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January 4, 2021

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9912-IFC
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**

Dear Administrator Verma:

On behalf of Prevent Blindness and the millions of people of all ages whom we represent across the country, including those who live with low vision, vision impairment, and those who have or are at risk for vision-related eye diseases; we appreciate the opportunity to respond to the Center for Medicare and Medicaid Services (CMS) Interim Final Rule "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency".

Prevent Blindness is the nation's leading nonprofit, voluntary organization committed to preventing blindness and preserving sight. We strive to improve our nation's vision and eye health by enhancing state and community capacities through our core competencies of early detection, improved access to eye care, patient empowerment, care coordination, public policy, research, advocacy, public awareness, and health education. As well, protecting and expanding access to sight-saving care is our priority for patients across the age continuum.

The Families First Coronavirus Response Act (FFCRA), signed into law on March 18, includes an option for states to receive enhanced federal Medicaid funding. In exchange for the additional funds, states must agree to comply with maintenance of effort (MOE) protections. These protections help ensure individuals are able to get and stay covered during the crisis and receive needed services. The FFCRA includes an explicit requirement to preserve enrollee's existing benefits – both their enrollment in Medicaid overall, and the services for which they have been eligible. At a time of such turmoil, Congress chose to protect enrollees and ensure access to services by maintaining the "status quo."

We are writing to express our deep concern about several provisions of this Interim Final Rule (IFR). In a reversal of CMS's stated policy from March to October 2020, this IFR would now allow states to impose numerous types of coverage restrictions for individuals who are enrolled in Medicaid, including reduced benefits; reduced amount, duration, and scope of services; increased cost-sharing; and reduced post-eligibility income. The IFR will also result in terminations for some individuals who should not be terminated. **We oppose these revisions to the MOE, which are inconsistent with the FFCRA and will result in harm for Medicaid enrollees. We recommend that CMS withdraw these provisions.**

Reduction of "Optional" Benefits

Prevent Blindness is sharply opposed to the rule's provisions that grant states sweeping authority to reduce optional Medicaid benefits; cut the amount, duration and scope of benefits; increase utilization management; increase cost-sharing; and reduce post-eligibility income – all with no consequences for their enhanced matching funds under the FFCRA. These changes contravene the letter and intent of the statute, and will result in significant harm for enrollees.

We are particularly alarmed by the provisions to cut vision services under Medicaid benefits. Medicaid and the Children's Health Insurance Program (CHIP) have historically been a critical and necessary access point for low-income populations to receive essential vision and eye care. Because children and families and increasingly non-elderly adults with and without disabling conditions rely on Medicaid to access vision and eye care services, Prevent Blindness reinforces our position for policies that protect Medicaid expansion and sustain enrollment levels without eliminating vision and eye health care and services (including eye examinations, treatments, correction for refractive errors, and chronic disease management services).

Eye disorders rank 5th among the top 8 chronic conditions in the United States, with the overall cost of vision problems calculated at $172 billion annually. Eye health problems, which are more prevalent in racial and ethnic minority populations, have a strong correlation to many chronic health conditions such as smoking, depression, and falls. Diabetes, one of the most common chronic diseases among adults, can lead to vision loss through diabetic retinopathy, diabetic macular edema, cataracts, and glaucoma. Without intervention, inflation-adjusted costs could rise to $717 billion by 2050 as our population continues to age. Implementation of the proposed MOC would result in further vision health inequities in a high-risk population.

The Centers for Disease Control and Prevention (CDC) predict that vision and eye problems are prevalent in 90 million Americans—more than 3 of every 5 persons over the age of 40. These numbers are projected to increase, including rates of diabetes-related retinopathy, glaucoma, cataracts, age-related macular degeneration, and vision impairment and blindness by as much as 150% by 2050 without the kind of interventions, such as those in the Medicaid program, that integrate vision and eye health into overall health and wellness. This is not the time to implement policies that significantly weaken our national vision and eye health, which is largely preventable with cost-effective solutions of prevention, early detection, and access to treatment.

Vision impairments are not only potentially devastating to the patient, but they can be incredibly costly if left unaddressed. **Vision impairment, including private and public payments for medical care long-term care, patients' out-of-pocket costs, direct and indirect costs, lost productivity, and consequential lost tax revenue cost the United States $167 billion in 2019. This figure will to increase to $274 billion by 2032, just as the last ranks of the baby boomer generation will become Medicare-eligible. By 2050, national expenditures on vision impairments and eye disease will surpass $717 billion**. **The proportion of these costs paid by government programs will, as based on cost projections, increase from 32.6% to 41.4% by 2050.** Furthermore, a recent analysis of 24,000 hospitalized patients determined that patients with vision loss experienced longer hospital stays and high readmission rates, resulting in $500 million in excess costs. The same study indicated a readmission rate of 23.1% for Medicare enrollees with severe vision loss compared to those without vision loss at 18.7%. Children's vision problems cost our country $10 billion annually, with families shouldering 45% of these costs. Putting off our national vision and eye health until costs are enormous on the back end represents a significant missed opportunity, given that the most severe incidents of vision loss and eye disease are largely preventable.

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Prior Authorization and Utilization Management Requirements

The IFR would also allow states to impose new prior authorizations and other utilization management requirements, including step therapy. These can harm Medicaid enrollees and providers in typical times, and these issues are likely to be significantly exacerbated during COVID-19. Presently, many providers are overwhelmed caring for COVID-19 patients. Increased prior authorizations will divert them from that essential work. More importantly, we have serious concerns with how these policies will affect people who have vision and eye health problems and rely on treatments to protect their sight.

Prevent Blindness values the patient/doctor relationship and the need for patient choice in making their own treatment decisions with their provider that are in the best interest of patient health. We are particularly concerned about the impact step therapy may have on a patient's vision and eye health due to treatment delays, additional doctor visits, and use of an insurance pre-approval process.

Ultimately, delaying patient's access to the treatment of his or her choice that has been prescribed by a provider of his or her choosing could mean time lost in stemming progressive loss of sight. We are concerned that relying on prior authorization and step therapy protocols places an undue hardship on patients who are facing advancing loss of vision – **patients who may not have the luxury of time to try multiple treatments before losing their sight.**

Moreover, overloaded clinician offices and limited in-person visits make it more likely patients will "fall through the cracks" and not get their medications or other services when a prior authorization is needed. This concern is backed up by survey research, which reports that of the 52% of people whose families skipped or postponed care during the previous three months due to coronavirus, 82% did so because the doctor's office was closed or had limited appointments. Research has found that patients are more likely to discontinue needed medications when prior authorizations are required. A survey of certain Medicaid-enrolled providers in Texas found that they saw prior authorizations as a significant burden. They agreed that prior authorizations take time away from patients, and reduce the pool of providers that will see Medicaid patients due to administrative burden.

We urge CMS to withdraw this proposal.

Increased Cost-Sharing

The IFR would allow states to increase cost-sharing, which would also harm Medicaid enrollees. Research over the last four decades has consistently concluded that the imposition of cost-sharing on low-income populations reduces both necessary and unnecessary care and correlates with increased risk of poor health outcomes. Further, the pandemic increases the harm caused by cost-sharing. The pandemic has significantly increased 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.

Use of an Interim Final Rule

We do not believe CMS should have implemented these policies – which directly and materially access to health care for tens of millions of enrollees during a pandemic – as an interim final rule. The Administrative Procedure Act anticipates that that government agencies will implement regulations only after receiving and considering public comment and that interim final rules will be used rarely and only of necessity – for example when a comment period would be "contrary to the public interest." There is no significant exigency associated with a notice and comment period for the policy contained in this IFR, whereas **reducing health care eligibility, decreasing benefits, and**

increasing costs during a pandemic without an opportunity to comment will lead to immediate harms and is clearly contrary to the public interest.

These policies will cause substantial harms before CMS has time to finalize the rule – harms that could have been avoided had CMS solicited public comments, like ours, before the rule went into effect.

Conclusion

This is an unprecedented pandemic, and Congress took unprecedented measures under the Families First Coronavirus Response Act to make sure Medicaid enrollees can access the services they need. The aforementioned provisions of the Interim Final Rule contradict the law, and needlessly take health care away from people at a time when health care is more important than ever. **We strongly oppose these provisions of the Interim Final Rule, and urge HHS to withdraw them immediately.**

Thank you for considering our position. If you have further questions, please contact Sara D. Brown, Director of Government Affairs, at sbrown@preventblindness.org.

Sincerely,

Jeff Todd
President and CEO
Prevent Blindness