



November 7, 2022

*Submitted via the Federal Regulations.gov Portal*

Chiquita Brooks-LaSure  
Administrator, Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

**RE: Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes RIN 0938-AU00**

Dear Administrator Brooks-LaSure,

We are writing on behalf of the Federal AIDS Policy Partnership - HIV Health Care Access Working Group (“HHCAGW”) and allied organizations. HHCAGW 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. We are writing to express our support for the Centers for Medicare and Medicaid Services’ (“CMS”) Notice of Proposed Rulemaking regarding Streamlining the Medicaid, Children’s Health Insurance Program (“CHIP”), and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes (“NPRM”).

Many people living with HIV rely on Medicaid as a main source of coverage. Forty-two percent of adults living with HIV are covered by Medicaid, compared to just 13% of the general population.<sup>1</sup> Ensuring access to effective HIV care, treatment, and support through the Medicaid program is critical 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.<sup>2</sup> HHCAGW therefore supports the provisions of the NPRM that make it easier for people living with and at risk of HIV to enroll in and maintain their eligibility for Medicaid and CHIP, particularly the proposals to align non-MAGI enrollment and renewal

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<sup>1</sup> Kaiser Family Foundation, *Medicaid and HIV* (Oct. 1, 2019), available at: <https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/>.

<sup>2</sup> 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.

processes with current MAGI rules, to implement required steps that state Medicaid agencies must take when responding to beneficiary mail that has been returned as undeliverable, and to allow noninstitutionalized beneficiaries who qualify under the medically needy regulations to estimate medical expenses that are reasonably constant and predictable.

### **1. Facilitating Medicaid enrollment and minimizing coverage gaps improves health outcomes for people with HIV and reduces the risk of HIV transmission.**

Broadly speaking, HHCAGW supports the proposals in the NPRM that aim to simplify Medicaid eligibility to better ensure that eligible individuals can enroll and remain enrolled. Medicaid is the largest source of health insurance for people living with HIV, and the number of Medicaid beneficiaries living with HIV has increased over time as people with HIV are living longer and people continue to be newly diagnosed with HIV.<sup>3</sup> HIV also disproportionately affects lower income people, people with lower educational attainment, people of color, sexual minorities,<sup>4</sup> and people who lack secure and stable housing.<sup>5</sup> Thus, changes to the Medicaid eligibility rules that make it simpler and easier for people to enroll in and remain on Medicaid are especially important to support people living with HIV and to promote greater equity in access to health care.

HHCAGW particularly supports changes to the rules that will reduce Medicaid churn, which occurs when Medicaid beneficiaries enroll, disenroll, and reenroll in Medicaid within short periods of time, resulting in coverage gaps. Research has linked churn with care disruptions such as having to change doctors, skipping medication doses, or stopping prescription medications, and with overall decline in health and in quality of medical care.<sup>6</sup> Adults who lose Medicaid coverage are more likely to defer medical care, lessening their use of preventive and primary care services, and to have more emergency room visits.<sup>7</sup>

Avoiding these types of coverage gaps and care interruptions is critical for people living with HIV, who usually take daily medication called antiretroviral therapy (ART).<sup>8</sup> When taken as prescribed, ART can suppress viral load, prevent disease progression, and reduce the risk of transmission.<sup>9</sup>

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<sup>3</sup> Kaiser Family Foundation, *Medicaid and HIV* (Oct. 1, 2019), <https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/>.

<sup>4</sup> Jennifer Pellowski et al., *A pandemic of the poor: social disadvantage and the U.S. HIV epidemic*, 68 *American Psychologist* 197 (2013) <https://doi.org/10.1037/a0032694>.

<sup>5</sup> Kinna Thakrar et al., *Homelessness, HIV, and Incomplete Viral Suppression*, 27 *Journal of Health Care for the Poor and Underserved* 145 (2016), <https://perma.cc/W8RH-CZBP>.

<sup>6</sup> Ben Sommers et al., *Insurance Churning Rates for Low-Income Adults Under Health Reform: Lower than Expected But Still Harmful for Many*, 35 *Health Affairs* 1816 (2016), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0455>.

<sup>7</sup> S. Sugar, et al., Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic* (Apr. 12, 2021), <https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf>; Ritesh Banerjee et al., *Impact of discontinuity in health insurance on resource utilization*, 10 *BMC Health Serv Res.* 195 (2010), doi: [10.1186/1472-6963-10-195](https://doi.org/10.1186/1472-6963-10-195).

<sup>8</sup> Centers for Disease Control and Prevention, *What is HIV Treatment?* (2021), available at: <https://www.cdc.gov/hiv/basics/livingwithhiv/treatment.html>.

<sup>9</sup> See, e.g., National Institute of Allergy and Infectious Diseases, *10 Things to Know About HIV Suppression*, <https://www.niaid.nih.gov/diseases-conditions/10-things-know-about-hiv->

But ART non-persistence – defined as not taking ART for at least two consecutive days – has precarious effects on health, including higher mortality and morbidity rates.<sup>10</sup>

In addition to threatening the health of people living with HIV, Medicaid coverage gaps impede access to prevention for people at risk of HIV. One of the best ways to prevent HIV acquisition is with pre-exposure prophylaxis (“PrEP”).<sup>11</sup> When used as prescribed, PrEP reduces the risk of contracting HIV from sex by about 99%,<sup>12</sup> and Medicaid generally covers PrEP.<sup>13</sup> However, many people at risk for HIV do not yet take it, and its use is less common among people at particularly high risk, including people of color and transgender people.<sup>14</sup> A key barrier that prevents people from taking PrEP is lack of insurance coverage.<sup>15</sup> Moreover, for PrEP to be maximally effective, patients must adhere to their dosing regimen and persist with treatment throughout periods of high HIV risk.<sup>16</sup> When Medicaid beneficiaries lose coverage or experience coverage gaps, they may lose access to PrEP or otherwise interrupt their regimen, placing them at increased risk of acquiring HIV.

## **2. HHCAGW supports provisions in the NPRM that will simplify Medicaid eligibility, facilitate enrollment, and reduce churn.**

HHCAGW supports the many provisions of the NPRM that aim to reduce administrative burdens on Medicaid and CHIP beneficiaries and decrease the likelihood of churn. The provisions related to aligning non-MAGI renewal processes with MAGI requirements, establishing minimum standards for state responses to returned mail, and allowing noninstitutionalized spenddown beneficiaries to estimate reasonably constant and predictable medical expenses are especially promising for people living with and at risk of HIV. HHCAGW therefore urges CMS to include these provisions in the Final Rule and to require states to implement them as early as feasible given the impending unwinding of the public health emergency.

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[suppression#:~:text=NIAID%2Dsupported%20research%20has%20demonstrated,to%20an%20HIV%2Dnegative%20partner.](#)

<sup>10</sup> Marya Gwadz, et al., *Stopping, Starting, and Sustaining HIV Antiretroviral Therapy: a Mixed-Methods Exploration Among African American/Black and Latino Long-Term Survivors of HIV in an Urban Context*, 21 *BMC Public Health* 419 (2021), <https://doi.org/10.1186/s12889-021-10464-x>.

<sup>11</sup> Centers for Disease Control and Prevention, *How effective is PrEP?*, <https://www.cdc.gov/hiv/basics/prep/prep-effectiveness.html>.

<sup>12</sup> *Id.*

<sup>13</sup> Assistant Secretary for Planning and Evaluation, Office of Health Policy, *Access to Preventive Services without Cost-Sharing: Evidence from the Affordable Care Act* (January 11, 2022), <https://aspe.hhs.gov/sites/default/files/documents/786fa55a84e7e3833961933124d70dd2/preventive-services-ib-2022.pdf>. Under the Affordable Care Act, Medicaid expansion enrollees are entitled to preventive services such as PrEP without cost-sharing; in traditional Medicaid, states are encouraged to offer preventive services to beneficiaries through increased federal funds. *Id.*

<sup>14</sup> Centers for Disease Control and Prevention, *PrEP for HIV Prevention in the U.S.*, <https://www.cdc.gov/nchstp/newsroom/fact-sheets/hiv/PrEP-for-hiv-prevention-in-the-US-factsheet.html>.

<sup>15</sup> L. Garrison & J. Harberer, *Pre-exposure Prophylaxis Uptake, Adherence, and Persistence: A Narrative Review of Interventions in the U.S.*, 61 *American Journal of Preventative Medicine* S73 (2021), <https://doi.org/10.1016/j.amepre.2021.04.036>.

<sup>16</sup> Ya-Lin A. Huang, et al., *Persistence with Human Immunodeficiency Virus Pre-exposure Prophylaxis in the United States, 2012–2017* (2022), 72 *Clinical Infectious Diseases* 379, <https://DOI: 10.1093/cid/ciaa037>.

A. *We strongly support CMS’s proposal to align enrollment and renewal requirements for non-MAGI beneficiaries with MAGI policies.*

HHCAWG strongly supports the provisions of the NPRM that aim to simplify enrollment, eligibility, and renewal processes for non-MAGI beneficiaries—namely those who qualify for Medicaid based on age, blindness, or disability—by allowing them to benefit from streamlined eligibility rules that already apply to MAGI-based Medicaid beneficiaries. Currently, states are required to accept a single, streamlined application through several different modalities (including online, by phone, by mail, or in person) for applicants seeking MAGI-based Medicaid, and applicants may not be required to attend an in-person interview.<sup>17</sup> MAGI-based beneficiaries also receive prepopulated renewal forms, have at least 30 days to return the forms, and are entitled to reconsideration if they return the forms late but within 90 days of termination.<sup>18</sup> In addition, MAGI-based beneficiaries cannot be required to attend in-person interviews for renewal, and renewals can only be conducted on an annual basis.<sup>19</sup> However, non-MAGI beneficiaries are not yet entitled to these simplifications, such that some of the most medically vulnerable Medicaid beneficiaries, including those with disabilities, remain subject to greater administrative burdens than MAGI-based beneficiaries despite being more likely to have stable incomes.

HHCAWG therefore supports CMS’s proposal to extend the aforementioned rules to non-MAGI beneficiaries to reduce procedural barriers to enrollment and renewal that can result in loss of coverage. As discussed above, maintaining consistent health insurance is especially critical for people living with HIV, so eliminating unnecessary administrative barriers to Medicaid coverage is crucial. Moreover, people living with HIV often face challenges to complying with onerous administrative requirements to maintain enrollment. People living with HIV have reported finding the enrollment and renewal process burdensome, even with assistance from case managers and social workers, and have expressed wishing that the process was shorter and less frequent.<sup>20</sup> HIV is also disproportionately concentrated among populations that are more likely to struggle to comply with complex enrollment and renewal processes, such as those with lower educational attainment<sup>21</sup> or without stable housing.<sup>22</sup> In addition, in-person interview requirements pose particular barriers to enrollment and renewal, as many individuals living with HIV lack access to transportation.<sup>23</sup> These transportation concerns are elevated in more rural areas; for example, AIDS

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<sup>17</sup> 42 C.F.R. § 435.907.

<sup>18</sup> 42 C.F.R. § 435.916(a).

<sup>19</sup> *Id.*

<sup>20</sup> Kathleen A. McManus et al., *Patient Perspective of People with HIV Who Gained Medicaid Through Medicaid Expansion: A Cross-Sectional Qualitative Study*, 38 *AIDS Research and Human Retroviruses* 580 (2022), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9297321/>. Even those who already benefit from policies that apply to MAGI-based Medicaid have reported experiencing enrollment-related stress, especially at the time of recertification. Lindsey Dawson et al., *The ACA and People with HIV: An Update* (May 2016), <https://www.hivlawandpolicy.org/sites/default/files/The%20ACA%20and%20People%20with%20HIV-%20An%20Update.pdf>.

<sup>21</sup> Jennifer Pellowski et al., *A pandemic of the poor: social disadvantage and the U.S. HIV epidemic*, 68 *American Psychologist* 197 (2013) <https://doi.org/10.1037/a0032694>.

<sup>22</sup> Kinna Thakkar et al., *Homelessness, HIV, and Incomplete Viral Suppression*, 27 *Journal of Health Care for the Poor and Underserved* 145 (2016), <https://perma.cc/W8RH-CZBP>.

<sup>23</sup> Lynda M. Sagrestano et al., *Transportation Vulnerability as a Barrier to Service Utilization for HIV-positive Individuals*, 26 *AIDS Care* 314 (2014), <https://www.tandfonline.com/doi/abs/10.1080/09540121.2013.819403?journalCode=caic20>

Alabama, which provides navigator and Medicaid enrollment assistance, notes that the vast majority of their appointments with Medicaid applicants occur telephonically or require a navigator to travel to a location geographically accessible to the applicant.

Given the barriers that people living with HIV face to maintain Medicaid eligibility and their heightened need for consistent coverage—coupled with the fact that most Medicaid beneficiaries living with HIV qualify through a disability pathway<sup>24</sup>—simplifying enrollment and renewal processes for non-MAGI beneficiaries is an urgently needed step to improve access to health care for this population. HHCAGW therefore urges CMS to finalize and promptly implement its proposal to align non-MAGI enrollment and renewal requirements with current MAGI rules.

*B. We strongly support CMS's proposed rules to establish actions states must take in response to returned mail.*

Pre-COVID-19, Medicaid beneficiaries faced a number of administrative barriers in redetermination processes, including termination of coverage due to lost mail or mail received past the beneficiary's redetermination paperwork due date. This issue is particularly relevant for Medicaid beneficiaries who are people of color, since they experience housing inadequacy and unaffordability at disproportionate rates,<sup>25</sup> and for people living with HIV, who are disproportionately likely to lack stable housing.<sup>26</sup>

These administrative barriers in the Medicaid redetermination process have real-life impacts on beneficiaries. For example, pre-COVID-19, the AIDS Foundation Chicago ("AFC") assisted a single adult in Chicago who went to an emergency room with extreme dizziness after being unable to access his necessary blood pressure medication. He had lost his Medicaid coverage because he did not timely receive his redetermination paperwork, and as a result had been unable to fill his prescription. He had also received no notice from Medicaid explaining why he was terminated, and it took about two months for the advocate assisting him to determine what had happened and to get him reenrolled in Medicaid. His emergency room visit may have been avoided had he timely received his redetermination paperwork, and had there been systems in place to prevent loss of coverage due to mailing errors, which, for many Medicaid beneficiaries, may be outside their control.

Therefore, we support CMS' proposals to create minimum standards for actions that States must take in response to returned mail. For example, we fully support the proposal that States be required to check for updated mailing address information in existing and reliable data sources, such as the

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<sup>24</sup> Kaiser Family Foundation, *Medicaid and HIV* (Oct. 1, 2019), <https://www.kff.org/hiv/aids/fact-sheet/medicaid-and-hiv/>.

<sup>25</sup> Compare Bradley Corallo, Kaiser Family Foundation, *Housing Affordability, Adequacy, and Access to the Internet in Homes of Medicaid Enrollees* (Sept. 22, 2021) <https://www.kff.org/medicaid/issue-brief/housing-affordability-adequacy-and-access-to-the-internet-in-homes-of-medicaid-enrollees/> (discussing the prevalence of various indicators of housing inadequacy and unaffordability among different racial and ethnic groups of Medicaid beneficiaries) with MACPAC, *Medicaid and CHIP Data Book* (Dec. 2021) <https://www.macpac.gov/wp-content/uploads/2021/12/MACStats-Medicaid-and-CHIP-Data-Book-December-2021.pdf> (indicating breakdown of all Medicaid beneficiaries by race).

<sup>26</sup> Kinna Thakrar et al., *Homelessness, HIV, and Incomplete Viral Suppression*, 27 *Journal of Health Care for the Poor and Underserved* 145 (2016), <https://perma.cc/W8RH-CZBP>.

Medicaid Enterprise System (“MES”), State agencies’ contracted managed care plans, and third-party data sources such as the U.S. Postal Service (“USPS”) National Change of Address (“NCOA”) database, the databases for State agencies that administer SNAP and TANF, and the State Department of Motor Vehicles. While Medicaid beneficiaries that AFC serves do not always regularly engage with their State Medicaid agency, they more regularly engage with their managed care plans, and thus managed care plans are more likely to have accurate and up-to-date information. Additionally, with the safeguards implemented by the USPS NCOA system to ensure accuracy of change of address requests, it is also a readily accessible and reliable source of information. For the same reasons, we also support CMS’ proposal that States be allowed to update a beneficiary’s address on file to reflect a new address (sourced from a managed care organization or USPS) even when the State is unable to confirm with the beneficiary directly the accuracy of the new address, and we encourage CMS to consider making this provision mandatory.

We also support requiring State agencies to attempt to contact beneficiaries through means other than postal mail when mail is returned to State agencies and when additional contact information is available. There are many reasons why State agency mail could fail to reach a beneficiary who nevertheless still resides in the state, including errors attributable to USPS or to the agency itself, as well as inadvertent failure or inability on the part of beneficiaries to provide a reliable forwarding address. As such, it is paramount that state agencies be required to exercise due diligence by (1) sending notices to the address on record as well as any identified new mailing addresses, and (2) attempting to contact beneficiaries through additional modalities, such as by phone, electronic means, email, and text.

*C. We strongly support CMS’s proposal to permit noninstitutionalized spenddown beneficiaries to estimate medical expenses they are constant and predictable.*

Even though changes to financial eligibility criteria and the Affordable Care Act have facilitated expanded enrollment in Medicaid, which in turn have decreased the number of people who qualify as “medically needy,” the program is still a vital pathway to Medicaid coverage for many low-income individuals with high health care needs.<sup>27</sup> HHCAWG supports the proposal to grant States the option to make it easier for some people to enroll, and stay enrolled, in Medicaid by expanding the deduction of prospective expenses for medically needy eligibility. People living with HIV have many predictable, ongoing medical expenses, including prescription drug regimens and required lab tests, that should be considered as deductible noninstitutionalized expenses.

ART is a life-long treatment; once a person is diagnosed with HIV and they begin treatment, current medical best practice is to continue treatment for the rest of their life.<sup>28</sup> Treatment regimens for HIV entail a combination of prescription drugs, taken daily, and often in the form of a single tablet that combines multiple drugs into one pill. As discussed above, adherence to this daily regimen is necessary to suppress viral load and improve health outcomes. Comorbidities are also common among people living with HIV, especially individuals with HIV who are aging (50 years

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<sup>27</sup> Kaiser Commission on Medicaid & The Uninsured, *The Medically Needy Program: Spending and Eligibility Update*, Kaiser Family Foundation (December 2012), <https://www.kff.org/wp-content/uploads/2013/01/4096.pdf>

<sup>28</sup> HIV.gov, *HIV Treatment Overview* (June 7, 2022), <https://www.hiv.gov/hiv-basics/staying-in-hiv-care/hiv-treatment/hiv-treatment-overview>

and older).<sup>29</sup> Hypertension and diabetes are two of the most common comorbidities for people living with HIV, and both can require consistent access to prescription drugs.<sup>30</sup> Prescription drug costs for antiretrovirals specifically, and other maintenance drug costs generally, are incredibly high and account for a significant proportion of an individual's regular medical expenses.

In the NPRM, CMS invited commenters to identify other reasonably constant and predictable medical costs that a noninstitutionalized medically needy Medicaid beneficiary may incur. HHCAWG therefore notes that regularly scheduled doctors' visits and lab tests are constant and ongoing components of HIV management protocol. Lab tests to monitor HIV viral load are required every 3 or 6 months, depending on length of time on ART and whether viral suppression is sustained.<sup>31</sup> Additionally, tests to assess kidney function, lipids, and cholesterol are often required to ensure that prescribed drugs are effective and appropriate considering the patient's unique circumstances.<sup>32</sup> Lab tests and prescription drugs costs should qualify as noninstitutionalized medical expenses that can be deducted from a person's income at the start of their budget period for the medically needy pathway to Medicaid eligibility.

### **3. HHCAWG urges CMS to prioritize the above proposals for urgent implementation.**

Finally, as the COVID-19 Medicaid continuous coverage requirement comes to an end and states begin eligibility redeterminations for millions of people, the above proposed changes would help reduce coverage loss among non-MAGI beneficiaries and those who are at risk of not receiving critical written communications from their State Medicaid agencies, including many people with or at risk of HIV. Further, the medically needy regulation change would help address a longstanding issue contributing to churn for some of neediest beneficiaries. We therefore urge CMS to prioritize these provisions for prompt implementation, so that beneficiaries can benefit from these improved processes before the public health emergency unwinding begins.

As many as 15 million people are estimated to lose Medicaid or CHIP coverage during the unwinding, many of whom will do so for procedural reasons rather than changes in eligibility.<sup>33</sup>

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<sup>29</sup> R.A. Roomaney, B. van Wyk, V. P-van Wyk, *Aging with HIV: Increased Risk of HIV Comorbidities in Older Adults*, International Journal of Environmental Research and Public Health (February 2022), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8872228/#:~:text=A%20comorbidity%20was%20present%20in,C1%3A%2011.0%E2%80%9315.4%25>.

<sup>30</sup> J. Gallant, P. Y Hsue, S. Shreay, N. Meyer, *Comorbidities Among US Patients with Prevalent HIV Infection – A Trend Analysis*, 216 Journal of Infectious Diseases 1525 (Dec. 15, 2017). <https://academic.oup.com/jid/article/216/12/1525/4743770>.

<sup>31</sup> HIV.gov, *Laboratory Testing for Initial Assessment and Monitoring of People with HIV Receiving Antiretroviral Therapy, Clinical Info*, <https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/tests-initial-assessment-and-follow-full#:~:text=If%20HIV%20RNA%20is%20detectable,testing%20every%203%E2%80%936%20months.&text=For%20patients%20on%20ART%2C%20viral,measured%20every%203%E2%80%936%20months>.

<sup>32</sup> R. Pebody, *HIV Testing and Health Monitoring, Other Blood Tests*, AIDS MAP (February 2017), <https://www.aidsmap.com/about-hiv/other-blood-tests>.

<sup>33</sup> Assistant Secretary for Planning and Evaluation, Office of Health Policy, *Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches* (August 19, 2022), <https://aspe.hhs.gov/sites/default/files/documents/60f0ac74ee06eb578d30b0f39ac94323/aspe-end-mcaid-continuous-coverage.pdf>; see Jennifer Tolbert and Meghana Ammula, Kaiser Family Foundation, *10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Requirement* (October 21, 2022),

Moreover, these coverage losses are predicted to be disproportionately concentrated among Black and Latino people, of whom high percentages will likely lose coverage for solely procedural reasons.<sup>34</sup> These communities are also overrepresented among people living with HIV—in 2019, Black people comprised just 13.4% of the U.S. population but 40.3% of people living with HIV in the United States, while Latino people accounted for 18.5% of the U.S. population but 24.7% of people living with HIV in the United States.<sup>35</sup> Further, people with limited English proficiency, people with disabilities, and people with transient living situations are also anticipated to be at greater risk of losing coverage during the unwinding.<sup>36</sup> These intersecting disparities underscore the urgent need for CMS to promptly implement strategies to protect Medicaid and CHIP coverage during the unwinding for systematically marginalized populations, particularly those disproportionately affected by HIV.

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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 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](mailto:mtomazic@law.harvard.edu)) with the Center for Health Law and Policy Innovation and Rachel Klein ([rklein@tmail.org](mailto:rklein@tmail.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  
AIDS United  
American Academy of HIV Medicine  
APLA Health

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<https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-requirement/>.

<sup>34</sup> Assistant Secretary for Planning and Evaluation, Office of Health Policy, *Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches* (August 19, 2022), <https://aspe.hhs.gov/sites/default/files/documents/60f0ac74ee06eb578d30b0f39ac94323/aspe-end-mcaid-continuous-coverage.pdf>.

<sup>35</sup> HIV.gov, *What is the Impact of HIV on Racial and Ethnic Minorities in the U.S.?* (2022), <https://www.hiv.gov/hiv-basics/overview/data-and-trends/impact-on-racial-and-ethnic-minorities>.

<sup>36</sup> Jennifer Tolbert and Meghana Ammula, Kaiser Family Foundation, *10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Requirement* (October 21, 2022), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-requirement/>.



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