

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

October 27, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & 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 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

Justice in Aging appreciates the opportunity to provide comments on the above-referenced Reopening of the Public Comment Period for the Interim Final Rule (IFR) regarding the temporary increase in Federal Medical Assistance Percentage during the COVID-19 public health emergency (PHE). Justice in Aging strongly supports the Centers for Medicare & Medicaid Services' (CMS) proposal to rescind §433.400 of the IFR and reinstate the original interpretation of section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA).

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 on the IFR's negative impact on low-income older adults and persons with disabilities who have had their Medicaid benefits reduced or terminated during the Public Health Emergency (PHE). Our comments both reiterate our objections to the IFR we submitted when the rule was initially proposed and also include additional support for why §433.400 of the IFR should be rescinded. We agree with CMS that the harm caused to Medicaid enrollees and the fiscal realities in states warrants the swift rescission of the IFR. Medicaid coverage and benefits should be immediately and automatically reinstated for those who have lost access to essential care during the PHE.

I. [§433.400 of the IFR Contradicts the Statutory Protections of the FFCRA](#)

CMS's interpretation of the enrollment requirements in Section 6008(b)(3) of FFCRA addressing state obligations for maintenance of effort (MOE) during the PHE is directly contrary to the

clear mandate of the statute and CMS’s own previous guidance released in spring 2020 to states clarifying obligations under the MOE.

As an organization advocating on behalf of low-income older adults, the focus of our concerns is the impact of the IFR on Medicaid-eligible individuals who are newly eligible for Medicare during the PHE. The IFR interpretation, which CMS described as a “blended approach” in the IFR, is inconsistent with both the letter and spirit of Section 6008 of FFCRA. It deprives Medicaid enrollees of critical services during the PHE contrary to the clear mandate of the statute, and creates inequitable and inconsistent outcomes.

A. The IFR Interpretation Significantly Reduces Access to Medicaid Services for Older Adults and People with Disabilities

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.

The statute is clear that there are only two exceptions to maintaining continuous coverage: 1) the individual requests voluntary termination of Medicaid eligibility; or 2) the individual ceases to be a resident of the state. CMS had originally interpreted the straightforward statutory language in a straightforward way. In the original and subsequently updated FAQ, CMS told states that, to meet MOE requirements, an individual’s Medicaid benefits could 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.¹ In applying that requirement to individuals in the adult group who are turning 65 or who obtain Medicare, 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 Medicaid coverage.

¹ CMS Families First Coronavirus Response Act – Increased FMAP FAQ, 6 (Mar. 24, 2020) (updated Apr. 13, 2020), available at <https://sss.usf.edu/covid19/resources/medicaid/Family%20First%20Coronavirus%20Response%20Act%20%20Increased%20FMAP%20FAQs.pdf>.

² FMAP FAQ, Question 27.

In contrast, the IFR's interpretation, asserting that the plain language of the statute is "somewhat ambiguous," created 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.³

Further, for individuals in the adult coverage group who only qualify for a Medicare Savings Program (MSP), the state satisfies the MOE if they move them into the MSP without providing any other Medicaid benefits.⁴ Following the release of the IFR, CMS has repeatedly informed states that they are not only authorized to terminate full Medicaid coverage, but are required to do so if an individual is eligible and enrolled in an MSP.⁵ On the other hand, if an individual qualifies for no Medicaid program, the individual must continue to get the full adult group coverage.⁶

The IFR dramatically affects access to Medicaid benefits for individuals in the adult group who become eligible for MSP enrollment and 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 Qualified Individual (QI) MSP, the IFR interpretation means that the vast majority of adult group individuals moving into Medicare qualify for an MSP and thus lose all Medicaid services. Consequently, they only receive affordability assistance which includes 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 and people with disabilities who 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 that are not covered by Medicare, have lost access to essential care. Further, individuals who only qualify for Specified Low-income Beneficiary (SLMB) or QI coverage are also now 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.

³ IFR 42 C.F.R. § 433.400(c)(2)(i)(A).

⁴ IFR 42 C.F.R. § 433.400(c)(2)(i)(B).

⁵ CMS COVID-19 Medicaid & CHIP All State Call, Nov. 17, 2020, available at <https://www.medicaid.gov/state-resource-center/downloads/allstatecall-20201117.pdf>; CMS COVID-19 Medicaid & CHIP All State Call, Dec. 1, 2020, at pages 29-30, available at <https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/cmcsmedicaid-and-chip-all-state-calls/cmcs-medicaid-and-chip-all-state-calls-2020/index.html>.

⁶ IFR 42 C.F.R. § 433.400(c)(2)(iii).

B. The IFR Interpretation is Inconsistent with Statutory Requirements

In depriving almost all individuals in the adult group enrolled in an MSP to any Medicaid covered services, CMS imposes 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 which 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

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-servicesupports/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.

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 have in fact suddenly lost them in the midst of the pandemic.

Those most affected by the IFR are individuals relying on Medicaid-covered home and community-based services (HCBS) who risk hospitalization or institutional placement when those services are abruptly withdrawn. These outcomes are particularly dangerous in light of the strain that hospitals and nursing facilities have faced and continue to face, a concern that FFRCA's provisions specifically 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 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 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 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 leads to results that are startlingly inequitable and dizzyingly complex:

- If an individual qualifies for premium-free Part A and is eligible for any MSP, the state meets 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.

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

¹¹ 85 Fed. Reg. at 71165.

- 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.

- If the individual is eligible for the Qualified Medicare Beneficiary (QMB) program, the state meets its MOE obligations by enrolling the individual in the QMB program, which would pay Part A and Part B premiums.
- If the individual is eligible for the Specified Low-Income Benefit (SLMB) program or as a Qualified Individual (QI), the state has no mechanism to pay the individual's Part A premium so is 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, and states who have voiced support for these newly created exceptions to coverage in the IFR have provided no basis for why a subset of low-income older adults and people with disabilities should be deprived of coverage. Further, these outcomes most certainly do 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, which has been made evident by the confusion that has ensued.

II. The IFR has Caused Significant Harm to Low-Income Older Adults

Justice in Aging has continuously maintained that the IFR would lead to significant harm to older adults, which has proven true. In our original comments, we strongly opposed the new interpretation of the enrollment requirements outlined in Section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA).¹³ We then joined over 160 national and state organizations requesting that the Biden Administration rescind the IFR in a letter dated April 6, 2021, which outlined examples in which states had already or planned to take action to terminate Medicaid coverage or reduce benefits for older adults, people with disabilities, and

¹² 85 Fed. Reg. at 71163.

¹³ Justice in Aging, Comments on RIN 0938-AU35 Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, (Dec. 4, 2020), submitted electronically via regulations.gov and available at <https://justiceinaging.org/wp-content/uploads/2021/01/IFR-Justice-in-Aging-comments-1-4-2021.pdf>.

lawfully residing immigrants during the PHE.¹⁴ Most recently, Justice in Aging filed a lawsuit in federal court with Disability Rights Connecticut, the National Health Law Program, and Stinson, LLP on behalf of a proposed nationwide class of plaintiffs who have been harmed by the termination of their Medicaid benefits as a result of the IFR.¹⁵

The IFR's negative impacts affect those individuals most at-risk and negatively impacted by the pandemic. Older adults account for 75% of COVID-19 deaths.¹⁶ Low-income older adults eligible for Medicaid have been disproportionately impacted. Individuals dually eligible for Medicare and Medicaid are over two times more likely to be hospitalized than individuals with Medicare only.¹⁷ The loss of Medicaid has only increased their risk in total contradiction of the FFCRA, public health considerations, and CMS's own goals.

We direct CMS to the sign on comments Justice in Aging and the National Health Law Program submitted on October 25, 2022, with over 150 organizational signatories detailing harms to older adults and people with disabilities across the country.¹⁸

III. State Budget Predictions Were Unjustifiable as Cause to Cut Medicaid under the IFR and Never Materialized

When providing justification for allowing states to cut Medicaid during the PHE under the IFR, CMS predicted that state budgets would be adversely impacted by the COVID-19 pandemic.¹⁹ This rationale for cutting Medicaid was unjustifiable at the time the IFR went into effect and is even more so today as those predictions were never realized, as CMS acknowledges in its proposal to rescind the IFR.²⁰ Every state opted to take the increased federal match pursuant to the FFCRA and by doing so have seen flush budgets. This increased FFCRA funding— a total of \$100.4 billion as of May 2022²¹, combined with other federal relief under the American Rescue Plan Act, and the CARES Act created budget surpluses across the country. In a recently released survey of states' Medicaid programs, the vast majority of states reported that they did not anticipate state revenue shortfalls or cuts to Medicaid budgets in 2023 due to the increased

¹⁴ Justice in Aging, Letter to Rescind the IFR, (Apr. 6, 2021), available at <https://justiceinaging.org/wp-content/uploads/2021/04/MOE-IFR-Implementation-sign-on-letter-2021.04.06-Final.pdf>.

¹⁵ *Carr v. Becerra*, Case 3:22-cv-00988 MPS (U.S. Dist. Ct. D. Conn.) (Aug. 26, 2022), complaint available at <https://justiceinaging.org/wp-content/uploads/2022/09/43-Amended-Complaint-Class-Action.pdf>.

¹⁶ CDC, COVID-19 Death Data and Resources, available at <https://www.cdc.gov/nchs/nvss/covid-19.htm>.

¹⁷ CMS, Preliminary Medicare COVID-19 Data Snapshot, Dec. 2021, available at

<https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf>.

¹⁸ NHeLP JIA Sign on IFIR Implementation Oct 2022, posted Oct. 25, 2022, ID CMS-2020-0129-0241, also available at <https://justiceinaging.org/nhelp-jia-sign-on-comments-ifir-recission-submitted-oct-25-2022-with-signatures/>.

¹⁹ 85 Fed. Reg. at 71161.

²⁰ 87 Fed. Reg. at 58457.

²¹ Kaiser Family Foundation, "Fiscal and Enrollment Implications of Medicaid Continuous Coverage Requirement During and After the PHE Ends," May 2022, available at <https://www.kff.org/medicaid/issue-brief/fiscal-and-enrollment-implications-of-medicare-continuous-coverage-requirement-during-and-after-the-phe-ends/>.

funding they received from FFCRA.²² To the extent that states now claim that rescinding the IFR would result in fiscal harm, state budgets and the states themselves say otherwise. More significantly, administrative costs to the state were outweighed at the time the IFR was initially issued and remain far outweighed by the harm that has come to enrollees who have lost access to essential coverage during the pandemic.

IV. The IFR Should be Immediately Rescinded and Coverage Automatically Reinstated

Given that the IFR directly contradicts the statute and has significantly harmed Medicaid enrollees most negatively impacted by the pandemic and is not justified by state budget considerations, we agree with CMS that the IFR should be rescinded. We urge CMS to rescind §433.400 of the IFR *effective immediately* following the close of the 30-day notice and comment period. Once effective, we also urge CMS to require states to *immediately and automatically reinstate coverage* to those who have lost access to coverage and benefits as a result of the IFR.

The burden to reinstate coverage should not fall on individuals to reapply. Placing the burden on individuals will cause unnecessary delay and could prevent reinstatement of coverage entirely if the individual does not receive the notice or is unable to navigate the application process – especially considering these Medicaid enrollees have significant health care needs and face barriers to enrollment in the best of circumstances. Nor should enrollees be required to be reassessed for HCBS before services can begin. Instead, the plan of service that was in place when services were reduced or terminated should be restored until a new assessment can be conducted. Reassessments could take months to complete depriving older adults and people with disabilities of needed care while further straining the limited workforce available to conduct these applications and assessments in states. CMS should provide needed technical assistance to states with unique operational challenges in making these changes effective immediately.

Thank you again for the opportunity to submit comments. If any questions arise concerning this submission, please contact me at achrist@justiceinaging.org.

Sincerely,



Amber Christ
Managing Director, Health Advocacy

²² Kaiser Family Foundation, “Medicaid Enrollment & Spending Growth: FY 2022 & 2023,” Oct. 2022, available at <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2022-2023/>.