



October 27, 2022

Chiquita Brooks-LaSure
Administrator
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

On behalf of the nation's Medicaid Directors, NAMD is offering this response to the reopened public comment period on the Interim Final Rule interpreting the Families First Coronavirus Response Act's Medicaid continuous enrollment requirement [CMS-9912-N]. While our members understand the context leading the Centers for Medicare and Medicaid Services (CMS) to propose reverting to its initial interpretation of this statutory provision, NAMD has serious reservations about implementing this policy reversion at this stage of the COVID-19 Public Health Emergency (PHE). Specifically, we anticipate that implementing this policy change will:

- Distract from critical state preparations for the end of the PHE and conducting Medicaid redeterminations post-PHE.
- Not be able to be implemented on a timeframe that coheres with the anticipated end of the PHE.
- Create confusion for individuals receiving Medicaid services.
- Result in unintended consequences for underlying Medicaid eligibility for certain populations currently enrolled who will need to be redetermined post-PHE.

NAMD strongly encourages CMS to refine its interpretation of statute to mitigate these concerns. Specifically, we ask that CMS implement a narrower policy that provides relief for identified individuals who experienced significant changes in service provision based on movement within a coverage tier under the November 2020 FFCRA interpretation, that such policy is applied solely on a prospective basis, and that common-sense flexibilities under current guidance around post-eligibility treatment of income and to terminate coverage in instances of agency error or verified fraud be maintained.

NAMD is a bipartisan, nonprofit, professional organization representing leaders of all Medicaid agencies across the country. NAMD represents, elevates, and supports state and territorial Medicaid leaders to deliver high value services to the millions of people served by Medicaid and CHIP so they can achieve their best health and thrive in their communities.

Re-Implementing Previous Interpretation Imposes Opportunity Costs on Unwinding Preparations and Other Priorities

The current interpretation of the FFCRA continuous enrollment requirement has been in place for nearly two years, since November 2020. While not every state fully implemented this guidance due to systems limitations, the vast majority have done so. States have made good faith efforts to comply with CMS's written policy, which has been reiterated in a variety of written and verbal communications to states.

Over this same time period, states have continually prepared for the end of the PHE and the significant effort of conducting redeterminations for individuals enrolled in Medicaid since the onset of the continuous enrollment requirement. CMS's stance on what will be required during this post-PHE redetermination period has evolved, and so too have state preparations. CMS has been a strong partner and collaborator in these efforts, and has a deep appreciation of the complexities of state planning, messaging, operations, and systems preparations.

While it is not possible to predict with certainty when the PHE will end, the most recent renewal effective October 14, 2022 will see the PHE extend through early January 2023 at minimum – representing nearly three years under the Medicaid continuous enrollment requirement. Recognition of this fact is leading many state agencies to plan as though January 2023 will be the last month for which this requirement will be in effect. Should this assumption prove accurate, it is imperative that state teams and their federal counterparts at CMS be wholly focused on final preparations for unwinding the PHE.

This readiness will be severely taxed if states are required to undo policy that has been in place for nearly two years. A policy reversion will create new demands on already overtaxed state eligibility teams responsible for unwinding preparations, require development of new and potentially confusing messaging for Medicaid members, necessitate systems changes which compete with other existing demands on state systems, and require significant manual processes for identification of and outreach to impacted Medicaid members. The time, effort, and resources necessary to effectuate a policy change of this magnitude will directly and negatively impact state readiness for unwinding. It will also have negative effects on state budget assumptions built around the November 2020 guidance, which will impact the overall availability of resources to dedicate to unwinding preparation and implementation once the massive work of redetermining every individual on Medicaid begins.

CMS will almost certainly face similar competing demands on its staff bandwidth and resources. CMS will likely need to develop new guidance for states and field a wide array of technical assistance requests if the policy reversion moves forward, which imposes opportunity costs on federal resources that would be better spent on additional preparation for the end of the PHE.

In addition to the opportunity costs imposed on PHE unwinding preparations, CMS's proposal also detracts from states' abilities to advance other program priorities, such as advancing payment reform efforts, implementing non-PHE systems enhancements, or meeting other CMS-imposed deadlines.

Implementation of a Policy Reversion is Not Tenable Over a Short Timeframe

It is NAMD's expectation that this policy reversion, should it be finalized, will become effective at most 60 days after publication in the Federal Register, likely sometime in January 2023. This would directly intersect with the end of the current PHE declaration, should it prove to be the final one. Based on these assumptions, states would be in the immensely difficult position of reverting existing policy – with the host of challenges and opportunity costs discussed above – while simultaneously initiating long-planned activities keyed off of receipt of notice from the U.S. Department of Health and Human Services that the PHE will end.

This will not be tenable situation. Even if the PHE is renewed beyond January 2023, states will not have the necessary lead time to comply with CMS's proposed wholesale policy reversion within a 60-day window. Depending on the extent to which states needed to make regulatory, policy, and systems changes to implement the November 2020 guidance, up to 12 months would be necessary to meet CMS's reverted interpretation of statute.

Should the PHE end in January 2023, thereby ending the continuous enrollment requirement at the end of that month, it may appear that these concerns are moot. There could be only a few weeks in January 2023 in which the continuous enrollment requirement remains in effect, after which individuals impacted by the change in CMS's interpretation of this requirement could be appropriately redetermined and transitioned to different coverage.

While this is true in theory, it is unlikely to be true in practice. NAMD understands that most states plan to conduct redeterminations by renewal date throughout the redetermination period, thereby minimizing the need for processes to move renewal dates forward for specific members or subpopulations. But it is precisely these types of processes that would be necessary to expedite redeterminations for individuals most impacted by state implementation of CMS's November 2020 guidance.

For the opportunity cost reasons discussed above, it is unlikely that states will be able to effectuate this in the time between the rule's publication and the potential initiation of redeterminations. This leaves states in the position of needing to reinstate coverage to impacted individuals during the redetermination period while also conducting a redetermination for those same individuals at a later date. This is a recipe for significant member confusion.

Some states relied on CMS's November 2020 guidance to implement state legislative changes for Medicaid cost-sharing. Both the interim rule itself, subsequent CMS Frequently Asked Questions documents, and verbal CMS communications indicated such changes were permissible. Should CMS reverse this stance, states who implemented such changes in good faith would instead need to seek state legislative changes – which are time-intensive to obtain – or potentially forgo the FFCRA's enhanced match.

In fee-for-service programs, there are challenges for how to navigate timely filing requirements for providers who may choose to bill Medicaid for services rendered from November 2, 2020 through the time in which the state implements CMS's policy reversion. Providers may have denied claims from this period that the state would need to reprocess; in addition to the workload, the state could lose federal match on claims that are older than eight quarters given that this change does not appear to meet one of the exceptions in [45 CFR § 95.19](#). Additionally, some providers may wish to submit claims that they previously did not bill, which may require states to override their own timely filing limits. There would also be increased demands on state program integrity staff to verify that providers billing Medicaid for services during this period did not also directly bill patients for the same services. Navigating this tangle of retroactive billing issues would create significant demands on state staff.

Some states implemented CMS's November 2020 guidance via disenrollment from certain managed care programs for which a member was no longer eligible and transferred enrollment to either a new Medicaid managed care plan or fee-for-service, in accordance with permissible changes across Minimum Essential Coverage (MEC) categories. Having to offer reinstatement in previous managed care plans for which the member is clearly no longer eligible would not be feasible for state systems, which in some cases cannot allow even manual overrides in these circumstances. Resolving this would take significant time and systems resources.

Attempts to Reinstate Previous Coverage Will Create Confusion for Medicaid Members and Stakeholders

When the PHE ends, clear communications for Medicaid members, their families, Medicaid providers, community-based organizations, and other partners around key dates and key activities will be imperative. States are already dedicating immense resources to developing these communications, which must be nuanced to help all stakeholders understand the impact of the end of the PHE, the redetermination period, and what their roles in it are. States and CMS have worked together in identifying and attempting to solve a variety of communications challenges for over a year.

Implementing the proposed CMS policy reversion and reinstating previous Medicaid coverage to impacted individuals will exponentially increase the complexity of these

communications efforts, with a limited window of time to develop the communications strategy.

States are already concerned about ensuring effective messaging and outreach to Medicaid members during the redetermination period. Layering on an entirely new, unrelated strand of communications related to coverage reinstatement could lead to members not providing the information necessary for the state to complete a redetermination.

The vast majority of members who experienced a change in their MEC category under the November 2020 guidance were not negatively impacted by that change. For these members, receiving outreach from states about reinstating coverage they no longer need or want will almost certainly be confusing, especially if the member misinterprets this outreach as related to a full redetermination of coverage.

CMS is rightly focused on minimizing procedural denials of Medicaid coverage during the redetermination period. States share this goal. Unfortunately, the confusing communications environment that will be created by CMS's proposed policy reversion will increase the likelihood of procedural denials as members potentially misinterpret communications related to reinstatement of previous coverage and communications related to redeterminations, thereby not providing necessary information to the state to complete a redetermination.

Unintended Consequences are Possible for Some Medicaid Members

In addition to the risks of procedural denials due to the confusing communications environment discussed above, other specific populations are likely to experience unintended consequences if certain flexibilities within the November 2020 guidance are removed.

The clearest area of risk here is around post-eligibility treatment of income (PETI) rules for individuals living in long-term care settings. Prior to November 2020, CMS did not allow increases in PETI-based cost sharing amounts for these settings. CMS revised this in its November 2020 guidance and allowed states to increase PETI-based cost sharing. This allowed states to enact increases in cost sharing when a member reported an increase in income. This is an important flexibility because if a Medicaid member is in a long-term care setting and their cost sharing does not increase when their income increases, they are likely to accumulate assets that will make them ineligible for Medicaid coverage when the PHE ends. Many states felt that this was an unacceptable risk.

Should CMS remove these PETI-based cost sharing flexibilities, there is a major concern that individuals will become ineligible for Medicaid coverage and be unable to continue residing in the long-term care setting. This is virtually guaranteed if removing

the PETI-based cost sharing flexibilities is applied retroactively, as individuals would likely receive a lump sum payment that would almost certainly put them over asset limits for eligibility. It will also create major administrative challenges for providers, managed care organizations, and state eligibility teams. It is highly unlikely that state systems staff and systems vendors would have the capacity to implement a PETI cost-sharing freeze on short notice, as well.

A Right-Sized Policy Solution is Needed to Mitigate These Challenges

NAMD acknowledges that a subset of individuals did experience negative outcomes from implementation of CMS's November 2020 guidance. A targeted policy solution that is tailored to the specific experiences of these individuals is appropriate. However, CMS's proposal to revert to its pre-November 2020 policy interpretation across the board is not a targeted solution. It is sweeping, overly broad, and introduces so many opportunity costs, additional complexities in already complex plans, and potential points of failure in implementation that it will likely cause more problems than it solves.

NAMD recommends that CMS refine its policy to focus specifically on those individuals who were negatively impacted by an MEC category change. The population that most likely falls into this group are those who were transitioned from Medicaid-funded home- and community-based services (HCBS) into a Medicare Savings Program (MSP), whereby Medicare becomes the primary source of coverage and Medicaid is responsible for paying for Medicare cost sharing. Medicare does not provide HCBS, and it is likely that such individuals were negatively impacted by such a change.

In identifying a narrower policy, CMS must also acknowledge the realities of state capacity to execute on it as the post-PHE redetermination period approaches. CMS should give states an appropriate runway to implement any changes and require that such changes be applied solely on a prospective basis.

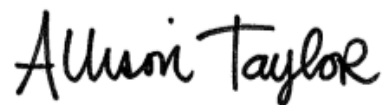
Further, CMS should maintain certain flexibilities within the November 2020 guidance. It should maintain the flexibility around PETI-based cost sharing to mitigate the impacts on underlying Medicaid eligibility discussed above. CMS should also maintain common-sense flexibilities for states to terminate Medicaid coverage in verifiable instances of agency eligibility errors made at the point of an initial eligibility determination, in documented instances of eligibility fraud, and when a PARIS match indicates an individual is enrolled in Medicaid and receiving services in another state. It does not make sense to require states to maintain Medicaid coverage in these instances.

Finally, if CMS does move forward with its policy reversion in some fashion, it should provide states with assurances regarding future audits of the period in which the tiered coverage policy was in place. Specifically, CMS should clearly indicate that, whether a state did implement its policies or a state did not implement its policies due to insurmountable resources and systems challenges or due to lack of response CMS to

specific implementation questions submitted in the initial IFR comment period, the state was acting appropriately within the bounds of federal statute.

We thank CMS for its consideration of state perspectives on the continuous coverage requirement. We strongly encourage a right-sized, common-sense approach that matches the scale of the identified challenge, while preserving state and federal resources for conducting post-PHE redeterminations and unwinding as effectively as possible.

Sincerely,



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