

January 4, 2021

VIA ELECTRONIC SUBMISSION

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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

As organizations dedicated to promoting the health of our nation's children and pregnant women, we write to offer 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. The changes of this interim final rule with request for comment (IFC) will have far-reaching implications for the millions of children and families who rely on Medicaid, including children with special health care needs, pregnant women, and those from low-income families.

Make no mistake: the COVID-19 pandemic is harming children. More than 2 million children have tested positive for COVID-19 since the onset of the pandemic, representing about 12% of all cases.¹ COVID-19 can have serious consequences for children's health, such as the newly identified multisystem inflammatory syndrome in children associated with COVID-19, and experts are still unsure of the long-term health implications for those who have contracted the virus. Beyond the harm caused by the infection itself, many factors unique to this pandemic (eg, uncertainty, rapidly changing and conflicting messages, duration of the crisis, need for quarantine, and use of face coverings) increase its effects on emotional and behavioral health,² adding complexity and severity to the worrying increase in pediatric suicidal ideation and self-harm.³

The impact of COVID-19 in the United States has also exposed long-standing inequities by race, ethnicity, and income for children and families. COVID-19 cases and deaths are disproportionately higher among Black and Hispanic children than among their white peers.⁴ Moreover, the pandemic continues to severely exacerbate existing and alarming social inequities along racial and ethnic lines through such fundamental issues as housing stability, employment status, health care access, and food security.

¹ <https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/children-and-covid-19-state-level-data-report/>

² <https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/interim-guidance-on-supporting-the-emotional-and-behavioral-health-needs-of-children-adolescents-and-families-during-the-covid-19-pandemic/>

³ Suicide Ideation and Attempts in a Pediatric Emergency Department Before and During COVID-19. Ryan M. Hill, Katrina Rufino, Sherin Kurian, Johanna Saxena, Kirti Saxena, Laurel Williams. Pediatrics Dec 2020, e2020029280; DOI: 10.1542/peds.2020-029280.

<https://pediatrics.aappublications.org/content/early/2020/12/15/peds.2020-029280>

⁴ Racial and/or Ethnic and Socioeconomic Disparities of SARS-CoV-2 Infection Among Children. Monika K. Goyal, Joelle N. Simpson, Meleah D. Boyle, Gia M. Badolato, Meghan Delaney, Robert McCarter, Denice Cora-Bramble Pediatrics Oct 2020, 146 (4) e2020009951; DOI: 10.1542/peds.2020-00995.

<https://pediatrics.aappublications.org/content/146/4/e2020009951>

Medicaid and CHIP have proven to be powerful first responders to public health crises, including the COVID-19 pandemic. The programs are cost-effective and well-suited to distribute resources quickly and equitably to areas of greatest need. As millions of families suffer job loss and experience financial stress during the economic downturn, Medicaid and CHIP continue to act as an essential lifeline for children and families, ensuring children have access to vital services like vaccinations, developmental screenings, and treatment for acute and chronic illnesses.

The Families First Coronavirus Response Act (FFCRA) offered an option for states to receive enhanced federal Medicaid funding if they comply with certain maintenance of effort (MOE) protections. These protections help ensure continuity of care for children and families during the Public Health Emergency (PHE). CMS's initial interpretation of the continuous coverage provision prevented states from making cuts to benefits or increasing cost-sharing for Medicaid beneficiaries while they are enrolled. That was consistent with the plain reading of the FFCRA statutory language, which explicitly defines an enrollee's existing coverage to include both their enrollment in Medicaid and "*such benefits*" for which they have been eligible.

This IFC reverses the previous CMS interpretation, allowing states to impose numerous types of coverage restrictions for individuals enrolled in Medicaid, including reduced benefits; reduced amount, duration, and scope of services; and increased cost-sharing. We oppose these revisions to the MOE, which are inconsistent with the FFCRA and will result in harm for children and families enrolled in the Medicaid program.

We urge CMS to withdraw these provisions and instead work with us to strengthen the program, such as by removing red tape barriers to access. Our specific comments are below:

Undermining the Continuous Enrollment Provision

As stated above, CMS initially used a plain language interpretation of continuous enrollment to mean that states could not alter eligibility or enrollment except where an individual voluntarily requested termination or moved to another state as laid out by the statute. However, the new interpretation under the IFC undermines the continuous coverage protections of the FFCRA by excluding individuals who are not "validly enrolled."⁵ Although CMS notes that the state must provide advance notice of termination and fair hearing rights to those beneficiaries who were not "validly enrolled," we are concerned that states will need to spend significant time and financial resources implementing these changes, which are mandatory, to their eligibility systems.

Moreover, the IFC authorizes states to terminate coverage for certain individuals who should be protected under the FFCRA. For example, under Medicaid's Immigrant Children's Health Improvement Act (ICHIA) option, states can cover lawfully present immigrant children and pregnant women without a 5-year waiting period. However, under the IFC a state could be allowed to restrict Medicaid eligibility for children once they turn 21, or for women who finish their 60-day postpartum period. Excluding this population from the MOE protections is particularly troubling because immigrant communities have been disproportionately affected by COVID-19. We oppose these changes, which are in contradiction with the plain reading of the statute.

Elimination of Optional Benefits

The IFC gives states sweeping authority to reduce optional Medicaid benefits. CMS notes that under the IFC, states are permitted to make "programmatic changes," such as changes to the medical necessity criteria or

⁵According to CMS, a beneficiary is not validly enrolled "if the agency determines the eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of "agency error or fraud (as evidenced by a fraud conviction) or abuse (as determined following completion of an investigation. . .) attributed to the beneficiary or the beneficiary's representative, which was material to the determination of eligibility."

utilization control procedures in determining coverage for benefits, elimination of optional benefits coverage, and increases in cost-sharing responsibilities. Notably, states that institute these cuts would still be eligible for the temporary FMAP increase.

Children are not little adults; they require services and care specifically suited to their unique development and growth needs. Because of their continuous growth and development, children’s need for a full set of pediatric and age-appropriate benefits is particularly acute, and gaps in benefits can result in life-long health consequences that generate extensive and avoidable costs. Unlike many private health insurance plans, Medicaid guarantees specific benefits designed especially for children. Medicaid’s Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits are the definitive standard of pediatric care, covering an array of services like developmental, dental, vision and hearing screenings, and allowing health problems to be diagnosed and treated appropriately and as early as possible.

According to CMS, EPSDT is designed to “assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.”⁶ Federal statute requires the EPSDT benefit to cover “necessary health care, diagnostic services, treatment, and other measures...to correct or ameliorate defects along with physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.” In practice, the IFC allows states to make their medical necessity definitions more restrictive during the public health emergency, placing caps on utilization in the name of cost-savings, which is contrary to CMS’ bold mission statement of EPSDT.

Additionally, while nearly all medically necessary services for children are mandatory under the EPSDT benefit, this rule puts optional coverage pathways at risk. Many Medicaid eligibility pathways for children with disabilities are optional, and 34 states provide some optional home and community-based long-term services and supports offered through Section 1915(c) waivers. Facing budgetary pressures from the ongoing pandemic and recession, states could choose to cap enrollment. Even if enrollment in optional eligibility pathways is not capped or eliminated, states may scale back provider payments or restrict utilization through optional waivers, which will still diminish children’s access to care.

Changes to Eligibility Groups

Citing the Secretary’s rulemaking authority under section 1102 of the Act and section 1902(a)(19) of the Act to “ensure that care and services are provided in a manner consistent with the best interests of beneficiaries,” the IFC establishes three new tiers of Medicaid coverage, allowing states to move people from one eligibility category to another in certain circumstances, even when that would result in an individual receiving fewer benefits.

For example, women who – as a result of the COVID-19 PHE – have remained enrolled in Medicaid and have surpassed the statutorily-mandated 60-day period for postpartum coverage may be deemed eligible for coverage under Medicaid expansion. States would now be required to move these women into the adult expansion group for the remainder of the PHE. In some instances, this may result in decreased benefits, such as a reduction in coverage for case management, parenting education, and breastfeeding support.

Overall, we are concerned that the new coverage tiers outlined by CMS would lead to cuts to services and utilization that would threaten the health of children and families, and therefore oppose its implementation.

⁶ <https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html>

Increases in Cost-Sharing

The IFC would also allow states to increase cost-sharing on Medicaid enrollees. Research has demonstrated that cost sharing for those with low-incomes can prevent individuals eligible for coverage from enrolling, and those enrolled in coverage from seeking care.⁷ Even relatively small cost sharing amounts can have these effects.⁸ The joint impacts of the pandemic and the recession also exacerbate the harms of cost-sharing, increasing 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. Our organizations cannot support imposing additional costs on low-income children and families during a time when so many are already struggling financially.

1332 Waivers

Under the IFC, CMS also proposes to allow the “modification” of public notice, comment, and hearing requirements for Section 1332 waiver requests. This will result in state proposals and CMS approvals that have no meaningful stakeholder input. As we outlined in our previous comment letter, our organizations believe that recently revised guidance is inconsistent with the statutory requirements of Section 1332 and could have far-reaching negative effects on children, pregnant women, and families.⁹ Therefore, we reiterate our call for the Departments to rescind the 2018 guidance and retain the previous 2015 Section 1332 guidance consistent with statutory requirements.

Administrative Burden of Redeterminations During and After the PHE

Under the terms of the IFC, states will ultimately have to determine eligibility and enrollment, in addition to analyze different coverage tiers and benefit categories, for millions of Medicaid beneficiaries. In its regulatory impact analysis, CMS provides no estimate of the number of people who could lose coverage because of these changes. Nor does CMS estimate specific costs or savings by state or federal governments attributable to the IFC.

We anticipate the changes CMS promulgated through the IFC to be administratively burdensome for states to implement, with such massive changes to each state’s eligibility system likely leading to errors and inaccurate coverage denials. The time and money required to implement these changes would be far better spent reducing red tape barriers to accessing coverage such as bolstering ex parte renewal processes, leveraging data from other public program like SNAP and WIC to streamline eligibility, and updating beneficiary addresses to ensure that outdated information does not lead to coverage loss.

In conclusion, the changes of this IFC will have far-reaching implications for the millions of children and families who rely on Medicaid, including children with special health care needs, pregnant women, and those from low-income families. We urge CMS to withdraw these provisions and instead work to strengthen the program. Our organizations stand ready to assist with efforts to protect children and families during this crisis. If you have questions on any of the issues discussed in this letter, please contact Stephanie Glier at sglier@aap.org.

⁷ S. Artiga, P. Ubri, and J. Zur, “The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings,” (Washington: Kaiser Family Foundation, July 1, 2017), available at <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>.

⁸ *Ibid.*

⁹ <https://downloads.aap.org/DOFA/FINAL--SKG1332.pdf>

Sincerely,

American Academy of Pediatrics

Children's Defense Fund

Family Voices

First Focus on Children

Georgetown Center for Children and Families

March of Dimes

National Association of Pediatric Nurse Practitioners