February 3, 2022

Submitted via the Federal Medicaid.gov Portal

The Honorable Xavier Becerra, Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

RE: MassHealth 1115 Demonstration Extension Request

Dear Secretary Becerra,

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 health care and support services. We are writing regarding Massachusetts' Section 1115 Demonstration extension request and offer the following comments.

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 thirteen percent of the general population.[1] Ensuring access to effective HIV care, treatment, and supports through the Medicaid program is important to the health of people living with HIV and to public health. When HIV is effectively managed and individuals stay engaged in treatment and virally suppressed, there is no risk of sexual transmission.[2] HHCAWG writes to express our support for a number of MassHealth's innovative proposals to address health equity. We also write to express our concern that continuation of Massachusetts' retroactive eligibility waiver threatens to undermine access to care for people living with HIV.

1. **CMS should approve Massachusetts' proposals to further health equity**

HHCAWG strongly supports MassHealth's commitment to achieving greater health equity, including through: (a) providing pre-release coverage to individuals incarcerated in state Departments of Correction (DOC) and County Correctional Facilities (CCF), (b) providing

[1] *Medicaid and HIV*, KAISER FAMILY FOUND. (Oct. 1, 2019), https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/.
[2] R. Eisinger, C. Dieffenbach, A. Fauci, *HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittable*, 321 JAMA 451 (2019), doi:10.1001/jama.2018.21167.

continuous coverage for people experiencing homelessness and for justice-involved individuals, and (c) expanding housing supports and other social supports through enhancement of the Flexible Services Program.

These bold initiatives hold significant potential to reduce health disparities, address health-related social needs, and improve access to coverage and care for individuals living with HIV. These initiatives are also consistent with CMS' stated policy priorities around coverage and access, equity, and innovation and whole person care.[3]

A. Pre-Release Coverage for Justice-Involved Individuals

We support MassHealth's proposal to extend Medicaid coverage to individuals in state and local correctional facilities 30-days prior to release.

Health insurance coverage is a critical resource for justice-involved individuals living with HIV. Individuals in carceral settings are 5 to 7 times more likely to have HIV than the general population.[4] Many people learn of their HIV diagnosis for the first time while they are in prison or jail.[5] Furthermore, HIV infection in carceral settings reflects the same racial disparities that we see both in the HIV epidemic more broadly and in the criminal justice system; Black men are 5 times more likely to be diagnosed with HIV in prison compared to white men.[6] Unfortunately, continued access to HIV care post-release is often inadequate because of poor linkage to care, resulting in poor health outcomes over time.[7] And although Massachusetts has made efforts to improve continuity of care post release, gaps remain.

Appropriate access to care during and following incarceration, especially in the initial weeks and months following release, is crucial. People are in a period of significant transition and the likelihood of disruption is high. Despite Medicaid being, as explained by the Department's Assistant Secretary for Planning and Evaluation (ASPE) "a key source of coverage for this high needs, high risk population, facilitating access to much needed physical and behavioral health services,"[8] justice-involved individuals face complex barriers to accessing care upon release. Medicaid enrollment and coverage reinstatement delays, difficulties establishing care, and challenges relaying medical histories are common. Health risks are further exacerbated by difficulties meeting basic health-related social needs, such as housing. Research shows that newly-

[3] Chiquita Brooks-LaSure and Daniel Tsai, *A Strategic Vision for Medicaid and the Children's Health Insurance Program (CHIP)*, HEALTH AFFAIRS BLOG, November 16, 2021.
[4] *Prisons and Jail*, THE CENTER FOR HIV LAW AND POLICY, https://www.hivlawandpolicy.org/issues/prisons-and-jails.
[5] *Id*.
[6] Shufang Sun, Natasha Crooks, Rebecca Kemnitz & Ryan P. Westergaard, Re-entry experiences of Black men living with HIV/AIDS after release from prison: Intersectionality and implications for care, 211 Social Science & Medicine 78 (2018), doi: 10.1016/j.socscimed.2018.06.003.
[7] Benjamin Ammon, et al., *HIV Care After Jail: Low Rates of Engagement in a Vulnerable Population*, 95 J OF URBAN HEALTH 488 (2018), doi:10.1007/s11524-018-0231-0; David Alain Wohl & David Loren Rosen, *Inadequate HIV care after incarceration: case closed*, 5 THE LANCET E64 (2018), doi:10.1016/s2352-3018(17)30210-2.
[8] JHAMIRAH HOWARD, ET AL., ASPE ISSUE BRIEF: THE IMPORTANCE OF MEDICAID COVERAGE FOR CRIMINAL JUSTICE INVOLVED INDIVIDUALS REENTERING THEIR COMMUNITIES, 6 (2016), https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//146076/MedicaidJustice.pdf.

released individuals with HIV present to emergency rooms in far higher numbers than the general population, for reasons that may be preventable through outpatient care.[9]

Extending Medicaid coverage to incarcerated individuals 30-days prior to release has the potential to improve continuity of care post release in a number of ways.

First, access to pre-release coverage provides the opportunity to resolve administrative issues that come up during the enrollment or reinstatement process. MassHealth has in place a process for paper applications to be completed and submitted up to 30 days prior to the release date with a specific cover letter for that purpose available to correctional facilities. However, the actual determination is not made until the date of release. Thus, the applicant, and those who assisted with the application, only learn of problems that may prevent a favorable determination until after the individual is released. Pre-release enrollment allows for early resolution of these problems and provides the opportunity for approval of any prior authorizations necessary for post-release care, to effectively arrange access to services in advance, and to otherwise minimize harmful disruptions.

Pre-release coverage will also allow transitions of care to be streamlined and immediate. Currently, MassHealth eligibility and enrollment for individuals in state and local correctional facilities are at best "suspended" during incarceration, queued up for a determination upon release, or limited to an inpatient hospital benefit. This delay makes it almost impossible for social workers, correctional personnel, or health care providers offering in-reach services in cooperation with one or more of the facilities or family members to arrange services on the day of release or shortly thereafter, resulting in post-release disruptions in care which can be detrimental for individuals with HIV. Relatedly, pre-release coverage encourages a stronger likelihood of engagement in care post-release, because community providers and care coordinators will have the opportunity to establish a relationship with members and have access to the information they need from correctional providers.

Pre-release coverage may also allow HIV-negative individuals access to critical prevention tools, like pre-exposure prophylaxis (PrEP), that are not otherwise available in correctional settings. As of 2019, HIV prevention medication had not been integrated into any correctional setting.[10] Research suggests, however, that people leaving prison may be especially vulnerable to HIV infection.[11] Moreover, the recent market approval of a long-acting injectable HIV prevention medication improves the ability to reduce risk of HIV acquisition in preparation for reentry.

Pre-release coverage has the potential to greatly improve continuity of care for individuals living with HIV post-release. We encourage CMS to approve this proposal.

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[9] Alfredo G. Puing, Xilong Li, Josiah Rich & Ank E. Nihawan, *Emergency department utilization by people living with HIV released from jail in the US South*, 8 HEALTH & JUSTICE (2020), doi:10.1186/s40352-020-00118-2.
[10] Lauren Brinkley-Rubinstein, et al., *The Path to Implementation of HIV Pre-exposure Prophylaxis for People Involved in Criminal Justice Systems*, 15 CURR HIV/AIDS REP 93 (2018), doi:10.1007/s11904-018-0389-9.
[11] Jack Stone, et al., *Incarceration history and risk of HIV and hepatitis C virus acquisition among people who inject drugs: a systematic review and meta-analysis*, 18 LANCET INFECT. DIS. 1397 (2018), doi:10.1016/S1473-3099(18)30469-9.

B. Continuous Coverage for People Experiencing Homelessness and Justice-Involved Individuals

We support MassHealth's proposals to provide 24-months continuous coverage to individuals identified as experiencing homelessness and 12-months continuous coverage post-release to justice-involved individuals. Continuous coverage for these populations is a critical tool to improve continuity of and engagement in care.[12] As MassHealth acknowledges in its request, "churning" of eligible individuals in and out of coverage is a long-standing problem. This is especially true for individuals with HIV, where interruptions in HIV treatment can lead to negative health outcomes.[13]

Income volatility is common in the MassHealth program. In 2017, 34% of those terminating their coverage through the Massachusetts Health Connector were individuals transitioning to MassHealth, and 31% of new Health Connector enrollees were transitioning from MassHealth.[14] Medicaid recipients with chronic health conditions, including HIV, who undergo changes in coverage experience higher emergency department utilization, increased acute care costs, increased uncompensated care costs, and overall worse health outcomes.[15]

Both justice-involved individuals and people experiencing homelessness are significantly more likely than the general public to be living with HIV and, furthermore, to experience challenges related to accessing and remaining engaged in care.[16] For these reasons, improved access to coverage and continuity of care are urgently needed. We encourage CMS to approve these proposals to expand access to continuous coverage.

C. Expansion of Social Supports

We are supportive of MassHealth's proposals to expand housing supports for people experiencing homelessness who do not meet the federal definition for chronically homeless and people facing eviction related to disability status. Research shows that housing is a critical determinant of health; housing instability and homelessness create barriers to health care access, to medication

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[12] Bradley Corallo, Rcahel Garfield, Jennifer Tolbert & Robin Rudovitz, *Medicaid Enrollment Churn and Implications for Continuous Coverage Policies*, KAISER FAMILY FOUND. (Dec. 14, 2021), https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/.

[13] *See Discontinuation or Interruption of Antiretroviral Therapy*, HIV.GOV (Apr. 8, 2015), https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/discontinuation-or-interruption-antiretroviral-therapy ("[Discontinuation of ART can result in] viral rebound, acute retroviral syndrome, increased risk of HIV transmission, decline of CD4 count, HIV disease progression, development of minor HIV-associated manifestations such as oral thrush or serious non-AIDS complications (e.g., renal, cardiac, hepatic, or neurologic complications), development of drug resistance, and the need for chemoprophylaxis against opportunistic infections as a result of CD4 decline.").

[14] D. NELSON & J. RUSHAKOFF. MASSACHUSETTS' REMAINING UNINSURED: WHO THEY ARE AND HOW TO COVER THEM, 26 (2019), https://www.hks.harvard.edu/sites/default/files/degree%20programs/MPP/files/PAE%20Final%20-%20Nelson%20Rushakoff%20NO%20LOGO%20NO%20NAME.pdf.

[15] X. Ji, et al., *Discontinuity of Medicaid Coverage: Impact on Cost and Utilization among Adult Medicaid Beneficiaries with Major Depression*, 55 MED. CARE 735 (2017), doi:10.1097/MLR.0000000000000751; J.C. Rusley, et al., *Discontinuity of Medicaid Coverage Among Young Adults with HIV*, 33 AIDS PATIENT CARE AND STDS 89 (2019), doi:10.1089/apc.2018.0272.

[16] Kinna Thakarar, Jake R. Morgan & Mari-Lynn Drainoni, *Homelessness, HIV, and Incomplete Viral Suppression*, 27 J HEALTH CARE POOR UNDERSERVED 145 (2016), doi:10.1353/hpu.2016.0020; *supra* n. 4.

management, and to health outcomes.[17] This is particularly true for people living with HIV. A systematic literature review found that 94% of studies associated worse HIV medical care outcomes among those who were homeless, unstably housed, or inadequately housed compared to "housed" people with HIV, and 93% found worse rates of adherence to antiretroviral treatment among those who were homeless or unstably housed.[18] Of the 13 studies that examined emergency room and inpatient visits among people with HIV, all found higher rates of emergency visits or inpatient stays among those who were homeless or unstably housed.[19] MassHealth's proposal to expand access to housing support can have a meaningful impact on the well-being and health of individuals living with HIV in Massachusetts.

Additionally, we support the continuation and enhancement of MassHealth's Flexible Services Program, which provides targeted, evidence-based, nutrition and housing support to MassHealth enrollees. In addition to the impact of housing on access to HIV care and treatment outcomes, discussed above, access to nutritious foods is critical support overall health and immune health in people living with HIV.[20]

We encourage CMS to approve MassHealth's proposals to expand access of social supports to MassHealth enrollees.

2. CMS should reject Massachusetts' proposal to waive retroactive eligibility

HHCAWG strongly opposes the Commonwealth's continued elimination of three-month retroactive coverage for the majority of the MassHealth population.

Although three-month retroactive coverage is available to all Medicaid beneficiaries under federal law,[21] MassHealth has significantly reduced the retroactive eligibility period for most members through its 1115 waiver, such that most MassHealth members are only allowed ten days of retroactive coverage.[22] This waiver, which was originally conceived as an experimental demonstration project, has been in place in some form since 1997. This waiver has served as a critical barrier to coverage, in a way that is inconsistent with the goals of the Medicaid program.[23] Although we support MassHealth's proposal to reinstate three-month retroactive coverage for pregnant women and children, the entire MassHealth population needs to have this protection.

Without retroactive coverage, Medicaid beneficiaries forgo vital health care and/or incur significant medical expenses. Continuity of care and continued medication adherence are critically important for individuals living with HIV. By eliminating the opportunity for retroactive coverage,

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[17] *Housing Instability*, HEALTH PEOPLE.GOV, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/housing-instability.
[18] Angela A. Aidala, et al., *Housing Status, Medical Care, and Health Outcomes Among People Living With HIV/AIDS: A Systematic Review*, 106 AM J PUB HEALTH e1, e5 (2016), doi:10.2105/AJPH.2015.302905.
[19] *Id*.
[20] *HIV and Nutrition and Food Safety*, HIVINFO.NIH.GOV (August 31, 2021), https://hivinfo.nih.gov/understanding-hiv/fact-sheets/hiv-and-nutrition-and-food-safety.
[21] 42 U.S.C. § 1396a(a)(34).
[22] *MassHealth Medicaid Section 1115 Demonstration Waiver List*, Centers for Medicare and Medicaid Services (Oct. 23, 2018), https://www.mass.gov/doc/1115-masshealth-demonstration-waiver-waiver-list-10-23-18-0/download.
[23] Eliminating retroactive coverage subverts the objectives of the Medicaid Act because it "by definition, reduce[s] coverage". *Stewart v. Azar*, 313 F. Supp. 3d 237, 265 (D.D.C. 2019).

beneficiaries may face gaps in their health care coverage that prevent them from maintaining the care that they need, putting their health at risk.[24]

In states where retroactive eligibility opportunities have been waived under Section 1115, newly Medicaid-eligible individuals have been saddled with COVID-19-related expenses that otherwise would have been covered by their Medicaid program.[25] When Indiana received permission to waive retroactive coverage in 2015, CMS required the state to continue to provide some retroactive coverage to parents and caretaker relatives. Among those who took advantage of this opportunity, retroactive coverage covered an average of $1,561 per person, an amount that most people with low incomes are unable to afford on their own.[26] Retroactive coverage is a lifeline for low-income people who rely on Medicaid to cover prohibitively expensive medical costs. For individuals with HIV, antiretroviral therapy and necessary health care appointments can cost thousands of dollars a month, without insurance.[27]

Same-day initiation of treatment for HIV after diagnosis is the gold standard in care, but that may not happen if a patient has to worry about whether costs will be covered because the state has removed retroactive coverage. Without access to retroactive coverage, individuals with HIV may avoid necessary care, resulting in potentially severe health consequences. Eliminating retroactive coverage also causes providers to stop providing care to individuals who are eligible for Medicaid but have not enrolled.[28] As a result, low-income individuals experience a substantial delay in receiving necessary services.[29]

For these reasons, we strongly urge CMS to reject MassHealth's proposal to continue its waiver of retroactive eligibility.

We have included numerous citations to supporting research, including internet links. We direct CMS to each of the materials we have cited, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If CMS is not planning to

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[24] *See* Lindsey Dawson & Jennifer Kates, *Insurance Coverage and Viral Suppression Among People with HIV, 2018*, KAISER FAMILY FOUND. (Sept. 24, 2020), https://www.kff.org/hivaids/issue-brief/insurance-coverage-and-viral-suppression-among-people-with-hiv-2018/ ("[S]ustained viral suppression rates varied by payer, and were higher among those with private insurance or Medicare, compared to the uninsured.").

[25] *See* Paul Shafer, Nicole Huberfeld & Ezra Golberstein, *Medicaid Retroactive Eligibility Waivers Will Leave Thousands Responsible For Coronavirus Treatment Costs*, HEALTH AFFAIRS (May 8, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200506.111318/full/ (finding that newly-eligible Medicaid beneficiaries often experience circumstantial delays accessing coverage, exactly at the moment when they need coverage most).

[26] Letter from Vikki Wachino, Dir., Ctr. for Medicaid & CHIP Servs., to Tyler Ann McGuffee, Ins. & Healthcare Policy Dir., Office of Governor Michael R. Pence (July 29, 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf.

[27] *See Cost Considerations and Antiretroviral Therapy*, HIV.GOV (Jun. 3, 2021), https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/cost-considerations-and-antiretroviral-therapy.

[28] *Supra* n. 13.

[29] *See, e.g.,* Jessica Schubel, Ctr. on Budget & Policy Priorities, *Ending Medicaid's Retroactive Coverage Harms Iowa's Medicaid Beneficiaries and Providers*, OFF THE CHARTS (Nov. 9, 2017), https://www.cbpp.org/blog/ending-medicaids-retroactive-coverage-harms-iowas-medicaid-beneficiaries-and-providers.

consider these materials part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies and articles into the record.

Thank you for the opportunity to provide feedback and for your thoughtful consideration of these comments. If you have further questions, please reach out to HHCAWG co-chairs Maryanne Tomazic (mtomazic@law.harvard.edu) with the Center for Health Law and Policy Innovation and Rachel Klein (rklein@taimail.org) with The AIDS Institute.

Respectfully submitted by the undersigned organizations:

AHF
AIDS Alabama
AIDS Alliance for Women, Infants, Children, Youth & Families
AIDS Foundation Chicago
American Academy of HIV Medicine
APLA Health
Center for Health Law and Policy Innovation
Community Access National Network - CANN
Community Research Initiative, Inc. (CRI)
HealthHIV
HIV Dental Alliance
HIV Medicine Association
iHealth
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