525 Clinton Street
Bow, NH 03304
Voice: 603-228-2830
Fax: 603-228-2464

61 Elm Street
Montpelier, VT 05602
Voice: 802-229-0002
Fax: 802-223-2336

December 28, 2020

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8013

RE: Comments on RIN 0938-AU35 Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency Interim Final Rule with Comment (IFC)

Dear Administrator Verma:

Bi-State applauds the work of CMS, HHS, CDC, and FDA in the development, distribution of, and payment for COVID-19 vaccines. As you know, these are desperately needed to mitigate the pandemic that is causing such havoc to our nation. We appreciate the opportunity to provide comment on RIN 0938-AU35, "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency Interim Final Rule with Comment (IFC)".

Established in 1986, Bi-State is a nonpartisan, nonprofit 501(c)(3) charitable organization promoting access to effective and affordable primary care and preventive services for all, with special emphasis on underserved populations in Vermont and New Hampshire. Bi-State's combined Vermont and New Hampshire membership includes 21 Federally Qualified Health Centers, one Look-Alike, one Rural Health Clinic, Planned Parenthood of Northern New England, Vermont Coalition of Clinics for the Uninsured, North Country Health Consortium, Community Health Access Network, and the Area Health Education Centers in both Vermont and New Hampshire. Our members reach into our rural communities offering support to those who live there. This is especially important during natural disasters and public health emergencies. In collaboration with federal, state, and local governments, our health centers are prepared and eager to move forward to provide access to the COVID-19 vaccine within their communities.

However, we are very concerned that the vaccine reimbursement policies outlined in this Interim Final Rule will leave health centers severely underfunded and underutilized at a time when they are needed most. This IFC does not include specific details on Medicaid vaccine reimbursement, which is the most common barrier for health centers when providing adult immunizations; it provides no upfront financial protection for Medicare vaccine reimbursement, meaning providers may not receive payment until 2022; it fails to provide guidance for facilities even though health centers are on the front lines of COVID-19 testing and will continue as leaders in administering the vaccine; it does not include payment for practice overhead costs; and is

completely silent on the unique payment structure that protects the financial viability of health centers.

Throughout this pandemic, our members have done their part. They are ready and willing to continue to combat the pandemic through vaccine provision. That is only possible if they have the tools and resources to administer the COVID-19 vaccine to our patients. That is why Bi-State strongly urges CMS to withdraw this Interim Final Rule and instead adopt policies that ensure sufficient vaccine administration reimbursement rates, as well as, other Medicaid policies that will adequately protect our members and the patients they serve.

We provide a summary of the comments here, with more detail below.

Summary of Comments

Bi-State encourages CMS to do the following:

- *Ensure that FQHCs receive Medicare reimbursement at 100 percent of their reasonable costs for the COVID-19 vaccine and its administration. CMS should also require that FQHCs receive interim payments for vaccine administration based on the Part B Physician Fee Schedule.*
- *Require states to cover COVID-19 vaccine administration and specimen collection as a mandatory service for FQHCs under Medicaid state plans as a condition of the 6.2% FMAP increase under section 6008(b)(4).*
- *Issue guidance encouraging states to propose APMs that provide upfront payments for vaccine administration to compensate for the additional resources required to meet the demand for vaccinations and related outreach.*
- *Revise the proposed, narrow interpretation of Section 6008(b)(4) of the FFCRA as it does not support Congressional intent to ensure all Medicaid beneficiaries have access to COVID-19 testing services and treatments, which includes individuals with coverage through 1115 demonstration.*
- *Revise the proposed interpretation of 6008(b)(3) of the FFCRA by defining "enrolled or benefits" to mean "validly enrolled" and permitting States to reduce or terminate benefits for Medicaid beneficiaries while receiving additional federal funding.*
- *Issue new guidance that reinstates the original interpretation of section 6008 of FFCRA.*
- *Revokes the changes made to Section 1332 waiver process.*

Detailed Comments

Ensuring Sufficient Medicare Reimbursement for FQHCs for Senior Care Vaccinations: Section A – Medicare Coding and Payment for COVID-19 Vaccine

- *As required by the CARES Act Section 3713, CMS should ensure that FQHCs receive Medicare reimbursement at 100 percent of reasonable costs for the COVID-19 vaccine and its administration. Additionally, CMS should require that FQHCs receive interim payments for vaccine administration based on the Medicare Part B Physician Fee Schedule. This is in*

recognition of FQHCs' critical role in fighting the pandemic and the need for health centers to divert resources to provide vaccinations to Medicare patients.

Nationwide, health centers serve over 2 million Medicare beneficiaries a year, many of whom would not otherwise have access to primary and preventative care. Our members in New Hampshire and Vermont serve 10% of Granite Staters and 45% of Vermonters who are Medicare enrollees. Ensuring adequate reimbursement for health centers administering the vaccine must be a top priority of any CMS guidance related to the COVID-19 vaccine. However, the current version of the IFC, taken together with existing Medicare laws and regulations, will result in FQHCs not receiving reimbursement for vaccine administration until 2022, leaving providers to potentially cover millions of dollars in uncompensated care.

CMS states the following in the IFC: "Given that the COVID–19 vaccine and administration was added to the same subparagraph as the flu and pneumococcal vaccines and administration under section 1861(s)(10)(A) of the Act, we believe it would be appropriate to use billing processes for COVID–19 vaccinations that are similar to those in place for flu and pneumococcal vaccinations."[1] However, CMS' discussion of Medicare payment for vaccinations at Section II.A of the rule (Medicare Coding and Payment for COVID-19 Vaccine) does not address FQHCs except that payment for the vaccine in FQHCs, among other facility settings, is based on reasonable cost.[2] Bi-State agrees that the Medicare FQHC payment for the COVID-19 vaccine should be treated similarly to the flu and pneumococcal vaccines to the extent the law requires FQHCs to be paid at 100 percent of their reasonable costs for all three vaccines and their administration. The FQHC and RHC benefits, defined in Section 1861(aa) (1) and (3) of the Act, include "physicians' services," including "items and services described in section 1861(s)(10)." Social Security Act §1861(s)(10)(A) lists the flu and pneumococcal vaccines. CARES Act Section 3713 amended §1861(s)(10)(A) of the Social Security Act to add the COVID-19 vaccine to this list.

§1833(a)(3) of the Social Security Act provides for cost-based payment for FQHC services furnished prior to FY2015, with payment generally being limited to 80 percent of reasonable costs except in the case of the services listed in §1861(s)(10)(A). This authority required Medicare to pay FQHCs for FQHC services on a reasonable cost basis before the implementation of the Medicare FQHC PPS in FY2015. When CMS first implemented the Medicare FQHC cost-based payment methodology in 1996, CMS interpreted Social Security Act §§ 1833(a)(3) and 1861(s)(10)(A) to require that the flu and pneumococcal vaccines and their administration be covered at 100 percent of reasonable cost as a "pass through" – meaning the costs associated with the vaccines were to be excluded from the costs associated with the bundled FQHC per-visit rate and instead reimbursed through the cost report reconciliation as a discrete cost center.[3] The vaccines would not be subject to cost-sharing unlike FQHC services; instead, the full reported costs would be reimbursed.[4] CMS promulgated 42 C.F.R. § 405.2466(b)(1)(iv) implementing this

[1] 85 Fed. Reg. at 71,147.
[2] 85 Fed. Reg. at 71,145.
[3] HHS, Health Care Financing Administration, Final Rule, Medicare Program; Payment for Federally Qualified Health Center Services, 61 Fed. Reg. 14,651 (Apr. 3, 1996).
[4] Bi-State needs additional clarity from CMS if the costs associated with administering monoclonal antibodies for COVID-19 will be paid for off the FQHC costs report.

interpretation, and FQHCs were required to isolate the costs associated with flu and pneumococcal vaccines and their administration in their annual cost reporting.

When CMS implemented the Medicare FQHC prospective payment system (PPS) in FY2015, CMS explained that even though the Affordable Care Act required the implementation of a new PPS payment methodology for FQHC services, the legacy statutory payment authority under Social Security Act § 1833(a)(3) still required 100 percent cost reimbursement of flu and pneumococcal vaccine costs incurred by FQHCs. CMS indicated its intent to continue reimbursing FQHCs for costs through a discrete category on the cost report rather than through the new bundled PPS rate.[5] CMS rejected commenters' recommendation that "influenza and pneumococcal vaccines should be billed at time of service, either with or without an encounter, and be paid using the national MAC fees, with an annual reconciliation on the cost report between the payments and the reasonable costs of these vaccines," concluding that the commenters' recommendation would not be "necessary" because "FQHCs are accustomed to reporting and receiving payment for the reasonable costs for these vaccines and their administration through the annual cost report, and we believe that an annual reconciliation between vaccine fee amounts and reasonable costs would create an additional administrative burden for FQHCs and MACs."[6]

This background is relevant because applying equal regulatory treatment of the COVID–19 vaccine and administration as applies to the flu and pneumococcal vaccines does not reflect the need under COVID-19. Not only is distribution urgent, but it is also on a scale far larger than that of the usual flu season. It is critical that CMS provide for interim payments to cover the costs of COVID-19 vaccine administration for FQHCs. CMS has authority to provide for interim payments for vaccine administration on a claim-by-claim basis, which in turn would be reconciled with FQHCs' actual costs upon reconciliation of the cost report. The interim payments are necessary to ensure that FQHCs can redirect their clinical and administrative resources to administer large volume of vaccines in the necessary short amount of time. We recommend that FQHCs be paid according to the vaccine administration codes in the Part B Physician Fee Schedule, with total payments for vaccine administration to be settled to actual costs through the cost report reconciliation.[7] We recommend that CMS amend 42 C.F.R. § 405.2466(b)(1)(iv) accordingly.

Of note, the main rationale CMS cited in 2014 for refusing to provide interim payments for vaccine administration – administrative burden on Medicare Administrative Contractors (MAC) – is not a valid justification in 2020. FQHCs have been statutorily required to include detailed coding on Medicare claims since 2011, and MACs are now more accustomed to paying FQHCs under Part B-style fee schedule rates for a wider variety of services, such as chronic care management, virtual communication services, and telehealth during the Public Health Emergency (PHE). The administrative burden on FQHCs to code and submit accurate claims for vaccine administration

---

[5] HHS, CMS, Final Rule, Medicare Program; Prospective Payment System for Federally Qualified Health Centers, 79 Fed. Reg. 25449 (May 2, 2014).
[6] *Id.*
[7] In the case of some services for which Medicare pays FQHCs based on PFS rates, such as chronic care management, virtual communication services and (during the PHE) telehealth services, CMS has elected to create a G code encompassing all services of that type under the Physician Fee Schedule provide for a payment to FQHCs based on the national average non-facility rates for the bundled component service codes. NACHC recommends this as a method for developing an interim per-administration payment for COVID-19 vaccines.

and the burden on MACs to process fee schedule claims and reconcile those payments against FQHCs' reported costs at fiscal year-end are minimal when considered in the context of the vital role FQHCs will play as COVID-19 immunizers. We urge CMS to amend 42 C.F.R. §405.2466(b)(1)(iv) and its cost reporting instructions / template in accordance with the recommendations above.

Protecting Vaccine Access for Medicaid Enrollees: Section B – COVID-19 Vaccine Coverage for Medicaid, CHIP, and BHP Beneficiaries

- *Bi-State encourages CMS to require states to cover COVID-19 vaccine administration and specimen collection as a mandatory service for FQHCs under Medicaid state plans as a condition of the 6.2% FMAP increase under section 6008(b)(4).*

In our view, current law requires that COVID-19 vaccine and its administration be treated as a mandatory component of Medicaid FQHC services. Specifically, under §1905(l)(2)(A) of the Social Security Act, "federally qualified health center services' means services of the type described in subparagraphs (A) through (C) of section 1861(aa) (1)." Section 1861(aa)(1)(A), in turn, encompasses (among other categories) physicians' services, including "services described in section 1861(s)(10)." Section 1861(s)(10) refers to various types of vaccinations and was amended through CARES Act Section 3713 to include the COVID-19 vaccine and its administration. As such, the COVID-19 vaccination and its administration are included within the core FQHC services that each state is required to cover.[8]

Vaccine administration

As a required FQHC service, the COVID-19 vaccine and administration must be covered by Medicaid in all instances when furnished by health centers, regardless of the scope of Families First Coronavirus Response Act (FFCRA) Section 6008(b) and its maintenance of effort requirements. State Medicaid programs then must cover the COVID-19 vaccine and administration so long as the patient's Medicaid benefit generally includes FQHC services. States are required, per §§1902(bb) and 1905(a)(2)(C) of the Act, to ensure that the full bundle of FQHC services and other ambulatory services covered under the state plan are taken into account in setting FQHCs' PPS rates. As CMS stated in a 2001 guidance, "The Medicaid PPS rate must include all Medicaid covered services allowed under §1905(a)(2)(B) and (C) of the Social Security Act, which includes mandatory services."[9] Taken together, each state should be required to provide CMS with assurance that FQHC payments relating to COVID-19 vaccine and its administration will

---

[8] The U.S. Court of Appeals for the Ninth Circuit held in 2013 that California unlawfully limited the scope of its FQHC/RHC benefit by excluding dentist services from the FQHC benefit, even though the definition of "physicians' services," per the Medicare statute, includes services rendered by dentists. The court stated: "We hold that Medicaid imposes on participating states an obligation to cover 'rural health clinic' services and 'Federally-qualified health center services,' and Medicaid imports the Medicare definition of those terms." Calif. Assn of Rural Health Clinics v. Douglas, 738 F.3d 1007, 1016 (9th Cir. 2013). Here, the CARES Act amended the list of vaccines included in section 1861(s)(10)(A) and through incorporation, amended the definition of "rural health clinic services" (Section 1861(aa) (1)) upon which the Medicaid definition of FQHC services is based.

[9] State Medicaid Director Letter #01-014, New FQHC/RHC Payment Provisions (2001).

be fulfilled, either through: (1) a scope change rate adjustment[10], or (2) through the use of an alternative payment methodology (APM), per Section 1902(bb)(6) of the Act, to carve out the COVID-19 vaccine and its administration and it be paid outside the PPS rate.

Under this statutory authority, the addition of the COVID-19 vaccine to the FQHC benefit qualifies as an increase in the scope of services for every FQHC. CMS should ensure that states incorporate the costs associated with COVID-19 vaccine administration into FQHCs' payment. We acknowledge that states currently have the flexibility to pursue an FQHC APM, per §1902(bb) (6) of the Act, to provide discrete payment for the vaccinations, because in some instances, administration of a vaccine would not fulfill states' definition of an FQHC "visit," and therefore would not trigger a PPS payment. However, any APM relating to payment for the COVID-19 vaccine would require CMS approval. We encourage CMS to work with states in determining which payment solution will provide the most optimal rates for FQHCs and be implemented expeditiously.

Testing specimen collection
Many of these concerns apply to FQHCs' collection of COVID testing specimens. States are required to cover "COVID-19 testing services and treatments" that meet the criteria set forth in FFCRA Section 6008. FQHCs in NH and VT have played an indispensable role in providing COVID-19 testing, collecting testing specimens, and sending them to external labs for results. However, in many instances Medicaid agencies have not adjusted FQHC payment to ensure that FQHCs receive a payment for specimen collection. Similar to vaccine administration, the specimen collection does not meet states' criteria for an FQHC "visit," and does not trigger a PPS payment. States should either provide for an FQHC scope change rate adjustment to encompass the costs associated with the specimen collection or amend the State plan to pay for it separately as an APM.

Bi-State appreciates the Administration's commitment to ensuring that we all have timely access to a COVID-19 vaccine without cost-sharing and no matter their source of coverage. As health centers continue to play a key part in the nation's COVID-19 vaccine strategy, we appreciate CMS' support to ensure health centers are reimbursed for all COVID-19 testing services and treatments.

- *Bi-State encourages CMS to issue guidance urging states to propose APMs that provide upfront payments for vaccine administration to compensate for the additional resources required to meet the demand for vaccinations and related outreach.*

Given the urgency, CMS should encourage states to propose APMs that provide upfront payments for vaccine administration to compensate for the additional resources required to meet the demand for vaccinations. In a national survey, Avalere found that 80% of health practices indicated that an increase in vaccine administration fees would aid practice sites in

[10] Id. In previous guidance, CMS made clear that States are required to make these rate adjustments to reflect changes in the "type, intensity, duration and/or amount of services" even if these services do not require a face-to-face visit with a FQHC/RHC provider. States are required to adjust their PPS rates to take into account "any increase or decrease in the scope of services." Social Security Act 1902(bb)(3)(B).

overcoming barriers created and exacerbated by the COVID-19 pandemic.[11] Our health centers are already experiencing increased calls regarding the vaccine and there will be additional demand on health center staff for follow ups for patients. Health centers will be allocating greater time or staff to address patient questions and continued alternative administration arrangements like drive-through clinics and pop-up locations in our vulnerable and rural communities. It is vital that Medicaid reimbursement rates reflect the time and resources that health center staff will devote to educating patients on COVID-19 treatments and the value of getting vaccinated in a timely manner.

We appreciate the efforts CMS has already taken to provide states greater flexibility through Medicaid disaster relief State Plan amendments to pay higher rates for COVID-19 vaccine administration[12]. We also expect that states may initially use the influenza vaccine administration rate for COVID-19 vaccine administration payments. However, we strongly encourage CMS to provide guidance to states on the importance of establishing rates that acknowledge the additional complexity associated with COVID-19 vaccine administration. Given the severity of the pandemic, HHS anticipates that immunization rates for COVID-19 are likely to be higher than for influenza, although initial rates may be lower until an adequate supply is available.[13] The COVID-19 vaccine will likely have different, more complex barriers – a lack of understanding regarding the importance of vaccines, fears about vaccine safety, concerns about insurance coverage, the need for a second booster – than the influenza and pneumococcal vaccines, and payment rates should reflect the resources health centers will need to combat these barriers.

As such, CMS should encourage states to set varying rates under APMs for the administration of different types of COVID-19 vaccines. For example, if an approved COVID-19 vaccine requires multiple doses, health center staff will have to allocate more time and resources to patient engagement to ensure patients return for the second vaccine dose. In order to have a fully staffed work force, Bi-State strongly urges CMS to provide guidance to states on establishing vaccine administration reimbursement rates that will fully honor the time and resources health centers devote to COVID-19 treatments.

- *CMS' narrow interpretation of Section 6008(b)(4) of the FFCRA does not support Congressional intent to ensure all Medicaid beneficiaries have access to COVID-19 testing services and treatments, which includes individuals with coverage through 1115 demonstration.*

We are concerned that CMS has chosen to take a limited view of the requirements of Section 6008(b)(4) of the FFCRA with regard to COVID-19 testing services and treatments during and after the PHE that excludes eligibility groups whose coverage is limited by statute or under a current Section 1115 demonstration. We believe CMS' interpretation is contrary to the requirements of Section 6008(b)(4) and inconsistent with Congressional intent to ensure that the Medicaid

---

[11] Avalere, The COVID-19 Impact on US Routine and Seasonable Vaccine Administrations. October 2, 2020.
[12] CMS, Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost Sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program Toolkit. (2020)
[13] *Id.*

program covers testing services and treatment – including the vaccine and administration of the vaccine for COVID-19 – to reach the most vulnerable populations. Bi-State disagrees with CMS' interpretation that states can receive a temporary 6.2% in FMAP while denying COVID-19 testing services and treatment to Medicaid beneficiaries based on the scope of their pre-PHE coverage. In the interest of public health, CMS should interpret the requirements under Section 6008(b)(4) of the FFCRA to cover COVID-19 testing services and treatments for all those currently enrolled in Medicaid.

In the IFC's preamble, CMS broadly looks to Section 3716 of the CARES Act as a basis for its conclusion that the 6.2% FMAP increase per Section 6008 of FFCRA does not require states to cover COVID-19 testing services and treatments for individuals whose coverage is limited by statute or under an 1115 demonstration. CMS notes that Congress allowed states to include these groups as meeting the definition of "uninsured," and therefore qualify for COVID-19 testing and treatment under Section 3716. The agency appears to conclude that Congress included these limited benefit recipients as "uninsured" because they would otherwise not be able to receive testing and treatment services under 6008(b) of FFCRA.

Section 3716 of the CARES Act does not support CMS' narrow interpretation to deny coverage to Medicaid beneficiaries with limited benefits under Section 6008(b)(4) of the FFCRA. Moreover, it is based on Congress having decided to provide testing and treatment to these groups of needy Medicaid recipients, but to not provide them with the simple solution to avoiding the costs of treatment: a COVID-19 vaccination. To avoid such an illogical conclusion, CMS has the discretion to read these laws to apply both Sections 3716 and Section 6008(b)(4) of the FFCRA to individuals whose coverage is limited by statute or under an 1115 demonstration, which would allow states to receive 100% FMAP for COVID testing and treatment under Section 3716 and its regular FMAP plus the 6.2% per Section 6008.

CMS has the responsibility to extend the Federal Medicaid reimbursement for beneficiaries who would not traditionally access adult vaccine coverage considering the ongoing PHE. Given that COVID-19 continues to acutely impact low-income populations, individuals with limited Medicaid benefits should not be penalized for their enrollment in less comprehensive coverage. We urge CMS to consider the circumstances of a global pandemic to provide treatment options with no cost sharing, like vaccine coverage, to individuals whose coverage does not traditionally cover adult vaccines. The IFC's interpretation of the maintenance of effort provision of Section 6008 of the FFCRA is especially harmful to FQHCs and their patients, which must provide care to all regardless of ability to pay. In recognition of the growing financial strains created by the pandemic, Bi-State strongly encourages CMS reconsider their interpretation of Section 6008(b)(4) and cover all Medicaid beneficiaries, including those with limited benefits.

Preserving Medicaid Coverage for Low-Income Populations: Section F – Temporary Increase in Medicaid Funding

- *CMS misinterprets section 6008(b)(3) of the FFCRA by defining "enrolled or benefits" to mean "validly enrolled" and permitting States to reduce or terminate benefits for Medicaid beneficiaries while receiving additional federal funding.*

Bi-State believes it is unreasonable for CMS to interpret the term "enrolled for benefits" in Section 6008(b)(3) of FFCRA to mean "validly enrolled" for purposes of FFCRA section 6008. This interpretation of the maintenance of enrollment statutory requirement, and subsequent allowance for states to claim the temporary FMAP increase while reducing or terminating Medicaid recipients' benefits is inconsistent with the Social Security Act. CMS does not have the authority to create Section 42 CFR 433.400, which provides states the flexibility to make eligibility determinations that are not permitted under statute during the PHE. While we acknowledge that states are facing budget constraints as a result of the pandemic, they should not be permitted to resolve budget deficits at the expense of vulnerable populations during a pandemic.

CMS's interpretation of Section 6008(b)(3) of FFCRA is inconsistent with § 1902(a)(19) of the Social Security Act, which requires safeguards to assure that eligibility for care and services will be provided in a manner that is in the best interests of recipients. It is hard to grasp how the creation of the Section 42 CFR 433.400 "validly enrolled" definition is in the best interests of Medicaid recipients when this section was created to allowed Medicaid programs to adjust a beneficiary's eligibility category to reduce scope of services and modify cost sharing and post-eligibility treatment of income without violating the condition in Section 6008(b)(3) of the FFCRA. Bi-State urges CMS to reinterpret section 6008 to reflect previous guidance that prohibited states from reducing benefits for any beneficiary enrolled in Medicaid during the PHE and still qualify for increased FMAP.

Additionally, Bi-State needs additional guidance from CMS on what type of agency errors, under Section 433.400(b), qualify as "erroneous" to permit Medicaid programs to terminate the eligibility of beneficiaries who are not "validly enrolled." In the interests of beneficiaries, there should be greater safeguards to prevent states from abusing their discretion in defining agency errors broadly to remove as many beneficiaries from the program as possible. Terminations based on "agency error" could translate into a decrease in Medicaid enrollment. This would be similar to when, in 2018, states such as Missouri and Texas used administrative barriers to terminate beneficiaries from Medicaid before their regular annual eligibility redetermination dates. In its regulatory impact analysis, CMS provides no estimate of the number of people who could lose coverage as not "validly enrolled." Additionally, Bi-State needs more clarity on provider payments for beneficiaries that are determined to not be validly enrolled.

- *Bi-State requests that CMS issue new guidance that reinstates the original interpretation of Section 6008 of FFCRA.*

Optional benefits in the Medicaid program are essential to patient health. CMS proposes to give states the flexibility to eliminate optional benefits – including dental, vision, and targeted case management services – in an effort to reduce costs. However, experience shows that when

optional benefits are cut, the result is an increase in overall associated costs.[14] Cuts to optional benefits in Massachusetts in 2002 and 2003 and in California in 2009 resulted in a decline in provider reimbursement as well as increases in costs associated with untreated health needs.[15] This led to increased dependence on emergency departments. We urge CMS to return to previous guidance that keeps in place states' benefits packages if accepting an increase in funding.

Also related to the guidance on Section 6008, research demonstrates that requiring contributions from patients for health care and related services has an adverse effect on lower-income populations, particularly those on Medicaid.[16] In a review of 65 papers published between 2000 and 2017, the Kaiser Family Foundation found that premiums and other forms of required financial contributions in Medicaid were a barrier to receiving and maintaining long-term coverage.[17] Given the severe economic toll of the COVID-19 pandemic, now is not an appropriate time for states to be shifting more costs onto consumers of the Medicaid program.

Preserving Intent of 1332 Innovation Opportunities: Section IV – Provisions of the Interim Final Rule Regarding State Innovation Waivers

- *Bi-State urges CMS to revoke the changes made to Section 1332 waiver process.*

The IFC will allow states to request that public notice requirements for Section 1332 waiver applications be waived during the PHE if certain conditions are met. It will also allow CMS to waive public notice requirements for approved Section 1332 waivers during the PHE when the application of the public notice procedures would be contrary to the interests of consumers. Both policies would violate the spirit and intent of the Section 1332 innovation opportunities for states.

The public notice and comment period associated with Section 1332 waivers is statutorily required. NACHC supports adequate notification that offers the opportunity for stakeholders to provide public comment on the implications – both positive and negative – of regulatory changes pursued through Section 1332 authority. Removing the requirements for public notice threatens the ability for providers to learn of proposed changes and provide valuable public comment in a timely manner. This change in public notice is particularly ill-advised during the PHE, when providers need to have a clear understanding of all the tools and flexibilities available to them and their states to combat the pandemic.

Further, this proposal is not necessary. States already have the option to request 1135 waiver authority for the explicit purpose of making rapid changes in the event of a PHE, which the majority of states, including New Hampshire and Vermont, have already used during the COVID-

[14] Kaiser Family Foundation. Few Options for States to Control Medicaid Spending in a Declining Economy. April 2008.
[15] Health Affairs. Eliminating Medicaid Adult Dental Coverage In California Led To Increased Dental Emergency Visits And Associated Costs. May 2015.
[16] National Health Law Program. Medicaid Premiums and Cost Sharing. March 26, 2014.
[17] Kaiser Family Foundation. The Effects of Premiums and Cost Sharing On Low-Income Populations. June 2017.

19 pandemic. Bi-State applauds CMS for working with states to ensure that they can quickly respond to this crisis under the authorities provided by 1135 waivers. We do not, however, support the changes made to the Section 1332 waiver process set forth in this IFC.

In closing, thank you for your consideration of our comments. Please contact Georgia Maheras, Vice President of Policy and Strategy, with any questions (gmaheras@bistatepca.org).

Sincerely,
Tess Kuenning
Tess Stack Kuenning, CNS, MS, RN
President and Chief Executive Officer