cost-sharing in order to access health care is a foolhardy disinvestment in their health.

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

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[2] National Health Law Program - Medicaid Premiums and Cost Sharing at p.14 ("Impact of cost sharing on low-income populations") (accessed January 4, 2021).
[3] Pew Research Center - Economic Fallout From COVID-19 Continues to Hit Low-Income Americans the Hardest (see chart entitled "Financial pain points during coronavirus outbreak differ widely by race, ethnicity and income") (accessed January 4, 2021).
[4] U.S. Bureau of Labor Statistics - Ohio Unemployment, 2010-2020 (238144 unemployed in October 2019, compared to 355681 in October 2020) (accessed January 4, 2021).
[5] Feeding America - The Impact of Coronavirus on Food Insecurity in 2020 (accessed January 4, 2021).
[6] Ohio Housing Finance Agency - Ohio Housing Needs Assessment, FY21 (accessed December 31, 2020).

preserving individuals' benefits, and can cause substantial harm. This harm will disproportionately fall on certain groups, including people with disabilities and older adults.

We are also concerned that states will need to spend significant effort implementing these changes to their eligibility system. This effort would be far better spent doing other work, such as bolstering their *ex parte* renewal processes and updating addresses to better prepare for conducting redeterminations at the end of the public health emergency. Moreover, such massive changes to each states' eligibility system will likely generate errors.

General Eligibility Exceptions

Additionally, the IFR authorizes states to terminate coverage for individuals that should be protected under the FFRCA. This violates Congress' intent and should be rescinded. This reinterpretation undermines the health security of lawfully present new mothers and their newborn babies, at a time when maternal and infant health is at the center of racial health disparities in the U.S. in general and in Ohio in particular.

Under Medicaid's Immigrant Children's Health Improvement Act (ICHIA) option, which Ohio has elected, states can cover lawfully present immigrant children and pregnant women without a 5 year wait. However, once these children turn 21 and these women finish their 60-day postpartum period, the IFR requires states to restrict their eligibility to the limited emergency Medicaid eligibility group. Essentially, with no statutory basis, CMS is saying that the MOE does not apply to this population – an exclusion that is particularly troubling because immigrant communities have been disproportionately affected by COVID-19.[7]

The position that pregnancy-related (or full) Medicaid should cover new mothers for a full year postpartum has been advanced for some time, well before the current public health emergency. The research that supports that contention also supports the benefit of continued pregnancy-related Medicaid during the pandemic.[8] In the area of mental health alone, the impact of COVID-19 isolation on postpartum depression, a danger to both maternal and infant health, is a reasonable pandemic-related justification.

1332 Waiver 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

[7] Center for Disease Control and Prevention - COVID-19 Case Investigation and Contact Tracing among Refugee, Immigrant, and Migrant (RIM) Populations: Important Considerations for Health Departments (accessed December 31, 2020).
[8] Kaiser Family Foundation - Expanding Postpartum Medicaid Coverage (accessed January 4, 2021).

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".[9] This process is essential to ensure that consumers have input into proposed waivers.

OCHC provides policy makers with the voice of consumers. The notice and comment period afforded OCHC and other stakeholders *before* a 1332 waiver application is filed, and before CMS makes a decision on that application, provides consumers with meaningful input. In contrast, CMS's change shifting notice and comment later in the process renders consumer input virtually meaningless. The attention of policy makers is challenging to grab under current conditions. If opportunities for input are shifted to later in the application process, when changes are arguably more difficult to make, discourages consumers input and diminishes its relevance, contradicting the purpose of providing avenues for stakeholder engagement.

Availability of COVID-19 Vaccines

As of January 4, 2021, more than 350,000 people in the United States have died as a result of COVID-19, with over 20 million confirmed cases.[10] Ohio has experienced more than 725,000 cases and more than 9,000 deaths,[11] has a currently testing positivity rate over 17%.[12] Public health experts agree that widespread use of a safe and effective preventive vaccine will be essential to curb this deadly pandemic.

Two COVID-19 vaccines have been approved in the U.S. When Congress enacted the FFCRA, it cognized the vital importance of coverage and access to COVID-19 vaccines, providing that state Medicaid programs receive enhanced federal funding if they cover approved COVID-19 vaccines and provide access without cost sharing, during the period of the public health emergency.

However, 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

[9] 76 Fed. Reg. 13556 (Mar. 14, 2011).
[10] Johns Hopkins University - Coronavirus Resource Center (accessed January 4, 2021).
[11] Ohio Department of Health - Coronavirus (COVID-19) Homepage (accessed January 4, 2021).
[12] Johns Hopkins University - Coronavirus Resource Center (accessed January 4, 2021).

under § 1115 waiver authority.[13] 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 FFCRA makes no distinction between full and limited benefit Medicaid categories and specifically applies vaccination requirements to waiver programs. The obvious intent of the provision was to ensure widespread access to COVID-19 vaccination. CMS should not invent an ambiguity and then interpret it contrary to the statute's overriding intent. Congress is well familiar with limited scope benefits categories and would have carved out exceptions to FFRCA if it wanted to carve out such exceptions.

Barring access to lifesaving COVID-19 vaccines would hamper efforts to combat the pandemic, and would harm tens of thousands of individuals who rely on Medicaid limited benefit programs. 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 restrict 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.

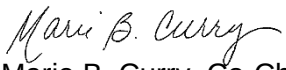
Finally, we have included citations and direct links to research and other materials. We request that the full text of material cited, along with the full text of our comment, be considered part of

[13] *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).

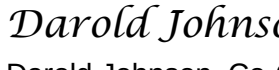
the formal administrative record for purposes of the Administrative Procedures Act. If HHS is not planning to consider these citations and linked materials as part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies into the record.

Thank you for the opportunity to comment on this important issue. If you have further questions, please contact Marie Curry at mcurry@communitylegalaid.org or Darold Johnson at djohnson@oft-aft.org.

Sincerely,



Marie B. Curry, Co-Chair
Ohio Consumers for Health Coverage



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