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February 2, 2024

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

Submitted Electronically via www.federalregister.gov

RE: [CMS-2447-IFC] Medicaid; CMS Enforcement of State Compliance With Reporting and Federal Medicaid Renewal Requirements Under Section 1902(tt) of the Social Security Act

Dear Secretary Becerra:

The Centers for Medicare & Medicaid Services issued an interim final rule with request for comments (IFC) on December 6, 2023 to implement new requirements and enforcement authorities on Medicaid eligibility redeterminations. This rule implements provisions from the Consolidated Appropriations Act, 2023 (CAA, 2023) that add to the original Medicaid redetermination provisions states agreed to follow from the Families First Coronavirus Response Act (FFCRA). As a state-based public policy organization in Minnesota, Center of the American Experiment has a particular interest in ensuring that the federal government operates as a good faith partner with Minnesota and every other state.

Unfortunately, the enactment and implementation of the CAA, 2023 unnecessarily and unlawfully threatens states with federal funding reductions and civil monetary penalties. This is not how a good faith partner operates. Nor is it consistent with the limits the U.S. Constitution places on federal actions to coerce states to implement federal policies. The following comments summarize how the CCA, 2023 unlawfully breached the agreement FFCRA made with states. We urge CMS to abandon this IFC and instead work to ensure redeterminations keep eligible people covered using the procedures and enforcement authorities states agreed to use.

FFCRA followed precedent from prior temporary FMAP increases

In response to the COVID-19 outbreak in early 2020, Congress passed and President Trump signed FFCRA into law to provide fiscal relief to state and help ensure that people retained access to health care coverage. Specifically, FFCRA § 6008 increased the Federal Medicaid Assistance Percentage (FMAP) rate by 6.2 percentage points for states so long as states agreed to certain maintenance of effort (MOE) requirements. Among these MOE requirements, states must agree to maintain eligibility for Medicaid enrollees through the end of the PHE if they were

currently enrolled or became enrolled in Medicaid during the PHE. This is referred to as the continuous enrollment condition. Every state agreed to this condition in exchange for the temporary increase in the FMAP.

FFCRA relied on the existing Medicaid redetermination procedures and enforcement authorities. This largely followed the precedent from the two other times the FMAP was temporarily increased through the Jobs and Growth Tax Relief Reconciliation Act of 2003 (JRTRRA) and the American Recovery and Reinvestment Act of 2009 (ARRA).[1] Both of these laws imposed MOE conditions to receive the FMAP increase and largely relied on the existing Medicaid policies and procedures. However, ARRA did add two reporting requirements. The law required states to file quarterly reports documenting any days they failed to comply with prompt payment requirements[2] and a report on how the state spent the additional federal funds.[3] ARRA was later amended to extend the FMAP increase by 6 months.[4]

Just days after FFCRA became law, the CARES Act amended FFCRA to delay the MOE requirement that restricted states from increasing premiums by 30 days.[5] FFCRA was later amended by the Consolidated Appropriations Act, 2021 to make a technical correction regarding the FMAP increase for the District of Columbia.[6] Thus, until the CCA, 2023 became law, every federal law unilaterally amending a bargain with states involving a temporary increase of the FMAP rate gave states a better deal.

CAA, 2023 unilaterally amends the bargain with states

There can be no dispute that FFCRA represents a bargain between the federal government and the states. The federal government offered to temporarily increase the FMAP rate for states. In return, the states had to agree to certain MOE conditions, including the requirement to maintain continuous coverage for Medicaid enrollees until the end of the PHE. Every state agreed to this bargain and began receiving increased FMAP rates beginning January 1, 2020. This bargain did not impose any reporting requirements on states and relied on the existing Medicaid processes in place for redeterminations.

On December 29, 2022—nearly three years into this agreement—Congress passed and President Biden signed the CCA, 2023 into law which unilaterally amends this bargain. These amendments delinked the end of the FMAP increase from the end of the PHE; repealed the expected approach to closing out the FMAP increase; gave states the option to take a new approach to phase out FMAP increase; added new reporting requirements related to redeterminations; and imposed new enforcement authorities related to reporting and redeterminations. The IFC implements these new reporting and enforcement authorities.

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[1] *See* Congressional Research Service, *Medicaid Recession-Related FMAP Increases* (May 7, 2020); and Congressional Research Service, *Health Care Provisions in the Families First Coronavirus Response Act, P.L. 116-127* (April 17, 2020).
[2] ARRA § 5001(f)(2)(A)(ii).
[3] ARRA § 5001(g)(1).
[4] Public Law 111–226 § 201.
[5] CARES Act § 3720.
[6] Consolidated Appropriations Act, 2021, § 2, Division X, Sec. 11.

CAA, 2023 repeals expected approach to ending the FMAP increase

As the original bargain was structured, states could depend on receiving the FMAP increase for at least two months after the continuous enrollment condition ended. This structure relies on three elements.

- First, under section 319 of the Public Health Service Act (PHSA), the initiation of the PHE in January 2020 meant the 90-day extensions of the PHE would land in the first month of each quarter.[7]
- Second, FFCRA provided the FMAP increase through the end of the *quarter* in which the PHE ends.
- Third, FFCRA conditioned the FMAP increase on states providing continuous coverage through the end of the *month* in which the PHE ends.

Prior to the CAA, 2023 becoming law, every PHE 90-day renewal occurred in the first month of each quarter in step with the requirements of the PHSA. While the federal government may end a PHE at any time, the timing of PHE renewals set an expectation that the obligation on states to provide continuous coverage would cease at the end of the first month of the quarter and the FMAP increase would continue for at least two months until the end of the quarter.

The CAA, 2023 repealed the connection between the end of the PHE and the end of the FMAP increase and the MOE requirements. Instead, the new law allowed states to continue taking the higher 6.2 percentage point FMAP until March 31, 2023 and ended the continuous enrollment condition on the same date. Therefore, states could not receive the 6.2 percentage point FMAP increase for any period of time after the continuous enrollment condition ended. This created an abrupt and unexpected end to the FFCRA deal states originally agreed to in 2020.

CAA, 2023 offers states a new bargain to phase out the FMAP increase

Instead of an abrupt end to the 6.2 percentage point FMAP increase, CAA, 2023 offers states another bargain to phase out the increase from April 1, 2023 to December 31, 2023. This offer comes with new conditions. The original MOE conditions minus the continuous coverage requirement must be met. The state must agree to conduct redeterminations in line with whatever "alternative processes and procedures" the federal government approves. The state must also maintain up to date contact information for people subject to redetermination and attempt to contact people who are determined ineligible due to returned mail before they are disenrolled. While this may be a new offer, it is an offer states cannot refuse. CAA, 2023 did not give states a reasonable timeframe to redetermine Medicaid enrollments before the FMAP increase ended as it did under the original agreement.

CAA, 2023 imposes new reporting requirements and enforcement authorities

Regardless of whether a state takes the new offer or not, CAA, 2023 imposes new reporting requirements and enforcement authorities related to Medicaid eligibility redeterminations.

[7] 42 U.S. Code § 247d(a)(2).

Importantly, these new provisions apply to states regardless of whether they took the second offer or not. The CAA, 2023 added these provisions to the Social Security Act and applies them to the redetermination activities of each State conducted from April 1, 2023 to June 30, 2024. All states will be conducting these activities. Therefore, as the IFC explains, this applies to all states "regardless of whether a State is continuing to claim the FFCRA FMAP increase."[8]

The new enforcement authorities represent a dramatic change to the original bargain. As passed, FFCRA relied on the reporting and enforcement authorities already in place. States are used to reporting a lot of Medicaid data to the federal government and might be annoyed by the additional reporting CCA, 2203 requires, but probably would not be offended. States, however, are not used to the federal government threatening them with punitive funding reductions and civil money penalties. Yet, the CAA, 2023, without state consent, newly empowers the federal government to reduce the FMAP for states who do not meet the federal redetermination and reporting requirements. In addition, it allows the federal government to require states to submit a corrective action plan and impose civil monetary penalties on any state that fails to submit or implement a corrective action plan.

Altogether, the CAA, 2023's amendments to FFCRA and the SSA fundamentally changed the bargain FCCRA made with states in 2020. States were forced to accept delinking the FMAP increase from the PHE. States were not allowed to quickly end continuous coverage using the standard redetermination rules while still receiving the FMAP increase for two months. States were forced to accept new conditions if they wanted to phase out the FMAP increase after the continuous enrollment condition ended. Finally, states had to comply with burdensome new reporting requirements and threats of new punitive funding reductions. All of this reflects a remarkable level of bad faith and bullying from the federal government.

CAA, 2023 impermissibly forces states to participate in a federal program

Beyond acting in bad faith, the federal government's amendment to FFCRA and the SSA are unlawful. While Congress can use the spending power to encourage states to participate in federal programs, the U.S. Supreme Court instructs that the spending power "does not include surprising participating States with post-acceptance or `retroactive' conditions."[9] Yet, that is exactly what the CAA, 2023 does.

The Supreme Court's instruction just quoted come from Chief Justice Robert's analysis of the spending power in *NFIB v. Sebelius*. Here, the Court held that the ACA impermissibly coerced states to expand Medicaid by threatening the loss of Medicaid funding. NFIB presented a more difficult constitutional question because the ACA amended the SSA and the SSA includes a provision that provides the "right to alter, amend, or repeal any provision …." Roberts needed to further explain how "'if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously.'"[10] While FFCRA involves Medicaid funding, Congress passed it separately to provide fiscal relief to states and encourage continuous coverage. Therefore,

[8] 88 FR 84713, 84715.
[9] Nat. Fedn. of Indep. Business v. Sebelius, 567 US 519, 584(2012), *quoting* Pennhurst State School and Hospital v. Halderman, 451 U.S. 1, at25 (1981).
[10] Id at 583, *quoting* Pennhurst State School and Hospital v. Halderman, 451 U.S. 1, at 17 (1981).

Congress did not reserve any right to alter or amend the agreement that FFCRA made with states. Yet, Congress still amended FFCRA to delink the FMAP increase from the end of the PHE and effectively forced states to accept a new agreement. Because FFCRA retroactively changes the rules of a *current program* it effectively forces states to accept the new rules. This goes beyond the type of impermissible coercion to adopt a *new program* that the Court found in NFIB.

The CAA, 2023 added the new reporting requirements and enforcement authorities to the SSA versus directly amending FFCRA. Maybe this was designed to take advantage of Congress's reserved right to amend Medicaid in the SSA. However, this is clearly aimed at amending only the FFCRA agreement and, therefore, including it in the SSA should not give Congress more flexibility to alter the agreement as it might with another Medicaid program.

Congress was always free to include these conditions and enforcement authorities when it originally passed FFCRA. As noted previously, Congress did include reporting requirements in ARRA. In addition, Congress could amend the agreement to give states a better deal as it did when it extended the ARRA FMAP increase. But the Constitution does not permit Congress to add a burdensome reporting requirement to FFCRA retroactively. Nor does it allow Congress to target punitive enforcement authorities to FFCRA retroactively.

CMS should abandon the new IFC rules and work to regain trust with states

The IFC focuses on implementing the CAA, 2023's new reporting requirements and enforcement authorities. These additions to the FFCRA agreement are clearly an unconstitutional exercise of Congress's spending power. Instead of implementing an unconstitutional law, HHS should use the redetermination procedures and enforcement authorities in place when FFCRA became law. Those are the lawful authorities.

The Medicaid program is partnership that requires good faith from both sides to work effectively. The threats of new penalties on states in CAA, 2023 insulted states. It suggested that states weren't taking the redetermination process seriously. Yet, states have just as strong an incentive as the federal government to ensure that eligible people retain Medicaid coverage. In fact, states have more direct political accountability to make sure the Medicaid program works. The federal government breached the bargain FFCRA struck with states and undermined a good faith partnership with states. The federal government should work to make amends. To start, HHS should abandon this IFC and go back to working side by side with states using your shared Medicaid tools to connect the most vulnerable to high quality health coverage.

Sincerely,

/ *Peter Nelson* /

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