JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

January 8, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

*Submitted via regulations.gov*

**Re: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program (CMS-9895-P)**

Justice in Aging is writing in response to the above referenced proposed rule. Our comments address three proposed changes: 1. eliminating the 42 CFR § 435.601(d)(4) comparability requirement in the use of income and/or resource disregards for non-MAGI Medicaid eligibility groups; 2. permitting Marketplaces to accept applicants' attestation of incarceration status without additional electronic verification; and 3. removing the prohibition on non-pediatric oral health services as an essential health benefit (EHB).

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 healthcare, economic security, and the courts for older adults with limited resources. We focus our efforts primarily on those who have been marginalized and excluded from justice such as older adults of color, older women, LGBTQ+ older adults, older adults with disabilities, and older adults who are immigrants or have limited English proficiency. Justice in Aging has decades of experience with Medicare and Medicaid and we advocate to improve access to comprehensive high-quality health care for all low-income older adults through these programs as well as the Marketplace.

## Increase State Flexibility in the Use of Income and Resource Disregards for Non-MAGI Populations (42 CFR § 435.601)

As explained below, we recommend that CMS withdraw for further study the proposed elimination of 42 C.F.R. § 435.601(d)(4). Although we recognize and appreciate CMS's expressed intent in deleting section 435.601(d)(4), we also recognize the benefits of comparability principles as applied to Medicaid. In general, comparability requirements protect Medicaid enrollees by requiring that they be treated fairly — that one Medicaid enrollee or population is not disadvantaged as compared to other enrollees or populations. As advocates for Medicaid enrollees, we value how comparability requirements prevent particular enrollees or populations from being left behind.

The proposed elimination of the section 435.601 comparability requirement carries with it both pros and cons. On one hand, the elimination of the requirement might allow state Medicaid programs to make beneficial changes, for example (as suggested by CMS in discussing this proposal), a resource disregard for persons with disabilities "who have accumulated resources through saving their earned income."[1] On the other hand, state Medicaid programs could use the increased flexibility to effectively

[1] 88 Fed. Reg. at 82,524.

reduce benefits by eliminating one eligibility route while creating a facsimile of that eligibility route for only a subpopulation by offering that subpopulation a disregard. For example, a state might eliminate special-income-limit eligibility and then restore only a portion of that eligibility by offering targeted disregards within a federal-poverty-limit eligibility group. Or, in another example, a state could eliminate Medicare Savings Programs income and asset limits that are more generous than the federal minimums and instead choose to target smaller subpopulations.

These risks are real. We know from experience that states often face budgetary pressures and, as a result of those pressures, target Medicaid programs for cuts. Worse, because of Medicaid enrollees' often limited political clout, targeted cuts frequently become a reality.

Furthermore, given the logistics of targeted disregards, eliminating section 435.601(d)(4) would add complexity to already burdensome non-MAGI eligibility rules and work against CMS's efforts to streamline eligibility and increase enrollment. Part of the benefit of comparability is operational uniformity, which would be compromised under CMS's proposal.

The only limits on this flexibility CMS articulates are preexisting requirements that "the subpopulation is reasonable and does not violate other Federal statutes (for example, it does not discriminate based on race, gender, sexual orientation or disability)."[2] These requirements, however, appear to be inadequate. Discrimination against subpopulations may well be harmful even if the subpopulation is not based on race, gender, sexual orientation or disability, and it is not clear what "reasonable" means or how CMS would apply and enforce such a standard. The vagueness of the standard would likely lead to broad CMS acquiescence to state proposals for targeted disregards.

In a cost analysis, CMS acknowledges that it does not know how many states would use this flexibility, or which populations would be impacted and to what extent.[3] Likewise, while acknowledging some potential risk, CMS concludes with no solid evidence that that the proposed regulatory change would generally benefit enrollees:

> It is possible that, in eliminating the comparability rule from 42 CFR 435.601(d), a State might narrow an existing disregard that is broadly available to an eligibility group to discrete members of the group. However, CMS has not received inquiries from States on the feasibility of such an approach to the same extent that we have received questions from States on whether they may use income and/or resource disregards to expand eligibility in a targeted manner. CMS believes that, in the absence of a comparability rule in 42 CFR 435.601(d), States would on the whole utilize disregard-related authority to expand eligibility instead of contracting it.[4]

We believe that CMS is too sanguine in its evaluation of potential risks and benefits. At this point, CMS has articulated little evidence that states would only or primarily use this new flexibility in a beneficial way. To our knowledge, this issue was not raised with stakeholders prior to the release of the proposed regulatory change. Also, the current public comment opportunity has been hampered by the release of this proposed change within the Marketplace-focused Notice of Benefit and Payment Parameters for

[2] 88 Fed. Reg. at 82,525
[3] 88 Fed. Reg. at 82,627.
[4] 88 Fed. Reg. at 82,525.

2025, and a 45-day comment period including the December/January time during which many are on vacation. Eliminating this comparability requirement is a significant change and we are concerned that advocates for the populations directly impacted—primarily older adults and people with disabilities—have not had sufficient notice or opportunity to weigh in.

In addition to our concerns about the practical ramifications of the proposed change, we also question the legal foundation. CMS has operated for decades with the understanding that the statutory requirement of comparability in "standards" requires that disregards be applied equally across an eligibility group. In accord, in authorizing targeted disregards for home- and community-based services, Congress found it necessary to explicitly direct that section 1902(a)(17) not be construed to prohibit such disregards.[5] Indeed, as a practical matter, application of a disregard can be functionally equivalent to changing a standard.

For all these reasons, we urge CMS to reconsider this proposal and then, as appropriate, re-release it with a fuller discussion of potential risks and benefits, a more robust legal discussion of the effect of statutory comparability requirements, and a longer comment period outside of the end-of-year holiday season. CMS presents the proposed change as a clear step forward, but we believe that the benefits do not necessarily exceed the risks, particularly given the inadequate consideration of risks in the Federal Register discussion, and the compressed public comment period.

## Verification Process Related to Eligibility for Enrollment in a QHP through the Exchange (45 CFR § 155.315(e))

We support the proposed changes to section 155.315(e), permitting all Marketplaces to accept applicants' attestation of incarceration status without additional electronic verification. Minimizing enrollment barriers for people who have been incarcerated or otherwise involved with the criminal legal system advances health equity and will particularly benefit Black, Native, Latino and other communities that are disproportionately incarcerated due to systemic racism.

Justice in Aging implores CMS to also take action to ensure people leaving incarceration who are eligible for Medicare can access coverage and care. Specifically, we ask CMS to amend the Medicare custody definition at 42 C.F.R. § 411.4(b) to align with post-incarceration coverage policies in the Marketplace and Medicaid.[6] Because the Medicare restrictions on payments for people leaving incarceration are overly broad and imprecise, some older individuals returning to the community cannot access Medicare providers due to conditions of their release, and those who do not qualify for Medicaid face significant health care costs and may forgo care.

[5] Sustaining Excellence in Medicaid Act, Pub. L. No. 116-39, § 1.

[6] Medicare regulation bars provider payments for any Medicare-covered services for individuals who are "under supervised release, on medical furlough, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule." 42 CFR 411(b). This regulation is inconsistent with CMS policies that eliminated coverage exclusions for people living in the community under parole, in halfway houses, or other similar conditions. *See* Centers for Medicare & Medicaid Services, "SHO # 16-007 Re: To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities," Q2 and Q3 (April 28, 2016); Centers for Medicare & Medicaid Services, "Incarceration and the Marketplace: Frequently Asked Questions" (May 3, 2016).

## Provision of EHB (45 CFR § 156.115)

**Oral Health**

We strongly support HHS's proposal to remove the prohibition on non-pediatric oral health services as an essential health benefit (EHB). Oral health is essential in maintaining overall health and addressing health disparities. Yet, the current exclusion for EHB plans has prevented coverage of oral health services and access to this essential care. Oral health care is expensive, so it is not surprising that those without dental coverage cite not being able to pay for treatment as the biggest barrier to accessing care.[7] Obtaining coverage would allow many people who cannot currently afford to pay for treatment to access care and improve their health outcomes. As the harm from lack of access to oral health care compounds over the lifetime, providing dental coverage to adults as EHB would also improve health outcomes among older adults, reducing costs on Medicare and Medicaid.

Adults experience high rates of poor oral health, with certain populations impacted more acutely. Today, 90% of adults aged 20 to 64 experience tooth decay.[8] Fifty percent of adults are diagnosed with gum disease, with the greatest prevalence of severe gum disease impacting Hispanic and Black adults.[9] The impact of poor oral health on overall health is substantial and exacerbates health disparities while driving increased health care spending for chronic conditions. For example, the impact of untreated gum disease has been identified as a risk factor for Alzheimer's disease, diabetes, and heart disease – health conditions disproportionately impacting Black and Hispanic individuals.[10] Further, untreated gum disease can lead to infections like aspiration pneumonia--particularly for individuals with chronic obstructive pulmonary disease—resulting in costly hospitalizations,[11] while ongoing pain associated with untreated oral health disease increases the likelihood that opioids will be prescribed and abused.[12] Research further shows that untreated tooth decay resulted in nearly $50 billion in lost productivity.[13]

Increasing coverage will increase access to needed care for Marketplace enrollees while also reducing disparities. Research demonstrates, for example, that expanding dental coverage through Medicaid expansion reduced disparities in annual dental visits for Black adults by 75% and for Hispanic adults by 50%.[14] Notably, disparities did not decline in states where dental coverage and benefits were minimal.

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[7] Vujicic, M. et al., "Dental Care Presents the Highest Level of Financial Barriers, Compared to Other Types of Health Care Services," Health Affairs (Dec. 2016); *see also*, Gupate, N. & Vujicic, M., "Main Barriers to Getting Needed Dental Care All Relate to Affordability," American Dental Association, Health Policy Institute (2019).
[8] National Institutes of Health, "Oral Health in America: Advances and Challenges," Section 3A: Oral Health Across the Lifespan: Working Age Adults (2021).
[9] *Id*.
[10] *Id.*
[11] Bansal, et al., "Potential Role of Periodontal Infection in Respiratory Diseases: A Review," Journal of Medicine and Life (2013).
[12] Nack, B., et al., "Opioid Use Disorder in Dental Patients: The Latest on How to Identify, Treat, Refer and Apply Laws and Regulations in Your Practice," (2017); Brat, G., et al., "Postsurgical prescriptions for opioid naïve patients and association with overdose and misuse: retrospective cohort study," National Institutes of Health (2018); Schroeder, A., et al., "Association of opioid prescriptions from dental clinicians for US adolescents and young adults with subsequent opioid use and abuse," National Institutes of Health (2019).
[13] National Institutes of Health, "Oral Health in America: Advances and Challenges," Section 3A: Oral Health Across the Lifespan: Working Age Adults (2021).
[14] Wheby, G., et al, "Racial And Ethnic Disparities In Dental Services Use Declined After Medicaid Adult Dental Coverage Expansions," Health Affairs (Jan. 2022).

This is instructive for EHB expansions. We urge CMS to consider means of standardizing dental coverage and creating baseline coverage standards and benefit packages. Private and employer-sponsored dental plans widely utilize waiting periods for covered services, low annual benefit caps, high cost sharing, and exclusions of preventative and restorative dental treatment. These cost containment and utilization controls are prohibited for other medical care but yet remain commonplace in dental coverage. CMS has an opportunity to establish more parity between dental coverage and medical coverage in this rulemaking.

**Vision, Long-Term Care, and Other Benefits**

CMS asks whether similar changes should be proposed with regard to provision of "routine non-pediatric eye exam services and long-term/custodial nursing home care benefits." We support removing prohibitions on vision and long-term care and any other services by rescinding section 156.115(d) entirely. We do not believe that the ACA requires prohibiting coverage of any of these benefits, and having this regulatory provision unjustifiably restricts states' ability to update their EHB benchmark plans. As with the proposal to remove the prohibition on adult dental, CMS would open the door to ensuring access to comprehensive health and long-term services and supports and advancing health equity.

## Conclusion

Thank you for the opportunity to comment. Justice in Aging urges HHS to finalize this rule as soon as possible. If any questions arise concerning this submission, please contact Eric Carlson, Director of Long-Term Services and Supports Advocacy, ecarlson@justiceinaging.org, and Natalie Kean, Director of Federal Health Advocacy, at nkean@justiceinaging.org.

Sincerely,

Amber Christ
Managing Director of Health Advocacy