

February 9, 2021

Acting Secretary Norris Cochran
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Secretary Cochran:

As outlined in our respective transition memos, the Medicare Rights Center and the Center for Medicare Advocacy share a commitment to increasing the well-being and economic security of older adults, people with disabilities, and their families through access to high-quality, affordable health care.¹ We write today to urge swift action to strengthen Medicare, Medicaid, and the Affordable Care Act in ways that will advance these goals. Presented below, matters requiring immediate attention include simplifying Medicare transitions during the COVID-19 public health emergency,² enhancing Medicare outreach and enrollment strategies, and intensifying regulatory review efforts.³ Looming deadlines and unmet needs make these improvements urgent.

COVID-19

Older adults and people with disabilities have been among the hardest hit by COVID-19. They have a high risk of infection, serious illness, and even death from the virus,⁴ as well as disproportionate rates of unemployment due to the pandemic's economic fallout.⁵ Despite being eligible for Medicare, some have been unable to connect with their coverage. We urge you to ensure that all Medicare-eligible individuals can access their earned Medicare benefits during this crisis.

Reinstate COVID-19 Medicare Enrollment Flexibilities. If people do not have health insurance or cannot afford to pay for care, they will avoid medical treatment—a dangerous result at the best of times, but especially troubling for public health and the safety of at-risk populations during a pandemic.⁶ CMS acknowledged these realities last year, establishing two critical COVID-19 related Medicare enrollment

¹ Medicare Rights Center, "Policy Recommendations for the Biden Administration" (January 18, 2021), <https://www.medicarerights.org/policy-documents/policy-recommendations-for-the-biden-administration>; Center for Medicare Advocacy, "Transition Memorandum for Biden Administration Department of Health & Human Services (HHS)" (December 2020), <https://medicareadvocacy.org/transition-memo-2020/>.

² Executive Order 13997, "Executive Order on Improving and Expanding Access to Care and Treatments for COVID-19" (January 21, 2021), <https://www.federalregister.gov/documents/2021/01/26/2021-01858/improving-and-expanding-access-to-care-and-treatments-for-covid-19>.

³ Ron Klain, Assistant to the President and White House Chief of Staff, "Memorandum to the Heads of Executive Departments and Agencies: Regulatory Freeze Pending Review" (January 20, 2021), <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/regulatory-freeze-pending-review/>.

⁴ Centers for Disease Control and Prevention, "If You Are at Higher Risk" (last updated January 4, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html>.

⁵ See, e.g., Kenneth Terrell, "Unemployment's Toll on Older Workers Is Worst in Half a Century" (October 21, 2020), <https://www.aarp.org/work/working-at-50-plus/info-2020/pandemic-unemployment-older-workers.html#:~:text=En%20espa%C3%B1ol%20%7C%20During%20the%20first,the%20livelihoods%20of%20older%20adults>; Gina Livermore and Jody Schimmel Hyde, "Workers with Disabilities Face Unique Challenges in Weathering the COVID-19 Pandemic" (May 28, 2020), <https://www.mathematica.org/commentary/workers-with-disabilities-face-unique-challenges-in-weathering-the-covid-19-pandemic>.

⁶ Centers for Disease Control and Prevention, "If You Are at Higher Risk" (last updated January 4, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html>.

flexibilities: Equitable Relief for Premium Part A and Part B;⁷ and a Special Enrollment Period for Part C and Part D.⁸

These coverage pathways have lapsed, but the need for them remains. We continue to hear from Medicare-eligible individuals who have experienced mismanaged Medicare transitions, who are without affordable coverage, and who cannot access benefits for which they qualify under the law. To help people connect with their Medicare at a time when they need it most, we again strongly urge the Centers for Medicare & Medicaid Services (CMS) to reinstate these policies without delay.⁹ They should remain in effect through December 31 of the year the Public Health Emergency (PHE) ends, at a minimum, and coverage should begin no later than the first day of the month following enrollment.

This commonsense change fits within with the administration's *National Strategy for the COVID-19 Response and Pandemic Preparedness*. It would advance several of those cornerstone goals by increasing access to care and treatment for those most at risk.¹⁰ It would also further U.S. Department of Health and Human Services (HHS) compliance with recent White House initiatives that seek to implement that framework. This includes the January 21 *Executive Order on Improving and Expanding Access to Care and Treatments for COVID-19*,¹¹ which directs HHS to "evaluate Medicare...and take any available steps to promote insurance coverage for safe and effective COVID-19 treatments and clinical care," and the January 28 *Executive Order on Strengthening Medicaid and the Affordable Care Act*, which asks HHS to establish a Special Enrollment Period for Marketplace coverage "in light of the exceptional circumstances caused by the ongoing COVID-19 pandemic."¹² We applaud these efforts to facilitate access to coverage and care, and urge the administration not to leave older adults and people with disabilities behind.

Redefine Hospital Inpatient Status to Respond to Harm from "Outpatient" Observation. One of the flexibilities that CMS has employed in order to maintain or increase access to care during the PHE is to allow individuals to qualify for skilled nursing facility (SNF) coverage without having a prior 3-day inpatient hospital stay.¹³ This has enabled many people to access SNF coverage, including those who have had hospital stays that have been classified as "outpatient" observation status, which does not currently count toward the 3-day prior hospital stay requirement. While we recognize that it would

⁷ Centers for Medicare & Medicaid Services, "Enrollment Issues for COVID-19 Pandemic-Related National Emergency Questions and Answers for Medicare Beneficiaries" (last accessed February 1, 2021), <https://www.cms.gov/files/document/enrollment-issues-covid-ab-faqs.pdf>.

⁸ Centers for Medicare & Medicaid Services, "Special Enrollment Period (SEP) for Individuals Affected by a FEMA-Declared Weather-Related Emergency or Other Major Disaster: Applicable for COVID-19" (May 5, 2020), <https://www.cms.gov/files/document/special-enrollment-period-sep-individuals-affected-fema-declared-weather-related-or-other-major.pdf>.

⁹ Medicare Rights Center, Center for Medicare Advocacy, *et al.*, "Letter to CMS on Extending Enrollment Flexibilities" (February 5, 2021), <https://www.medicarerights.org/pdf/020521-letter-on-medicare-enrollment-flexibilities.pdf>.

¹⁰ The White House, "National Strategy for the COVID-19 Response and Pandemic Preparedness" (January 21, 2021), <https://www.whitehouse.gov/wp-content/uploads/2021/01/National-Strategy-for-the-COVID-19-Response-and-Pandemic-Preparedness.pdf>.

¹¹ Executive Order 13997, "Executive Order on Improving and Expanding Access to Care and Treatments for COVID-19" (January 21, 2021), <https://www.federalregister.gov/documents/2021/01/26/2021-01858/improving-and-expanding-access-to-care-and-treatments-for-covid-19>.

¹² See The White House, "Fact Sheet: President Biden to Sign Executive Orders Strengthening Americans' Access to Quality, Affordable Health Care" (January 28, 2021), <https://www.whitehouse.gov/briefing-room/statements-releases/2021/01/28/fact-sheet-president-biden-to-sign-executive-orders-strengthening-americans-access-to-quality-affordable-health-care/>; Executive Order 14009 "Strengthening Medicaid and the Affordable Care Act" (January 28, 2021), <https://www.federalregister.gov/documents/2021/02/02/2021-02252/strengthening-medicare-and-the-affordable-care-act>.

¹³ See, e.g., Centers for Medicare & Medicaid Services, "COVID-19 Emergency Declaration Health Care Providers Fact Sheet" (March. 13, 2020), <https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf>.

likely take Congressional action to permanently extend this waiver, CMS does have the authority to change the interpretation of a qualifying hospital stay through sub-regulatory guidance. In other words, as discussed at length in a Center for Medicare Advocacy memorandum, the Secretary of HHS has authority under the Medicare statute to include a hospital patient's time in observation as hospital inpatient time for purposes of determining whether the patient qualifies for Part A coverage of a subsequent stay in a SNF.¹⁴ Such relief, if pursued, would not be as broad as a waiver of the 3-day requirement altogether, but would help many people who are otherwise barred from SNF coverage due to spending time in the hospital under observation status.

Adopt Telehealth Flexibilities for Speech Generation Devices (SGDs). Our organizations recognize both the promise and perils of expanding telehealth flexibilities beyond the current PHE,¹⁵ and note that certain inequities in the use and access to telemedicine have already been exacerbated during the pandemic.¹⁶ While CMS has adopted an extensive array of telehealth flexibilities during the PHE, it has neglected to include evaluation for prescription of speech generation devices (SGDs) and therapeutic services for use of SGDs, forcing individuals who require SGDs to attend a face-to-face appointment with a clinician during a pandemic when there is a safe and efficacious alternative.¹⁷ We strongly support the use of telehealth with Medicare-covered SGD codes, and urge CMS to treat SGD coverage as equivalent to other telehealth-covered services, effective retroactively to March 1, 2020.

Medicare Outreach and Enrollment

A rapidly aging population, complex Medicare rules and timelines, and an ever-evolving health care landscape mean a growing number of individuals face increasingly difficult Medicare coverage decisions. The administration must act quickly to better empower current and future beneficiaries to make optimal choices, both initially and annually.

Implement the Beneficiary Enrollment Notification and Simplification (BENES) Act. Key provisions of the bipartisan BENES Act were recently signed into law and are set to take effect in 2023.¹⁸ The enacted policies update Medicare enrollment rules to end lengthy waits for coverage, expand critical administrative flexibilities, and inform future policymaking on enrollment period alignment. To ensure these changes are made in a thoughtful and timely manner, we ask the agency to immediately launch a transparent implementation process that engages stakeholders and explores how the new policies can advance health equity goals.

¹⁴ Center for Medicare Advocacy, "CMS has Authority Under Existing Law to Define Inpatient Care" (July 16, 2014), <https://medicareadvocacy.org/cms-has-authority-under-existing-law-to-define-inpatient-care/>.

¹⁵ Center for Medicare Advocacy & Medicare Rights Center, "Joint Principles re: Telehealth" (July 2020), <https://medicareadvocacy.org/joint-principles-from-center-for-medicare-advocacy-and-medicare-rights-center-medicare-expansion-of-telehealth-helps-beneficiaries-access-care-during-the-pandemic-but-caution-is-needed-bef/>.

¹⁶ See, e.g., Center for Medicare Advocacy "Weekly Alert: Study Finds Inequities in Telehealth Care" (January 21, 2021), <https://medicareadvocacy.org/study-finds-inequities-in-telehealth/>.

¹⁷ See, e.g., Center for Medicare Advocacy, "Weekly Alert: Speech Generating Devices: Beneficiary Voices Silenced Once Again by CMS" (January 28, 2021), <https://medicareadvocacy.org/sgds-and-telehealth/>.

¹⁸ "Consolidated Appropriations Act, 2021," P. L. 116-260 (December 27, 2020), <https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf>.

Guarantee Objectivity in Consumer Materials. As our organizations have highlighted, in recent years official Medicare enrollment materials and outreach strategies have often failed to provide objective, neutral information about coverage options, appearing to promote Medicare Advantage over Traditional Medicare.¹⁹ As CMS begins work on 2021 Fall Open Enrollment and other materials, we urge the agency to ensure that all communications are unbiased and accurate.

Regulatory Review

We anticipate that in accordance with the January 20 White House memo, *Regulatory Freeze Pending Review*, HHS is or soon will be reviewing recent and pending rules, guidance, and agency actions for potential changes. As part of that effort, we urge the agency to consider the recommendations below. Where additional rulemaking or congressional action may be needed, we encourage those processes to begin quickly.

Immediately Pause New “Geo” Demonstration Model. We again²⁰ strongly urge you to immediately halt the Direct Contracting “Geo” model aimed at coordinating care and clinical management for people with Traditional Medicare.²¹ We are concerned by the timing of its roll-out and the subsequent rush to implement it, especially amid significant information gaps about how it will work. There is no valid policy or program reason to proceed in a hurried manner, or without ample study and stakeholder feedback.

Immediately Pause New Medicaid Managed Care Organization (MCO)-based Direct Contracting Entity Model. This model would force dually eligible beneficiaries in Traditional Medicare into complex relationships with managed care organizations that they did not choose.²² The model appears to include many of the same troubling features, rushed timeline, and information gaps as the flawed “Geo” model. There is, again, no valid policy or program reason to proceed in a hurried manner, or without ample study and stakeholder feedback.

Rescind New Part D Model Flexibilities. We encourage CMS to rescind the formulary flexibilities it recently extended to plans that participate in the Part D Payment Modernization Model.²³ As analysis of earlier proposals that relax restrictions requiring plans to cover substantially all medications in the six

¹⁹ See, e.g., Medicare Rights Center, Center for Medicare Advocacy, et al., “Joint letter to CMS re: inaccuracies in the draft Medicare & You Handbook for 2019” (May 15, 2018), <https://www.medicarerights.org/policy-documents/letter-to-cms-re-inaccuracies-in-the-draft-medicare-you-handbook-for-2019>; Medicare Rights Center & Center for Medicare Advocacy, “Joint letter to CMS re: education and outreach materials for the current Medicare Annual Coordinated Election Period” (November 16, 2018), <https://www.medicarerights.org/pdf/11.16.18-joint-ltr-cms.pdf>.

²⁰ See Joint Letter Requesting Acting HHS Secretary to Suspend Implementation of Geographic Direct Contracting Model Demonstration from Aging Life Care Association, Center for Medicare Advocacy, Justice in Aging, Medicare Rights Center, National Adult Day Services Association (NADSA), National Association of Social Workers (NASW) and National Council on Aging (NCOA) (January 29, 2021), <https://medicareadvocacy.org/wp-content/uploads/2021/02/Geo-DC-Demo-Sign-On.pdf>.

²¹ Centers for Medicare & Medicaid Services, “CMS Announces New Model to Advance Regional Value-Based Care in Medicare” (December 3, 2020), <https://www.cms.gov/newsroom/press-releases/cms-announces-new-model-advance-regional-value-based-care-medicare> and “Geographic Direct Contracting Model” (December 3, 2020), <https://www.cms.gov/newsroom/fact-sheets/geographic-direct-contracting-model-geo>.

²² Centers for Medicare & Medicaid Services, “Direct Contracting Model: Professional and Global Options Medicaid Managed Care Organization (MCO)-based Direct Contracting Entity (DCE) Fact Sheet” (last visited February 2, 2021), <https://www.cms.gov/newsroom/fact-sheets/direct-contracting-model-professional-and-global-options-medicare-managed-care-organization-mco>.

²³ Centers for Medicare & Medicaid Services, “Part D Payment Modernization Model Calendar Year (CY) 2022 Fact Sheet” (January 19, 2021), <https://www.cms.gov/newsroom/fact-sheets/part-d-payment-modernization-model-calendar-year-cy-2022-fact-sheet>.

protected classes shows, these flexibilities are unlikely to significantly drive down costs and may greatly restrict access, above and beyond the impact of utilization management tools.²⁴

Suspend Expansion of Medicare Home Health Value-Based Purchasing Model (HHVBP). On January 8, 2021, CMS announced plans to expand the HHVBP model. This model, however, discriminates against people with longer term and chronic conditions that are not improving.²⁵ It significantly limits access to home health care for beneficiaries who need it most, and directly conflicts with the *Jimmo v. Sebelius* settlement.²⁶ One major flaw of HHVBP is that it does not provide any meaningful measurement criteria for people who qualify for home health care under the law, but who have an illness or injury that will not improve, or will improve relatively slowly. The HHVBP system does not include quality “points” for home health agencies that help maintain an individual’s on-going condition, or slow decline. As a result, the HHVBP design penalizes agencies that serve people with longer term and chronic conditions by taking payments back from agencies serving people who do not meet the improvement criteria. The HHVBP model should not continue, let alone expand, until quality care for all patients is included in the measurements and policies are developed that provide fair access to care for all qualifying beneficiaries.

Revisit Recent C and D Rules, Including Specialty Tier Flexibilities and Marketing Changes. We urge CMS to reconsider its permission for Part D standalone and Medicare Advantage plans to create two formulary specialty tiers.²⁷ Based on our experience working with people with Medicare, we are concerned this flexibility will create even more confusion and difficulty for beneficiaries, hindering their efforts to find the best plan or access needed medications. Further, we urge CMS to reverse its determination that marketing guidelines for Medicare Advantage supplemental benefits are unnecessary.²⁸ The current lack of such guidance creates an environment in which beneficiary confusion and impermissible plan marketing practices can thrive. In addition, we urge CMS to reverse the extensive revisions made to the Medicare Communications & Marketing Guidelines (MCMG) in 2019 without public input, including the provisions that blur the distinction between education and marketing events.²⁹

Rescind the SUNSET Rule. Proposed on November 4, 2020, the Securing Updated and Necessary Statutory Evaluations Timely (SUNSET) rule would impose an expiration provision on most HHS regulations and establish an onerous review process for the agency to use to determine which rules, if any, should be retained or revised.³⁰ This would lead to chaos for Medicare beneficiaries, providers, and

²⁴ Avalere, “Impact of Protected Class Utilization Management in Medicare Part D” (June 2, 2020), <https://avalere.com/wp-content/uploads/2020/06/Impact-of-Protected-Class-Utilization-Management-in-Medicare-Part-D-.pdf>.

²⁵ Center for Medicare Advocacy, “Weekly Alert: CMS Plans to Expand Program that Interferes with Patient Access to Medicare Covered Home Health Care” (January 14, 2021), <https://medicareadvocacy.org/cms-to-expand-harmful-hh-system/>.

²⁶ Center for Medicare Advocacy, “Improvement Standard and Jimmo News” (last accessed February 2, 2021), <https://medicareadvocacy.org/medicare-info/improvement-standard/>.

²⁷ 86 Fed. Reg. 5864, 5934.

²⁸ 86 Fed. Reg. 5864, 5992.

²⁹ See, e.g., Center for Medicare Advocacy, “Comments to February 2020 CMS Proposed Rule (CMS-4190-P)” (April 6, 2020), <https://www.medicareadvocacy.org/wp-content/uploads/2020/04/CMA-CD-Comments-2020.pdf>; Medicare Rights Center, “Comments on CMS-4190-P: Medicare and Medicaid Programs Contract Year 2021 and 2022” (March 6, 2020), <https://www.medicarerights.org/policy-documents/comments-on-cms-4190-p-medicare-and-medicicaid-programs-contract-year-2021-and-2022>; and Center for Medicare Advocacy “Weekly Alert: Final 2022 Rule for Medicare Parts C and D Released By Trump Administration” (for a discussion of marketing concerns, see, in particular, the Addendum) (February 4, 2021), <https://medicareadvocacy.org/part-c-and-d-rule-analysis/>.

³⁰ RIN 0991-AC24; Docket No. HHS-OS-2020-0012.

payers and would force federal agencies to engage in hundreds of hours of pointless busywork each year, reducing their capacity to manage other, more critical issues, like ensuring access to coverage and care in a pandemic. We oppose this ill-conceived and destructive proposal and ask the administration to withdraw it in its entirety.³¹

Ensure Access to Healthcare.gov. Under the Notice of Benefit and Payment Parameters (NBPP) for 2022³²—and the recently-approved “Georgia Access Model”³³—states may deny their residents access to Healthcare.gov as a one-stop shop for unbiased health insurance information and enrollment, forcing them to rely on private plan and broker sites instead. The NBPP also further reduces Healthcare.gov user fees, which help finance the Marketplace and its consumer safeguards. These harmful shifts would undermine informed decision-making, likely leading to sub-optimal coverage choices and more Americans becoming un- or under-insured. We support swift action to terminate these bad faith policies, as well as a reversal of the 2018 user fee cuts.

Revoke Changes to Medicaid Maintenance of Effort (MOE) Requirements. The Families First Coronavirus Response Act (FFCRA) authorized a temporary 6.2% federal medical assistance percentage (FMAP) increase for states that meet certain MOE conditions.³⁴ CMS originally interpreted those obligations as precluding states from maneuvering people within Medicaid tiers. But the agency recently, and starkly, reversed itself in the fourth COVID-19 Interim Final Rule (IFC).³⁵ Under the new policy, states may move people from one Medicaid eligibility category to another and remain in compliance with the FFCRA MOE, even if those changes restrict the enrollee’s benefits or increase their costs. We oppose this deeply flawed reinterpretation and urge the agency to revert to its previous policy.³⁶

Restore Medicaid Safeguards. Medicaid is a critical source of coverage for many Americans, including over 12 million people with Medicare.³⁷ It has long been associated with a range of positive health behaviors and outcomes, such as better health status; higher rates of preventive health screenings; lower likelihood of delaying care; decreased hospital and emergency department utilization; and lower

³¹ See, e.g., Medicare Rights Center, “Comments on Securing Updated and Necessary Statutory Evaluations Timely (SUNSET) proposed rule” (January 4, 2021), <https://www.medicarerights.org/pdf/010421-comments-sunset-rule.pdf>; Center for Medicare Advocacy, “Weekly Alert: In Waning Days of Trump Administration, HHS Issues Harmful Final Rule Putting an Expiration Date on Core Medicare and Other Regulations” (January 14, 2021), <https://medicareadvocacy.org/harmful-sunset-rule/>.

³² Medicare Rights Center, “Comments on [CMS-9914-P] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations” (December 29, 2020), <https://www.medicarerights.org/pdf/122920-comments-notice-benefit-payment-parameters-2022.pdf>.

³³ Medicare Rights Center, “Comments on Georgia’s modified State Relief and Empowerment Waiver proposal under Section 1332 of the Affordable Care Act (ACA)” (September 16, 2020), <https://www.medicarerights.org/pdf/091620-comments-georgia-proposed-1332-waiver.pdf>.

³⁴ Families First Coronavirus Response Act, 134 STAT. 208, Pub. Law 116-127 Sec. 6008, (March 18, 2020).

³⁵ Centers for Medicare & Medicaid Services, “[CMS-9912-IFC] Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency” (November 11, 2020), <https://www.federalregister.gov/documents/2020/11/06/2020-24332/additional-policy-and-regulatory-revisions-in-response-to-the-covid-19-public-health-emergency>.

³⁶ Medicare Rights Center, “Comments on Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency” (January 4, 2020), <https://www.medicarerights.org/pdf/010421-comments-covid-ifr.pdf>.

³⁷ Centers for Medicare & Medicaid Services, “People Dually Eligible for Medicare and Medicaid” (March 2020), https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf.

mortality rates.³⁸ But beneficiaries must be able to access Medicaid services in order to experience these improvements. Recent policies allowing and even encouraging states to restrict eligibility and benefits have made that much more difficult. We urge the administration to immediately reverse these damaging program changes. This includes the January 2018 “Work and Community Engagement Requirements in Medicaid” guidance³⁹ and the January 2020 “Healthy Adult Opportunity Initiative.”⁴⁰ We also ask the agency to reject pending state waivers that would further those or other impermissible objectives, and to remedy or withdraw any such waivers that may already be in place.⁴¹

Thank you for your consideration. We look forward to working together to advance our shared goals.

Sincerely,

Medicare Rights Center
Center for Medicare Advocacy

CC:

Liz Richter, Acting Administrator, Centers for Medicare & Medicaid Services
Jeff Wu, Acting Principal Deputy Administrator, Centers for Medicare & Medicaid Services and Deputy Director for Policy, Center for Consumer Information and Insurance Oversight
Cheri Rice, Acting Deputy Administrator and Director, Center for Medicare
Jerry Mulcahy, Director, Medicare Enrollment and Appeals Group, Center for Medicare

³⁸ Robert Wood Johnson Foundation, “Medicaid’s Impact on Health Care Access, Outcomes and State Economies” (February 1, 2019), <https://www.rwjf.org/en/library/research/2019/02/medicaid-s-impact-on-health-care-access-outcomes-and-state-economies.html#:~:text=Of%20all%20types%20of%20health,and%20taxes%20paid%20as%20adults.>

³⁹ Centers for Medicare & Medicaid Services, “State Medicaid Director Letter, RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries” (January 11, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>.

⁴⁰ Centers for Medicare & Medicaid Services, “State Medicaid Director Letter, RE: Healthy Adult Opportunity” (January 30, 2020), <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf>.

⁴¹ See, e.g., Center for Medicare Advocacy, Medicare Rights Center, *et al.*, “Joint Comments on TennCare II Demonstration Amendment 42: Modified Block Grant and Accountability” (December 24, 2019), <https://www.medicareadvocacy.org/wp-content/uploads/2020/01/TennCare-Amendment-42-Comments-to-HHS-from-JIA-CMA-MRC-NAELA.pdf>; Medicare Rights Center, “Comments on TennCare Demonstration” (December 27, 2019), <https://www.medicarerights.org/policy-documents/comments-tenncare-demonstration-amendment-42>; Paul Shafer, *et al.*, “Medicaid Retroactive Eligibility Waivers Will Leave Thousands Responsible For Coronavirus Treatment Costs” (May 8, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200506.111318/full/>.