October 27, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: 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 (CMS-9912-N)

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to comment on CMS-9912-N, Temporary Increase in Federal Medical Assistance Percentage (FMAP) in Response to the COVID-19 Public Health Emergency (PHE). We urge the Centers for Medicare and Medicaid Services (CMS) to protect Medicaid beneficiaries' access to care by rescinding 42 CFR §433.400 and returning to the agency's original interpretation of the maintenance of effort provisions under the Families First Coronavirus Response Act (FFCRA).

The undersigned organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country, including millions receiving healthcare coverage through the Medicaid program. Our organizations have a unique perspective on what patients need to prevent disease, cure illness, and manage chronic health conditions. Our breadth enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion. We urge CMS to make the best use of the knowledge and experience our patients and organizations offer in response to the interim final rule.

In March 2017, our organizations agreed upon three overarching principles[1] to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit (EHB) package.

In December 2020, many of our organizations submitted comments on the interim final rule (IFR) "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency" expressing our deep concerns with the IFR's inaccurate interpretation of the Medicaid maintenance of effort provisions under the FFCRA.[2] We urged the Department to rescind the provisions at 42 CFR §433.400 and return to the correct interpretation of the conditions with which states must comply in exchange for the increase in the FMAP that were laid out in CMS guidance following passage of the FFCRA. The statute clearly requires states not to reduce the amount, duration, or scope of benefits or modify patients' cost sharing in order to be eligible for the temporary increase in FMAP. Allowing states to change beneficiaries from one eligibility category to another and reducing their benefits harms the patients we represent. For example, as documented in Carr v. Becerra, Connecticut Medicaid enrollees who were receiving full Medicaid coverage in March 2020, and thus protected by FFCRA, saw their full benefits terminated due to eligibility for a Medicaid "Medicare Savings Program" without the same benefits. These individuals live with serious medical conditions, including Friedreich's Ataxia, severe circulatory abnormalities, and multiple sclerosis. By transitioning them from full coverage to a Medicare Savings Program, these individuals lost access to medical, dental, and transportation services, risking worsened illness, new health problems, financial hardship, institutionalization, and even death.

We once again urge CMS to rescind 42 CFR §433.400 and no longer allow states to reduce the amount, duration, and scope of benefits or modify beneficiary cost-sharing while the state receives the enhanced FMAP. As CMS discusses in its notification reopening the comment period on this issue, the fiscal concerns for states have changed over the past two years. In fact, the Kaiser Family Foundation estimates that the increased FMAP has provided states with more than twice the funds needed to cover additional enrollees due to the maintenance of effort requirements.[3] Even if states raise fiscal concerns, that would not justify allowing states to reduce the amount, duration, and scope of benefits as required under the FFCRA in exchange for the enhanced match.

CMS states that if it does rescind 42 CFR §433.400, it may require states to offer Medicaid beneficiaries whose coverage was changed an opportunity to reenroll in their prior coverage. Our organizations disagree with this approach and urge CMS to require states to immediately and automatically restore beneficiaries to their previous coverage retroactively to the date coverage was terminated and provide enrollees notice of such action. We also urge CMS to make the rule effective upon finalization, to minimize the wait for enrollees to get relief from their health and financial losses. CMS should also

[1] Consensus Health Reform Principles. Available at: https://www.lung.org/getmedia/0912cd7f-c2f9-4112-aaa6-f54d690d6e65/ppc-coalition-principles-final.pdf.

[2] Comments on Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (CMS-9912-IFC), December 18, 2020. Available at: https://www.lung.org/getmedia/104284cb-1445-4ccd-aacd-787bb30bb912/ppc-ifc-4-comments-final_1.pdf.

[3] Kaiser Family Foundation. Fiscal and Enrollment Implications of Medicaid Continuous Coverage Requirements During and After the PHE Ends. May 10, 2022. Available at: https://www.kff.org/medicaid/issue-brief/fiscal-and-enrollment-implications-of-medicaid-continuous-coverage-requirement-during-and-after-the-phe-ends/.

clarify that this retroactive period of coverage during the full duration of the PHE as required by FFRCA should be reinstated regardless of when the PHE ends or a state ceases to accept enhanced FFRCA funding. For example, if the PHE ends (or a state rejects enhanced funding) prior to the finalization of the rule, it should not diminish a state's obligation to provide coverage for the duration of time that the PHE *was* in effect (and the state *was* accepting enhanced funding). Patients should not have to go through administrative red tape to reinstate the coverage they were legally entitled to, and placing this burden on patients could exacerbate inequities in coverage.

Thank you for the opportunity to provide these comments. If you have any questions, please contact Hannah Green with the American Lung Association at hannah.green@lung.org.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund
American Liver Foundation
American Lung Association
Asthma and Allergy Foundation of America
Cancer Support Community
Cystic Fibrosis Foundation
Epilepsy Foundation
Family Voices
Hemophilia Federation of America
Lupus Foundation of America
March of Dimes
Muscular Dystrophy Association
National Alliance on Mental Illness
National Eczema Association
National Health Council
National Hemophilia Foundation
National Patient Advocate Foundation
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society