FEDERAL AIDS POLICY PARTNERSHIP
HIV HEALTH CARE ACCESS WORK GROUP

March 21, 2020

The Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Proposed Extension of Healthy Indiana Plan Section 1115 Demonstration Project

Dear Secretary Azar,

The HIV Health Care Access Working Group (HHCAWG) appreciates the opportunity to comment on Indiana's proposal for a ten-year extension of the Healthy Indiana Plan (HIP) (the "Indiana Extension") 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.

Medicaid is a critical source of health coverage for people living with HIV. Forty-two percent of adults living with HIV are covered by Medicaid, compared to just 13% of the general population.[1] These individuals rely on the Medicaid program for the healthcare and treatment that keeps them healthy and productive. Ensuring uninterrupted access to effective HIV care and treatment is also important to public health goals. When HIV is effectively managed, the risk of transmitting the virus drops to zero.[2]

For the reasons discussed in detail below, we oppose the Indiana Extension. Particularly, we believe that a 10-year extension is impermissible, and that the core components of the HIP demonstrations cannot and should not be renewed.

I. Section 1115 demonstrations cannot be extended for 10 years

[1] *Medicaid and HIV*, KAISER FAMILY FOUND. (Oct. 1, 2019), https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/.
[2] Myron S. Cohen et al., *Antiretroviral Therapy for the Prevention of HIV-1 Transmission*. 375 NEW ENG. J. MEDICINE, 830 (2016).

Indiana proposes to extend the HIP demonstration for 10 years. CMS clearly does not have statutory authority to approve this extension. The Social Security Act states in two separate provisions that Section 1115 demonstrations may only be extended for up to 3 years.[3]

Though CMS has claimed that certain "routine, successful, non-complex" demonstrations could be extended for up to 10 years at a time,[4] this interpretation is not reasonable, and it contradicts the unambiguous text of the statute.

Even if CMS's interpretation would stand, HIP is far from "routine, successful, [and] non-complex." HIP comprises a complicated web of member contributions, tobacco surcharges, co-pays, work requirements, annual account rollovers, plan switching, benefit waivers, and reporting requirements covering 5 different health plans for over half a million people. Several of its components, like the new Workforce Bridge Account, are not routine. Likewise, premiums appear to be unsuccessful, and the Gateway to Work program and tobacco surcharges have not been implemented long enough to be evaluated, let alone prove success. Indiana claims that its extension is warranted "[d]ue to the long standing and proven core features of HIP and the minimal changes made in the 2018 approval."[5] But the addition of work requirements, premium tiering, and tobacco surcharges in the 2018 approval are certainly not "minimal," and Indiana's own independent evaluations do not show a track record of success.

For these reasons, we believe that HHS cannot and should not approve the 10-year Indiana Extension.

II. Key components of HIP cannot be renewed

A. HIP's work requirements cannot be extended

Indiana proposes to extend its community engagement requirements in HIP for 10 years, despite the fact that they are impermissible under 1115, ineffective, and already problematic.

First, work requirements are not a valid demonstration under Section 1115, because they do not promote the objectives of Medicaid. Section 1115(a) allows waivers for "any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives" of Medicaid. The core objective of Medicaid is "to furnish… medical assistance;"[6] or as the D.C. Circuit Court recently put it, the "principal objective of Medicaid is

[3] Social Security Act § 1115(e)(2), 42 U.S.C. § 1315(e)(2) ("the State . . . may submit to the Secretary a written request for an extension, of up to 3 years"); Social Security Act § 1115(f)(6), 42 U.S.C. § 1315(f)(6) ("An approval of an application for an extension of a waiver project under this subsection shall be for a period not to exceed 3 years").
[4] BRIAN NEALE, DIR., CTR. FOR MEDICAID & CHIP SERVS., U.S. CTR. FOR MEDICARE & MEDICAID SERVS., CMCS INFORMATIONAL BULLETIN: SECTION 1115 DEMONSTRATION PROCESS IMPROVEMENTS (Nov. 6, 2017), https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib110617.pdf.
[5] IND. FAMILY & SOC. SERVS. ADMIN., RENEWAL REQUEST FOR THE HEALTHY INDIANA PLAN (HIP) SECTION 1115 WAIVER (PROJECT NUMBER 11-W-00296/5) 43 (Jan. 31, 2020).
[6] Social Security Act § 1901, 42 U.S.C. § 1396.

providing health care coverage."[7] The court affirmed, by vacating HHS's approval of the Arkansas Works program,[8] that work requirements do not promote this objective.

In order to approve a Section 1115 demonstration, "the Secretary must address whether it creates a risk that beneficiaries will lose their Medicaid coverage."[9] Indiana's own proposal, however, admits that work requirements will create such a risk. Indiana's calculations indicate that 25% of enrollees will lose coverage, or about 24,000 individuals every year.[10] Thus, Indiana's community engagement requirements will likely be struck down in pending litigation.[11] In the face of this legal challenge, it is inappropriate to renew these work requirements and the rest of the HIP program for an additional 10 years.

Second, work requirements are ineffective and detrimental to beneficiary health. While community engagement may be associated with better health, it does *not* follow that working leads better health outcomes. On the contrary, individuals who are healthy and have access to health care are able to focus on finding and keeping employment. Penalizing unemployed individuals by dropping their Medicaid coverage will only make it more difficult for them to find and hold a job.

Likewise, work requirements are likely to be ineffective at increasing employment. Most adults on Medicaid are already working, and most of those who are not have significant barriers to work.[12] A robust body of research shows that Medicaid work requirements would fail to increase long-term employment or reduce poverty.[13] Instead, work requirements will cause individuals to lose coverage, even if they do complete the necessary work or qualify for an exemption.

Work reporting requirements are burdensome for both individuals and the state. Though we recognize that people living with HIV may qualify for an exemption as medically frail,[14] we are concerned that the complexity involved in tracking and applying exemptions will likely cause some individuals to erroneously lose coverage.[15] Examples from other public benefits programs like Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy

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[7] *Gresham v. Azar*, No. 19-5094 2020 U.S. App. LEXIS 4751, at *12 (D.C. Cir. Feb. 14, 2020).
[8] *See Gresham v. Azar*, No. 19-5094 2020 U.S. App. LEXIS 4751, at *24 (D.C. Cir. Feb. 14, 2020).
[9] *Philbrick v. Azar*, 397 F. Supp. 3d. 11, 23 (D.D.C. 2019).
[10] *See* IND. FAMILY & SOC. SERVS. ADMIN., AMENDMENT REQUEST TO HEALTHY INDIANA PLAN (HIP) SECTION 1115 WAIVER EXTENSION APPLICATION (PROJECT NUMBER 11-W-00296/5) Attach. A at 11 (Jul. 20, 2017).
[11] *See* Complaint, Rose v. Azar, 1:19-cv-02848 (D.D.C. filed Sept. 23, 2019).
[12] *See* Rachel Garfield et al., *Understanding the Intersection of Medicaid and Work: What Does the Data Say?*, KAISER FAM. FOUND. (Aug. 8, 2019), https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/.
[13] *See* LaDonna Pavetti, *Work Requirements Don't Cut Poverty, Evidence Shows*, CTR. ON BUDGET & POL. PRIORITIES (June 6, 2016), https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows.
[14] *See Conditions That May Qualify You as Medically Frail*, IND. FAMILY & SOC. SERVS. ADMIN., https://www.in.gov/fssa/hip/2465.htm.
[15] *See* Rachel Garfield et al., *Understanding the Intersection of Medicaid and Work: What Does the Data Say?*, KAISER FAM. FOUND. (Aug. 8, 2019), https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/.

Families (TANF) shows that states often make mistakes and end up sanctioning beneficiaries that are not formally subject to the work requirements.[16]

Third, Indiana's attached HIP evaluation provides no data to indicate work requirements' potential success, but already contains data suggesting problems. Since enforcement has been postponed due to pending litigation,[17] there are no data on the biggest concern of work requirements: coverage loss.[18] However, less than 1% of individuals who would be required to report their working hours have done so.[19] This low reporting rate could be an indicator of problems with access, awareness, or the requirements themselves, and suggests that many individuals would fail to report hours once enforcement takes effect. According to the evaluation, about 30% of members interviewed did not even know if they were required to report hours.[20] The report also raised concerns about members' ability to comply with reporting requirements if they do not have phone or email.[21] Indiana is aware of these problems, but has done nothing to address them. Instead, Indiana asks to continue the program as is for another 10 years. Approving an extension for so long is not only impermissible, but also irresponsible.

Therefore, HHS cannot approve the work requirement component of the Indiana Extension.

B. HIP's premiums and cost-sharing structure cannot be extended

Indiana provides two main types of plans: HIP Plus, which requires premiums; and HIP Basic, which provides fewer benefits and requires co-payments. Indiana is seeking to extend this arrangement, as well as to modify premiums and co-pays without HHS approval. However, Indiana's independent evaluation shows that premiums and co-pays are contributing to disenrollment. Therefore, HHS cannot renew the member payment structure of HIP as a demonstration that promotes the objectives of Medicaid.

Repeated reports from Indiana's independent evaluation group have shown that HIP premiums are causing people to lose coverage. In the most recent report, the Lewin Group found that HIP Plus disenrollments had increased from 23% (79,667 individuals) in 2016 to 32% (125,495 individuals) in 2018.[22] Rather than promoting the goal of "providing health care coverage,"[23] the HIP Plus plan is moving away from it. While 76% of members had continuous HIP Plus coverage in 2015, only 60.5% of members had continuous coverage in 2018.[24]

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[16] *See, e.g.*, USDA OFF. OF INSPECTOR GENERAL, FNS CONTROLS OVER SNAP BENEFITS FOR ABLE-BODIED ADULTS WITHOUT DEPENDENTS (2016), https://www.usda.gov/oig/webdocs/27601-0002-31.pdf; Gayle Hamilton et al., *National Evaluation of Welfare-to-Work Strategies: How Effective Are Different Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs*, MANPOWER DEMONSTRATION RESEARCH CORP. Table 13.1 (2001).
[17] *See* IND. FAMILY & SOC. SERVS. ADMIN., RENEWAL REQUEST FOR THE HEALTHY INDIANA PLAN (HIP) SECTION 1115 WAIVER (PROJECT NUMBER 11-W-00296/5) 23 (Jan. 31, 2020).
[18] *See* LEWIN GRP., HEALTHY INDIANA PLAN INTERIM EVALUATION REPORT 107 (Dec. 18, 2019).
[19] *See* LEWIN GRP., HEALTHY INDIANA PLAN INTERIM EVALUATION REPORT 89 (Dec. 18, 2019).
[20] *See* LEWIN GRP., HEALTHY INDIANA PLAN INTERIM EVALUATION REPORT 96 (Dec. 18, 2019).
[21] *See* LEWIN GRP., HEALTHY INDIANA PLAN INTERIM EVALUATION REPORT 100 (Dec. 18, 2019).
[22] *See* LEWIN GRP., HEALTHY INDIANA PLAN INTERIM EVALUATION REPORT 157 (Dec. 18, 2019).
[23] *Gresham v. Azar*, No. 19-5094 2020 U.S. App. LEXIS 4751, at *12 (D.C. Cir. Feb. 14, 2020).
[24] *See* LEWIN GRP., HEALTHY INDIANA PLAN INTERIM EVALUATION REPORT 149 (Dec. 18, 2019).

These coverage losses can be directly attributed to premiums. The Lewin Group's previous analysis indicated that out of about 195,000 individuals faced with premiums in 2015 and 2016, 57,189 (about 29%) were disenrolled or not enrolled due to nonpayment at least once.[25] The main reason for failing to pay was affordability. Indiana recognized as early as 2014 that premiums as low as $5 will lead to disenrollment for very low-income individuals.[26] Yet it has continued to impose premiums at all income levels.

Even if individuals can afford to pay, premiums impose an additional administrative barrier that can lead to disenrollment. Among members who missed or have never made HIP premium payments, "confusion about the payment process" is cited as the second-most common concern.[27] In the state comment process, Indiana was made aware of (but did not address) concerns about premium changes throughout the year and other member barriers.[28]

Losing Medicaid coverage is not trivial — for many individuals, especially people living with HIV, Medicaid is a lifeline. Health coverage increases access to regular care and management,[29] which is critical for patients with chronic health conditions like HIV.[30] In Indiana, the Lewin Group has shown that patients who lost HIP coverage were less likely to fill prescriptions or to make appointments for routine and specialty care.[31] For individuals living with HIV, appointment and prescription disruptions can harm both individual and public health. Individuals that receive regular treatment and are virally suppressed cannot transmit HIV.[32] Ensuring access to care, therefore, decreases downstream health care costs.

Indiana's co-pay requirements are already deterring access to care, even with coverage superficially intact. In HIP Basic, the percentage of members who received any medical services has decreased from 82% in 2015 to 73% in 2018, while almost all HIP Plus members received medical services.[33] Extensive research shows that cost-sharing, even at levels less than $5, deter use of necessary care.[34] In Indiana, it appears that the presence of co-pays have deterred utilization of all types of health care — even preventive care services, for which cost-sharing

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[25] *See* LEWIN GRP., HEALTHY INDIANA PLAN 2.0: POWER ACCOUNT CONTRIBUTION ASSESSMENT ii (Mar. 31, 2017).
[26] *See* IND. FAMILY & SOCIAL SERVS. ADMIN., HIP 2.0 1115 WAIVER APPLICATION 28, (July 2, 2014).
[27] *See* LEWIN GRP., HEALTHY INDIANA PLAN 2.0: POWER ACCOUNT CONTRIBUTION ASSESSMENT 19 (Mar. 31, 2017).
[28] *See* IND. FAMILY & SOC. SERVS. ADMIN., RENEWAL REQUEST FOR THE HEALTHY INDIANA PLAN (HIP) SECTION 1115 WAIVER (PROJECT NUMBER 11-W-00296/5) 39 (Jan. 31, 2020).
[29] *See* Benjamin D. Sommers et al., *Health Insurance Coverage and Health — What the Recent Evidence Tells Us*, 377 NEW ENG. J. MED. 586 (2017).
[30] *See, e.g.*, Brian W. Ward, *Barriers to Health Care for Adults with Multiple Chronic Conditions: United States, 2012–2015*, 275 NAT'L CTR. H. STATISTICS DATA BRIEF 1 (2017).
[31] *See* LEWIN GRP., HEALTHY INDIANA PLAN 2.0: POWER ACCOUNT CONTRIBUTION ASSESSMENT 21 (Mar. 31, 2017).
[32] *See* Robert W. Eisinger et al., *HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittable*. 321 JAMA 451, 451 (2019).
[33] *See* LEWIN GRP., HEALTHY INDIANA PLAN INTERIM EVALUATION REPORT 46 (Dec. 18, 2019).
[34] See, e.g., Samantha Artiga, Petry Ubri & Julia Zur, *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings*, KAISER FAM. FOUND. ISSUE BRIEF (June 2017); Amitabh Chandra, Jonathan Gruber, & Robin McKnight, *The Impact of Patient Cost-Sharing on Low-Income Populations: Evidence from Massachusetts*, 33 J. HEALTH ECONOMICS 57–66 (2014).

does not apply.[35] Indiana itself acknowledges that co-pays are likely the cause of decreased health care utilization,[36] but still seeks to renew the co-pay structure for 10 years.

It is clear that the payment structure of HIP does not promote the objectives of Medicaid. Under HIP Plus, people are losing coverage; and under HIP Basic, people have the pretext of coverage but are discouraged from using it. Medicaid's premium and cost-sharing prohibitions for low-income beneficiaries exist for a reason, and it is time that they be put back in place. The HIP demonstration has continued for long enough. HIP has served to demonstrate that premiums and co-pays reduce coverage and access to care. It would be unnecessary, irresponsible, and impermissible under Section 1115 to renew the HIP demonstration after such evidence has come to light.

It should also be noted that the HIP payment structure is impermissible as it potentially violates civil rights laws. The evaluation included in the Indiana Extension suggests that HIP premiums are contributing to racial disparities in enrollment, which would violate Title VI of the Civil Rights Act of 1964.[37] Title VI prohibits any program receiving federal funds from discriminating on the basis of race.[38] As racially discriminatory motives are difficult to prove, the Supreme Court has recognized and allowed evidence of racially disparate impacts as violating Title VI.[39] In addition, numerous federal agencies, including HHS, have promulgated disparate impact regulations under Title VI. HHS's regulations state that:

> [I]n determining the types of services, financial aid, or other benefits, or facilities which will be provided under any such program, or the class of individuals to whom, or the situations in which, such services, financial aid, other benefits, or facilities will be provided under any such program, or the class of individuals to be afforded an opportunity to participate in any such program, may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin.[40]

Indiana's evaluation suggests that HIP premiums are unacceptably subjecting communities of color to a lower quality of health insurance, or preventing them from accessing insurance altogether. HIP Plus members who were black were significantly more likely to be disenrolled due to non-payment, or dropped to HIP Basic coverage, than non-Hispanic white members.[41] Additionally, when compared to the population of Indiana residents potentially eligible for HIP by income, HIP members were less likely to be Hispanic.[42] Indiana has not yet investigated the burdens, like premiums, that might be disproportionately preventing communities of color from

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[35] *See* LEWIN GRP., HEALTHY INDIANA PLAN INTERIM EVALUATION REPORT 30 (Dec. 18, 2019).
[36] *See* IND. FAMILY & SOC. SERVS. ADMIN., RENEWAL REQUEST FOR THE HEALTHY INDIANA PLAN (HIP) SECTION 1115 WAIVER (PROJECT NUMBER 11-W-00296/5) 42 (Jan. 31, 2020).
[37] 42 U.S.C. § 2000d et seq.
[38] 42 U.S.C. § 2000d et seq.
[39] *See, e.g., Lau v. Nichols*, 414 U.S. 563 (1974).
[40] 45 C.F.R. § 80.3(b)(2).
[41] *See* LEWIN GRP., HEALTHY INDIANA PLAN INTERIM EVALUATION REPORT 154 (Dec. 18, 2019).
[42] *See* LEWIN GRP., HEALTHY INDIANA PLAN INTERIM EVALUATION REPORT 26 (Dec. 18, 2019).

enrolling or staying enrolled in HIP. These disproportionate effects on communities of color as compared to white communities indicate that the HIP premium requirement acts in a racially discriminatory way to restrict access to health care. HHS should not approve an extension of a waiver with such disproportionate effects on communities of color

C. HIP's waiver of non-emergency medical transportation services should not be extended

Indiana has been allowed to waive the non-emergency medical transportation (NEMT) benefit for most enrollees, and proposes to extend this waiver for 10 years. This extension is unreasonable and should not be approved.

NEMT has long been a required Medicaid benefit,[43] due to the recognition that the Medicaid population has unique needs. While Medicaid benefits for the ACA expansion population are allowed to mirror private health insurance plans in many aspects, HHS has explicitly required states to include NEMT as a wraparound benefit.[44] In Indiana's case, HHS only granted an NEMT waiver on a 1-year time-limited basis, for a specific experimental purpose.[45] Now, after multiple delays, that experiment is completed, and there is no reason to extend the waiver any further — much less 10 years further.

Indiana has previously claimed that its experiment showed that NEMT services did not improve member access to services.[46] Previous commenters have pointed out the numerous fallacies in this claim.[47] What Indiana's experiment *did* show is that transportation is still a barrier to health care for HIP enrollees. Transportation contributed to missing an appointment for 25% of enrollees with the NEMT benefit and 32% of enrollees without NEMT.[48] Further, members who had the peace of mind of knowing NEMT was available to them were more likely to make an appointment for care.[49]

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[43] *See* 42 C.F.R. § 431.53.
[44] *See* 42 C.F.R. § 440.390.
[45] *See* Letter from Marilyn Tavenner, Adm'r, U.S. Ctrs. for Medicare & Medicaid Servs., to Joseph Moser, Medicaid Dir., Ind. Family & Soc. Servs. Admin. (Jan 27, 2015).
[46] *See* IND. FAMILY & SOC. SERVS. ADMIN., HEALTHY INDIANA PLAN (HIP) SECTION 1115 WAIVER EXTENSION APPLICATION 21 (Jan. 31, 2017).
[47] *See, e.g.*, Nat'l Health Law Program, Comment Letter on Healthy Indiana Plan 2.0 - Non-Emergency Medical Transportation (NEMT) (Sept. 11, 2016), https://public.medicaid.gov/gf2.ti/af/328098/39809/PDF/-/NHeLP_INCommentsNEMT09112016.pdf; Ind. Legal Servs., Inc., Comment Letter on Healthy Indiana Plan 2.0 - Non-Emergency Medical Transportation (NEMT) (Sept. 11, 2016), https://public.medicaid.gov/gf2.ti/af/328098/39805/PDF/-/Indiana_Legal_Services_NEMT_comments_91116_1.pdf; Joan Alker & Judy Solomon, Comment Letter on Healthy Indiana Plan 2.0 - Non-Emergency Medical Transportation (NEMT) (Sept. 8, 2016), https://public.medicaid.gov/gf2.ti/af/328098/39781/PDF/-/Indiana_NEMT_Waiver_Comments_0908.pdf.
[48] *See* LEWIN GRP., INDIANA HIP 2.0: EVALUATION OF NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) WAIVER 17 (Nov. 2, 2016).
[49] *See* LEWIN GRP., INDIANA HIP 2.0: EVALUATION OF NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) WAIVER 12 (Nov. 2, 2016).

NEMT is an important benefit for Medicaid enrollees. Transportation-based barriers disproportionately affect vulnerable populations like low-income individuals, older adults, women, minorities, and individuals living with chronic conditions.[50] Due to transportation-related difficulties, roughly 3.6 million Americans each year miss or delay essential medical care,[51] resulting in a sicker, more costly population. NEMT allows patients to access crucial health services, thereby improving health outcomes via a cost-effective (and often directly cost-saving)[52] intervention.[53] Additionally, NEMT is a vital benefit for programs like HIP covering the Medicaid expansion population. Expansion adults are roughly 50% more likely to use NEMT to access preventive services than other Medicaid enrollees.[54]

NEMT is particularly important for patients with chronic illnesses, whose regular care is vital to keeping them healthy.[55] Individuals with chronic conditions are particularly likely to miss appointments or delay care due to transportation barriers.[56] Because chronic diseases require ongoing management to prevent the escalation of symptoms, this trend can have a negative impact on patient health outcomes.[57] Systematic reviews have found that greater travel burdens are associated with later diagnosis, less appropriate treatment, and worse health outcomes;[58] and that transportation supports like NEMT improve overall health outcomes.[59] While we appreciate that the NEMT waiver does not apply to medically frail enrollees, including people living with HIV, we believe that NEMT should be available for all who need it.

As indicated by studies in Indiana and around the country, NEMT is a crucial Medicaid benefit that HIP enrollees should be able to access. Further extension of the HIP NEMT waiver is unwarranted.

Conclusion

We appreciate the opportunity to provide comments on the Indiana Extension. 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

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[50] *See* P. HUGHES-CROMWICK ET AL., TRANSPORTATION RESEARCH BD., NAT'L ACAD. OF SCI., ENG'G, & MED., COST-BENEFIT ANALYSIS OF PROVIDING NON-EMERGENCY MEDICAL TRANSPORTATION 4–5, 10–12 (2005).
[51] *See* Richard Wallace et al., *Access to Health Care and Nonemergency Medical Transportation: Two Missing Links*, 1924 TRANSPORTATION RESEARCH RECORD: J. TRANSPORTATION RESEARCH BOARD 76, 79 (2005).
[52] *See* P. HUGHES-CROMWICK ET AL., TRANSPORTATION RESEARCH BD., NAT'L ACAD. OF SCI., ENG'G, & MED., COST-BENEFIT ANALYSIS OF PROVIDING NON-EMERGENCY MEDICAL TRANSPORTATION 2 (2005).
[53] *See generally* P. HUGHES-CROMWICK ET AL., TRANSPORTATION RESEARCH BD., NAT'L ACAD. OF SCI., ENG'G, & MED., COST-BENEFIT ANALYSIS OF PROVIDING NON-EMERGENCY MEDICAL TRANSPORTATION 4–5, 10–12 (2005).
[54] *See* MaryBeth Musumeci & Robin Rudowitz, *Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers*, KAISER FAM. FOUND. ISSUE BRIEF 3 (2016).
[55] *See 1115 Waiver Element: NEMT*, FAMILIES USA, https://familiesusa.org/1115-waiver-element-nemt/.
[56] *See* P. HUGHES-CROMWICK ET AL., TRANSPORTATION RESEARCH BD., NAT'L ACAD. OF SCI., ENG'G, & MED., COST-BENEFIT ANALYSIS OF PROVIDING NON-EMERGENCY MEDICAL TRANSPORTATION 12–13, 27–28 (2005).
[57] *See* Samina T. Syed et al., *Traveling Towards Disease: Transportation Barriers to Health Care Access*, 38 J. COMMUNITY HEALTH 976, 989 (2013).
[58] *See* Massimo Ambroggi et al., *Distance as a Barrier to Cancer Diagnosis and Treatment: Review of the Literature*, 20 ONCOLOGIST 1378, 1379–82 (2015).
[59] *See* Laura E. Starbird et al., *A Systematic Review of Interventions to Minimize Transportation Barriers Among People with Chronic Diseases*, 44 J. COMMUNITY HEALTH 400–11 (2019).

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.

For the reasons described above, we urge HHS to reject the Indiana Extension in order to ensure that the 1115 waiver program promotes, rather than undermines, the objectives of the Medicaid program, and that vulnerable populations retain access to crucial medications and health care services. Please contact 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 with any questions.

Respectfully submitted by the undersigned organizations:

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 | Bailey House, Inc. | Black AIDS Institute |Center for Health Law and Policy Innovation | Communities Advocating Emergency AIDS Relief (CAEAR) | Community Access National Network (CANN) | Georgia AIDS Coalition | Harm Reduction Coalition | HealthHIV | HIV Medicine Association | Housing Works | 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 | National Working Positive Coalition| NMAC | Positive Health Solutions of the University of Illinois | Positive Women's Network - USA | San Francisco AIDS Foundation | SisterLove | Southern AIDS Coalition | The AIDS Institute | Treatment Access Expansion Project | Treatment Action Group | Thrive Alabama | Vivent Health