

HIV Health Care Access Working Group

December 6, 2015

The Honorable Sylvia Mathews Burwell, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Burwell,

We are writing on behalf of the HIV Health Care Access Working Group (HHCAWG) – a coalition of over 100 national and community-based HIV service organizations representing HIV medical providers, public health professionals, advocates, and people living with HIV who are all committed to ensuring access to critical HIV-related health care and support services. We appreciate the opportunity to submit comments on the Arizona proposed Section 1115 Medicaid demonstration, the AHCCCS program.

Arizona is the first state to request a waiver to alter implementation of its Medicaid expansion after initially expanding through a state plan amendment. Arizona's uninsured rate has dropped from 20.4 percent to 14.5 percent since health reform's coverage provisions took effect in 2014,¹ and these gains are due in large part to the state's decision to expand Medicaid. The state estimates that, if approved, as many as many as 571,000 current adult Medicaid beneficiaries would be impacted by these changes and be subject to its premium and co-pay obligations, work requirement, and five-year lifetime limit on coverage.

As with all 1115 waivers, states must articulate a sound hypothesis tied to a purpose that would promote the objectives of the Medicaid program. Changes to a state's program should not be approved if the waiver would make it harder for the expansion's target population of non-disabled adults to enroll in and maintain coverage, and obtain critical health services. Put another way, *CMS should reject a proposal that would leave Medicaid expansion beneficiaries worse off than they are in the absence of the requested changes.*

Medicaid is currently a lifeline for at least fifty percent of people with HIV who are in care – a percentage that is growing with the implementation of the Medicaid expansion in many states. Medicaid is an important safety-net program for people living with HIV and/or hepatitis and we must hold firm to the comprehensive coverage standards and critical protections that have been a hallmark of the Medicaid program. In particular, we urge CMS to maintain high standards with respect to:

- Cost Requirements
- Protecting the Medically Frail

¹ Dan Witters, "In U.S., Uninsured Rates Continue to Drop in Most States," *Gallup*, August 10, 2015, <http://www.gallup.com/poll/184514/uninsured-rates-continue-drop-states.aspx>.

- Work Requirements
- Lifetime Limits on Coverage

Premiums and co-pays for adult Medicaid beneficiaries

We strongly urge CMS to prohibit Arizona from enacting onerous premium and cost sharing requirements for beneficiaries. Numerous studies have demonstrated the detrimental effect of premiums and cost-sharing requirements on consumer access to care.² Individuals with HIV are particularly vulnerable to cost-sharing requirements, as they tend to need more services and require more medications than other populations. Increased cost sharing results in decreased medical adherence and increased use of the medical system. Moreover, discouraging individuals living with HIV from seeking treatment will ultimately result in much higher health care costs in the long-term due to the development of more complicated and costly health problems that could have been prevented by early interventions and consistent access to care.

The proposal is vague about what happens to people who miss their premium payments. For those with incomes above the poverty line, the state is proposing to lock them out of coverage for six months, and it appears this lockout would continue for the full time period – even if the person makes their back payments. Locking individuals living with HIV and other chronic, infectious diseases out of coverage will threaten both individual and public health, and we strongly urge CMS to reject this proposal. Furthermore, Indiana was granted authority to test a similar six-month lockout on beneficiaries above the poverty line so there is no reason to allow another state to test the same structure until information from Indiana is gathered and evaluated.

For people with incomes below the poverty line, unpaid premiums would not result in disenrollment, but would be treated as a debt owed to the state. More information is needed on how beneficiaries both above and below the poverty line would be treated if they miss a premium payment since the state only says that its Department of Revenue will determine "how to best operationalize the program" (page 4 of section 3 of the proposal).

We are also concerned about the lack of clarity included in the proposal about cost sharing. It is also unclear how co-pays would be paired with the premium obligations. The proposal says the state would charge copays "up to 3 percent of annual household income," and premiums "up to 2 percent of annual household income" (page 2 of section 3 of the proposal). In his cover letter to the application, Governor Ducey says co-pays will be "strategic" and will be collected if a person visits an emergency room for a non-emergent reason, visits a specialist without getting a referral from a primary care physician, or misses an appointment. Yet the state has also said it intends to charge co-pays "to the maximum extent allowed under federal law" as directed by the legislature," including a \$25 co-pay for non-emergency use of the emergency room that the state seeks under the authority of section 1916(f) of the Social Security Act. A more precise request is needed. Moreover, the state must demonstrate that charging co-payments for

² See, e.g., S. Artiga & M. O'Malley, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences," Kaiser Commission on Medicaid and the Uninsured (May 2005), available at <http://www.kff.org/medicaid/7322.cfm>; and L. Ku & V. Wachino, "The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities (July 7, 2005), available at <http://www.cbpp.org/files/5-31-05health2.pdf>.

particular visits will advance the goals of the Medicaid program. We believe that such a co-payment structure will deter access to medically necessary care and treatment.

Protecting the Medically Frail

We urge CMS to closely monitor Arizona's implementation of federal protections for "Medically Frail," particularly in light of recent federal clarifications to this standard. The federal definition constitutes the floor of who must be considered to be medically frail (and eligible for the traditional Medicaid benefits package), and CMS must ensure that Arizona's definition adequately protects people living with HIV and other chronic, complex conditions. We support use of the Medicaid Health Home eligibility criteria as a federal floor for the definition of medically frail. At a minimum, anyone living with HIV should automatically qualify as medically frail. CMS should require detailed information about state processes to identify and educate the medically frail to ensure that all medically frail enrollees are enrolled in the coverage that best meets their medical needs.

Work Requirements

While "AHCCCS Works" does not require employment for enrollment, it does require "all able-bodied adults" to work, be engaged in a job search, or attend school or a job training program. Work requirements have never been part of Medicaid and will only serve to enact additional barriers to coverage for low-income populations, particularly for individuals living with HIV and other chronic conditions who may be less likely to be able to participate in any kind of work incentive program due to illness.

Lifetime limit for Medicaid eligibility.

The state proposes to impose a five-year lifetime limit on Medicaid eligibility for "able-bodied" adults. Medicaid is a critical part of health reform's continuum of coverage, which assures non-elderly adults access to coverage even if their income fluctuates or their job status changes over time. Moreover, many low-income adults eligible under the Medicaid expansion are working, but don't have access to job-based coverage. This could be especially damaging to people living with long-term, chronic diseases, such as HIV or hepatitis, who could be determined to be "able-bodied," but also need long term care. A time limit on coverage in Medicaid has never been allowed, and Arizona's proposal to terminate coverage after five years should be rejected.

In addition, we are concerned that section 1115 waivers are being used to erode benefits in expansion states. In order to waive federal Medicaid law, the proposed demonstrations set forth in a section 1115 waiver must be consistent with Medicaid objectives, in particular, to extend coverage to low-income and vulnerable populations. Unfortunately, some demonstration proposals seek to change Medicaid guidelines in ways that reduce coverage or restrict eligibility. Specifically, imposing substantial conditions on eligibility like work requirements and higher premiums and co-pays that are not characteristically applied to a low-income population. These types of conditions will limit the scope of Medicaid expansion under the Affordable Care Act. Furthermore, section 1115 demonstrations are supposed to test innovations that are followed by research and study, but in many states 1115 waivers are seen as a political neutral alternative pathway to federal Medicaid funding. While we understand

that section 1115 waivers have enabled states to grow and expand the scope their Medicaid programs, it is essential that HHS do robust evaluation to ensure that the policy outcomes of the waivers are increasing access and assuring quality while not eroding benefits.

HHCAWG sincerely appreciates the opportunity to provide comments on the proposed 340B guidance. Please contact Amy Killelea with the National Alliance of State & Territorial AIDS Directors (akillelea@nastad.org), Andrea Weddle with the HIV Medicine Association (aweddle@hivma.org), or Robert Greenwald with the Treatment Access Expansion Project (rgreenwa@law.harvard.edu) if we can be of assistance.

Respectfully Submitted by the Steering Committee of the HIV Health Care Access Working Group,

AIDS Action Baltimore | AIDS Action Committee of MA | AIDS Alliance for Women, Infants, Children, Youth & Families | AIDS Foundation of Chicago | AIDS Research Consortium of Atlanta | The AIDS Institute | AIDS Project Los Angeles | AIDS Treatment Data Network | AIDS United | American Academy of HIV Medicine | Association of Nurses in AIDS Care | Community Access National Network | Communities Advocating Emergency AIDS Relief (CAEAR) Coalition | Gay Men's Health Crisis | Georgia AIDS Coalition | Harlem United | Health and Disability Advocates | HealthHIV | HIVictorious, Inc. | HIV Medicine Association | HIV Prevention Justice Alliance | Housing Works | Los Angeles LGBT Center | Moveable Feast | National Alliance of State and Territorial AIDS Directors | National Minority AIDS Council | The National Working Positive Coalition | Project Inform | San Francisco AIDS Foundation | South Carolina Campaign to End AIDS | Treatment Access Expansion Project | Treatment Action Group | VillageCare