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:

We appreciate the opportunity to submit comments on the Centers for Medicare and Medicaid Services (CMS) Interim Final Rule "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency". These comments are submitted by the Massachusetts Law Reform Institute, Health Care for All, Greater Boston Legal Services, and Health Law Advocates, organizations that advocate for low-income individuals in Massachusetts and work to ensure affordable access to health services. We submit these comments on behalf of our organizations and clients and the additional undersigned organizations.

On January 21, 2020, the CDC confirmed the first reported infection of COVID-19 in the United States, and on January 31, Health and Human Services Secretary Alex Azar declared a national public health emergency. By the time The Families First Coronavirus Response Act (FFCRA) was signed into law on March 18, the U.S. had 7,327 confirmed cases of COVID-19,[1] lockdowns and remote work had begun, and Treasury Secretary Mnuchin had warned that unemployment could soar as high as 20%. In response to a rapidly spreading pandemic and declining economy, Congress recognized the need to prioritize access to affordable health benefits. Congress included in the FFCRA a requirement that states receiving enhanced federal Medicaid funding must comply with the maintenance of effort (MOE) protections contained in section 6008(b) of the Act. These protections help ensure that individuals are able to get and stay covered during the crisis and receive needed services.

We believe that this Interim Federal Rule (IFR) contravenes the letter and spirit of the FFCRA by weakening these protections. In a reversal of CMS's prior stated policy and interpretation of the FFCRA, 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; and increased cost-sharing. Further, implementation of this IFR before it is finalized and during an administration change places an unnecessary administrative burden on states that will divert much-needed resources from the important work of responding to the pandemic. We also oppose allowing states to circumvent required transparency procedures for 1332 waivers and to receive enhanced funding despite refusing to cover COVID-19 vaccinations for some Medicaid enrollees.

[1] Jiang, Jeannette; Peterson, Emily; Heimer, Robert, "COVID-19 Updated Data & Developments- March 18, 2020" Yale School of Medicine (March, 2020). https://medicine.yale.edu/news-article/23224/

COVID-19 hit Massachusetts hard at the beginning of the pandemic and, as a result, it has the third highest total per capita COVID-19 death rate in the U.S. (11,804 total deaths).[2] COVID-19 continues to devastate Massachusetts, which has experienced an average of 4,716 new cases per day as of December 2020.[3] During the first six months of the pandemic, the number of individuals covered in Massachusetts' Medicaid program (MassHealth) as primary insurance had grown by 10%.[4] MassHealth now covers more than 1.9 million people, more than a quarter of our state population.[5] We are deeply concerned about this IFR's impact on MassHealth and other Medicaid programs across the country. We recommend that CMS withdraw the harmful provisions of the IFR discussed in these comments, and restore the original intent and effect of the FFCRA.

Administrative and Operational Burden

We are concerned that the changes imposed by this IFR are in conflict with the intention of the Maintenance of Effort (MOE) protections within the FFCRA. The MOE has allowed Medicaid members to be secure in their coverage during the uncertainty many households have experienced during the pandemic, including changes to health status, address and income. The updated IFR would be very difficult for states to operationalize and would divert staff from crucial work during a pandemic. It was complicated and time-consuming for Medicaid programs to operationalize the original MOE on an expedited timeframe; for CMS to now require another round of temporary changes in state operations in the midst of the emergency means that staff time would need to be redirected from more important tasks. Once the new changes are made state-by-state, they will need to fully train Medicaid call centers, eligibility workers and enrollment assisters to be able to ensure members get the correct determinations and information about their coverage. Call centers, eligibility workers and many enrollment assisters are working remotely for the first time ever. It would be incredibly difficult to provide the level of support needed for system changes at this time. The states' time would be far better spent bolstering their ex parte renewal processes and updating addresses to better prepare for conducting redeterminations at the end of the public health emergency.

In Massachusetts, Medicaid (MassHealth) uses two different eligibility systems and would need to develop complex logic to implement the tier system envisioned by the IFR. This system of tiers is something entirely new to Medicaid eligibility and operations. It would be difficult not only to operationalize these changes, but to have quality checks in place to ensure members are correctly determined in accordance with the rules. The COVID cases in Massachusetts have more than doubled in the last two months: as of December 21st, there have been 323,500 cases and 11,717 deaths. This would be a huge undertaking when the focus should be on maintaining coverage and benefits during the surge in COVID cases. Further, soon after MassHealth is required to make these changes, the rule could be significantly changed once it's finalized, or overturned after the transition to the Biden administration. Mandating movement within tiers

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[2] *Coronavirus in the U.S.: Latest Map and Case Count*, New York Times, *available at* https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html (last updated Dec. 23, 2020).
[3] *Id.*
[4] *Massachusetts Health Insurance Enrollment March 2020 through September 2020*, Center for Health Information and Analysis, *available at* https://www.chiamass.gov/assets/Uploads/enrollment/monthly-summaries/Enrollment-Monitoring-through-September-2020.pdf (last visited Dec. 23, 2020).
[5] *Id.*

would put members at risk of losing coverage improperly, which would divert staff time to fixing incorrect eligibility determinations.

During the pandemic people have experienced so much change, at a time when most sources of in-person assistance are not available, that it can be difficult to keep up with updates to existing Medicaid applications. There may have been errors in eligibility determinations, but reversing these determinations during the state of emergency could disrupt ongoing care. For example, Health Care For All heard from a family that had their household relationships and tax questions inputted incorrectly when they worked with a MassHealth agent and were improperly placed on MassHealth. Health Care For All's HelpLine was able to fix the application and the family members' coverage was protected. With the updated rule, two of the family members would have lost their MassHealth coverage and faced a gap in coverage, with one needing daily medications. Preventing any churn in coverage is an important tool in the fight against COVID, and we ask that you continue the strong protections of the original interim final rule.

Allowing Movement within Tiers Results in Reduced Coverage

CMS should abandon the coverage tiers system in the IFR which allows states to move people from one eligibility category to another within a "Tier" even when the move would result in an individual receiving lesser coverage. This system violates the FFCRA provision which requires preservation of an individual's benefits. Its reliance on the concept of minimum essential coverage (MEC) is irrelevant to anything in the FFCRA. Moving individuals to a narrower scope of coverage can cause substantial harm. This harm will disproportionately fall on certain groups, including people with disabilities and older adults.

Massachusetts does not have the limited benefit programs described in the rule as Tier 2 and 3 coverage. All available categories of MassHealth (Medicaid) coverage are in Tier 1 as defined in 20 CFR § 433.400 (c)(2)(1). However, not all categories of coverage defined as Tier 1 provide equivalent coverage. The IFR would allow individuals who become eligible for Medicare at age 65, or after a Social Security disability determination, to lose full MassHealth coverage (MassHealth Standard) and instead be given coverage through a Medicare Savings Program (MSP) known in Massachusetts as MassHealth Buy-In and MassHealth Senior Buy-In. This result is inconsistent with section 6008 of the FFCRA and defeats the statutory purpose of protecting enrollees and preserving their existing benefits during the public health emergency. Congress intended to provide continuity of health care coverage during this time when people have lost income, jobs and the ability to travel safely outside their homes, and when resources of health care providers and enrollment assisters are strained. The provision of this IFR, which allows movement within Tiers, contravenes the Congressional purpose.

In Massachusetts, individuals who are under age 65 can be eligible for MassHealth Standard coverage if their countable income is below 133% of the federal poverty level (FPL). At age 65, the income limit for MassHealth Standard drops to 100% FPL, income counting rules change, and a resource test is applied. Historically many Massachusetts residents have lost all MassHealth eligibility upon turning 65. Since January, 2020, eligibility for MassHealth MSP benefits was raised to an income limit of 165% FPL for seniors who become Medicare eligible. While this increased MSP income limit has been a huge benefit to seniors, under the IFR's

reinterpretation of FFCRA, eligibility for Medicare and MSP will cause a loss of more expansive MassHealth coverage. Because the IFR treats MSP coverage as equivalent to MassHealth Standard, individuals who turn 65 and become Medicare eligible may now have lesser coverage despite the clear intention of the FFCRA to preserve a member's Medicaid benefits during the pandemic. A similar loss of coverage can occur for individuals with disabilities who become Medicare eligible. Perversely, individuals turning 65 who are ineligible for MSP because their income and resources are too *high,* will retain MassHealth Standard coverage.

Medicare coverage does not provide the same benefits as full scope Medicaid. Coverage for critical services such as transportation, dental, vision, and hearing, as well as long term care services and supports in the community, are not part of the Medicare benefit. The Medicare benefit does not include personal care services, most medical supplies and nonprescription medication, all services which are covered by MassHealth Standard. Also, Medicare coverage of mobility equipment is limited and does not include the full range of equipment needed to actively participate in community living. The loss of MassHealth covered transportation during the COVID pandemic is particularly egregious, as travelling by public transportation increases the risk of COVID infection.

MSP coverage helps with the cost of Medicare, but does not add any new benefits to the Medicare coverage. Individuals who qualify for Senior Buy-In (countable income below 130% FPL) receive coverage for Medicare deductibles and coinsurance as well as Medicare premiums. Individuals who qualify for Buy-In (countable income between 130 and 165% FPL) only receive payment of the Part B premium, but no help with other out of pocket costs which are substantial. For example a Medicare beneficiary who is admitted to a hospital for treatment of COVID-19 would be subject to the Medicare Part A deductible of $1,408 per benefit period in 2020 ($1,484 in 2021). While some outpatient COVID testing and treatment is covered in full, under Part B, there is a $198 deductible in 2020 ($203 in 2021) and 20 percent coinsurance that applies to most services, including physician visits and emergency ambulance transportation.

The IFR's implementation of a tiers system harms Medicare beneficiaries. Most individuals age 65 and over and many people with disabilities are Medicare beneficiaries. Due to their older age and higher likelihood of having serious medical conditions almost all Medicare beneficiaries risk becoming seriously ill if they are infected with COVID-19.[6] This is not the population that should be singled out for a loss of health coverage during this public health crisis.

CMS's Tier Approach Violates the Plain Language of FFCRA

CMS's reinterpretation of FFCRA's maintenance of effort provision (section 6008(b)) is improperly based on the concept of "minimum essential coverage". This term is defined by the Internal Revenue Code and the Code of Federal Regulations, but it is foreign to the FFCRA. Instead, section 6008(b) of FFCRA provides that states receiving increased FMAP must "provide that an individual who is enrolled for benefits [as of March 18, 2020 and between March 18, 2020 and the end of the PHE]… shall be treated as eligible for such benefits" through the end of

[6]Center for Disease Control, Older Adults, At greater risk of requiring hospitalization or dying if diagnosed with COVID-19, (updated December 13, 2020) https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html

the PHE. As described above, different eligibility groups provide different benefits. By allowing states to move a Medicaid member from one eligibility group to another with less comprehensive benefits, CMS is ignoring the plain language of section 6008(b). Further, prior CMS interpretation of section 6008(b) does not refer to or rely on the concept of minimum essential coverage, and therefore does not support a statutory interpretation based on that concept. CMS's tier based reinterpretation of section 6008(b) violates the plain language of FFCRA. Finally, while CMS states in the preamble that its reinterpretation of the statute is designed to give states added flexibility, the provisions regarding tiered coverage appear to be requirements and as such reduce state flexibility.

Reductions in Optional Benefits and in Amount, Duration, Scope of Services

This IFR gives states sweeping authority to reduce optional Medicaid benefits and to change the amount, duration and scope of the benefits they offer. In response to budget constraints after the 2008 recession, 18 states, including Massachusetts, made cuts to Medicaid benefits.[7] Massachusetts has responded to economic pressure by making *significant* cuts to adult dental benefits- twice. Massachusetts eliminated nearly all adult dental benefits in 2002 and 2003. Although those benefits were restored in 2006, in 2010 Massachusetts made more cuts, eliminating coverage for fillings, crowns, root canals, periodontal services, and dentures.

Studies show that cutting adult dental benefits results in significantly increased visits to the emergency room. One study of a Massachusetts hospital found that in 2011, the year after adult dental benefits were cut, the number of emergency room visits for dental reasons increased by 14%.[8] The populations with the largest increases in dental related emergency room visits were people 55 and older, and Black and Hispanic patients: populations that are now disproportionately impacted by the pandemic.[9] Further, it's well documented that untreated dental issues contribute to a decline in overall health.[10] It is irresponsible to allow states to eliminate Medicaid benefits that would result in negative health outcomes and needlessly increase the burden on emergency departments during a pandemic. Furthermore, it contravenes the letter and intent of the FFCRA, which was passed to ensure that cuts to benefits wouldn't be made during the pandemic.

Increase in Cost-Sharing

This IFR would allow states to increase cost-sharing without violating the MOE provision of section 6008(b). Increasing cost-sharing would be especially harmful during a public health emergency and economic crisis. Massachusetts has been particularly hard-hit by the pandemic: in June and July 2020, Massachusetts had the highest unemployment rate in the nation (17.7%

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[7] Smith, Vernon et al. "Moving Ahead Amid Fiscal Challenges: A Loot at Medicaid Spending, Coverage and Policy Trends" *The Kaiser Commission on Medicaid and the Uninsured* (October 2011), page 91. https://www.kff.org/wp-content/uploads/2013/01/8248.pdf#page=93

[8] Neely, Martha et al. "Effects of cuts in Medicaid on dental-related visits and costs at a safety-net hospital." *American journal of public health* vol. 104,6 (2014) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4062004/

[9] Neely, Martha et al. "Effects of cuts in Medicaid on dental-related visits and costs at a safety-net hospital." *American journal of public health* vol. 104,6 (2014) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4062004/

[10] "Oral health: A window to your overall health", *The Mayo Clinic* (June, 2019) https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475

and 16.1% respectively)[11] and its unemployment rate is still higher than 34 other states.[12] Massachusetts imposes cost-sharing for pharmacy services; increasing these co-pays now would be harmful to MassHealth members. Studies show that even slight increases in co-pays cause significant declines in use, which increase the risk of poor health outcomes.[13] Especially now, it is critical that pharmacy co-pays aren't increased on MassHealth members, so that they can continue to access the prescriptions and vaccines they need to stay healthy without spending the money they need for other essential expenses.

Exceptions to the MOE Requirements of the FFCRA

Congress enumerated two specific exceptions to the MOE requirement in the FFCRA. A state may terminate a member's Medicaid coverage during the public health emergency period and still receive the enhanced FMAP only if the member has moved out of state or requested voluntary termination. FFCRA § 6008(b)(3). This IFR violates the FFCRA by expanding these exceptions to the MOE requirement. It mandates that states terminate minimum essential coverage ("MEC") of certain pregnant non-citizens and certain non-citizens turning 21. IFR Subpart G, § 433.400(d)(2). The IFR claims that continuing MEC coverage for these populations would violate federal law governing Medicaid eligibility. However, the FFCRA expressly suspends federal Medicaid eligibility rules. The FFCRA is designed to incentivize states to continue coverage for individuals despite circumstances that would normally render them ineligible. By improperly carving out additional exceptions to the FFCRA's suspension of eligibility rules, the IFR violates the letter and intent of the FFCRA and steps beyond the power and authority of administrative rule making.

Furthermore, the IFR's additional exceptions to the MOE provision discriminate on the basis of national origin. It targets eligibility changes related to immigration status but not other eligibility changes or procedural factors. The IFR creates a new, national origin-based MOE exclusion to deprive certain non-citizens from continued Medicaid coverage while allowing many others to maintain coverage even if they become ineligible for reasons not related to immigration status. This additional MOE exception violates Title VI of the Civil Rights Act of 1964 and the Due Process Clause of the U.S. Constitution and the Constitution of the Commonwealth of Massachusetts. 42 U.S.C. 2000d et seq. ("Title VI"); U.S. Const. amend. XIV § 1; Mass. Const. art. I, pt. I.

Further, the IFR's unauthorized additions to the exceptions of the MOE harms public health during a public health emergency. Congress passed the FFCRA in response to widespread suffering and economic harm caused by the COVID-19 pandemic, including an increased uninsured rate in the U.S.[14] The Massachusetts unemployment rate was just 2.8% at the

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[11] U.S. Bureau of Labor Statistics, Unemployment Rates by State Jan, 2020- July, 2020: https://www.bls.gov/opub/ted/2020/unemployment-rate-16-point-1-percent-in-massachusetts-4-point-5-percent-in-utah-in-july-2020.htm

[12] U.S. Bureau of Labor Statistics, Unemployment Rates for States: https://www.bls.gov/web/laus/laumstrk.htm

[13] Medicaid Premiums and Cost Sharing, NHeLP, David Machledt and Jane Perkins (March, 2014): https://healthlaw.org/resource/medicaid-premiums-and-cost-sharing/

[14] Daniel McDermott et al., *How Has the Pandemic Affected Health Coverage in the U.S.?*, Kaiser Family Foundation (Dec. 9, 2020).

beginning of March 2020 and dramatically increased to 16.2% by April.[15] The pandemic has dramatically increased the number of people in need of health services, including mental health care.[16]

The IFR's targeting of postpartum parents for disenrollment will undoubtedly cause higher rates of uninsured parents of young children. Research has shown that insured children of uninsured parents disproportionately face worse life outcomes, financial and otherwise, than those who have insured parents.[17] Health insurance is particularly important for parents in the first year after pregnancy: many pregnancy-related maternal deaths occur more than 60 days postpartum.[18] Conditions often triggered by pregnancy and childbirth such as diabetes and depression typically last more than 60 days postpartum.[19] Similar to the pandemic's disproportionate negative impact on people of color in Massachusetts and across the country, postpartum complications and death are also borne disproportionately by people of color.[20] The stress of the pandemic may exacerbate the prevalence of these conditions, particularly postpartum depression. Without Medicaid, new mothers will lack access to services to treat these conditions.

CMS Should Maximize Coverage of COVID-19 Vaccines, Without Cost-Sharing

Despite the clear public interest in making the COVID vaccine widely available, this IFR acts to limit access to COVID-19 vaccines. The IFR provides that states do not need to provide COVID-19 vaccination coverage for pregnant individuals in separate CHIP programs. This includes pregnant immigrants who may not be eligible for Medicaid due to their immigration status, but can obtain CHIP eligibility through their state's adoption of the Immigrant Children's Health Improvement Act (ICHIA) option or through coverage of the fetus of a pregnant immigrant, like in Massachusetts.

A widely available COVID-19 vaccine is essential to bringing the pandemic under control and combating the disastrous social and economic impacts of this public health emergency. To be effective, widespread dissemination of the vaccine must also extend to marginalized communities, including immigrants, people who are pregnant or postpartum, and other vulnerable populations. Immigrants have faced a disproportionate burden of exposure to COVID-19 because many work front-line, essential worker jobs as they endeavor to financially

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[15] *Local Area Unemployment Statistics*, U.S. Bureau of Labor Statistics, *available at* https://data.bls.gov/timeseries/LASST250000000000003?amp%253bdata_tool=XGtable&output_view=data&include_graphs=true (last updated Dec. 23, 2020).

[16] Nirmi et al., *The Implications of COVID-19 for Mental Health and Substance Use*, Kaiser Family Foundation (Aug. 21, 2020).

[17] Gianna Melillo, *Racial Disparities Persist in Maternal Morbidity, Mortality and Infant Health*, Am. Diabetes Assn. (Jun. 13, 2020).

[18] Andreea A. Creanga et al., *Pregnancy-Related Mortality in the United States, 2011-2013*, J. Obstet. Gynecol. 130(2):366-373 (Aug. 1, 2018).

[19] Kay Johnson et al., *The Next Steps to Maternal and Child Health in Medicaid: Filling Gaps in Postpartum Coverage and Newborn Enrollment*, Health Affairs (Jan. 9, 2020).

[20] Gianna Melillo, *Racial Disparities Persist in Maternal Morbidity, Mortality and Infant Health*, Am. Diabetes Assn. (Jun. 13, 2020). And Samantha Artiga et al., *Racial Disparities in COVID-19: Key Findings from Available Data and Analysis*, Kaiser Family Foundation (Aug. 17, 2020).

support their families in the face of gaps in governmental assistance.[21] Pregnant people have additionally been flagged as being at heightened risk for complications of COVID-19.[22] The American College of Obstetricians and Gynecologists issued a public advisory stating that symptomatic pregnant patients with COVID-19 are at an increased risk of more severe illness than their nonpregnant peers and thus pregnant patients would specifically benefit from vaccination.[23] Therefore, people who are members of immigrant communities while pregnant or postpartum are particularly at a disadvantage in the face of the COVID-19 pandemic and require access to a COVID-19 vaccine.

In Massachusetts, the COVID-19 pandemic has had a disproportionate health and economic impact on immigrant communities.[24] In addition to experiencing higher COVID-19 infection rates, immigrant communities have faced disproportional job loss, which leads to housing and food insecurities.[25] Unfortunately, it is these most vulnerable immigrant populations for whom CMS is not requiring vaccination coverage. In the best interests of public and individual health, CMS should take every measure to eliminate barriers to the COVID vaccine for all communities. We urge CMS to reconsider its policies and ensure that all communities can access the COVID vaccines without barriers.

CMS's Use of an Interim Final Rule

CMS should not have implemented these policy changes through an interim final rule, bypassing the public comment period before putting the rule into effect. The Administrative Procedure Act provides that government agencies will solicit and consider public comment before finalizing and implementing a rule change. Agencies may bypass this procedure with an interim final rule only out of necessity- when the notice and comment period would be impractical, unnecessary, or contrary to the public interest. 5 U.S. Code § 553(b). However, there is no justification for CMS' use of an interim final rule that outweighs the utility and public interest of having a notice and comment period before the rule goes into effect. As described above, implementing these changes is a huge administrative undertaking that would divert much-needed attention and human resources away from responding to the escalating COVID-19 pandemic. Further, using the interim final rule process only serves to add to states' confusion and administrative burden. As an interim final rule, it may be changed after states have already diverted significant resources to implement it. This is compounded by the fact that this rule making process is occurring during a major change in administration, which may result in further rule changes.

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[21] Hamutal Bernstein, Jorge González, Dulce Gonzalez, and Jahnavi Jagannath, Immigrant Serving Organizations' Perspectives on the COVID-19 Crisis, 1 (2020)

[22] *Vaccinating Pregnant and lactating patients against covid-19*, The American College of Obstetricians and Gynecologists,https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/12/vaccinating-pregnant-and-lactating-patients-against-covid-19, (last updated Dec. 21, 2020)

[23] *Vaccinating Pregnant and lactating patients against covid-19*, The American College of Obstetricians and Gynecologists, https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/12/vaccinating-pregnant-and-lactating-patients-against-covid-19, (last updated Dec. 21, 2020)

[24] MIRA (2020). The Impact of COVID-19 on Immigrants in Massachusetts: Insights from our Community Survey. Written by Marion Davis for the Massachusetts Immigrant and Refugee Advocacy Coalition. Boston, Mass. Available at http://www.miracoalition.org/cvsurvey

[25] *Id.* at 6.

CMS justified the need for this rule by citing states' requests for more flexibility in the interpretation of FFCRA § 6008, citing concerns about cost and a growing backlog of redeterminations. This justification is contradicted by CMS making states' adoption of the new tier approach mandatory- thereby reducing states' flexibility.

Bypassing Transparency Requirements of 1332 Waivers

CMS' interim federal rule allows the "modification" of public notice, comment, and hearing requirements for Section 1332 waiver requests pursuant to the Affordable Care Act, as well as post-award public hearings. However, this provision of the rule conflicts with the statutory requirements of Section 1332 by allowing states and CMS to bypass its transparency requirements. It allows the public notice and comment periods to occur after CMS conducts its federal review or after the state files their application. As a result, and in violation of the statute and congressional intent, state proposals and CMS approvals could proceed with no meaningful stakeholder input. In addition to using 1332 waivers to make health insurance more accessible, states may also use 1332 waivers to opt out of ACA requirements and reduce the public's access to affordable health care. Especially during a public health emergency, it is important to maintain public oversight of states' 1332 waiver requests.

Conclusion

In passing the FFCRA, Congress took unprecedented measures to ensure that Medicaid enrollees can access the services they need during this public health emergency. This IFR violates the letter and spirit of the FFCRA by gutting its MOE protections and putting vulnerable populations at risk of losing critical health benefits during a public health emergency. We urge HHS to withdraw the problematic provisions of this IFR immediately.

Thank you for the opportunity to comment on this important issue. If you have further questions, please contact Kate Symmonds at ksymmonds@mlri.org, or 617-357-0700 ext. 349.

Yours truly,

Kate Symmonds, Health Law Attorney
Massachusetts Law Reform Institute

Hannah Frigand, Director of Education & Enrollment Services
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Greater Boston Legal Services, on behalf of its clients

Andrew Cohen, Supervising Attorney
Alexandra Warren, Equal Justice Works Fellow Co-Sponsored by Merck & Co. and Baker McKenzie
Katherine Purrington, Staff Attorney, Medical-Legal Partnership for Immigrants
Health Law Advocates

This letter is also endorsed by the following Massachusetts organizations:

The Center for Public Representation
Central West Justice Center
Children's HealthWatch
The Conference of Boston Teaching Hospitals
The Disability Law Center
Lawyers for Civil Rights
Massachusetts Immigrant and Refugee Advocacy Coalition
Massachusetts Migrant Education Program, on behalf of the families it serves
Massachusetts Public Health Association
The Medicare Advocacy Project, on behalf of its clients
MetroWest Legal Services