FEDERAL AIDS POLICY PARTNERSHIP
HIV HEALTH CARE ACCESS WORK GROUP

September 16, 2017

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

Dear Secretary Price:

The HIV Health Care Access Working Group (HHCAWG) appreciates the opportunity to comment on Maine's proposal for a demonstration project under section 1115 of the Social Security Act. HHCAWG is 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- and Hepatitis C-related health care and support services.

The Medicaid program is a critical source of health coverage for life-saving care for people living with HIV in Maine and throughout the United States. More than 40 percent of people living with HIV in care count on the Medicaid program for the healthcare and treatment that keeps them healthy and productive.[1] Maine's longstanding HIV 1115 waiver provides lifesaving care and treatment to people living with HIV with income up to 250% FPL in the state. Ensuring uninterrupted access to effective HIV care and treatment is important to the health of people living with HIV and to public health.[2] When HIV is effectively managed, the risk of transmitting the virus drops to near zero.[3] Maine's proposals imposing additional cost sharing and work requirements on vulnerable populations threaten to reverse the progress in providing early access to prevention, care, and treatment and reducing healthcare costs made throughout the life of the state's HIV 1115 waiver.

We are concerned that Maine's waiver proposal will increase the harm to low-income people living with HIV who depend on the Medicaid program, and we urge CMS to continue to require protections for this population. Our concerns are outlined below.

EVEN NOMINAL PREMIUMS AND COST-SHARING CREATE BARRIERS TO TREATMENT FOR PEOPLE LIVING WITH HIV AND OTHERS WITH CHRONIC CONDITIONS

We support exempting individuals living with HIV from the additional cost sharing requirements of the waiver. However, for the other individuals at risk for HIV or living with another chronic condition, we are

[1] Kates, Jennifer and Lindsey Dawson. Insurance Coverage Changes for People with HIV Under the ACA. Kaiser Family Foundation. February 2017.
[2] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. Available at http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf.
[3] Cohen, MS., et al. Antiretroviral Therapy for the Prevention of HIV-1 Transmission. N Engl J Med 2016; 375:830-839. September 1, 2016.

concerned that increased cost sharing will act as a deterrent to care and treatment. The Maine proposal would require individuals and families with incomes between 51-100% FPL, which is just over $6,000 a year or $500 a month, to pay $10 monthly premiums or risk losing coverage for up to three months. The harmful impact of imposing premiums and cost sharing on low-income individuals is well documented, and was recently analyzed by the Kaiser Family Foundation (KFF). In the KFF report, the authors concluded that people with incomes under 100% of poverty were the most sensitive and affected by premiums.[4] Once people with chronic conditions lose their healthcare coverage they are likely to go without medically necessary care and treatment, and they are likely to get sicker and require costly medical interventions. The impact of premiums on low-income individuals' access to health coverage and services is well documented and does not require further study. While we recognize cost sharing will be limited to a five percent cap, cost sharing of this level is unreasonable and has not and should not be allowed for individuals living on such low income levels.

WORK REQUIREMENTS ARE COUNTER TO THE INTENT OF THE MEDICAID PROGRAM AND THREATEN THE UNINTERRUPTED HEALTH COVERAGE THAT PEOPLE LIVING WITH HIV NEED TO STAY HEALTHY AND PREVENT DISEASE PROGRESSION

We are very concerned by Maine's proposal to impose work requirements of 20 hours per week. We oppose any imposition of work requirements on Medicaid beneficiaries and strongly urge CMS to reject this proposal. Work requirements are not permitted under federal law and do nothing to forward the goals of the Medicaid program. Applying the work requirement to beneficiaries participating in Maine's longstanding HIV waiver is particularly troubling. The state has stated that the goal of the HIV waiver is to "provide more effective and earlier treatment to prevent, reverse, or delay disease progression." However, the new waiver's work requirements would leave low-income people living with HIV who are unable to work with access to only three months of coverage during the year, an access gap that would inevitably reverse the progress in early access to care and treatment under the HIV waiver. Many low-income people with HIV who are able to do so do work, but they often work at low-paying, seasonal or temporary positions. Their healthcare coverage cannot be seasonal or time-limited if they are going to successfully manage HIV and stay healthy so that they are able to work. Nearly eight in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60 percent are working themselves.[5] Of those not working, more than one-third reported that illness or a disability was the primary reason, 28 percent reported that they were taking care of home or family, and 18 percent were in school.[6]

The proposal notes an exemption for individuals "physically or mentally unable to work 20 hours per week." This vague exemption does nothing to address concerns that the work requirements will be applied to populations who, because of their conditions, are unable to work. There is simply no exemption process that would render the work requirements legal under federal law. However, for any exemption included in an 1115 waiver proposal – whether for work requirements or other provisions – we urge CMS to require the state to demonstrate how these individuals will be identified uniformly and fairly (e.g., provider referral, self-identification, and claims data review).

Furthermore, we are deeply concerned about the administrative costs and ability of Maine to effectively implement this provision as intended without unintentionally leaving some Medicaid beneficiaries

[4] Artiga, Samantha, Petry Ubri, and Julia Zur. The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings. KFF. June 1, 2017.
[5] Musumeci, M. Medicaid and Work Requirements. KFF. March 23, 2017.
[6] IBID.

without healthcare coverage despite either being exempt from the work requirements or meeting the requirements, but failing to adequately document and report work-related activities. A significant body of literature and evaluation data from the TANF Program indicates that it is very difficult to implement work requirements and ensure they are applied as intended without causing undue harm.[7] [8]

EMERGENCY DEPARTMENT COPAYMENTS WILL DETER MEDICALLY NECESSARY CARE AND LEAVE SOME MEDICAID BENEFICIARIES SICKER AND IN NEED OF MORE COSTLY CARE

Imposing a co-payment of $10 for an emergency department visit that results in the provision of one of the diagnosis codes defined by the state as "non-emergent" will deter some people living with HIV from accessing treatment when they are most in need. We urge CMS to reject this provision in the Maine application.

Urgent medical situations arise when people living with HIV and others are unable to access medical care from their outpatient medical provider or when their provider recommends that they seek emergency care. If they are unable to obtain the appropriate treatment in a timely manner their condition or infection will worsen and require more intensive medical care, including costly hospitalizations. Laypeople should not be required to judge whether their ultimate diagnosis will be included on the "non-emergent" list or not before seeking emergency care. This policy is short-sighted and will not only harm low income individuals in need of emergency care but will lead to higher medical costs in some cases.

We urge CMS to uphold federal law and the intent of the Medicaid program as it considers Maine's Section 1115 waiver. Please contact Amy Killelea with the National Alliance of State and Territorial AIDS Directors at akillelea@nastad.org, Andrea Weddle at aweddle@hivma.org with the HIV Medicine Association, or Robert Greenwald at rgreenwa@law.harvard.edu with the Center for Health Law and Policy Innovation with questions regarding how people with HIV would be affected by Maine's proposed waiver.

Respectfully submitted by:

ADAP Educational Initiative | AIDS Alabama | AIDS Action Baltimore | AIDS Alliance for Women, Infants, Children, Youth & Families | AIDS Foundation of Chicago | AIDS Research Consortium of Atlanta | AIDS United | American Academy of HIV Medicine | APLA Health | AIDS Resource Center of Wisconsin Community Access National Network (CANN) | Georgia AIDS Coalition | Harm Reduction Coalition | HealthHIV | HIV Medicine Association | Housing Works | Lambda Legal | Legal Council for Health Justice | Michigan Positive Action Coalition | Minnesota AIDS Project | National Alliance of State and Territorial AIDS Directors | National Latino AIDS Action Network | NMAC |National Viral Hepatitis Roundtable | Project Inform | Rocky Mountain CARES | San Francisco AIDS Foundation | SisterLove | Southern AIDS Coalition | Southern HIV/AIDS Strategy Initiative | The AIDS Institute |Treatment Access Group | Treatment Access Expansion Project

[7] LaDonna Pavetti, Michelle Derr, and Emily Sama Martin, "Assisting TANF Recipients Living with Disabilities to Obtain and Maintain Employment: Conducting In-Depth Assessments," Mathematica Policy Research, Inc., February 2008.

[8] LaDonna Pavetti, "Work Requirements Don't Cut Poverty, Evidence Shows," Center on Budget and Policy Priorities, June 2016.