February 2, 2024

The Honorable Xavier Becerra
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Medicaid; CMS Enforcement of State Compliance with Reporting and Federal Medicaid Renewal Requirements Under Section 1902(tt) of the Social Security Act (CMS–2447–IFC)

Dear Secretary Becerra:

Thank you for the opportunity to comment on interim final rule with comment period (IFR) regarding the Centers for Medicare and Medicaid Services' (CMS) enforcement of state compliance with reporting and federal Medicaid renewal requirements under Section 1902(tt) of the Social Security Act.

The undersigned organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country, including many individuals who rely on Medicaid coverage. 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.

In March of 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.

Our organizations remain deeply concerned that over 16 million people have lost Medicaid coverage so far due to unwinding of the continuous coverage requirements.[2] It is essential for CMS to ensure that states are not inappropriately disenrolling these individuals throughout this process. Our organizations are committed to working with you to ensure that those who are currently enrolled in Medicaid maintain their coverage if eligible or transition to other forms of quality, affordable care. Continued coverage is critical to health equity because it will help ensure that the patients we represent, including people of color, people with disabilities and individuals with chronic health conditions, continue to receive quality and affordable care.

The IFR was published and effective on December 6, 2023. The rule codifies provisions enacted by Congress in the Consolidated Appropriations Act (CAA) of 2022 regarding the phase down of additional federal funding for Medicaid, data reporting requirements and targeted enforcement tools associated with the lifting of the continuous coverage requirements for Medicaid in place from March 2020 through March 2023. Overall, our organizations support the provisions of this rule and commend CMS efforts to provide technical assistance as the agency monitors and conducts oversight over the impact of the unwinding on healthcare coverage for low-income children, families, and adults. We believe there are a few areas in the rule that could be strengthened as discussed below:

CMS Should Enforce Section 1902(tt) as Authorized by Congress

The enforcement authority under section 1902(tt) is precisely targeted to the related infractions, thus providing the agency with a practical and realistic tool. The proposed regulation has appropriately captured the statutory grant of authority without exceeding the scope of the statutory text. We support section 1902(tt) and the proposed regulations and believe this is a formula for effective Medicaid enforcement that should be repeated.

Our organizations urge CMS to make full and proper use of the enforcement authority that it has been granted and that will be established in these regulations. Congress will not see the value in providing CMS with such useful tools if CMS does not use them. It is CMS's responsibility to ensure that federal requirements are met when federal Medicaid dollars are spent – including the requirements at section 1902(tt). Congress has charged CMS with improving redetermination processes and provided CMS with the tools to accomplish that; it is CMS's duty to use the authority to accomplish its mission. Any reasonable enforcement efforts by CMS will be insulated by undeniable statutory authority and this uncontroversial regulatory interpretation.

In addition, we recommend that CMS not retroactively end accruals under section 430.49(e)(1)(ii) back to the date of corrective action plan submission. This would signal to states that they can effectively

[1] Partnership to Protect Coverage, Consensus Healthcare Reform Principles. Available at: https://www.protectcoverage.org/ppc-consensus-healthcare-reform-principles.
[2] Kaiser Family Foundation, Medicaid Enrollment and Unwinding Tracker. Available at: https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/.

remain out of compliance and be immune from permanent consequences as long as they *eventually* come into compliance.

CMS Should Reduce the Mitigating Circumstances in the IFR

Our organizations understand CMS's desire to focus its enforcement resources on the most egregious violations of redetermination requirements where federal intervention is likely the only avenue to protect eligible enrollees. Similarly, we are sympathetic to CMS resource constraints and agree that the CAA provides CMS with discretion to focus on the most serious and intransigent examples of noncompliance. However, we are concerned that the IFR creates more flexibility for CMS to identify mitigating circumstances than Congress intended.

We note CMS's discussion that the enforcement authorities outlined in the IFR may not be necessary because most states will come into voluntary compliance with both redetermination requirements, as defined, and with data reporting requirements. While we hope that is the case, we are nevertheless concerned that the IFR suggests that CMS may be reluctant to use the authorities Congress gave it to enforce clear instances of noncompliance. CMS estimates that only three states are likely to incur civil monetary penalties (CMPs) for failure to report data and that only five states could be subject to the rule's penalties for noncompliance with redetermination requirements. Given the large number of states experiencing difficulties with their eligibility and enrollment systems, this estimate seems low and suggests that CMS is narrowly construing its authority.

We are concerned that the breadth of mitigating factors included in the IFR will diminish CMS's ability to utilize the enforcement authorities and could mire CMS in discussions with states about whether mitigating circumstances exist. We urge CMS to consider altering its starting presumption that more states do not need to be put on corrective action plans (CAPs); utilizing a CAP is an effective way to bring states into compliance. While it may be true that most states will indeed follow a CAP if one is required (and thus not be subject to pauses in procedural terminations or to CMPs), we urge CMS to send a stronger signal to states that it is serious about enforcing known violations. We also recommend that CMS clarify what are "extraordinary circumstances" and ensure the definition does not allow noncompliance for foreseeable problems, such as short staffing.

CMS Should Broaden the Definition of Federal Redetermination Requirements

Section 1902(tt)(2)(B)(i) of the CAA clearly states, "The Secretary may assess a State's compliance with *all Federal requirements applicable to eligibility redeterminations…"* In new 42 C.F.R. § 430.5, the IFR improperly defines federal redetermination requirements to include only those described in 42 C.F.R. § 435.916. Although section 435.916 includes many requirements of the redetermination process through its language or cross-references, it does not include all of the federal redetermination requirements. For example, it would not include some civil rights protections important to people with disabilities or limited English proficiency and would only include critical due process protections through cross-references.

Although it may seem time limited because this section is related to the CAA enforcement authority, this narrow definition of "federal redetermination requirements" will remain in regulation. The rule could limit this definition until CMS has another occasion to define it again and could also impact advocacy efforts to push states to comply with redetermination requirements. CMS should broadly define this enforcement authority as it has done in other places, such as 42 C.F.R. § 430.35. At a minimum, the redetermination requirements should include the regulatory section on "Redeterminations of Medicaid

Eligibility" at sections 435.916 to .928 and the eligibility methods of administration found at sections 435.901 to .904.

CMS Should Continue Data Reporting Beyond the Unwinding

The IFR codifies specific state and federal data reporting requirements enacted by the CAA under Section 1902(tt)(1). The public reporting of 50-state data has been invaluable in assessing how the unwinding of the continuous enrollment requirement is impacting Medicaid enrollees and in identifying problem areas in need of corrective action. Our organizations urge CMS to maintain CAA state reporting requirements including public posting of state-level data. Robust data reporting is necessary for state Medicaid agencies to make informed decisions that impact the access and quality of care enrollees receive. Reliable and comparable 50-state data is essential for CMS to conduct its oversight responsibility and to enhance accountability and transparency in public coverage programs. We also encourage CMS to require disaggregation to the maximum extent possible, to identify the impacts on different populations, such as people with disabilities, children, and people of color.

The agency has the authority to require states to report performance related data that pre-dates the CAA and extends beyond the unwinding period; data reporting is a required condition for states to claim enhanced federal funding for Medicaid IT systems (90% federal funding for system development and 75% for maintenance and operations). To advance program accountability and improvement, renewal data reporting requirements should be transitioned to the Medicaid and CHIP Performance Indicators.

We also encourage CMS to amend the IFR to explicitly implement the Secretary's broad statutory authority (at 1902(tt)(1)(F)) to require additional data reporting subject to mandatory financial penalties.

Conclusion

Thank you for the opportunity to provide these comments. We look forward to continuing to partner with you on the implementation of these critical policies to improve the unwinding and the redetermination process in Medicaid more broadly.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund
American Lung Association
ALS Association
Arthritis Foundation
Asthma and Allergy Foundation of America
Cancer Support Community
Cancer*Care*
Child Neurology Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Lupus Foundation of America
Muscular Dystrophy Association
National Bleeding Disorders Foundation
National Eczema Association
National Health Council
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society
The Mended Hearts, Inc.