May 18, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue
Washington, DC 20001

Dear Secretary Becerra,

The United States has recently passed a terrible milestone: one million of our fellow Americans have now died from COVID-19. A staggering 93 percent of those deaths have been people aged 50 and older. They were our parents and grandparents, brothers and sisters, community members and friends. Like all Americans, AARP’s nearly 38 million members are eager to see an end to this pandemic, but while thousands of mostly older people continue to die of this virus every week, there continues to be a very real and ongoing public health emergency. We urge you to extend the public health emergency (PHE) until cases have declined significantly and there is an orderly transition in place to ensure all Americans can get the care they need.

In addition, many older Americans rely on programs and flexibilities authorized under the PHE to keep them safe. Chief among those is ensuring that medical countermeasures, such as testing, vaccines, and therapeutics, remain available and affordable to all who need them. Although most of these medical countermeasures would likely remain available as long as a separate emergency declaration exists pursuant to Section 564 of the Federal Food, Drug, and Cosmetic (FD&C) Act, ending the PHE would have serious implications on how much people must pay to access them. All people, including those enrolled in Medicare, Medicaid, private insurance, or without health coverage, should be able to access these countermeasures with minimal out-of-pocket cost sharing. Cost should never be a prohibitive factor for individuals taking reasonable steps to prevent or treat COVID-19.

Likewise, the end of the PHE would also impact the availability of health coverage for millions of people – especially for those enrolled in Medicaid. The Families First Coronavirus Response Act (FFCRA) provided states with an increase in federal Medicaid funding on the condition that those states not disenroll Medicaid beneficiaries during the emergency, even if their incomes or categorical eligibility status changed. When the PHE ends, however, states will have 12 months to redetermine the eligibility for virtually all Medicaid beneficiaries – a massive task for state Medicaid programs. A recent analysis from Urban Institute estimates that nearly 16 million people...
on Medicaid would be found to be ineligible during the redetermination process, including many who would be inappropriately disenrolled due to administrative complications. Because of this significant anticipated impact, the redetermination process should not occur prematurely, when the pandemic is still active and millions still rely on Medicaid for stable health and long-term services and supports coverage. AARP greatly appreciates the steps HHS is already taking to ensure a smooth transition for individuals when the redetermination process does eventually occur, including your May 10 letter to governors and the included resources that emphasize the need to help people maintain coverage. We call on HHS to continue this focus and work closely with states to reduce inappropriate disenrollments and facilitate individuals transitioning to other coverage for which they may be eligible, such as subsidized Marketplace coverage.

Coverage disruptions brought about by the end of the PHE might also cause people to inadvertently miss opportunities to enroll in Medicare and Medigap coverage when they become eligible. Changes to Medicaid enrollment and disenrollment processes and to Marketplace subsidies have caused confusion among people newly eligible for Medicare. Some of these individuals will lose Medicaid expansion coverage at the end of the PHE as part of the redetermination process, but the loss of Medicaid coverage does not trigger a Medicare special enrollment period (SEP). Similarly, individuals receiving Marketplace subsidies and those with COBRA continuation coverage have no access to a Medicare SEP. Furthermore, people who enroll in Medicare but do not end their Medicaid coverage during the PHE do not have a federal right to enroll in a Medigap plan without underwriting once they lose their Medicaid coverage. We appreciate the rule proposed in April (CMS-4199-P) that would address some of these issues and urge you to continue efforts to align Medicare enrollment policies and deadlines with other coverage policies to address these concerns and ease the transition out of the PHE.

Nursing homes and other long-term care facilities have been hit especially hard by the pandemic, as over 200,000 residents and staff have died due to COVID-19. A combination of COVID-19 emergency declaration blanket waivers, interim final rules with comment, and guidance from the Centers for Medicare & Medicaid Services (CMS) waived some existing nursing home requirements and protections, added some requirements for nursing homes, or took other steps. We appreciate that CMS has already ended some blanket waivers and will be ending additional blanket waivers, including one regarding training and certification of nurse aides, that will reinstate important nursing home resident protections. We encourage you to look at available data and consider extending through the PHE the emergency blanket waiver that permits physicians to delegate any required physician visit to a nurse practitioner, physician assistant, or clinical nurse specialist who is not an employee of the facility, who is working in collaboration with a physician, and who is licensed by the state and performing within the state’s scope of practice laws. If you extend this waiver, we also recommend that you modify the waiver to remove the physician supervision requirement to the extent that it is consistent with state law. We also observe that the waiver of the three-day inpatient hospital stay requirement for coverage of Medicare skilled nursing facility (SNF) care means that Medicare beneficiaries who are in the hospital under observation (outpatient status) and do not have a three-day inpatient hospital stay are eligible to get SNF care if needed. We also note the importance of continued testing, COVID-19 vaccinations and boosters, and reporting of COVID-19 nursing home resident and staff cases, deaths and other items, many of which are to continue beyond the PHE.
During the PHE, millions of individuals relied on essential care at home under Medicaid (home and community-based services, HCBS) or have become newly eligible for these critical services. Not only do these services help people live at home where they want to be, but they are also generally more cost-effective. On average, Medicaid can serve about three individuals in their homes and communities for the cost of one person in a nursing home. States used different authorities and tools to expand home care during the PHE, including Appendix K to make changes to 1915(c) HCBS waivers and Disaster Relief Medicaid State Plan Amendments. We urge you to continue working with states to ensure clear and timely processes to extend access to home care after the PHE or when Appendix K changes end and to ensure a smooth transition and continuity of care for individuals. We appreciate CMS efforts on the Medicaid HCBS investment in the American Rescue Plan Act (ARPA) and encourage continued stakeholder engagement on HCBS initiatives related to the PHE and beyond. We also suggest that via CMS you urge states to employ a process to create cohesiveness and coordination among HCBS spending efforts, including Appendix K, ARPA, and others. This would also include public disclosure and accountability for how any money is spent.

Finally, the Supplemental Nutrition Assistance Program (SNAP) serves as a lifeline for millions of people who are struggling to put food on the table, including 8.7 million households with at least one adult age 50 or older. The program reduces food insecurity and poverty and is linked to improved health outcomes. Growing evidence suggests SNAP is associated with fewer inpatient hospitalizations, emergency department visits, and long-term care admissions among older adults. We are concerned that the end of the PHE will result in major food assistance benefit losses for millions of people. Additionally, SNAP administrative waivers are set to expire the month after the PHE ends. This means that the states that follow an integrated model to jointly process SNAP and Medicaid eligibility may experience significant setbacks in timeliness of applications and increased churn (frequent entry and exit from SNAP). We urge you to ensure there is no disruption in the processing of applications so that older adults can continue accessing an adequate and nutritious diet, which is foundational to maintaining health, quality of life, and independence as people age.

Thank you for your consideration of the issues described above and how they will be impacted by the duration of the PHE. We urge HHS to continue the designation of an official public health emergency as long as an emergency exists, and when it does become time to wind down the emergency phase of this pandemic, we urge HHS to provide as much notice as possible and to work closely with consumer representatives and other stakeholders to ensure a smooth transition that minimizes any negative impacts on older Americans and the public. AARP stands ready to help with this effort in any way that we can. Please feel free to contact me or have your staff contact Megan O’Reilly at moreilly@aarp.org if you have any questions.

Sincerely,

Nancy A. LeaMond
Executive Vice President and Chief Advocacy & Engagement Officer

cc: Secretary Tom Vilsack, Department of Agriculture