FEDERAL AIDS POLICY PARTNERSHIP
HIV HEALTH CARE ACCESS WORK GROUP

February 7, 2020

Submitted via the Federal Medicaid.gov Portal
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Georgia "Pathways to Coverage" Section 1115 Demonstration Waiver Application

To Whom It May Concern:

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 and hepatitis C-related healthcare and support services. We appreciate the opportunity to provide comments on the Georgia "Pathways to Coverage" Section 1115 Demonstration Waiver Application (the Georgia Application).

The Medicaid program is a critical source of health coverage for life-saving care for people living with HIV. A significant portion (42 percent) of people living with HIV in care count on the Medicaid program for the health care and treatment that keeps them healthy and productive.[1] 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 zero.[3]

While we understand and support the value of work, HHCAWG is concerned about the work requirement, premium contribution, and copayment policies put forth in the Georgia Application. HHCAWG is concerned that Georgia Application would not provide meaningful access to care for many low-income individuals, including people living with HIV, people who do not have HIV but are at risk of exposure, and people living with HCV and other chronic health conditions. For the reasons discussed in detail below, we strongly oppose these facets of

[1] Medicaid and HIV, Kaiser Family Foundation. October 1, 2019.
[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.

Georgia Application and urge the Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS) to reject them.

I. The Georgia Application Violates the Core Objectives of Medicaid

The Georgia Application proposes a community engagement requirement for Medicaid. The Medicaid statute within the Social Security Act (SSA) does *not* allow for states to impose work requirements as a condition for receiving Medicaid benefits. Unlike in the Medicaid statute, the SSA expressly authorizes in other programs, such Temporary Assistance for Needy Family (TANF), for states to terminate beneficiaries' eligibility if they fail to comply with work requirements.[4] This omission of statutory authorization for work requirements is significant because the Medicaid statute *requires* a state plan to provide medical assistance to individuals in enumerated, mandatory eligibility groups.[5] As stated in multiple federal court decisions, this extends to the Medicaid expansion population should a state provide coverage to them.[6] Work requirements are in direct conflict with these requirements.

The Georgia Application should not be approved because work requirements violate the core purpose of Medicaid. Under Section 1115 Waiver Authority of the SSA, the Secretary of Health and Human Services may waive certain Medicaid requirements to the extent necessary to allow for an "experimental, pilot, or demonstration project which, in the judgement of the Secretary," is likely to assist in promoting the objectives of Medicaid.[7] The purpose of Medicaid is to enable states to furnish medical assistance to individuals "whose income and resources are insufficient to meet the costs of necessary medical services."[8] Various federal courts have held that the Secretary of Health and Human Service's decision to grant a Section 1115 Waiver is reviewable under the Administrative Procedure Act (APA),[9] using an "arbitrary and capricious" standard to determine the permissibility of the approval.[10]

In *Stewart v. Azar*, Judge Baosberg of the Federal District Court for the District of Columbia vacated the Secretary's approval of Kentucky HEALTH, a Section 1115 Demonstration Waiver Application.[11] Kentucky HEALTH proposed a work requirement for Medicaid beneficiaries, requiring individuals to work 20 hours a week in order to remain eligible for Medicaid.[12] By the states' own estimate, 95,000 individuals would likely lose Medicaid coverage.[13] Finding "the

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[4] SSA § 1931(b)(3)(A); 42 U.S.C. § 1396u-1(b)(3)(A).
[5] SSA § 1902(a)(10)(A)(i); 42 U.S.C. § 1396a(a)(10)(A)(i); SSA § 1902(a)(10)(B); 42 U.S.C. § 1396a(a)(10)(B).
[6] *See*, *e.g. Stewart v. Azar*, 2018 U.S. Dist. LEXIS 108862 (D. DC. 2018).
[7] 42 U.S.C. § 1315(a).
[8] 42 U.S.C. § 1396.
[9] *See, e.g., Stewart v. Azar,* 2018 U.S. Dist. LEXIS 108862 (D. DC. 2018); *Wood v. Betlach*, No. CV-12-08098, 2013 U.S. Dist. LEXIS 105027 (D. Ariz. July 26, 2013); *Beno v. Shalala*, 30 F.3d 1057, 1066 (9th Cir. 1994).
[10] 5 U.S.C. § 706(2)(A).
[11] *Stewart v. Azar*, 2018 U.S. Dist. LEXIS 108862 (D. DC. 2018).
[12] Kentucky HEALTH (2018) https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa3.pdf
[13] Kentucky HEALTH (2018) https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa3.pdf

secretary [had] paid no attention to that deprivation" and had not adequately considered whether Kentucky HEALTH would "help the state furnish medical assistance to its citizens, a central objective of Medicaid," Judge Boasberg held that the Secretary had erred in approving the plan.[14] This holding affirms that a waiver that does not promote the provision of health care and instead causes substantial coverage loss violates the core purpose of Medicaid and is thus impermissible under Section 1115. A similar holding was reached in reviewing work requirements approved in Arkansas's Medicaid program.[15]

II. The Work Requirements Contemplated by the Georgia Application Will Disproportionately Harm Individuals Living with Chronic Health Conditions

Individuals living with chronic illnesses stand to be disproportionately harmed by the combined effect of these proposals. Many individuals who live with a chronic illness that makes maintaining employment impossible are not considered "disabled" by Medicaid standards, and would be subject to the work requirement. Chronic illnesses can produce symptoms or disabilities that are not visible, yet serve as impediments to steady employment. Additionally, some chronic conditions like multiple sclerosis produce periods of inability to work due to medication side effects or symptom flare-ups; employees with these conditions require flexible work arrangements that can be hard to find or keep. Episodic disabilities can produce an uneven work history, which in turn can make it more difficult for a person to find consistent employment. These burdens particularly affect people living with chronic illnesses or disabilities, as consistent access to medical care is key to the management of symptoms and overall long-term wellness.

Further, while Georgia notes that it will allow for certain "good-cause" exemptions from the work requirements, this does not adequately protect individuals with chronic conditions that need access to care and treatment but cannot maintain employment. Georgia does not even make mention of exempting the "medically frail" from the work requirement, the baseline minimum outlined by CMS in its guidance.[16] Individuals that should not be sanctioned will likely end up penalized given the history of administering exemptions to work requirements in other public benefits programs. The administrative challenges associated with implementing work requirements would be more pronounced in Medicaid than in the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) programs, which have struggled with implementation. SNAP and TANF require substantial interactions with participants, including interviews and frequent reporting. States have encountered numerous obstacles to accurately applying these policies. States' administration of these policies in the SNAP program was error prone, applied inaccurately, and led to eligible individuals being denied benefits. When first implemented, a U.S. Food and Nutrition Service analysis found that policies were "difficult to administer and too burdensome for the States."

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[14] *Stewart v. Azar*, 2018 U.S. Dist. LEXIS 108862 (D. DC. 2018).
[15] *Gresham v. Azar,* 363 F. Supp. 3d 165 (D. DC 2019).
[16] Dear State Medicaid Director, *Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries*, Centers for Medicare & Medicaid Services: https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18002.pdf.

One of the biggest shifts was tracking benefit receipt over time, rather than circumstances in a single month, which was a fundamental change to program administration. Historical analysis of state experience implementing work requirements in TANF suggests that adding similar requirements to Medicaid could cost states thousands of dollars per beneficiary. HHCAWG wants to be clear that while work requirements are not permissible and are illegal under Medicaid, but at a minimum, individuals living with chronic conditions like HIV should be considered exempt from these requirements.

Georgia's application could even end up keeping people from gaining employment, because without health services, it will be more difficult for them to find and hold a job. A report from Ohio Department of Medicaid found that enrollees believed Medicaid made it easier to secure and maintain employment (52.1 percent) as well as, if unemployed, made it easier to look for employment (74.8 percent).[17] In a Michigan report on Medicaid beneficiaries, 69 percent of enrollees indicated Medicaid helped them "do better at work."[18] Similarly, Medicaid coverage has been associated with a reduction in financial stresses, such as by making it easier to buy food and pay rent, which helps individuals focus on finding and keeping jobs.[19] For individuals living with chronic illness and disabilities, enrollment in Medicaid has been shown to increase employment. A recent study found that in states that expanded Medicaid post-ACA, overall employment increased for individuals with disabilities from 41.3 percent to 47 percent.[20] This study also found that individuals were less likely to report not working because of a disability.[21] Overall, the compelling body of literature suggests that increasing Medicaid enrollment "itself acts as a work incentive program"[22] for individuals with disabilities, thus undermining the need for work requirements.

Georgia has not adequately considered the disproportionate effect these harmful policies will have on individuals living with chronic health conditions, despite numerous state comments speaking directly to this issue. It is clear from this Application that Georgia is not adequately protecting the health needs of its most vulnerable citizens.

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[17] The Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," January 2017, http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

[18] Renuka Tipirneni, Jeffrey Kullgren, John Ayanian, Edith Kieffer, Ann-Marie Rosland, Tammy Chang, Adrianne Haggins, Sarah Clark, Sunghee Lee, and Susan Goold, "Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches," University of Michigan, June 2017, http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-orjob-searches.

[19] Jessica Gehr and Suzanne Wikle, "The Evidence Builds: Access to Medicaid Helps People Work, December 2017, https://www.clasp.org/sites/default/files/publications/2017/04/The-Evidence-Builds-Access-to-Medicaid-Helps-People-Work.pdf

[20] Jean Hall, Adele Shartzer, Noelle Kurth, and Kathleen Thomas, "Medicaid Expansion as an Employment Incentive Program for People with Disabilities." American Journal of Public Health, 1236 (2018) https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2018.304536.

[21] Jean Hall, Adele Shartzer, Noelle Kurth, and Kathleen Thomas, "Medicaid Expansion as an Employment Incentive Program for People with Disabilities." American Journal of Public Health, 1235 (2018) https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2018.304536.

[22] Jean Hall, Adele Shartzer, Noelle Kurth, and Kathleen Thomas, "Medicaid Expansion as an Employment Incentive Program for People with Disabilities." American Journal of Public Health, 1235 (2018) https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2018.304536.

III. Conclusion

Georgia's proposal is not only inconsistent with the law and the purpose of Medicaid, it misses the obvious solution to providing coverage to Georgia's low-income residents: Medicaid expansion. Georgia is forefeiting an estimated $45.4 billion over a decade by refusing to expand Medicaid consistent with the Affordable Care Act.[23] With less uncompensated care, hospitals have more stability[24] and cost-sharing can be lowered for people with insurance.[25] Further, evidence has already shown that Medicaid expansion leads to better health outcomes, access, and affordability.[26] In states that expanded Medicaid, HIV testing increased,[27] allowing for earlier detection, treatment, and prevention. In expansion states, fewer people with HIV are uninsured,[28] which is also linked to a lower likelihood of death in the hospital.[29]

HHCAWG appreciates the opportunity to provide comment on the Georgia Application. Our comments include numerous citations to supporting research, including direct links to the research for HHS' benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments and the attached report be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

If you have further questions, please contact HHCAWG co-chairs HHCAWG Co-Chairs Phil Waters with the Center for Health Law and Policy Innovation at pwaters@law.harvard.edu, Amy Killelea with the National Alliance of State and Territorial AIDS Directors at akillelea@nastad.org, or Rachel Klein with The AIDS Institute at rklein@taimail.org.

Respectfully submitted by the undersigned organizations:

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[23] Louise Norris, *Georgia and the ACA's Medicaid Expansion*, HEALTHINSURANCE.ORG (Nov. 4, 2019), https://www.healthinsurance.org/georgia-medicaid/.

[24] *See* Richard C. Lindrooth et al., *Understanding The Relationship Between Medicaid Expansions And Hospital Closures*, 37 HEALTH AFFAIRS 111 (2018) (finding that states that did not expand Medicaid had a higher rate of hospital closures).

[25] *See* Hayes McAlister, *Moving the Needle for Medicaid Expansion in Tennessee Pt. 1*, TENN, JUSTICE CTR. (Jul. 7, 2019), https://www.tnjustice.org/medicaid-expansion-tennessee-important-moving-the-needle/.

[26] *See* Robin Rudowitz & Larisa Antonisse, Implications of the ACA Medicaid Expansion: A Look at the Data and Evidence, KAISER FAMILY FOUND. (May 23, 2018), https://www.kff.org/medicaid/issue-brief/implications-of-the-aca-medicaid-expansion-a-look-at-the-data-and-evidence/.

[27] *See* Yunwei Gai & John Marthinsen, *Medicaid Expansion, HIV Testing, and HIV-Related Risk Behaviors in the United States, 2010–2017*, 109 AM. J. PUBLIC HEALTH 1404, 1407 (2019) (finding a 3.22% increase in HIV test rates for Medicaid expansion states compared to non-expansion states).

[28] *See Medicaid's Role for Individuals with HIV*, KAISER FAMILY FOUND. (Apr. 18, 2017) https://www.kff.org/infographic/medicaids-role-for-individuals-with-hiv/ (finding that in expansion states, the percentage of uninsured individuals with HIV in care decreased from 14% in 2012 to 7% in 2014).

[29] Fred J. Hellinger, *In Four ACA Expansion States, the Percentage of Uninsured Hospitalizations for People With HIV Declined, 2012–14*, 34 HEALTH AFFAIRS 2061 (2015) (finding that in four expansion states, hospitalizations of uninsured patients with HIV fell from 13.7% to 5.5%, while in two nonexpansion states, hospitalizations of uninsured patients with HIV increased from 14.5% to 15.7%; and finding that patients with HIV who were uninsured were 40% more likely to die in the hospital).

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