

December 22, 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

**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:

Physicians for Reproductive Health (PRH) 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”. PRH is a physician-led national advocacy organization that works to improve access to comprehensive health care, including reproductive health care. Our network includes physicians of all specialties from across the country committed to meeting the health care needs of patients, regardless of income or source of health care coverage. As physicians we have witnessed first-hand the harm of the COVID-19 pandemic on families and communities across the nation, and we firmly believe that all people must have access to the health care coverage they need, including access to the COVID-19 vaccine, without cost sharing and without jeopardizing existing health coverage.

The Families First Coronavirus Response Act (FFCRA), signed into law on March 18, 2020, 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 acquire and maintain coverage during the crisis and receive needed services. The FFCRA included an explicit requirement to preserve enrollee’s existing benefits – both their enrollment in Medicaid overall, and the services for which they have been receiving. At a time of such turmoil, Congress chose to protect enrollees and ensure access to services by maintaining the “status quo.”

We are writing as physicians 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 patients who are enrolled in Medicaid, including reduced benefits; reduced amount, duration, and scope of

services; increased cost-sharing; and reduced post-eligibility income. The IFR will also result in terminations of coverage for some individuals. We oppose these revisions to the MOE, which are inconsistent with the FFCRA and will result in harm for Medicaid enrollees, especially during an ongoing public health emergency. We also oppose allowing states to circumvent required transparency procedures for Section 1332 waivers and receive enhanced funding despite refusing to cover COVID-19 vaccination for some Medicaid enrollees. We strongly urge CMS to withdraw these provisions that would be so detrimental to our patient communities.

Reduction of Optional Benefits

The IFR 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 –despite their enhanced matching funds under the FFCRA. These changes contravene the letter and intent of the Medicaid statute and will result in significant harm for patients reliant on these services.

Optional Medicaid benefits include essential services like prescription drugs, physical and occupational therapy, dental and vision services, home and community-based services, testing for individuals at elevated risk of breast cancer, and intimate partner violence screening. Since 2008, states have already made significant cuts to each of these services, and any additional cuts will only work to harm the patients we serve and worsen health outcomes.¹ For example, untreated vision and dental issues contribute to poor overall health. And lack of Medicaid coverage for vision services makes it more likely that a person will experience physical limitations.

In addition, with the stressors of the pandemic, social distancing, and economic hardship some patients report difficulty in accessing services and support when experiencing Intimate Partner Violence (IPV). These important services connect individuals with the support they need. IPV screenings are considered an optional benefit in non-ACA expansion states and elimination of this service puts patients at greater risk.

Furthermore, many providers of optional benefits are likely to be facing financial strain due to the pandemic, and cuts to optional services may put some of them out of business. For example, among home and community-based service providers serving individuals with intellectual and developmental disabilities, 77 percent have had to close one or more programs, and 16 percent do not anticipate these programs reopening post pandemic.

Reductions in the Amount, Duration and Scope of Services

The IFR would allow states to change the amount, duration, and scope of services. For example, when states faced budget constraints after the Great Recession, some states [placed](#) numerical

¹ After the previous economic downturn in 2008, [many](#) states made significant cuts to each of these services.

caps on benefits like physician visits and hospital days. While these capped services may have been adequate for some enrollees, in many cases they were not sufficient for others, such as people with chronic illnesses and disabilities.

The Medicaid program provides coverage for a comprehensive package of health benefits, which ensures the health, well-being, and security for millions of patients. Unfortunately, centuries of structural and institutional racism, resulting in discriminatory policies and practices have created barriers that make Black and Latina women more likely to have low-incomes and rely on Medicaid coverage than white women. Approximately 30 percent of Black women and 24 percent of Latina women ages 15 to 44 are enrolled in Medicaid, compared to 14 percent of white women. Cuts or changes to the amount, duration, or scope of Medicaid services would have a detrimental impact on all patients, but particularly patients of color, and harm the overall health, well-being, and economic security of the people we care for.

In addition, coverage restrictions unduly interfere in the patient-provider relationship by creating obstacles to the provision of medical care. These obstacles unfairly impact patients with low incomes who may not otherwise be able to afford basic health care without such coverage. As providers, under no circumstances should we be put in the position of denying health care services because of CMS's failure to maintain the status quo and comply with FFCRA requirements. Health care is a human right. In the midst of a pandemic CMS should be taking steps to expand health care coverage, not allowing states to limit it.

The Medicaid program currently provides essential health care coverage for reproductive health services such as birth control, family planning, STI testing and treatment, well-person exams, and life-saving cancer screenings. The program is a critical tool for reducing health and economic inequities among women of color and other historically marginalized communities. Approximately one in five women of reproductive age rely on Medicaid to access no-cost, critical reproductive health care. Medicaid is also the largest payer of reproductive health care coverage, paying for 75 percent of all public funds spent on family planning services. Importantly, Medicaid is also the primary source of coverage for essential pregnancy care, including prenatal and delivery care, for 42 percent of people giving birth. Any reduction to Medicaid's reproductive health services would harm the ability of patients to get the comprehensive health care they need and could lead to worsening health outcomes, including by exacerbating the nation's maternal mortality crisis – a result PRH strongly opposes.

Prior Authorization and Utilization Management Requirements

The IFR would also allow states to impose new prior authorizations and other utilization management requirements. These can harm Medicaid enrollees and providers in typical times, and these issues are likely to be significantly exacerbated during COVID-19. Presently, many providers are [overwhelmed](#) caring for COVID-19 patients. Increased prior authorizations will divert them from that essential work. Moreover, overloaded clinician offices and limited in-

person visits make it more likely patients will “fall through the cracks” and not get their medications or other services when a prior authorization is needed. This concern is backed up by survey research, which [reports](#) that of the 52 percent of people whose families skipped or postponed care during the previous three months due to coronavirus, 82 percent did so because the doctor's office was closed or had limited appointments.

Furthermore, burdensome prior authorization and utilization management requirements negatively impact the provider-patient relationship. Research has found that patients are more likely to discontinue needed medications when prior authorizations are required making it difficult for providers to ensure continuity of care. The current pandemic will likely serve to only worsen those impacts. For example, a [survey](#) of Medicaid enrolled providers in Texas found that they saw prior authorizations as a significant burden. These providers agreed that prior authorization takes time away from patients and reduces the pool of providers that will see Medicaid patients due to additional administrative burden. When health care providers are already reeling from the effects of the pandemic additional burdens and barriers to patient care are the last thing our communities need.

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 patients with low incomes reduces necessary care and correlates with increased risk of poor health outcomes. Furthermore, the pandemic has exacerbated the harm caused by cost-sharing. The pandemic has [significantly increased](#) financial hardship among families with low incomes and families of color. Black women are nearly twice as likely as white men to say that they have either been laid off, furloughed, or had their hours and/or pay reduced because of the pandemic. According to the latest Jobs Report, 37 percent of unemployed women have been out of work for longer than six months. And data from various states shows that Black and Latinx people are disproportionately contracting and dying of COVID-19, largely as a result of continued patterns of structural inequality and institutionalized racism placing communities at higher risk. Increasing economic burdens such as cost sharing makes it more likely that patients will be unable to afford the critical care they need and is likely to worsen existing health care inequities.

Post-Enrollment Income Verification

The IFR also permits states to modify their post-eligibility treatment of income (PETI) rules. This could leave enrollees with disabilities who are institutionalized or using a home and community-based services (HCBS) waiver program with less money to meet their basic needs, which could cause significant harm. For example, if states don't allow HCBS waiver enrollees to keep enough money each month to cover their living expenses, they may be [forced](#) into

congregate living facilities and institutions. This prospect is particularly frightening during the pandemic, given the [disproportionate impact](#) of COVID-19 on people in congregate settings.

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 preserving individuals' benefits, and can cause substantial harm. This harm will disproportionately fall on particular patient groups, including people with disabilities, people of color, 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. For example, under Medicaid's Immigrant Children's Health Improvement Act (ICHIA) option, states can cover lawfully present immigrant children and pregnant people without a five year wait. However, these protections are time limited. After the children turn 21 and at 60-days postpartum, the IFR requires states to restrict their eligibility to the limited emergency Medicaid eligibility group. Essentially, with no statutory basis and to the detriment of patients, CMS is saying that the MOE does not apply to this patient group – an exclusion that is particularly troubling because immigrant communities have been disproportionately affected by COVID-19. In some instances, depending on the state, COVID-19 testing and treatment may not be covered under emergency Medicaid. Furthermore, individuals will not have coverage for the management of chronic conditions, worsening health outcomes and potentially increasing the risk of death from COVID-19. By authorizing states to terminate Medicaid coverage, CMS will further harm patients at a time when they need access to care the most.

Valid Enrollment

Under the IFR, CMS narrows the definition of "valid enrollment" to exclude some enrollees who should be considered properly enrolled and covered by the protections of the FFRCA. CMS states that individuals eligible by presumptive eligibility are not "validly enrolled" for the purposes of the continuous coverage provision, on the theory that 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).² CMS’s attempt to distinguish presumptively eligible patients is therefore inconsistent with the Medicaid statute. Moreover, pandemic-related circumstances are making it extremely difficult for many people to complete a full Medicaid application before their presumptive eligibility period ends. Right now, many patients are struggling and are facing deep economic insecurity in addition to dealing with housing and food insecurity. CMS should be doing everything in its power to ensure enrollment in health coverage not narrowing the definition of who is “validly enrolled” and jeopardizing coverage for those in need.

In addition, CMS would allow states to terminate individuals for “fraud or abuse.” The IFR states that if the state conducts an abuse investigation under the applicable Medicaid regulations and finds there was abuse “material to the determination of eligibility”, the individual is not “validly enrolled”, and the state may have to terminate their Medicaid coverage. However, the applicable regulations give states a range of options to resolve an abuse investigation, and do not necessarily require an individual be disenrolled.³ CMS should not impose outcomes that supplant or skip the state processes already in place and specified by regulations.

Determinations of Ineligibility

The IFR writes that “if a state determines that a validly enrolled beneficiary is no longer eligible for Medicaid, including on a procedural basis”, the state meets the MOE requirements by “continuing to provide the same Medicaid coverage that the beneficiary would have received absent the determination of ineligibility.” This language needs clarification or correction. We note two important considerations.

First, we believe CMS should preserve the requirement that the MOE provision apply to *procedural* problems. For example, an individual who is delayed in responding to state outreach or requests for information may be dealing with serious health, economic, or housing problems related to the COVID-19 crisis, and such procedural breakdowns cannot be an excuse to discontinue eligibility in violation of the FFCRA.

Second, CMS must correct or clarify the use of the terms “determines” and “determination” in the regulation. No one protected by the MOE can be “determined” ineligible, as that would be contrary to the FFCRA’s requirement that during the PHE these enrollees be “treated as eligible”. We suggest CMS use a term such as a “nonactionable finding of ineligibility” instead of “determination of ineligibility.”

However, CMS should make clear that any such nonactionable finding of ineligibility during the public health emergency is not sufficient or even relevant to terminate someone at the end of the

² 42 U.S.C. § 1396(a)(47)(B)

³ See 42 C.F.R. § 455.16

PHE. CMS should clarify that *after* the PHE ends, individuals must receive a full redetermination, based on *current, point-in-time* information (current income, household composition, etc.).⁴ Such a review must consider all bases of eligibility, and give enrollees at least 30 days to respond to a request for information (for those eligible using modified adjusted gross income).⁵ After the MOE ends and a full redetermination occurs, if an individual is found ineligible they are entitled to due process protections, such as a notice of termination that includes the effective date of the action and appeal rights.⁶

Section 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 Section 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 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 Section 1332 waivers “promotes transparency, facilitates public involvement and input, and encourages sound decision-making at all levels of government”.⁷ This process is essential to ensure that stakeholders have input into proposed waivers. As a physician led organization it is important to us that we have an opportunity to weigh in on matters that significantly impact our patients as well as the practice of medicine.

Availability of COVID-19 Vaccines

As of December 15, 2020, more than 300,000 people in the United States [have died](#) as a result of COVID-19, with over 16 million [confirmed](#) cases. As health care providers and public health experts we agree that a safe and effective preventive vaccine will be essential to curb this deadly pandemic.

⁴ See e.g., 42 U.S.C. § 1396a(e)(14)(H); 42 C.F.R. § 435.603(h)(2).

⁵ 42 C.F.R. §§ 435.916(a)(3)(i)(B), (f)(1)

⁶ See e.g., 42 C.F.R. §§ 435.917(b)(2), 431.210

⁷ 76 Fed. Reg. 13556 (Mar. 14, 2011).

Congress recognized the vital importance of coverage and access to COVID-19 vaccines when it enacted the FFCRA. Congress provided 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 patients enrolled in Medicaid limited benefit programs. These Medicaid limited benefit programs include programs focused on the treatment of breast and cervical cancer, family planning programs, and some programs provided under Section 1115 waiver authority.⁸ Further, CMS does not provide any explanation or analysis on how it would determine which of the existing [fifty-seven](#) Section 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 vaccinations. CMS should not invent an ambiguity and then interpret it contrary to the statute's overriding intent.

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. As health care providers, many of whom are on the front lines of this pandemic, access to COVID-19 vaccines is critical. 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 impact access to health care for tens of millions of patients during a pandemic – as an interim final rule. The Administrative Procedure Act anticipates 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.

⁸ 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).

Conclusion

This is an unprecedented pandemic, and Congress took unprecedented measures under the FFRCA to make sure Medicaid patients could 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 the formal administrative record for purposes of the Administrative Procedures Act. If HHS is not planning to consider these citations 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 MiQuel Davies, Assistant Director of Policy at Physicians for Reproductive Health, mdavies@prh.org.

Sincerely,

Jamila Perritt

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President & CEO
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