

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

December 4, 2020

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Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically via [regulations.gov](https://www.regulations.gov)

Re: RIN 0938–AU35 Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency

Justice in Aging appreciates the opportunity to provide comments on the above-referenced Interim Final Rule with Request for Comments (IFR).

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income enrollees and populations that have been marginalized and excluded from justice such as women, people of color, people with disabilities, LGBTQ individuals, and people with limited English proficiency.

Our comments focus primarily on the new interpretation in the IFR of the requirement to maintain Medicaid beneficiary enrollment in order to receive the temporary increase in Federal funding in the Families First Coronavirus Response Act (FFCRA) and its impact on low-income older adults and persons with disabilities who become eligible for Medicare. In addition we will address other elements of the IFR including: allowing states to reduce optional Medicaid benefits during the PHE; excluding presumptively enrolled individuals from MOE requirements; limitations of Medicaid coverage of COVID-19 vaccines; and use of the IFR process for this rulemaking.

I. Temporary Increase in Federal Medicaid Spending—Enrollment Requirements

Justice in Aging opposes the change in CMS’s interpretation of the enrollment requirements in Section 6008(b)(3) of FFCRA, which address state obligations for maintenance of effort (MOE) with respect to Medicaid enrollment during the Public Health Emergency (PHE). One focus of our concerns specifically is the impact of the interpretation on Medicaid-eligible individuals who are newly eligible for Medicare. The IFR interpretation, which CMS describes as a “blended approach” is inconsistent with both the letter and spirit of Section 6008 of FFCRA. It deprives Medicaid enrollees of critical services, is contrary to the clear mandate of the statute, creates

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inequitable and inconsistent outcomes, and is confusing for states to administer and enrollees to understand.

Justice in Aging urges CMS to withdraw the interim final regulations and reinstate the [guidance](#) posted on April 13, 2020 (“Original FAQ”).¹

A. The IFR Interpretation Significantly Reduces Access to Medicaid Services for Individuals in the Adult Coverage Group Turning 65

Section 6008(b)(3) of FFCRA provides that a state may not receive increased Federal matching funds (FMAP) if:

the State fails to provide that an individual who is enrolled for benefits under such plan (or waiver) as of the date of enactment of this section or enrolls for benefits under such plan (or waiver) during the period beginning on such date of enactment and ending the last day of the month in which the emergency period described in subsection (a) ends shall be treated as eligible for such benefits through the end of the month in which such emergency period ends unless the individual requests a voluntary termination of eligibility or the individual ceases to be a resident of the State.

In the Original FAQ, CMS had interpreted this straightforward language in a straightforward way. The Original FAQ told states that, to meet MOE requirements, an individual’s Medicaid benefits may not be reduced during the PHE in amount, duration or scope, including in situations where the individual would otherwise lose Medicaid coverage entirely or would only qualify for a lesser level of benefits. In applying that requirement to individuals in the adult group who are turning 65, CMS told states that, if those individuals do not qualify for another full-scope Medicaid program, the state must retain them in adult coverage. If they meet the qualifications for a Medicare Savings Program (MSP), the state must also provide the Medicare premium benefits of the MSP for which they qualify.² In both cases, the individuals retain full adult group coverage.

In contrast, the IFR interpretation, asserting that the plain language of the statute is “somewhat ambiguous,”³ creates a construct that divides Medicaid coverage programs into tiers, with the highest tier for programs that provide Minimum Essential Coverage (MEC), a concept imported from the Affordable Care Act. If an individual in an MEC tier loses that coverage but qualifies for another Medicaid program in the MEC tier, that individual can be moved to the second program even if the benefit package is less comprehensive.⁴ Further, for individuals in the adult

¹ 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), available at www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf.

² Original FAQ, Question 27.

³ 85 Fed. Reg. at 71160.

⁴ Interim final regulation 42 C.F.R. § 433.400(c)(2)(i).

coverage group turning 65 who only qualify for a Medicare Savings Program (MSP), the state may move them into the MSP without providing any other Medicaid benefits.⁵ If an individual qualifies for no Medicaid program, the individual must continue to get the full adult group coverage.⁶

The IFR interpretation dramatically affects access to Medicaid benefits for individuals in the adult group turning 65 who have income above their state's Aged & Disabled Medicaid limit and below the income limit for the adult group, which is 138% of the Federal Poverty Level (using MAGI counting rules). Since the federally required floor for MSP income limits extends to 135% FPL for the QI program, the IFR interpretation means that the vast majority of adult group individuals moving into Medicare would qualify for an MSP and thus lose all Medicaid services. Instead, they would only receive Medicare premium protection and, in the case of Qualified Medicare Beneficiaries (QMBs), Medicare co-insurance protection. Thus, in the midst of the pandemic, these older adults who may have been relying on Medicaid coverage for long-term services and supports, for dental care, for non-emergency medical transportation and for many other services that are critical to their well-being, would suddenly lose access. Further, individuals who only qualify for Specified Low-income Beneficiary (SLMB) or QI coverage would also be subject to Medicare deductibles and co-insurance, and thus would not even be receiving their basic medical care without cost. This is exactly the result that the statute was designed to prevent and specifically prohibits.

B. The IFR Interpretation is Inconsistent with Statutory Requirements.

In depriving almost all individuals in the adult group turning 65 of access to any Medicaid covered services, CMS undertakes to impose on these older adults exactly what Section 6008(b)(3) is designed to prohibit—the loss of access to Medicaid-covered services during the PHE. To justify the claim that somehow taking away all access to Medicaid-covered services meets the requirement to treat such individuals as “eligible for such services,” CMS latches onto the concept of Minimum Essential Coverage (MEC), a concept not found anywhere in the Medicaid statute and not referenced in the FFCRA provision. MEC, imported from the Affordable Care Act, is barebones coverage as demonstrated by the fact that Medicare Part A, which is only the hospital benefit, qualifies. In contrast, Medicaid has always been characterized by its broad range of benefits. The Medicaid and CHIP Payment and Access Commission (MACPAC) describes the program as follows:

Medicaid's role among payers is unique. It provides coverage for health and other related services for the nation's most economically disadvantaged populations, including low-income children and their families, low-income seniors, and low-income people with disabilities. These populations are distinguished by the breadth and intensity of their health needs; the impact of poverty, unemployment, and other socioeconomic factors on their ability to obtain health care services; and the degree to

⁵ Interim final regulation 42 C.F.R. § 433.400(c)(2)(ii).

⁶ Interim final regulation 42 C.F.R. § 433.400(c)(2)(iii).

which they require assistance in paying for care. Medicaid provides benefits not typically covered (or covered to a lesser extent) by other insurers, including long-term services and supports. It also pays for Medicare premiums and cost sharing for more than 10 million people who are enrolled in both programs. It is also a major source of financing for care delivered by certain providers, particularly safety net institutions that serve both low-income and uninsured individuals.⁷

CMS itself stresses the centrality of long-term services and supports to the Medicaid program, particularly for older adults:

Millions of Americans, including children, adults, and seniors, need long-term care services because of disabling conditions and chronic illnesses, Medicaid is the primary payer across the nation for long-term care services. Medicaid allows for the coverage of these services through several vehicles and over the continuum of settings, ranging from institutional care to community-based long-term services and supports (LTSS).⁸

LTSS accounts for over 20 percent of Medicaid spending.⁹

In light of these bedrock characteristics of the Medicaid program, particularly with respect to how the program serves older adults, it strains the concept of maintenance of effort beyond recognition to claim that having MEC through Medicare, without any LTSS or other services, meets the mandate of Section 6008(b)(3) to protect Medicaid beneficiaries from loss of coverage. Many individuals relying on Medicaid to provide those services could suddenly lose them in the midst of the pandemic. To wipe away access to all these benefits in the pursuit of state “flexibility” causes serious harm to at-risk individuals that cannot be justified in light of the clear statutory mandate. Those most affected are individuals relying on Medicaid-covered home and community-based services who risk hospitalization or institutional placement if those services are abruptly withdrawn. These outcomes, never desirable under any circumstances, are particularly dangerous at this time when hospitals and nursing facilities are already being stretched to their breaking point, a concern that FFRCA’s provisions seek to address.

Although our primary statutory objection to the IFR interpretation is that substituting MEC for the actual scope of Medicaid coverage is contrary to the language and purpose of Section 6008, we note that CMS’s justification for only covering MSP premiums also is internally inconsistent with its own rationale for using MEC. In the IFR, CMS treats MSP programs as in a tier offering MEC. Medicare Savings Programs, however, are not in a coverage tier that provides MEC because they only pay for Medicare Part B, which is not MEC.¹⁰ To the extent that individuals have MEC, they receive it because of their entitlement to Part A coverage, not from their

⁷ MACPAC, “Medicaid 101,” available at www.macpac.gov/medicaid-101/

⁸ CMS, “Long Term Services & Supports,” available at www.medicaid.gov/medicaid/long-term-services-supports/index.html

⁹ HHS, 2016 Actuarial Report on the Financial Outlook for Medicaid, p. 6, available at www.medicaid.gov/medicaid/downloads/medicaid-actuarial-report-2016.pdf. Note that this amount significantly understates Medicaid payment for LTSS because it only includes fee-for-service spending on LTSS. The LTSS portion of capitated payments to Medicaid managed care plans is in addition to this figure.

¹⁰ The only exception would be QMB coverage for an individual without premium-free Part A.

Medicaid coverage. In the IFR, CMS notes this fact but decides anyway to shoehorn MSP-only coverage into its already tortured theory:

For such beneficiaries, the state satisfies the requirement described in paragraph (c)(2) of this section if it furnishes the medical assistance available through the Medicare Savings Program, because the coverage that beneficiary receives under the Medicare program qualifies as MEC (emphasis added).¹¹

CMS cannot simply assert that the state has fulfilled its statutory obligation because a Medicare program that the state is not funding provides services. Thus, CMS has failed, even within the logic of its own flawed construct, to justify its claim that moving someone from full-scope Medicaid to MSP-only in any way satisfies a state's maintenance of effort obligations.

C. The IFR Interpretation Creates Undue Complexity and Leads to Serious Inequities

For people becoming eligible for Medicare, the IFR interpretation leads to results that are startlingly inequitable and dizzyingly complex:

- If an individual qualifies for premium-free Part A and is eligible for any Medicare Savings Program (MSP), the state can meet its MOE obligations by dropping all Medicaid coverage other than the Part B Medicare premium payment and, in the case of the QMB program, the Medicare co-insurance payment protection.
- If the individual qualifies for premium-free Part A and is not eligible for any MSP, then the state must retain the individual in the adult coverage group because there is no other Medicaid program for which the individual qualifies. **Thus, lower income individuals who qualify for MSPs lose full-scope Medicaid coverage while those with higher incomes or more resources keep it.**

The illogic of the CMS approach becomes even more evident when looking at the situation of an individual who does not have premium-free Part A and thus does not have MEC when becoming eligible for Medicare. The IFR does not spell out the scenarios but, as we read the IFR, they would be as follows:

- If the individual is eligible for the Qualified Medicare Beneficiary (QMB) program, the state could meet its MOE obligations by enrolling the individual in the QMB program, which would pay Part A and Part B premiums.

¹¹ 85 Fed. Reg. at 71165.

- If the individual is eligible for the Specified Low-Income Benefit (SLMB) program or as a Qualified Individual (QI), the state would have no mechanism to pay the individual's Part A premium so would be required to keep the individual in the adult group throughout the PHE. **As in the case of individuals with premium-free Part A, those with higher incomes fare better than those that are more financially vulnerable.**

These results are clearly not what Congress contemplated. Further, they most certainly will not meet the asserted goal of the IFR to “help to ensure that states are determining eligibility, and providing care and services in a manner that is consistent with the simplicity of administration, as described in section 1902(a)(19) of the Act.”¹² There is nothing simple about the IFR interpretation, and experience suggests that many state eligibility systems are not up to the task of adjusting to its complexities, much less then readjusting after the end of the PHE. Moreover, the challenges of clearly and accurately communicating to affected individuals the changes that are being made and how those changes will affect their coverage would be daunting.

II. Allowing States to Reduce Optional Medicaid Benefits Will Lead to Significant Harm to Older Adults

The IFR permits states to reduce or eliminate “optional” Medicaid benefits, including home and community-based services and dental, vision, and hearing that are all essential for the health and safety of low-income older adults – particularly during the public health emergency.

Allowing states to reduce these benefits during the pandemic is dangerous and puts the health and lives of older adults at real risk. Home and community based services (HCBS) allow older adults to receive care in their homes and communities rather than having to seek care in nursing facilities or other congregate settings in which 40 percent of all COVID-19 deaths have occurred with communities of color facing the most risk in these settings.¹³

Untreated dental, vision, and hearing negatively impact overall health. Among people with COVID-19, those with poor oral health tend to get sicker and are more likely to die.¹⁴ The lack

¹² 85 Fed. Reg. at 71163.

¹³ AARP, Nursing Home COVID-19 Dashboard, available at <https://www.aarp.org/ppi/issues/caregiving/info-2020/nursing-home-covid-dashboard.html> (accessed Jan. 3, 2021).

¹⁴ Sampson V, Kamona N, Sampson A. Could there be a link between oral hygiene and the severity of SARS-CoV-2 infections? *Br Dent J.* 2020 Jun;228(12):971-975. doi: 10.1038/s41415-020-1747-8. PMID: 32591714; PMCID: PMC7319209.

of oral health treatment also exacerbates diabetes and numerous other health conditions placing those already at high risk at higher risk of contracting or dying from COVID-19.¹⁵

Allowing states to rip needed services away from people during this public health emergency contravenes the law and is a dramatic departure from CMS's previous interpretation that recognized that robust Medicaid coverage is integral to keeping communities safe and healthy during the COVID-19 pandemic.

III. Excluding Presumptively Enrolled Individuals from MOE Requirements is Contrary to FFCRA and Endangers Already At-Risk Older Adults

CMS narrows the definition of “valid enrollment” to exclude some enrollees who should be considered properly enrolled and covered by the protections of the FFCRA. For example, CMS states that individuals eligible by presumptive eligibility are not “validly enrolled” for the purposes of the continuous coverage provision because these individuals “have not received a determination of eligibility under the state plan.” However, the Medicaid statute consistently describes presumptive eligibility as “*determining*, on the basis of preliminary information, whether any individual is eligible for medical assistance...” (emphasis added).¹⁶ Therefore, distinguishing presumptively eligible populations as having not been “determined” eligible is inconsistent with the Medicaid statute.

Moreover, many older adults and people at greater risk of serious illness from COVID-19 are having to shelter in place and are facing additional barriers right now that make it extremely difficult to complete a full Medicaid application before their presumptive eligibility period ends. Their usual support networks, including social services and family or friends, may not be accessible or they may have difficulty gathering required paperwork. The process may be particularly difficult for individuals experiencing homelessness or displacement, individuals with developmental and psychiatric disabilities, and individuals with limited English proficiency. These individuals are not “ineligible” for Medicaid—they simply face increased barriers to applying. CMS should allow these individuals to continue on Medicaid until the end of the public health emergency.

¹⁵ Sampson V, Kamona N, Sampson A. Could there be a link between oral hygiene and the severity of SARS-CoV-2 infections? *Br Dent J.* 2020 Jun;228(12):971-975. doi: 10.1038/s41415-020-1747-8. PMID: 32591714; PMCID: PMC7319209.

¹⁶ 42 U.S.C. § 1396(a)(47)(B).

IV. The Limitations of Medicaid Coverage of COVID-19 Vaccines Are Contrary to Congressional Intent and Would Harm Older Adults

Under FFCRA, Congress recognized the vital importance of coverage and access to COVID-19 vaccines by 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, in this IFR, CMS is inexplicably seeking to limit access to COVID-19 vaccines by allowing states to exclude coverage of vaccinations for people enrolled in Medicaid limited benefit eligibility groups. 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 under § 1115 waiver authority.¹⁷

The FFCRA makes no distinction between full and limited benefit Medicaid categories and specifically applies vaccination requirements to waiver programs. Congress clearly intended to ensure widespread access to COVID-19 vaccination. Therefore, CMS cannot carve out certain populations from this provision.

More importantly, barring access to lifesaving COVID-19 vaccines would hamper efforts to combat the pandemic and would harm not only the individuals who rely on Medicaid limited benefit programs, but older adults and all of us. Over 80% of the 300,000+ people who have died from COVID-19 are older adults, and a disproportionate share are people of color. Public health experts agree that not only should older adults and individuals who care for them be vaccinated, but that widespread uptake of the vaccine is essential to herd immunity and stopping this deadly pandemic. This cannot happen if the vaccine is not covered for all Medicaid populations.

Restricting Medicaid coverage of the vaccine 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.

V. Use of an Interim Final Rule Is Inappropriate

We do not believe CMS should have implemented these policies – which directly and materially access to health care for tens of millions of enrollees during a pandemic – as an interim final

¹⁷ 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).

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 policies described in this IFR. But reducing health care eligibility, decreasing benefits, and increasing costs during a pandemic without an opportunity contravenes the public interest. These policies will cause substantial harms before CMS can finalize the rule – harms that could have been avoided had CMS solicited public comments, like ours, before the rule went into effect.

VI. Conclusion

Justice in Aging urges that CMS withdraw the interim final regulations in their entirety. The regulations are inconsistent with the clear mandate of FFCRA and will harm older adults who constitute one of the most at-risk segments of the Medicaid population. Thank you again for the opportunity to submit comments. If any questions arise concerning this submission, please contact Amber Christ, Directing Attorney, at achrist@justiceinaging.org.

Sincerely,



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