# EXHIBIT 54

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

COMMONWEALTH OF MASSACHUSETTS, et al.

Plaintiffs,

v.

MEHMET OZ, M.D., et al.

Defendants.

Case No. 1:26-cv-12962

**DECLARATION OF ELIZABETH A. KAPLAN**

I, Elizabeth Kaplan, declare under penalty of perjury and in accordance with the laws of the United States and of Massachusetts that:

1. I am the Director of Health Care Access and a Clinical Instructor in the Health Law and Policy Clinic at the Center for Health Law & Policy Innovation of Harvard Law School. An important part of our mission is to advocate for public policies that expand access to health care for people living with chronic conditions, particularly HIV.

2. I am also a co-chair of the Federal AIDS Policy Partnership's HIV Health Care Access Workgroup ("HHCAWG"). HHCAWG is a coalition of national and community-based organizations representing HIV medical providers, public health professionals, advocates, and people living with HIV who are all committed to ensuring access to critical HIV health care and support services.

## I. Uninterrupted Access to Health Care is Critical for HIV Treatment and Prevention.

3. "HIV (human immunodeficiency virus) is a virus that attacks the body's immune system. Without treatment, it can lead to AIDS (acquired immunodeficiency syndrome)," a life-threatening condition.[1]

4. As of 2019, more than 700,000 people with AIDS in the United States had died since the beginning of the epidemic.[2] In 2022, in the United States, "nearly 5,000 people died with HIV as the underlying cause of death, and about 8,000 died with HIV as a contributing cause of death."[3]

5. Today, treatment with antiretroviral therapy (ART) is recommended for all people living with HIV beginning as soon as possible after an HIV diagnosis.[4]

6. HIV is not curable and requires lifelong adherence to treatment, including regular medical monitoring to ensure that a person's ART regimen is working effectively.[5]

7. Most people living with HIV in the United States today take ART as a daily oral regimen, although long-acting injectable treatment is available for some individuals.[6]

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[1] *About HIV*, Centers for Disease Control and Prevention (Jan. 14, 2025), https://perma.cc/L8A4-Q9NW.
[2] *The HIV/AIDS Epidemic in the United States: The Basics*, KFF (Feb. 2019), https://files.kff.org/attachment/Fact-Sheet-HIV-AIDS-in-the-United-States-The-Basics.
[3] *The HIV/AIDS Epidemic in the United States: The Basics*, KFF (Aug. 16, 2024), https://www.kff.org/hiv-aids/the-hiv-aids-epidemic-in-the-united-states-the-basics/
[4] *See, e.g.*, *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV: Initiation of Antiretroviral Therapy*, HIV.gov (Sept. 25, 2025), https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/initiation-antiretroviral-therapy ("*Initiation of Antiretroviral Therapy*").
[5] *See HIV Treatment Adherence*, HIVinfo.NIH.gov (Jan. 13, 2025), https://perma.cc/8CL5-Q93K; *Initiation of Antiretroviral Therapy*, *supra* n.4.
[6] *See Taking Your HIV Medicine as Prescribed*, HIV.gov (last visited Aug. 18, 2026), https://perma.cc/V23R-2QUP; *FDA-Approved HIV Medicines*, HIVinfo.NIH.gov (June 8, 2026) https://perma.cc/QSH3-JYET; Deanna Kerrigan et al., *Factors Associated With Preference for Long-Acting Injectable Versus Daily Oral Antiretroviral Therapy Among People With HIV: Findings From the*

8. With regular access to ART and medical monitoring, people living with HIV can achieve viral suppression, which is defined as <200 copies/mL of HIV RNA.[7] People living with HIV whose HIV is virally suppressed can live long and healthy lives. They also cannot transmit HIV to others, making viral suppression an important tool to end the HIV epidemic.[8]

9. For people living with HIV, interruptions in access to health care can jeopardize viral suppression—sometimes within as few as three to six days of stopping treatment.[9] Viral rebound can threaten the immune system and lead to medication resistance, and it enables HIV transmission.[10]

## II. Medicaid Is the Primary Source of Coverage for People Living with HIV in the United States.

10. Medicaid provides coverage for approximately 40% of nonelderly adults living with HIV in the United States.[11] In 2022, Medicaid contributed 45% of all federal funding for domestic HIV care and treatment.[12]

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*SELIGO Study*, 101 J Acquired Immune Deficiency Syndrome 183, 189 (Feb. 1, 2026) (less than 3% of adults living with HIV who participated in survey reported being on long-acting injectable ART).

[7] *See, e.g.*, *Viral Suppression and an Undetectable Viral Load*, HIV.gov (last visited Aug. 18, 2026), https://perma.cc/N6PC-9A6Y; *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV: Antiretroviral Therapy to Prevent Sexual Transmission of HIV (Treatment as Prevention),* HIV.gov (Sept. 25, 2025), https://perma.cc/VSE4-4NWL ("*Antiretroviral Therapy to Prevent Sexual Transmission of HIV*").

[8] *See, e.g.*, *Initiation of Antiretroviral Therapy*, *supra* n.4; *Antiretroviral Therapy to Prevent Sexual Transmission of HIV*, *supra* n. 7; *HIV Treatment Prevention*, HIV.gov, https://perma.cc/RNB8-98QQ (last visited Aug. 18, 2026).

[9] *See Antiretroviral Therapy to Prevent Sexual Transmission of HIV*, *supra* n.7; UNAIDS, *Q&A on the impact of the interruption of treatment for people living with HIV* (May 15, 2025), https://www.unaids.org/sites/default/files/2025-05/20250520_QA-ART-Interruption_0.pdf.

[10] *See, e.g.*, *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV: Management of People with HIV and Antiretroviral Therapy Experience*, HIV.gov (Sept. 12, 2024), https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/virologic-failure; *Antiretroviral Therapy to Prevent Sexual Transmission of HIV*, *supra* n.7; Alexis Palmer et al., *Viral suppression and viral rebound among young adults living with HIV in Canada*, Medicine (Baltimore) (2018), https://pmc.ncbi.nlm.nih.gov/articles/PMC6392935/pdf/medi-97-e10562.pdf ("Viral rebound increases vulnerability to illness, treatment failure, cART resistance, and the potential for HIV transmission.").

[11] Lindsey Dawson et al., *Medicaid and People with HIV*, KFF, (Mar. 27, 2023), https://www.kff.org/hivaids/issue-brief/medicaid-and-people-with-hiv/.

[12] *Id.*

11. Medicaid expansion is especially important, covering 60% of adult, nonelderly Medicaid enrollees with HIV in expansion states,[13] and offering these individuals full scope health insurance without them having to wait until they have become disabled due to advanced HIV.[14]

12. Under H.R. 1, to keep their Medicaid coverage, people living with HIV who access Medicaid through the expansion pathway must either show that they are meeting the community engagement requirement or that they qualify for an exception or exclusion.

13. More than half of people living with HIV are age 50 and older, a group that is more likely to experience comorbidities and HIV medication side effects.[15] These challenges can be compounded by barriers to work requirements compliance that impact older adults generally, including age discrimination that makes it difficult to find employment and caregiving responsibilities for spouses, parents, or adult children with disabilities.[16]

## III. HIV is a "serious or complex medical condition" as defined in H.R. 1.

14. Congress in H.R. 1 excluded from Medicaid work requirements people who are "medically frail or otherwise [have] special medical needs," and defined that category by five conditions joined by "or": a disability as defined under the Social Security Act; a substance use disorder (SUD); a disabling mental disorder;

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[13] Lindsey Dawson & Jennifer Tolbert, *Medical Frailty and Medicaid Work Requirements: Challenges for People with HIV*, KFF (July 1, 2026), https://www.kff.org/medicaid/medical-frailty-and-medicaid-work-requirements-challenges-for-people-with-hiv/.
[14] Jennifer Kates & Lindsey Dawson, *Insurance Coverage Changes for People with HIV Under the ACA*, KFF, (Feb. 14, 2017), https://www.kff.org/affordable-care-act/issue-brief/insurance-coverage-changes-for-people-with-hiv-under-the-aca/#footnote-209018-4.
[15] *HIV and Older People*, HIVinfo.nih.gov (April 21, 2026), https://perma.cc/JY68-KJY4.
[16] Nari Rhee, *Medicaid Cuts—Including Work Documentation Requirements—Harm Older Adults*, UC Berkeley Labor Center (June 23, 2025), https://laborcenter.berkeley.edu/medicaid-cuts-including-work-documentation-requirements-harm-older-adults.

a physical, intellectual, or developmental disability that significantly impairs activities of daily living; or a "serious or complex medical condition."[17]

15. HIV is a "serious or complex medical condition" because it requires consistent, continuous, lifelong treatment to prevent advancement to AIDS, a life-threatening condition.[18] People living with HIV are also at elevated risk for comorbidities such as cardiovascular disease.[19] Adding to HIV's seriousness, when not virally suppressed, HIV is infectious and transmissible to others.[20]

16. Recognizing the seriousness of HIV, the Centers for Medicare and Medicaid Services (CMS) identified HIV as a "serious chronic medical condition," suggesting that Medicaid members living with HIV should be exempt from rules requiring enrollment in an Alternative Benefit Plan (ABP).[21]

17. CMS has also recognized HIV as a "serious, high-risk" condition for which patient navigation and other more intensive services may be reasonable and necessary in the Medicare context.[22]

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[17] P.L. 119-21, § 71119(a)(9)(A)(ii)(V).
[18] *See* ¶¶ 3-9 *supra*.
[19] *See, e.g.*, Allison Webel et al., *A Review of Chronic Comorbidities in Adults Living with HIV: State of the Science*, 32 J. Assoc. Nurses in AIDS Care 322 (Feb. 4, 2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC8815414/
[20] *See Antiretroviral Therapy to Prevent Sexual Transmission of HIV*, supra n.7; *How HIV Spreads*, Centers for Disease Control and Prevention (Nov. 25, 2024), https://perma.cc/SS9G-NJNY.
[21] *See* Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 Fed. Reg. 42,160, 42,233 (July 15, 2013) ("We agree with the commenters that illnesses such as HIV/AIDS, viral hepatitis, cancer and end stage renal disease are all serious chronic medical conditions.").
[22] *See* Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program, 88 Fed. Reg. 78,818, 78,938 (Nov. 16, 2023) ("Examples of a serious, high-risk condition/illness/disease include, but are not limited to… HIV/ AIDS"); Centers for Medicare & Medicaid Services, CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 12461 (July 24, 2025), https://perma.cc/G3NY-LB3M ("HIV is a single, serious condition, and/or a complex condition," such that a provider who has an ongoing relationship with a patient with HIV may use an "add-on" billing code to reflect the "inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship.").

18. Several states recognized HIV diagnosis as qualifying an individual for exemption from state-based Medicaid work requirement proposals under the first Trump Administration.[23]

19. Several state policies implementing the ABP exemption rules also specifically acknowledge HIV diagnosis as qualifying an individual for exemption.[24]

20. Prior to publication of the Interim Final Rule (IFR) on June 3, 2026,[25] through my work as a co-chair of HHCAWG, I was aware of several states impacted by the Medicaid community engagement requirement that intended to acknowledge HIV as a "serious or complex medical condition" warranting exclusion from community engagement under P.L. 119-21, § 71119(a)(9)(A)(ii)(V)(ee). For example, HIV was included in Nebraska's published Medicaid Work Requirements: Medically Frail Exemption Conditions Index, which was made public before publication of the IFR.[26]

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[23] *See, e.g.*, Arizona Section 1115 Waiver Amendment Request: AHCCCS Works Waiver, 9 (Dec. 19, 2017), https://perma.cc/7A5M-RTV2 (those with HIV/AIDS would be considered "medically frail," qualifying for exemption under proposed work requirement); Section 1115 demonstration waiver request for Kentucky HEALTH, 26 (Aug. 24, 2016), https://perma.cc/J4JX-MEVN ("individuals otherwise eligible for Kentucky HEALTH who are … diagnosed with HIV/AIDs, … will automatically be determined medically frail upon verification of the qualifying condition"); Healthy Michigan Plan (HMP) § 1115 Demonstration Extension Application Amendment, Attachment K – Part 1, 6 (Sept. 10, 2018), https://perma.cc/YW3V-FMXW (agreeing with commenters that "beneficiaries with complex chronic conditions may have difficulty meeting the workforce engagement requirement" and adding HIV, cystic fibrosis, and several other conditions to Michigan's medically frail exemption list).

[24] *See, e.g.*, Indiana State Plan Amendment: IN-15-0025-HIP Plus ABP, ABP 2a (Oct. 29, 2015), https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IN/IN-15-0025.pdf ("All individuals with an active disability determination by the Social Security Administration or a confirmed diagnoses of HIV/AIDS from the Indiana State Department of Health will be confirmed medically frail without having to self report their frail status"); Massachusetts State Plan Amendment: MA-23-0067, 6 (Feb. 9, 2024), https://perma.cc/8QQZ-AXF4.

[25] Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33,348 (June 3, 2026).

[26] Nebraska Medicaid Work Requirements, Medically Frail Exemption Conditions Index, 4 https://perma.cc/T3TJ-49AV.

## IV. The IFR's "Significant Impairment" Requirement Will Make It Harder for People Living with HIV to Keep their Coverage, Threatening Their Health.

21. Under the plain language of H.R. 1, a condition or diagnosis need only qualify as a "serious or complex condition" in order for a person with that diagnosis to be excluded from the community engagement requirements. Since HIV is a serious or complex condition—as states were already beginning to acknowledge[27]—HIV diagnosis alone should exempt a person from having to show that they meet these requirements.

22. The IFR adds a new requirement on top of the definition of "medically frail or [having] special medical needs," requiring that a qualifying condition—including a "serious or complex" condition—must *also* "significantly impair[]" a person's ability to meet the community engagement requirement.[28] Thus, someone who is living with HIV but is at least theoretically able to complete 80 hours per month of work or similar activities would no longer qualify for the medical needs exclusion, and would need to meet the community engagement requirements (or qualify for a different exemption) to retain Medicaid coverage.

23. Requiring people living with HIV to prove that they are too sick to work to protect them from loss of Medicaid puts coverage at risk for people whose health *depends* on continuous access to care. In other words, instead of encouraging and supporting people with a serious chronic condition to work, the IFR makes it so that a person with HIV who is deemed able to meet the community engagement requirements can be at risk of losing their Medicaid

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[27] *See* ¶ 20 *supra*. *See also* Louisiana Dep't of Health, *Medical Frailty Codes* (Preliminary and non-exhaustive. Updated as of Feb. 1, 2026), Administrative Record, Bates No. 004386, Serious + Complex Conditions: Immunodeficiency (including on Louisiana's list of qualifying conditions codes for "HIV disease" and "Asymptomatic HIV infection status"); Utah Dep't of Health & Human Servs., *Comprehensive ICD-10 Code List for Medical Frailty*, Administrative Record, Bates No. 004761 (including on Utah's list four HIV-related codes).

[28] 91 Fed. Reg. at 33,472.

coverage, jeopardizing their health. Paradoxically, once they become too sick to work, they would then qualify for the very exclusion that could have protected them from coverage loss in the first place.

24. The IFR's discussion of HIV is also ambiguous and vague. In the preamble to the IFR, CMS identifies "acuity" as relevant to significant impairment, but does not explain why this is an appropriate basis for that determination or how states should define or weigh it against other relevant considerations. CMS suggests that a person with lower "acuity" HIV is "less likely" to be significantly impaired, but does not explain what this means, or how it interacts with important factors such as the demands of ongoing treatment, comorbid mental health and other conditions, stigma-related barriers to care or employment, and other circumstances that could meaningfully affect a person with HIV's ability to comply with community engagement requirements.[29]

25. Depending on how it is interpreted, the IFR may also expose people living with HIV to privacy issues. For example, Medicaid enrollees may need to disclose private medical information (beyond what already appears in their Medicaid claims) to eligibility workers to prove they are "sick enough" to qualify for the exclusion.

[29] *See, e.g.*, *A qualitative study of barriers to employment experienced by people living with HIV in Toronto and Ottawa*, Int. J. Equity Health (Jan. 14, 2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC7807879/ (study participants reported common barriers in their efforts to obtain and maintain employment, including HIV stigma in the workplaces and mental health challenges); *An Insight Into Organizational HIV Stigma & Discrimination*, ViiV Healthcare U.S. (last visited Aug. 20, 2026), https://viivhealthcare.com/en-us/supporting-the-hiv-community/against-stigma/hiv-stories/organizational-stigma/.

## V. The IFR's Limit on the Use of Self-attestation Further Threatens Coverage for People Living with HIV.

26. Importantly, the new requirement to do community engagement is not simply a requirement to complete 80 hours per month of qualifying activities—it is also a requirement to ensure that the state Medicaid agency can verify a person's completion of these activities. Thus, even people who are compliant with community engagement based on their activities or qualification for an exemption can still be vulnerable to losing their Medicaid coverage.[30] The IFR's limit on the use of self-attestation to verify medical frailty status increases the administrative burden of compliance on the population that can least afford to lose their coverage—those with elevated medical needs, including people living with HIV.

27. Many people with HIV may not have claims or encounters that document their HIV status. For example, a person who was recently diagnosed may not yet have a trusted provider who could provide this documentation, especially if the person was diagnosed outside of a traditional care setting.[31] Similarly, an individual who only recently gained Medicaid eligibility (because they were previously covered by an employer, moved from out of state, or recently became financially eligible) may have little or no relevant data available to the state.

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[30] *See* Matthew Buettgens et al., *Projected Reductions in Medicaid Expansion Enrollment Under OBBBA's Work Requirements and Six-Month Redeterminations: National and State Estimates for 2028*, Urban Institute and Robert Wood Johnson Foundation, ix (March 25, 2026) https://www.rwjf.org/en/insights/our-research/2026/03/millions-could-lose-health-coverage-due-to-new-rules.html (estimating Medicaid expansion enrollment declines of 19-37% "among those who are working because some who are meeting the work requirement would be unable to manually verify compliance and because others are working less than 80 hours per month but do not have monthly income equivalent to 80 work hours at the federal minimum wage").

[31] HIV testing is performed in many locations, including "health care provider offices, health centers, community centers, health departments, pharmacies, and more"; there are also self-tests that a person can administer at home or in private. *HIV Testing Locations*, HIV.gov (last visited Aug. 20, 2026), https://perma.cc/4ZXS-T9HU.

28. Many people living with HIV face added barriers to compliance with administrative burdens. For example, people living with HIV are disproportionately impacted by homelessness and housing instability.[32] A person who is homeless may lack consistent access to mail, phones, or the internet, which can make it difficult for them to receive communications from their state Medicaid agency explaining what they need to do to keep their coverage; they may also lack a secure place to store documentation, or access to transportation.[33] These factors could make it harder for a person living with HIV who also experiences homelessness to provide documentation of their medical condition to the state Medicaid agency.

29. Administrative burdens have likely prevented access to exemption and accommodation processes for people with disabilities in similar work requirement programs. For example, Arkansas' medically frail exemption reached only 11% of beneficiaries subject to the work requirement, even though nearly 30% of those without an exemption who weren't working reported at least one serious health limitation.[34] Georgia's Pathways to Coverage program requires an eight-step accommodation process;[35] although it is unclear how

[32] *See, e.g.*, *Behavioral and Clinical Characteristics of Persons with Diagnosed HIV Infection–Medical Monitoring Project, United States, 2023 Cycle (June 2023–May 2024)*, Centers for Disease Control and Prevention (March 16, 2026), https://perma.cc/YR5S-KBGZ (in 2023, 20% of people living with HIV reported unstable housing or homelessness).
[33] *See, e.g.*, Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion, Kaiser Commission on Medicaid and the Uninsured (Sept. 2012), https://www.kff.org/wp-content/uploads/2013/01/8355.pdf.
[34] *See Medicaid Work Requirements Don't Protect People With Disabilities*, Center on Budget & Policy Priorities (Nov. 14, 2018), https://www.cbpp.org/research/health/medicaid-work-requirements-dont-protect-people-with-disabilities.
[35] *See How Medicaid Work Requirements Hurt People with Disabilities*, National Health Law Program (Dec. 2024), https://healthlaw.org/wp-content/uploads/2025/01/Machledt_NHeLP_WorkRequirementsandPeoplewithDisabilities_January-Update.pdf.

many people access the program through this process, overall, the program has enrolled only a small fraction of those estimated to be eligible.[36]

## VI. The IFR's 12-Month Lookback Period Also Threatens Coverage for People Living with HIV.

30. The IFR limits states to a 12-month lookback period for claims and encounter data used to determine whether someone is medically frail or has special medical needs. This limitation harms people with ongoing conditions such as HIV where relevant claims fall outside the 12-month window.

31. Given that HIV is an incurable condition, older claims remain reliable evidence of a person's HIV status; requiring duplicative proof of that diagnosis merely because the relevant claims are more than 12 months old creates an unnecessary administrative burden for Medicaid enrollees, providers, and Medicaid agency staff.

32. With adherence to treatment, including attending regular medical appointments and adhering to an ART regimen, people living with HIV can achieve viral suppression.[37] However, many people living with HIV face barriers to adhering to regular HIV care, such as unmet socioeconomic needs, substance use, or serious mental health issues.[38] Housing instability, in particular, is a widely recognized barrier to HIV care retention.[39] People living with HIV who

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[36] *See* Leah Chan, Pathways to Coverage: Looking Back Two Years and Into the Future, Georgia Budget & Policy Institute (Oct. 13, 2025), https://gbpi.org/pathways-to-coverage-looking-back-two-years-and-into-the-future/ ("About 8,077 Georgians were actively enrolled in the Pathways to Coverage program by the end of the first two years, which represents no more than 7% of uninsured, low-income adults from working households.").

[37] *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents With HIV: Limitations to Treatment Safety and Efficacy: Adherence to the Continuum of Care*, HIV.gov (Sept. 12, 2024), https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/adherence-continuum-care?view=full.

[38] *See id.*

[39] See, e.g., Angela Aidala, *Housing Status, Medical Care, and Health Outcomes Among People Living With HIV/AIDS: A Systematic Review*, 106 Am. J. Public Health e1-e23 (Jan. 2016), https://pmc.ncbi.nlm.nih.gov/articles/PMC4695926/pdf/AJPH.2015.302905.pdf.

experience socioeconomic and other barriers to care should not be denied access to Medicaid coverage simply because they do not have medical claims or encounter data from within the past 12 months that confirms their HIV status.

33. People living with HIV and other serious or complex conditions cannot afford to lose their coverage even temporarily due to administrative errors or unnecessarily complex red tape—as noted above, an HIV treatment lapse of even a few days or weeks may potentially lead to serious health consequences.[40]

## VII. Due to the Importance of Maintaining Uninterrupted Access to Medicaid for People Living with HIV, HHCAWG and Others Provided Materials to CMS Before June 1, 2026, Regarding the Need to Exempt People Living with HIV from Community Engagement Requirements.

34. On October 28, 2025, the Center for Health Law and Policy Innovation, along with HHCAWG co-chairs The AIDS Institute and AIDS United, sent a letter to the Centers for Medicaid and CHIP Services (CMCS).[41] Members of these organizations and other groups affiliated with HHCAWG had a follow-up meeting on December 5, 2026, with Kirsten Jensen, Gene Coffey, and Martin Burian, staff at CMCS. During the meeting, the HHCAWG representatives reiterated the points in the letter and explained why HIV is unique, in the sense that people living with HIV can be virally suppressed and able to fully participate in community life, but continuous access to treatment is critical to avoid the risks of viral rebound, treatment resistance, and serious illness or death. The CMCS staff made no policy commitments but asked some granular questions about HIV, such as how soon after treatment interruption a person

[40] *See* ¶ 9, *supra* and sources cited.
[41] Letter from The AIDS Institute, AIDS United, and the Center for Health Law and Policy Innovation to Caprice Knapp, October 28, 2025 (attached as Exhibit A). *Accord* Administrative Record, Bates No. 003912 – 003914.

might experience HIV viral rebound, and how well the ABP regulations protect people with HIV.

35. On January 21, 2026, the HIV + Hepatitis Policy Institute sent a letter to CMS Administrator Dr. Mehmet Oz urging CMS to "include an explicit exemption for all people living with HIV" in federal guidance implementing the Medicaid community engagement requirement.[42]

36. On May 12, 2026, the HHCAWG co-chairs met with Phillip Pollman and Trenesha Fultz-Mimms, staff at the Office of Management and Budget (OMB), to discuss CMS's forthcoming IFR on Medicaid community engagement requirements.[43] In conjunction with the meeting, we provided the following documents further explaining how people living with HIV are covered under Medicaid and emphasizing the importance of recognizing HIV as a "serious or complex condition":

a. Lindsey Dawson, Priya Chidambaram, and Jessica Mathers, *5 Key Facts About Medicaid Coverage for People with HIV*, KFF, April 1, 2025, https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-with-hiv/;[44]

b. The AIDS Institute, *Closing the Health Coverage Gap Is the Key to Ending the HIV and Hepatitis C Epidemics*, Oct. 25, 2021;[45]

c. The AIDS Institute, *7 Reasons to Exempt People with HIV from Medicaid's Community Engagement Requirement*, Oct. 2025,

[42] Letter from HIV+Hepatitis Policy Institute to Administrator Oz, Jan. 21, 2026, https://hivhep.org/wp-content/uploads/2026/01/HIV-Hep-Medicaid-Community-Engagement-for-HIV-1.21.26.pdf (attached as Exhibit B). *Accord* Administrative Record, Bates No. 004317.
[43] *See* EO 12866 Meeting 0938-AV98, Sept. 12, 2026 (screenshot attached as Exhibit C).
[44] Attached as Exhibit C(i).
[45] Attached as Exhibit C(ii).

https://www.theaidsinstitute.org/eliminating-hiv/fact-sheet-7-reasons-for-medicaid-requirement-exemptions-for-pwh;[46] and

d. Copy of the October 28, 2025, HHCAWG co-chairs letter to CMCS.[47]

37. On May 20, 2026, the HHCAWG co-chairs sent a follow-up letter to HHS Secretary Robert F. Kennedy, Jr., Administrator Oz, and OMB Director Russell Vought reiterating the importance of exempting people living with HIV from Medicaid community engagement.[48] We received no response to this letter.

38. The IFR and its preamble do not acknowledge or consider the points raised in the above letters and meetings.

DATED: August 28, 2026.

*/s/ Elizabeth Kaplan*
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[46] Attached as Exhibit C(iii).
[47] Exhibit A, *supra* n.41.
[48] Letter from HHCAWG to Secretary Kennedy et al., May 20, 2026 (attached as Exhibit D).

# EXHIBIT A

October 28, 2025

Caprice Knapp, PhD
Deputy Administrator and Director (Acting)
Center for Medicaid and CHIP Services (CMCS)
7500 Security Boulevard
Room S3-14-07
Baltimore, MD 21244

Re: Medicaid Community Engagement Reporting Requirement

The AIDS Institute, AIDS United, and the Center for HIV Law and Policy Innovation are leading national organizations working to ensure access to care for people living with and vulnerable to HIV. Given the significant health risks and unique nature of HIV, we write to urge you to exempt people with HIV from the Medicaid community engagement requirement included in H.R. 1. We also request to meet with you to discuss how this exemption could be designed to minimize disruptive impact on access to HIV care and treatment.

In 2019, President Trump launched the Initiative to End the HIV Epidemic. His commitment to invest in innovative strategies to bring an end the HIV epidemic in the United States has helped to move our country closer to achieving that goal. Consistent access to health care coverage and treatment for people with HIV is crucial to continuing that progress and Medicaid is a critical source of that coverage.[1] Forty percent of adults living with HIV are covered by Medicaid, compared to just 15% of the general population.[2] Medicaid provides 45% of all federal funding for HIV treatment.[3] But people with HIV make up a very small share of Medicaid enrollees overall – less than one-half of a percent.[4]

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[1] *See* Lindsey Dawson, Priya Chidambaram & Jessica Mathers, *5 Key Facts About Medicaid Coverage for People with HIV*, KAISER FAM. FOUND. (Apr. 1, 2025), https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-with-hiv/.
[2] *Id.*; Lindsey Dawson et al., *Medicaid and People with HIV*, KAISER FAM. FOUND. (Mar. 27, 2023), https://www.kff.org/hiv-aids/medicaid-and-people-with-hiv/.
[3] *Id.*; Lindsey Dawson et al., *Medicaid and People with HIV*, KAISER FAM. FOUND. (Mar. 27, 2023), https://www.kff.org/hiv-aids/medicaid-and-people-with-hiv/.
[4] Lindsey Dawson et al., *5 Key Facts About Medicaid Coverage for People with HIV*, KAISER FAM. FOUND. (Apr. 1, 2025), https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-with-hiv/.

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, broadly.[5] When HIV is effectively managed and individuals stay engaged in treatment and virally suppressed, people with HIV can live healthy lives and there is no risk of sexual transmission.[6]

**HIV is a serious and complex chronic illness**

H.R. 1 requires states to exempt people with "special medical needs" – including people with "serious or complex medical conditions" – from community engagement requirements.[7] HIV is the very definition of a serious and complex medical condition, requiring consistent, continuous, lifelong treatment to prevent advancement to AIDS. Continuous insurance coverage and access to care is critical to enabling people living with HIV to achieve viral suppression and positive health outcomes.[8] But because HIV is infectious, consistent management is also necessary to prevent others from acquiring it and to achieve an end to the epidemic.

As a result, CMS has historically recognized that HIV is a "serious chronic medical condition" warranting special treatment related to Medicaid eligibility and coverage,[9] as have several states.[10] We urge you to cement this recognition of the impact that HIV has on people and

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[5] *See* Dawson, Chidambaram & Mathers, *supra* note 1 (finding that "Medicaid is the primary payer for HIV care and treatment" but in 2022, federal Medicaid spending on HIV still represented less than 2% of total federal Medicaid spending).

[6] *See* Myron S. Cohen et al., *Antiretroviral Therapy for the Prevention of HIV-1 Transmission*, NEJM (2016); Robert W. Eisinger, Carl W. Dieffenbach & Anthony S. Fauci, *HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittable*, 321 JAMA 451 (2019).

[7] *See* One Big Beautiful Bill Act, Pub. L. No. 119-21, 139 Stat. 72, 312; HEALTH AND ECONOMIC LIVELIHOOD PARTNERSHIP (HELP) SECTION 1115 DEMONSTRATION WAIVER APPLICATION, MONT. DEP'T PUB. HEALTH & HUM. SERV. 14 (2025) ("*Montana Waiver Proposal*").

[8] Lindsey Dawson and Jennifer Kates, *Insurance Coverage and Viral Suppression Among People with HIV*, 2018, KFF, (Sept. 4, 2020), https://www.kff.org/hiv-aids/insurance-coverage-and-viral-suppression-among-people-with-hiv-2018/.

[9] *E.g.*, Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 Fed. Reg. 42,160, 42,233 (July 15, 2013) ("We agree with the commenters that illnesses such as HIV/AIDS, viral hepatitis, cancer and end stage renal disease are all serious chronic medical conditions."); Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program, 88 Fed. Reg. 78,818, 78,938 (Nov. 16, 2023) ("Examples of a serious, high-risk condition/illness/disease include, but are not limited to… HIV/AIDS"); Centers for Medicare & Medicaid Services, CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 12461 (Jan. 18, 2024) https://www.cms.gov/files/document/r12461cp.pdf ("[I]f the practitioner is furnishing ongoing care related to a patient's single, serious and complex condition, e.g., … HIV, then the add-on code G2211 could be billed. The add-on code G2211 captures the inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship.").

[10] *E.g.*, ARIZONA SECTION 1115 WAIVER AMENDMENT REQUEST: AHCCCS WORKS WAIVER, 9 (Dec. 19, 2017), https://www.azahcccs.gov/shared/Downloads/News/AHCCCSWorks1115WaiverAmendmentRequest.pdf (those with HIV/AIDS would be considered "medically frail," qualifying for exemption under proposed work requirement); Indiana State Plan Amendment: IN-15-0025-HIP Plus ABP, ABP 2a (Oct. 29, 2015), https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IN/IN-15-0025.pdf ("All individuals with an active disability determination by the Social Security Administration *or* a confirmed diagnoses of HIV/AIDS from the Indiana State Department of Health will be confirmed medically frail without having to self report their frail status." (emphasis added)

communities by specifically exempting people with an HIV diagnosis from H.R. 1's community engagement requirement.

**Community engagement requirements will disproportionately harm people with HIV**

People living with HIV will be disproportionately challenged by the effects of this requirement. HIV can produce symptoms or disabilities that are not visible yet serve as impediments to steady employment.[11] For example, HIV can produce periods of inability to work due to medication side effects, periods of illness, or the need to attend many doctors' appointments; thus, employees with HIV may require flexible work arrangements that can be hard to find or keep.[12] More than half of people living with HIV are age 50 and older,[13] a group that is particularly likely to have difficulty complying with work requirements.[14] For people living with HIV, loss of Medicaid due to arbitrary denials and administrative red tape can lead to care disruptions that can pose enduring, costly, and complex health risks.[15]

We understand that implementing the community engagement requirement and other aspects of H.R. 1 is a complex job that requires balancing many different considerations. We look forward to working with you to ensure that these important decisions do not undermine the goal we share with President Trump: achieving once and for all an end to the HIV epidemic in the United States. Please reach out to Rachel Klein, Deputy Executive Director at The AIDS Institute at rklein@taimail.org or (202) 815-2973 to arrange a time to meet.

Sincerely,

Rachel Klein
Deputy Executive Director
The AIDS Institute

Leslie McGorman
Senior Director of Policy & Strategy
AIDS United

Liz Kaplan
Director of Health Care Access
Center for Health Law & Policy Innovation

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[11] Rachel Garfield, Robin Rudowitz & Anthony Damico, *Understanding the Intersection of Medicaid and Work*, KAISER FAM. FOUND. (Jan. 2018), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-andWork.

[12] Catherine H. Maulsby et al., *A Scoping Review of Employment and HIV*, 24 AIDS BEHAV. 1, 5 (2020) https://pmc.ncbi.nlm.nih.gov/articles/PMC7716244/pdf/nihms-1650652.pdf ("Among employed individuals, those who have workplace accommodations are more likely to be adherent to HIV medications than those without an accommodation.").

[13] HIV.gov, Aging with HIV, (Sept. 8, 2025), https://www.hiv.gov/hiv-basics/living-well-with-hiv/taking-care-of-yourself/aging-with-hiv.

[14] Nari Rhee, Medicaid Cuts—Including Work Documentation Requirements—Harm Older Adults, UC Berkeley Labor Center (June 23, 2025), https://laborcenter.berkeley.edu/medicaid-cuts-including-work-documentation-requirements-harm-older-adults/.

[15] Elizabeth Hamlyn et al., *Plasma HIV Viral Rebound Following Protocol-Indicated Cessation of ART Commenced in Primary and Chronic HIV Infection*, PLOSONE (2012); Gerald Friedland & Ann Williams, *Attaining Higher Goals in HIV Treatment: The Central Importance of Adherence*, 13 AIDS S61 (1999) ("Therefore, potent and continuous suppressive therapy for the duration of viral replicative capability is necessary for therapy to be effective.").

# EXHIBIT B

HIV+HEP
POLICY INSTITUTE

January 21, 2026

Dr. Mehmet Oz
Administrator, Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington DC 20201

**RE: Medicaid Community Engagement Requirement and People Living with HIV**

Dear Administrator Oz:

The **HIV+Hepatitis Policy Institute** is a leading national HIV and hepatitis policy advocacy organization promoting quality and affordable healthcare for people living with or at risk of HIV, hepatitis, and other serious and chronic health conditions.

**We write to urge you to include an explicit exemption for all people living with HIV in upcoming federal guidance relating to the new Medicaid community engagement requirement mandated by HR 1.**

People with HIV are living with a lifelong **serious and complex medical condition** and have **special medical needs**: they cannot stay healthy without *continuous* access to their lifesaving HIV treatment. Any gap in treatment risks serious health consequences, including failure of viral suppression and the risk of onward transmission. Longer treatment gaps are potentially disabling, allowing progression to AIDS, after which life expectancy is limited.

People with serious and complex medical conditions and special medical needs are statutorily exempt from the community engagement requirement; however, absent federal guidance, states can define which populations qualify. We urge CMS to explicitly state that all people living with HIV (both symptomatic and asymptomatic) have special medical needs and fall under this exemption.

This interpretation is consistent with long-standing federal precedents. For decades, Congress and Unites States DHHS have considered HIV (both symptomatic and asymptomatic) as a serious, life-threatening, and potentially disabling condition.[1]

**We believe that all people living with HIV should be exempt from the community engagement automatically and not have to navigate cumbersome new procedures to document their status with each Medicaid recertification. Since HIV is a lifetime condition**

[1] For example, 28 CFR 35.108(b)(2) or 78 FR 42233

**that will not change over time, this assessment should only be carried out once.**

Under statute, states are directed to maximize *ex parte* verification of eligibility in relation to the community engagement requirements. Automatic exemption through use of data already available to the Medicaid program (such as diagnostic codes and claims data) minimizes the burden on the enrollee. It also reduces the administrative burden on the state and on the health-care workforce providing care to people with HIV.

To put the onus on individuals living with HIV to navigate administratively cumbersome forms of verification of HIV status is unnecessary and puts their health at risk. In addition, since people with HIV face continuing stigma and discrimination, many are reluctant to disclose their HIV status in Medicaid enrollment and recertification paperwork, further amplifying the importance of using e*x parte* verification of HIV status.

**Continuous access to Medicaid for people living with HIV is critical to sustaining our national progress towards ending the HIV epidemic and will directly support the goals of the *Ending the HIV Epidemic* initiative launched by President Trump in his first administration**.

Approximately forty percent of people living with HIV nationwide are enrolled in Medicaid, making humane and clinically sound implementation of the new community engagement requirements of the highest importance to them, their clinical care teams, and communities.

We appreciate the opportunity to submit these comments and are ready to assist you in any way. Should you have questions or comments, please feel free to contact me at cschmid@hivhep.org or Kevin Herwig at kherwig@hivhep.org. Thank you very much.

Sincerely,



Carl E. Schmid II
Executive Director

cc: Mr. Daniel Brillman, Deputy Administrator and Director, Center for Medicaid and CHIP Services

# EXHIBIT C

reginfo.gov/public/do/viewEO12866Meeting?viewRule=true&rin=0938-AV98&meetingId=1597623&acronym=0938-HHS/CMS

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# View EO 12866 Meeting 0938-AV98

**Title:** Establishing State Community Engagement Requirements for Certain Individuals Under Section 1902(xx) of the Social Security Act (CMS-2454)

**Agency/Subagency:** 0938-HHS/CMS

**Stage of Rulemaking:** Interim Final Rule Stage

**Meeting Date/Time:** 05/12/2026 01:30 PM

**Requestor:** The AIDS Institute **Requestor's Name:** Rachel Klein **Requestor's Client:** HIV Health Care Access Working Group

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**Documents:**

| List of Documents |
|---|
| 5 Key Facts About Medicaid Coverage for People with HIV _ KFF |
| Coverage-Gap-Issue-Brief_draft-V7 |
| 7 Reasons to Exempt PWH from Medicaid Work Requirement |
| Exempting PWH from Medicaid Community Engagement Letter 10-25 |

**Attendees:**

| List of Attendees | Participation |
|---|---|
| • Rachel Klein - The AIDS Institute | Teleconference |
| • Terri Wilder - SAGE | Teleconference |
| • Elizabeth Kaplan - Center for Health Law & Policy Innovation | Teleconference |
| • Leslie McGorman - AIDS United | Teleconference |
| • Dori Molozanov - NASTAD | Teleconference |
| • Phillip Pollman - OMB | Teleconference |
| • Trenesha Fultz-Mimms - OMB | Teleconference |

# EXHIBIT C(i)

KFF The independent source for health policy research, polling, and news.

# 5 Key Facts About Medicaid Coverage for People with HIV

**Authors:** Lindsey Dawson, Priya Chidambaram, and Jessica Mathers

**Published:** Apr 1, 2025

Medicaid is the primary source of insurance coverage for people with HIV, playing a key role in financing HIV care and prevention efforts. Despite the importance of Medicaid for people with HIV, they represent a very small share of program enrollees overall (less than one-half of a percent). Most Medicaid enrollees with HIV qualify for the program through the Affordable Care Act (ACA)'s Medicaid expansion and disability-related pathways.

Policy proposals being considered by Congress to reduce federal spending for the Medicaid program could have negative implications for people with HIV and those at risk. It is unclear what specific policies might be implemented to achieve federal reductions and a range of options are being considered, but reductions in federal Medicaid funding would shift costs to states and could result in coverage losses, reduction in benefits, cost-shifting to HIV safety-net programs, and/or reductions in payment rates to providers, if states do not offset federal dollars. Policies imposing Medicaid work requirements, which could happen through the Congressional budget process or via waiver approvals, would impact people with HIV as well, likely leading to coverage losses. Coverage losses among people with HIV would likely increase demand on the nation's HIV safety-net program, the Ryan White Program (which could also face cuts in Congress though the program's funding has already not kept pace with inflation or growing need). Loss of Medicaid coverage could result in

interruptions in HIV care and treatment, which could lead to increased morbidity and mortality as well as HIV transmission.

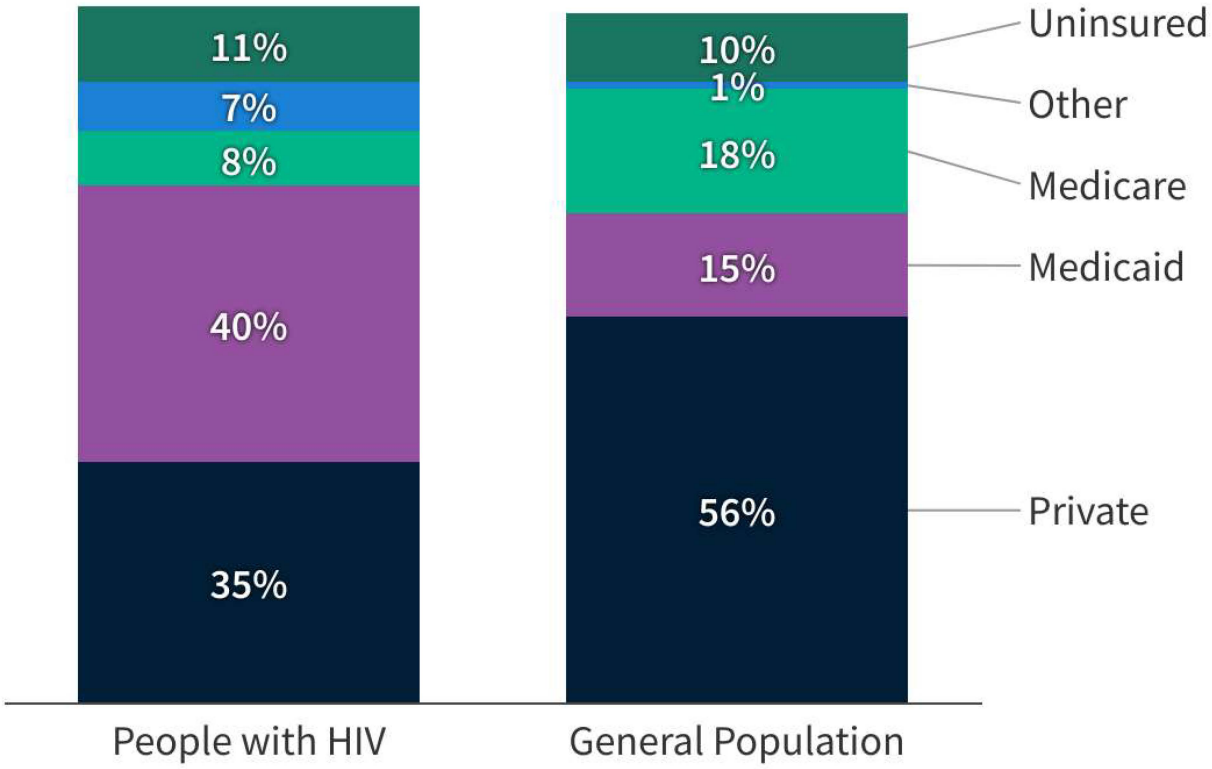
# 1. Medicaid is the primary source of insurance coverage for people with HIV.

Medicaid is the single largest source of coverage for adults with HIV in the U.S., with four in ten estimated to be covered by the program (40%). By comparison, only 15% of adults in the general population have Medicaid coverage (Figure 1). Medicaid has helped to provide HIV care since the HIV epidemic began in the early 1980s. Coverage and benefits have grown over time as people with HIV are living longer, new infections continue to occur, and due to the Medicaid program's expansion under the Affordable Care Act (ACA). Higher rates of Medicaid coverage reflect the fact that people with HIV have lower-incomes (33% of adults with HIV have incomes below 100% FPL compared to 11% of adults overall). Additionally, a large share of people with HIV have a disability (42%) and one in four (25%) people with HIV on Medicaid are dually eligible for Medicare, compared to 14% of enrollees without HIV.

Figure 1

**Medicaid is the Primary Source of Insurance Coverage for People with HIV**

Distribution of U.S. population by insurance coverage and HIV status




Note: Data sources are different for people with HIV and the general population and statistical testing was not performed.

Source: Data in both columns are from 2018 and from: KFF. Issue Brief. Insurance Coverage and Viral Suppression Among People with HIV, 2018 https://www.kff.org/hivaids/issue-brief/insurance-coverage-and-viral-suppression-among-people-with-hiv-2018/

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# 2. Medicaid is the primary payer for HIV care and treatment

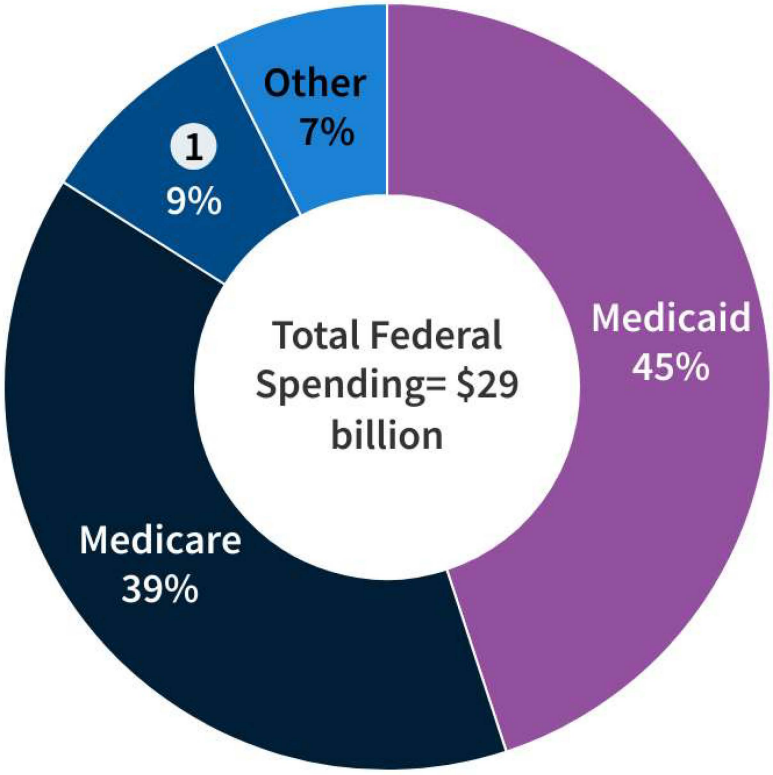
While Medicaid spending on people with HIV is a small share of all Medicaid spending, it accounts for an estimated 45% of all federal spending on HIV care and is the largest source of public financing for HIV care in the U.S, followed by Medicare.

Still, in FY 2022, CMS estimates federal Medicaid spending on HIV represented less than 2% of total federal Medicaid spending. In addition, states also contribute to Medicaid spending on HIV (Medicaid is jointly financed by state and federal governments). Medicaid spending on HIV has increased over time, reflecting growing numbers of enrollees with HIV and the rising costs of care and treatment. In this way, it differs from the Ryan White Program, which is dependent on Congressional appropriations and funding levels do not automatically adjust to meet the needs of a growing population and increasing medical costs.

Figure 2

**Medicaid is the Primary Payer for HIV Care and Treatment**

Distribution of U.S. federal spending on HIV by program, FY 2022




1 Ryan White

Note: Total Medicaid funding includes only federal spending. A small amount of VA prevention funding is included in "other" as it was not possible disaggregate care and prevention funding for that account. Several accounts in the "other" category are estimates carried forward from FY17.

Source: Calculation based on KFF review of Congressional Budget Justifications, other budget documents, and personal agency correspondence

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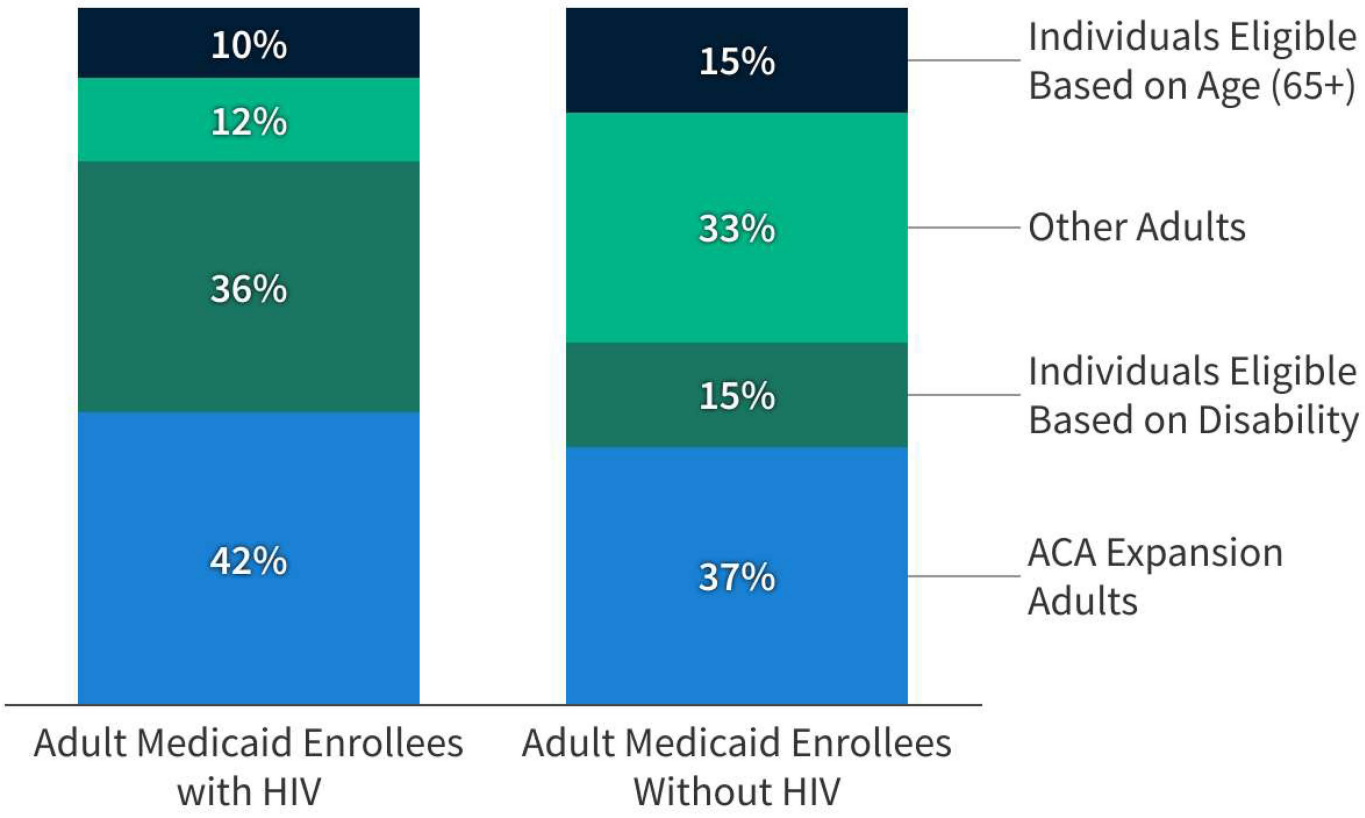
# 3. Medicaid expansion is the most common pathway to program eligibility for people with HIV.

Over four in ten (42%) Medicaid enrollees with HIV have coverage through the ACA's Medicaid expansion, making it the primary pathway to Medicaid eligibility for this population. In Medicaid expansion states, over half (51%) of adults with HIV have coverage through the expansion. This pathway was created under the ACA to provide coverage to low-income adults on the basis of income without other categorical requirements like disability or pregnancy. Individuals with HIV who qualify through the expansion pathway may be able to access early treatment that could help stave off disability and significantly improve health outcomes. However, not all states offer the expansion pathway and today over one-third (35%) of people with HIV live in one of ten states that has not opted to expand Medicaid. Medicaid enrollees with HIV continue to enroll through the disability pathway at much higher rates than those without HIV (36% v 15%) and it remains the primary entry point to coverage for adults with HIV in non-expansion states, two-thirds (66%) of whom have disability-related coverage (compared to 30% in expansion states).

Figure 3

**Medicaid Expansion is the Most Common Pathway to Program Eligibility for Adults with HIV**

Distribution of adult Medicaid enrollees by eligibility group, by HIV status, 2021




Note: This analysis reflect enrollees 18 and older (348,000 enrollees with HIV and 59.7 million enrollees without HIV). 49 states and D.C. were included in this analysis; Mississippi was excluded due to missing or inconsistent data. For Medicaid enrollees without HIV, the "Other Adults" category includes 2% of enrollees who are 19 but qualified via the children's pathway.

Source: KFF analysis of the T-MSIS Research Identifiable Files, 2021

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# 4. Medicaid enrollees with HIV are more likely to have substance use disorders,

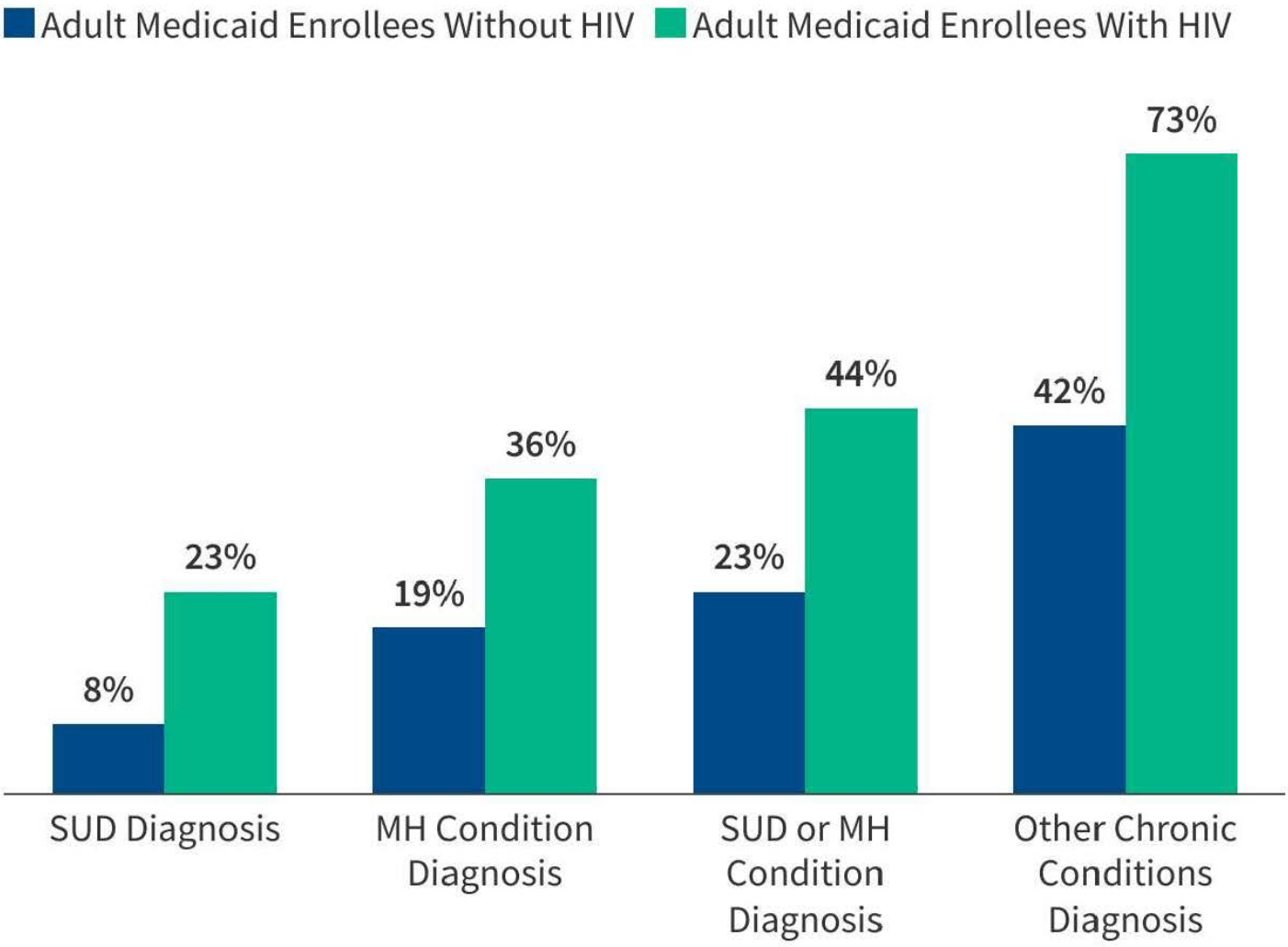
# mental health conditions, and other chronic conditions relative to those without HIV.

Medicaid enrollees with HIV experience comorbidities at higher rates than those without HIV, including those related to mental health and substance use disorders. Nearly three-quarters (73%) of Medicaid enrollees with HIV have one of 34 other chronic conditions, compared to 42% of enrollees without HIV (see Figure 4 notes for details). Enrollees with HIV are more than twice as likely to be medically complex than enrollees without HIV, with about one-third (32%) having three or more chronic conditions in addition to HIV, compared to 13% of enrollees without HIV (data not shown). Adult enrollees with HIV are also twice as likely to have either a substance use disorder or mental health condition diagnosis (44% v 23%) compared to those without HIV. Enrollees with HIV are nearly ten times more likely than enrollees without HIV to have a hepatitis diagnosis. However, likely reflecting curative treatments now available, that share has declined from 14% of enrollees in 2013 to 6% in 2021 (data not shown). These differences between enrollees with HIV and without HIV likely reflect a range of both medical and social factors that combine to increase the risk and prevalence of these co-occurring conditions.

Figure 4

# Adult Medicaid Enrollees with HIV are More Likely Than Those Without HIV to Have Substance Use Disorder, a Mental Health Condition, and Other Chronic Conditions.

Rate of chronic conditions among adult Medicaid enrollees, by HIV status, 2021




Note: SUD = Substance Use Disorder. MH = Mental Health condition. This analysis reflect enrollees 18 and older who had no Medicare coverage in 2021 (260,000 enrollees with HIV and 46.3 million without HIV). Enrollees who had at least one month of Medicare coverage in 2021 were excluded from these calculations since these enrollees may not have sufficient claims in T-MSIS to identify chronic conditions. 49 states and D.C. were included in this analysis; Mississippi was excluded due to missing or inconsistent data. There are a total of 34 non-HIV chronic conditions captured in this analysis. This includes 29 conditions from the Chronic Condition Warehouse algorithm (excluding mental health); KFF's definition of obesity and hepatitis; Urban Institute's Behavioral Health Services Algorithm (BHSA) for definitions of SUD and Mental Health; and ASPE's definition of I/DD.

Source: KFF analysis of the T-MSIS Research Identifiable Files, 2021

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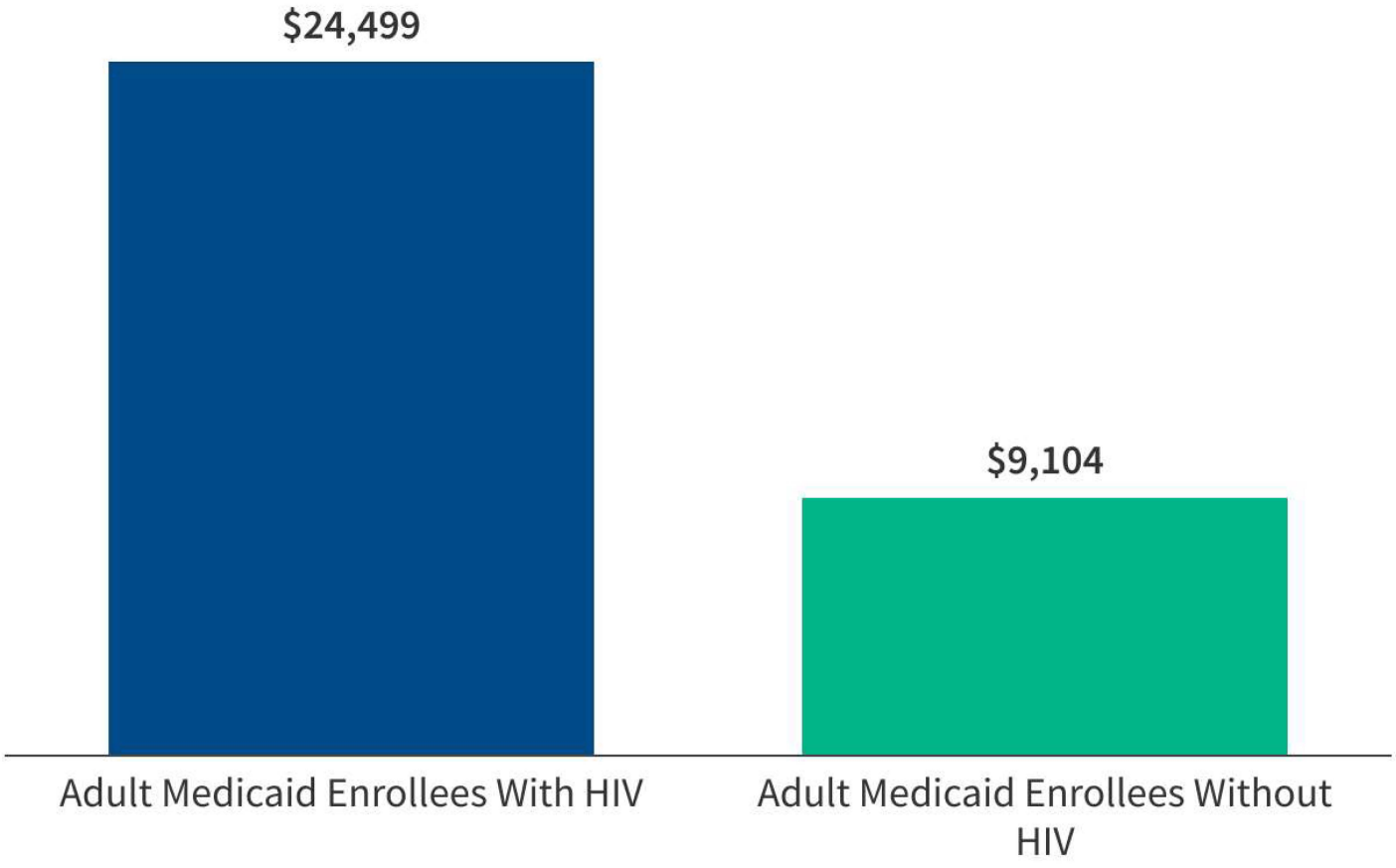
# 5. Spending for Medicaid enrollees with HIV is nearly three times higher than spending for those without HIV.

Spending on people with HIV enrolled in Medicaid is substantially higher than on those without HIV, reflecting higher health needs and costs of care. Average Medicaid spending per adult enrollee with HIV was about $24,000 in 2021, nearly three times that of adult Medicaid enrollees without HIV (about $9,000 per enrollee). While spending on enrollees with HIV was higher across all spending categories, the difference was especially marked in the drug/treatment category reflecting the relatively high cost of HIV medications (though notably, the drug spending data reflects pre-rebate amounts). Still, because people with HIV represent less than one-half of a percent of Medicaid enrollees overall, the net impact on Medicaid spending is small (less than 2%, see point 2 above).

Figure 5

## Spending for Adult Medicaid Enrollees with HIV is Nearly Three Times Higher Than Spending for Those Without HIV

Average annual per capita spending for adult Medicaid enrollees by HIV status, 2021




Note: This analysis reflect enrollees 18 and older (348,000 enrollees with HIV and 59.7 million enrollees without HIV). 49 states and D.C. were included in this analysis; Mississippi was excluded due to missing or inconsistent data. Average annual per capita spending calculations include fee-for-service spending, payments to managed care plans, and payments to Medicare.

Source: KFF analysis of the T-MSIS Research Identifiable Files, 2021

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### Methods

**Medicaid Claims Data:** Figures 3-5 in this analysis use the 2021 T-MSIS Research Identifiable Demographic-Eligibility and Claims Files (T-MSIS data) to identify Medicaid

enrollees with HIV.

**Identifying HIV in Medicaid Claims Data:** Enrollees with HIV were flagged if they had a relevant ICD 9 or ICD 10 code, any drug claims for a single tablet regiment (STR), or two or more other non-STR ARVs. A list of diagnosis and drug codes that were used for this analysis are available upon request.

**Enrollee Inclusion Criteria:** Enrollees were included if they were ages 18 or older and had at least one month of Medicaid coverage. Figure 4, which identifies rates of chronic conditions among those with and without HIV, also excludes those who had at least one month of Medicare coverage. These enrollees were excluded from these calculations since they may not have had sufficient claims in T-MSIS to identify chronic conditions.

**State Inclusion Criteria in Medicaid Claims Data:** To assess the usability of states' data, the analysis examined quality assessments from the DQ Atlas for service users in the "Other Services" and Drug files for 2021. 49 states and D.C. were included in this analysis. Mississippi was excluded since it received an "Unusable" rating on these measures.

**Defining Chronic Conditions (Figure 4):** This analysis used the CCW algorithm for identifying chronic conditions (updated in 2020), excluding its definition for mental illness, which was pulled from a different source. This analysis also included in its definition of chronic conditions substance use disorder, mental illness, obesity, hepatitis C, and intellectual and developmental disabilities (ASPE definition).

**Calculating Spending (Figure 5):** Average annual per capita spending calculations include fee-for-service spending, payments to managed care plans, and payments to Medicare. Spending was calculated by summing the total spending of all claims per enrollee in the T-MSIS claims files and manually adds Medicare premiums for those who are also enrolled in Medicare. Estimates here do not include prescription drug rebates and most supplemental payments to providers.

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# EXHIBIT C(ii)

THE AIDS INSTITUTE

TAI Policy Brief: October 25, 2021

# Closing the Health Coverage Gap Is the Key to Ending the HIV and Hepatitis C Epidemics

HIV and hepatitis C are at epidemic levels in the United States. Over more than 40 years, these diseases have ravaged the country, killing hundreds of thousands of people, devastating families and communities, and costing billions in health care costs. Thanks to revolutionary new medicines, people with either disease can be successfully treated and live long, healthy lives. Treatment also helps ensure that people living with HIV and hepatitis C cannot transmit these infectious diseases to others, stopping the epidemics in their tracks. But without health coverage, many low-income people living with HIV and hepatitis C cannot access or afford treatment and prevention. Health coverage is the key to health care, and ultimately ending the HIV and hepatitis C epidemics.

Health insurance remains out of reach for millions of Americans who live in states that have not taken advantage of the opportunity to expand Medicaid to all low-income adults. As a result, approximately two million low-income people remain uninsured in states – mostly in the South – that also have very high rates of HIV and hepatitis C. Improving access to health care will increase access to testing, prevention, care and treatment for these focus populations. If Congress closes the health coverage gap in those states, it can save lives, lessen health disparities, reduce the burden on our already strained health care system, and save the country billions of dollars.

**The first step to ending the HIV and hepatitis C epidemics is to make sure that people have access to health coverage. Health coverage opens the door to prevention, care, and treatment, all of which are needed to reduce the transmission of HIV and hepatitis C and prevent new cases.**

The AIDS Institute
National Policy Office
1627 "Eye" St NW, Suite 835 Washington, DC 20006 | Ph: 202-835-8373
Program, Policy, and Administrative offices
17 Davis Blvd, Suite 403, Tampa, FL 33606 | Tallahassee, FL | 813-258-5929
www.theaidsinstitute.org

## HIV and Hepatitis C Can Be Prevented and Cured – if People Have Access to Groundbreaking Medicines

Thanks to innovations in drug development and groundbreaking advancements in preventive measures, neither HIV nor hepatitis C is considered a death sentence today.

> **HIV**: When patients with HIV strictly adhere to their treatment regimens, not only can they live longer, healthier lives, but their HIV viral loads can be reduced to undetectable levels. This makes HIV untransmissible. And with the advent of pre-exposure prophylaxis (PrEP), a once-daily pill that prevents HIV infection, new cases can be avoided for people who are at a higher risk for contracting HIV.
>
> **Hepatitis C**: As with HIV, major advancements have been made in treating hepatitis C. Since these new treatments first came on the market in the 1990s, patients can now be cured in as little as eight weeks.

However, there are many people living with, and at risk for, HIV and hepatitis C who do not have access to these curative, life-saving treatments. Treatment costs are estimated to be between $1,500 and $4,500 each month for an HIV patient, depending on the medication or medications that are most appropriate; and hepatitis C treatment can be as high as $28,000 per month for a three-month course.[1,2] Most patients cannot afford these medicines without health insurance, but they cannot afford the kind of insurance they need due to the health coverage gap in their states.

## Why Is There a Coverage Gap?

The Supreme Court ruled in 2012 that the ACA's Medicaid expansion was optional for states, creating an unforeseen problem for low-income people in some states who needed health coverage. The ACA intended for states to expand their Medicaid programs by offering coverage to all residents with incomes up to at least 138% of the federal poverty level (FPL, which is $17,774 for an individual and $16,500 for a family of four).[3] Then the federal government would offer premium tax credits to people with incomes between 138-400% FPL (between $17,774-$51,520 for individuals) who bought coverage through the health insurance marketplaces. This would ensure that coverage was affordable and accessible for Americans at every income level.

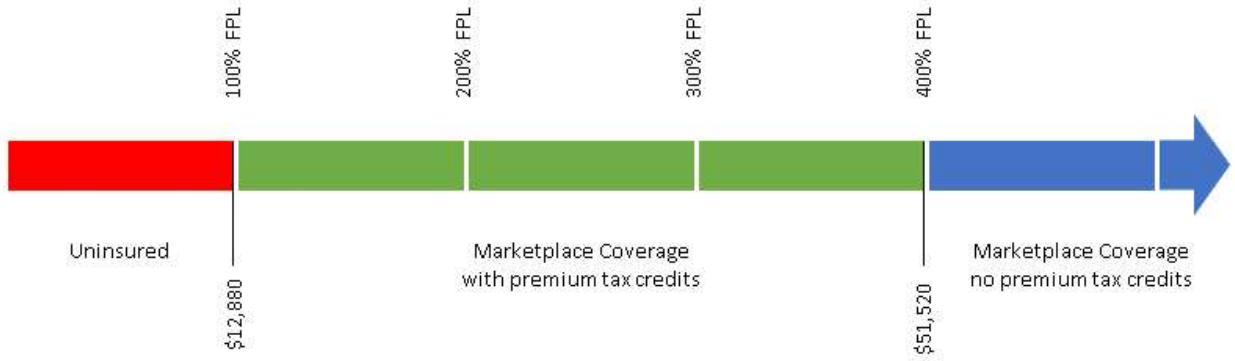
However, the ACA did not account for what would happen in states that opted not to expand Medicaid (non-expansion states). In those states, premium tax credits are available only to people with incomes at or above 100% FPL. Residents with incomes below 100% FPL but above their state's Medicaid eligibility level cannot get insurance through Medicaid or get help through premium tax credits. Without tax credits, monthly premiums for private insurance in these states can range from $325-$485 – amounts that are well beyond the budget of people making $12,880 or less per year. This leaves 2 million people without access to health care.

Figure 1.

Health Insurance Coverage by Income, Medicaid Expansion State




Health Insurance Coverage by Income, Coverage Gap State




## Which States Have This Coverage Gap, and Who Does It Affect?

To date, 12 states have yet to expand Medicaid: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

Many of these non-expansion states are at the nexus of the HIV and hepatitis C epidemics: The majority of these states are in the South, which is also home to a disproportionate share of people living with HIV and hepatitis C.

- The HIV epidemic continues to rage in the South: Southern states represent only 38% of the nation's population, but 53% of all new HIV diagnoses occurred in those states (according to the most recent data).[4]
- The ongoing opioid crisis has fueled the hepatitis C epidemic among younger adults aged 20-39, causing a 350% increase in new cases between 2010-2018.[5] Many of the states that have yet to expand Medicaid are among those hit hardest by the opioid epidemic[6]

Medicaid is a lifeline for people with these diseases, in the South and across the country.

**HIV**: Medicaid is the largest source of health coverage for people living with HIV, playing a critical role in preventing and treating the disease. However, an analysis by Kaiser Family Foundation found that Medicaid coverage for this group varies significantly across states. In non-expansion states, 20% of people living with HIV are uninsured, compared to 6% of people in states that have expanded Medicaid.[7] This has left nearly 86,000 people who have HIV without access to vital health coverage across the non-expansion states.[8]

**Hepatitis C**: People with hepatitis C are more likely to have Medicaid or be uninsured compared to people who don't have hepatitis C; those without insurance tend to have lower incomes.[9] A solution to close the coverage gap would provide a critical link to health care and treatment for this group.

Medicaid eligibility requirements in non-expansion states exclude many people who are not caregivers or disabled. This leaves a total of 2 million low-income residents without access to health insurance, including tens of thousands of people living with HIV and hepatitis C.[10] Low-income people of color are also overrepresented in the coverage gap population. And Black and Latino men and women have higher rates of new HIV diagnoses compared to people of other races and ethnicities.

Closing the coverage gap could give many low-income people access to much-needed health care, especially in the south where many barriers to health care exist such as poverty and rural landscapes. It could also help reduce persisting racial and ethnic disparities in health and health care. Ending these epidemics is possible if Congress expands health insurance and closes the coverage gap.

## Four Reasons Why Closing the Coverage Gap Is Essential

- It would help end the HIV and hepatitis C epidemics, saving thousands of lives
- It would reduce inequities in health and health care
- It would relieve the burden on the health care system
- It would save billions of dollars in health care spending

### Helping End the HIV and Hepatitis C Epidemics and Saving Lives

Several national plans have been developed that outline strategic goals and objectives with specific measures to end these epidemics. The more recent Ending the HIV Epidemic: A Plan for America (EHE initiative) is complimentary to the long-established HIV National Strategic Plan (the National Plan): The EHE initiative provides a focused strategy for targeted jurisdictions with disproportionately high rates of HIV, whereas the National Plan is a broader approach to addressing HIV across the United States. Both the HIV National Strategic Plan and the Viral Hepatitis National Strategic Plan cite lack of health insurance as a barrier to improving health outcomes and ending these epidemics.[11,12] The coverage gap presents a challenge to the ambitious goals of reducing new infections and reducing HIV and hepatitis C

disparities set out by these strategic plans, preventing an effective response. Without a solution that addresses the coverage gap, the decades of advocacy, billions of dollars in research, and public health resources that have been devoted to eradicating these diseases will be in vain.

To end the epidemics, additional funding to supplement existing state and federal resources is needed, program capacity must be expanded, and the cracks in the foundation of our health care system must be filled. The coronavirus pandemic made painfully clear our health care system is not a solid base to build upon. Temporary solutions had to be issued by the federal government to help fill the gaps during the emergency: Expanding access to premium tax credits, relaxing Medicaid eligibility criteria, waiving fees for testing and vaccinations.[13] Health care systems in states across the nation have been strained to their breaking point, including many of the 12 non-expansion states.

The four pillars of the EHE initiative are: diagnosis, treatment, prevention, and response.[14] But without access to insurance, our system of health care cannot provide any of these services to people with HIV or hepatitis C.

**HIV:** Consistent access and adherence to a prescription drug regimen is key to achieving viral suppression among people living with HIV. According to the Centers for Disease Control and Prevention (CDC), sustained viral suppression at levels that are undetectable makes it impossible to transmit HIV to others. Medicaid is crucial in this regard because it increases access to HIV treatment and prevention through coverage of prescription drugs, resulting in reduced transmission.[15] States that have expanded Medicaid, like Louisiana, have seen a significant reduction in HIV transmission.[16]

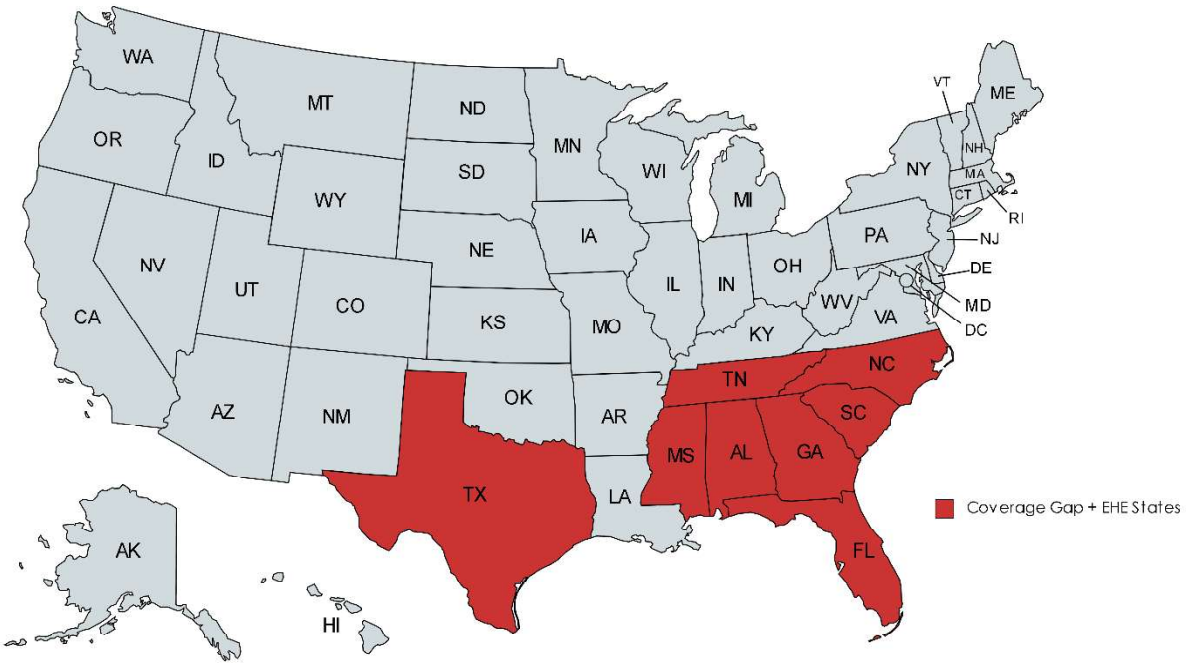
Another key factor in ending the HIV epidemic is improving access to PrEP to prevent the transmission of HIV. As a result of a decision by the U.S. Preventive Services Task Force, beginning this year, PrEP must be offered at no cost to beneficiaries in Medicaid expansion states.

**Hepatitis C:** The medical miracle of hepatitis C is that in a mere 25 years after the virus was discovered, a cure was developed. Today, there are several medications on the market that can cure a patient in eight weeks. In addition, the Task Force recommends that all adults aged 18-79 be screened for hepatitis C without having to pay any cost-sharing (they'll have no out-of-pocket costs). This will undoubtedly lead to more people being diagnosed, treated and cured.

By covering the costs of screening, diagnosis and treatment, Medicaid can play a role in eliminating this curable disease that silently kills if not treated. However, these best practices are available only to those enrolled in health insurance, which excludes people in non-expansion states. Ending these epidemics starts with improving access to health care by closing the coverage gap.

Figure 2.

The Map shows an overlap of states that have a coverage gap and were identified in the Ending the HIV Epidemic Initiative as priority jurisdictions. The HIV epidemic has disproportionately burdened southern states, where access to coverage has remained a challenge.




## Reducing Disparities in Health and Health Care and Improving Health Equity

Improving access to health coverage is inextricably linked to reducing racial and ethnic disparities in health and health care. This is especially true for patients with HIV or hepatitis C. Black Americans are disproportionately burdened by HIV and hepatitis C. They make up only 13% of the population, but they account for 42% of new HIV diagnosis.[17,18] And they are 2.3 times more likely than their white counterparts to have hepatitis C.[19]

Overall, 60% of all people who fall into the coverage gap are people of color, though they represent only 33% of the population of non-expansion states.[20] In states that have expanded Medicaid, Black and Hispanic residents have seen the greatest declines in uninsured rates.[21]

To end these epidemics, racial disparities in health, health care, and health coverage must be acknowledged and addressed. Closing the coverage gap is imperative to achieving health equity.

## Relieving the Burden on the Health Care System

The coverage gap affects not only people's health and the nation's ability to end these epidemics, but it also puts a strain on the health care system overall. Without health insurance,

a patient diagnosed with HIV or hepatitis C can't obtain routine care and treatment. Instead, that person may delay care until their condition worsens, or use emergency services as their primary source of care, burdening already strained health care systems. In 2020, community hospitals provided $41.61 billion in uncompensated care, much of that going to uninsured patients.[22] Uncompensated care costs are closely tied to the rate of uninsured people. States that have expanded Medicaid have seen a significant decline in uncompensated care: Uncompensated care costs fell 45% between 2013 and 2017 in those states, compared to 2% in non-expansion states.[23]

Coverage expansion has also alleviated the burden on safety net programs like the Ryan White HIV/AIDS Program. As a "payer of last resort," the Ryan White Program is intended to supplement other forms of health insurance. The program's funds cannot be used for services that are eligible for coverage by federal or state health insurance programs or by private insurance. In states that have expanded Medicaid, Ryan White Program dollars can go further because Medicaid pays for the majority of patients' care and treatment.

Texas has shown the stress that safety net programs, like the Ryan White Program can experience when states decide not to expand Medicaid. This year, Texas revealed that it was experiencing a $104 million budget crisis with its AIDS Drug Assistance Program,[24] which is an integral part of its Ryan White Program. This budget crisis is threatening access to medication for more than 21,000 people living with HIV.[25]

People enrolled in the Ryan White program have higher rates of viral suppression compared to the national average of people living with HIV.[26] The scaling up the success of the program to reach more people living with HIV hinges on health coverage also being expanded. Closing the coverage gap could help relieve the burden that state Ryan White HIV/AIDS Programs experience when they are forced to serve as the primary source of insurance rather than the safety net they were intended to be.

## Expanding Access to Health Insurance Makes Financial Sense

Expanding Medicaid eligibility to include people with incomes below 100% FPL could save states money, even if expansion meant more people enrolled in the program. Health insurance and access to health care improve health outcomes and prevent disability. Providing long-term or specialized medical care for a seriously ill patient who has experienced extensive, irreversible disease progression as a result of delayed care is far more costly than providing preventive care

**Hepatitis C:** If left untreated, hepatitis C causes liver damage, liver disease, cancer and even death. It also contributes to or exacerbates other serious and chronic health conditions, which in turn increases costs for the entire health care system. The average cost of treating a patient with hepatitis C is a one-time investment of $19,051, while the average cost to care for that person's accompanying health conditions and overall declining health is $205,760 over a lifetime.[27]

**HIV:** The lifetime treatment cost for a person with HIV is estimated to be over $350,000.[28] Compare this figure to the lifetime cost of preventing a person at high risk from getting infected at $96,700, saving $253,300 to prevent a single HIV infection.[29] These figures demonstrate the value of investing in treatment and prevention. Closing the coverage gap is the most fiscally responsible option for all states.

## Conclusion

There are many proposed policy solutions to close the coverage gap. States that have not yet expanded Medicaid could choose to expand their programs' eligibility criteria, and take advantage of enhanced federal funding to support the transition.[30] Congress has the opportunity to close the coverage gap by passing legislation. Some of the proposals build off of existing infrastructure, such as expanding eligibility for premium tax credits for people with incomes below 100% FPL.[31] Other options suggest offering a federally-run program that mirrors the state Medicaid programs, or a public option similar to Medicare.[32] It is imperative that Congress members or state leaders act now to close the coverage gap, regardless which option they choose. The AIDS Institute urges policy makers to find a way to close the coverage gap, ensuring the thousands of people living with HIV and hepatitis C who are currently without affordable health coverage can get the care they need. Closing the coverage gap will not only bring health insurance to millions of low-income people, reduce health disparities, and saving money; closing the coverage gap will save the lives of thousands of people with HIV and hepatitis who will have access to life-saving care and treatment. Closing the coverage gap is the key to ending the HIV and hepatitis epidemics.

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[1] K. M. Robinson, *Health for Hepatitis C Treatment Costs,* (WebMD, June 26, 2020), https://www.webmd.com/hepatitis/help-hepatitis-c-treatment-costs

[2] N. McCann, T. Horn, E. Hyle, *HIV Antiretroviral Therapy Costs in the United States, 2012-2018,* (Journal of the American Medical Association: Internal Medicine, February, 3, 2020), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2759735

[3] Federal Poverty Level is an economic measure of income used to determine eligibility for certain federal assistance programs. These guidelines are established annually by the Office of the US Assistant Secretary for Planning and Evaluation.

[4] US Department of Health & Human Services, *Ending the HIV Epidemic, https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview*

[5] A.B. Ryerson, S. Schillie, L. Barker, B. Kupronis, C. Wester, *Vital Signs; Newly Reported Acute and Chronic Hepatitis C Cases-United States, 2009-2018* (MMWR, April 10,2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6914a2.htm?s_cid=mm6914a2_w#F2_down

[6] National Institutes of Health, *Opioid Summaries by State,* (National Institute on Drug Abuse), https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state

[7] Lindsey Dawson, Jennifer Kates, *Insurance Coverage and Viral Suppression Among People with HIV, 2018,* (Kaiser Family Foundation, September 24, 2021), https://www.kff.org/hivaids/issue-brief/insurance-coverage-and-viral-suppression-among-people-with-hiv-2018/

[8] Analysis conducted by The AIDS Institute using data from the Centers for Disease Control 2019 HIV Surveillance Report and Prevention and Kaiser Family Foundation

[9] H. Bush, J. Paik, P. Golabi, L. Avila, C. Escheik, Z. Younossi, *Imapct of Hepatitis C Virus and Insurance Coverage on Mortality,* (The American Journal of Managed Care, February 7, 2019), https://www.ajmc.com/view/impact-of-hepatitis-c-virus-and-insurance-coverage-on-mortality

[10] R. Garfield, K. Orgera, A. Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid,* (Kaiser Family Foundation, January 21, 2021), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

[11] US Department of Health & Human Services, *National Strategic Plan: A Roadmap to End the Epidemic for the United States, 2021-2025,* https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf

[12] US Department of Health & Human Services, *Viral Hepatitis National Strategic Plan: A Roadmap to Elimination, 2021-2025, https://www.hhs.gov/sites/default/files/Viral-Hepatitis-National-Strategic-Plan-2021-2025.pdf*

[13] The White House, *Fact Sheet: President Biden's New Executive Actions Deliver Economic Relief for American Families and Businesses Amid the COVID-19 Crisis,* (January 22, 2021) https://www.whitehouse.gov/briefing-room/statements-releases/2021/01/22/fact-sheet-president-bidens-new-executive-actions-deliver-economic-relief-for-american-families-and-businesses-amid-the-covid-19-crises/

[14] HHS, https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/key-strategies

[15] A. Hollingsworth, S. Raman, D. Sacks, and K.Wen, *Panel Paper: Does Providing Insurance Coverage Reduce the Spread of Infectious Disease? The Impact of Medicaid Expansions on HIV Diagnoses*, Association for Public Policy Analysis and Management, 41st Annual Fall Research Conference, November 9, 2019, https://appam.confex.com/appam/2019/webprogram/Paper31657.html.

[16] E. Woodruff, "New HIV Cases in Louisiana Hit Decade Low in 2018; Health Officials Hopeful for Epidemic's End," NOLa.com, July 3, 2019 , https://www.nola.com/news/healthcare_hospitals/article_4c7e9078-9dd0-11e9-8d81-cf4844533a8d.html.

[17] G. Lukens, B. Sharer, *Closing Medicaid Coverage Gap Would Help Diverse Group and Narrow Racial Disparities* (Center on Budget and Policy Priorities, June 14, 2021), https://www.cbpp.org/research/health/closing-medicaid-coverage-gap-would-help-diverse-group-and-narrow-racial.

[18] Centers for Disease Control & Prevention, *Health Disparities in HIV/AIDS, Viral Hepatitis, STDs, and TB,* https://www.cdc.gov/nchhstp/healthdisparities/africanamericans.html

[19] Centers for Disease Control & Prevention, *Estimating Prevalence of Hepatitis C Virus Infection in the United States, 2013-2016*, https://www.cdc.gov/nchhstp/newsroom/2018/hepatitis-c-prevalence-estimates.html

[20] G. Lukens and B. Sharer, *Closing Medicaid Coverage Gap Would Help Diverse Group and Narrow Racial Disparities*

[21] E. Terlizzi, R. Cohen, M. Martinez, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January-September 2018*, (National Center for Health Statistics, February 2019), https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201902.pdf

[22] American Hospital Association, Fact Sheet: Uncompensated Hospital Care Cost, (Janurary 2021) https://www.aha.org/fact-sheets/2020-01-06-fact-sheet-uncompensated-hospital-care-cost

[23] M. Broaddus, *Uncompensated Care Costs Well Down in ACA Medicaid Expansion States,* (Center on Budget & Policy Priorities, October 21, 2020), https://www.cbpp.org/blog/uncompensated-care-costs-well-down-in-aca-medicaid-expansion-states

[24] T. Murphy, *A Texas ADAP Shortfall Is Threatening Medication Supply for People with HIV,* (The Body, March 26, 2021) https://www.thebody.com/article/texas-adap-shortfall-hiv-medication

[25] S. Ayres, *Budget Crunch for Texas HIV Drug Program Creates Crisis of Confidence,* (Spectrum Local News, April 5, 2021), https://spectrumlocalnews.com/tx/south-texas-el-paso/news/2021/04/05/budget-crunch-for-texas-hiv-drug-program-creates-crisis-of-confidence

[26] L. Cheever, *HRSA Announces Record High HIV Viral Suppression Rate in New 2019 Ryan White HIV/AIDS Program Client-Level Data Report,* HIV.gov (December 7, 2020), https://www.hiv.gov/blog/hrsa-announces-record-high-hiv-viral-suppression-rate-new-2019-ryan-white-hivaids-program

[27] F. Hood, *Treating Hepatitis C Saves Lives and Money* (The AIDS Institute, August 2021), https://aidsinstitute.net/documents/Fact-Sheet---Treating-Hepatitis-C-Saves-Lives-and-Money.pdf

[28] Centers for Disease Control & Prevention, HIV Cost-Effectiveness https://www.cdc.gov/hiv/programresources/guidance/costeffectiveness/index.html#:~:text=Currently%2C%20the%20lifetime%20treatment%20cost,than%20%24379%2C668%20per%20infection%20averted.

[29] B. Schackman, J. Fleishman, A. Su, B. Berkowitz, R. Moore, R. Walensky, J. Becker, C. Voss, A.D. Paltiel, M. Weinstein, K. Freedberg, K. Gebo, E. Losina, *The Lifetime Medical Cost Savings from Preventing HIV in the United States.* (Med Care, April 2015)

[30] E. Gee, N. Rapfogel, *Closing the edicaid Coverage Gap Would Save 7,000 Lives Each Year,* (Center for American Progress, September 10, 2021), https://www.americanprogress.org/issues/healthcare/news/2021/09/10/503687/closing-medicaid-coverage-gap-save-7000-lives-year/#:~:text=The%20most%20straightforward%20solution%20to,%2C%20evictions%2C%20and%20medical%20debt.

[31] Center for Health Law & Policy Innovation, *Filling the Medicaid Coverage Gap: A Federal Policy Priority for People Living with HIV,* (Harvard Law School, June 2021), https://www.chlpi.org/wp-content/uploads/2013/12/Filling-the-Medicaid-Coverage-Gap.pdf

[32] J. Holahan, M. Simpson, *Filling the Medicaid Gap with a Public Option,* (Urban Institute, July 14, 2021) https://www.urban.org/research/publication/filling-medicaid-gap-public-option

# EXHIBIT C(iii)

THE AIDS INSTITUTE

October 2025

# 7 Reasons to Exempt People with HIV from Medicaid's Community Engagement Requirement

*Beginning January 1, 2027, Medicaid expansion programs will have a new "community engagement" requirement that means people must show that they completed at least 80 hours of work, school, or a qualifying volunteer activity per month,* ***unless they are exempt****. States will soon be making decisions about how this requirement will work, including who is exempt from it. The law requires states to exempt people with "special medical needs," (including people who have a serious or complex chronic illness) from the requirement. Advocates should urge their state Medicaid agency and/or state legislatures to include people with HIV in that exempted group.*

Here are 7 reasons that states should exempt people with HIV from the community engagement requirement:

1) HIV is a serious and complex chronic condition that requires consistent and continuous treatment, medical monitoring, and care coordination to achieve "viral suppression" and stay healthy and able to work. CMS and states have already agreed that HIV is a serious and complex chronic illness in other contexts.[1]
2) HIV treatment is HIV prevention: People with an undetectable viral load cannot transmit HIV to others. Keeping people with HIV in treatment helps prevent the spread of HIV.[2]
3) Medicaid enrollees with HIV are more than twice as likely to have multiple chronic conditions (in addition to HIV) than enrollees without HIV (32% vs 13%).[3] Moreover, people with HIV are twice as likely to have either a substance use disorder or mental health condition (44% vs 23%),[4] which are also reasons to be exempted from the community engagement requirement. Managing HIV, multiple chronic conditions, and the red tape of community engagement requirements is difficult, so these populations should be exempt.
4) HIV can make it more difficult for people to adhere to a regular work schedule because of medication side effects, periods of illness, and the need to attend many doctors' appointments.[5] Employees with HIV may require flexible work arrangements that can be hard to find or keep. It is cruel to penalize people in this situation by removing access to lifesaving treatment.
5) Medicaid is a work support for people with HIV, because it provides consistent and continuous access to treatment that keeps people with HIV healthy. Disruption of care due to administrative reporting requirements undermine the ability of people to work and can lead to long term unemployment.[6]

6) Half of people with HIV enrolled in Medicaid are age 45-64,[7] and therefore face significant challenges entering the workforce if they are not already employed due to age discrimination and HIV stigma.[8] People aging with HIV face the early onset of aging-related health issues, making it even more important for older people with HIV to remain in continuous care.[9]

7) If people with HIV lose access to Medicaid, they are likely to look to Ryan White Care programs. These programs have not received any increase in federal funding in well over a decade and lack the resources to serve everyone with HIV. This will lead to benefit reductions, eligibility cuts, and wait lists, compromising care for all Ryan White clients, or require state budgets to supplement federal Ryan White program funding.

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[1] CMS has acknowledged that HIV and viral hepatitis are serious chronic illnesses in regulations regarding Medicaid benefits, Medicare payment and claims policies. AZ and IN exempted people with HIV from work requirement waiver programs.

[2] HIV.gov, "Viral Suppression and an Undetectable Viral Load," October 24, 2025. https://www.hiv.gov/hiv-basics/staying-in-hiv-care/hiv-treatment/viral-suppression

[3] Lindsey Dawson, Priya Chidambaram & Jessica Mathers, *5 Key Facts About Medicaid Coverage for People with HIV*, KFF, Apr. 1, 2025. https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-with-hiv/.

[4] Catherine H. Maulsby et al., "A Scoping Review of Employment and HIV," *AIDS and behavior* 24, 10 (2020) 2942-2955. https://pmc.ncbi.nlm.nih.gov/articles/PMC7716244/pdf/nihms-1650652.

[5] Ibid: Catherine H. Maulsby et al., "A Scoping Review of Employment and HIV," *AIDS and behavior* 24, 10 (2020) 2942-2955. https://pmc.ncbi.nlm.nih.gov/articles/PMC7716244/pdf/nihms-1650652.

[6] Ibid: Catherine H. Maulsby et al., "A Scoping Review of Employment and HIV," *AIDS and behavior* 24, 10 (2020) 2942-2955. https://pmc.ncbi.nlm.nih.gov/articles/PMC7716244/pdf/nihms-1650652.

[7] Lindsey Dawson, Priya Chidambaram & Jessica Mathers, *5 Key Facts About Medicaid Coverage for People with HIV*, KFF, Apr. 1, 2025. https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-with-hiv/.

[8] Nari Rhee, Medicaid Cuts—Including Work Documentation Requirements—Harm Older Adults, UC Berkeley Labor Center (June 23, 2025), https://laborcenter.berkeley.edu/medicaid-cuts-including-work-documentation-requirements-harm-older-adults/

[9] HIV.gov, *Aging with HIV*, September 8, 2025. https://www.hiv.gov/hiv-basics/living-well-with-hiv/taking-care-of-yourself/aging-with-hiv.

*The AIDS Institute is a national non-partisan, nonprofit organization that promotes action for social change through public policy, research, advocacy and education. For more information and to become involved, visit www.TheAIDSInstitute.org or write to us at info@taimail.org, and follow The AIDS Institute on X @AIDSAdvocacy, Facebook at www.facebook.com/The-AIDS-Institute, and LinkedIn @the-aids-institute.*

*This fact sheet was authored by: Rachel Klein, The AIDS Institute*

# EXHIBIT D

FEDERAL AIDS POLICY PARTNERSHIP
HIV HEALTH CARE ACCESS WORK GROUP

May 20, 2026

The Honorable Robert F. Kennedy, Jr.
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dr. Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

The Honorable Russell Vought
Director, Office of Management and Budget
725 17th Street, NW
Washington, DC 20503

Re: Medicaid Community Engagement Requirement

Dear Secretary Kennedy, Dr. Oz, and Director Vought:

On behalf of the HIV Health Care Access Working Group (HHCAWG)—comprised of organizations working to advance policies that ensure the millions of people living with HIV have consistent access to comprehensive care and treatment—we write to urge you to adopt a definition of medical frailty or special medical needs that gives full meaning to the category of people with a "serious or complex condition," which should include people living with HIV. Such a definition honors the language and intent of H.R. 1, ensuring that people who rely on Medicaid to manage serious, complex illnesses that do not meet the standard for disability are able to maintain their connection to ongoing medical care.

Medicaid is the cornerstone of President Trump's initiative to End the HIV Epidemic, which he announced in the State of the Union address in 2019. Medicaid is a crucial program for people with HIV, providing 45% of all federal funding for HIV treatment and providing access to care for 40% of all people living with HIV in the United States. In Medicaid expansion states, more than half of people with HIV who are enrolled in Medicaid are in the adult expansion group.

## I. "Serious or Complex Medical Condition" Does Not Require a Showing of Disability

The budget reconciliation act of 2025 (P.L. 119-21) or H.R. 1, the One Big Beautiful Bill Act, established for the first time national community engagement requirements for people who

access Medicaid through the expansion pathway. Recognizing the importance of Medicaid to people who are living with chronic illnesses and disabilities—including many people who are enrolled in Medicaid expansion, rather than traditional Medicaid[1]—Congress included a mandatory exemption from the community engagement requirement for people who are "medically frail or otherwise [have] special medical needs."[2] That broad category includes five statutorily mandated subcategories separated by the word "or," indicating that a person who falls into any *one* of the five subcategories qualifies as medically frail or having special medical needs.

Three of the five subcategories of people with special medical needs are people with disabilities: those who are blind or disabled under the Social Security Act definition of disability, those who have a "disabling mental disorder," and those with a "physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living." The other two subcategories—those with a "serious or complex medical condition" and those with a "substance use disorder"—by their plain terms do not require a showing of disability or inability to work. Had Congress wanted all five subcategories to require a showing of disability or physical or mental inability to work, it could have specified as much (as evidenced by the language that describes the other three categories), but Congress did not do so. The logical interpretation of this omission is that Congress recognized the importance of uninterrupted access to care for people living with serious or complex conditions, including HIV, and for people living with substance use disorders. The Centers for Medicare and Medicaid Services (CMS) should adopt an interpretation of "serious or complex medical condition" that adheres to Congress's plain intent and does not require a showing of disability.

Moreover, the federal government has elsewhere defined a "serious and complex condition" for the purpose of avoiding disruptions in access to health care. This common-sense definition should be applied to the Medicaid community engagement mandatory exemptions, where continuity of access to care is just as critical. At 26 USC § 9818(b)(2), the Internal Revenue Service defines a "serious and complex condition" as one that, in the case of a chronic condition, is "life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time." This definition does not require evidence that a person is already disabled; rather, the emphasis is on the potential for life-threatening or disabling consequences and the need for ongoing access to care.

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[1] Lindsey Dawson, Priya Chidambaram & Jessica Mathers, *5 Key Facts About Medicaid Coverage for People with HIV*, KAISER FAM. FOUND. (Apr. 1, 2025), https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-with-hiv/; Sara Rosenbaum et al., *Implementing Medicaid Work Reporting Requirements: Defining A 'Serious or Complex Medical Condition'*, Health Affairs Forefront (Jan. 12, 2026) https://www.healthaffairs.org/content/forefront/implementing-medicaid-work-reporting-requirements-defining-serious-complex-medical (finding high percentages of adults on Medicaid who are over 50 but under 65 who do not have known limitations in their ability to perform activities of daily living but who have two or more chronic conditions that make uninterrupted access to care critical).

[2] P.L. 119-21 § 71119(a)(9)(A)(ii)(V).

## II. HIV is a serious and complex chronic medical condition that qualifies a person for the medically frail or special medical needs exemption under H.R. 1

HIV is a serious and complex medical condition under the H.R. 1 definition because HIV requires consistent, continuous, lifelong treatment to prevent debilitating illness, potential drug resistance, and ultimately, the advancement to AIDS. 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, broadly. When HIV is effectively managed and individuals stay engaged in treatment, and achieve and maintain viral suppression, people with HIV can live healthy lives—including engaging in work, education, or other pursuits—and there is no risk of sexual transmission or community spread.[3] These outcomes require continuous access to HIV medications and related care, which in turn require uninterrupted insurance coverage.[4]

We are concerned that requiring people living with HIV to comply with the new work reporting requirements will create administrative barriers that will lead to improper terminations and lost access to crucial healthcare, even for people who are working. For people living with HIV, loss of Medicaid due to erroneous denials and administrative red tape could lead to care disruptions that can pose enduring, costly, and complex health risks such as the development of drug-resistant HIV.[5] Additionally, more than half of people living with HIV are age 50 and older,[6] a group that is particularly likely to have difficulty complying with work requirements due a variety of factors, including comorbidities that often lead to challenges maintaining employment, age discrimination that makes it difficult to find employment, or caregiving responsibilities for spouses, parents, or adult children with disabilities.[7]

Accordingly, the Centers for Medicare and Medicaid Services (CMS) has repeatedly recognized HIV as a "serious chronic medical condition" warranting special treatment related to Medicaid eligibility and coverage.[8] Several states have also recognized people living with HIV as

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[3] Myron S. Cohen et al., *Antiretroviral Therapy for the Prevention of HIV-1 Transmission*, NEJM, 2016; Robert W. Eisinger, Carl W. Dieffenbach & Anthony S. Fauci, *HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittable*, 321 JAMA 451, 2019.

[4] Lindsey Dawson and Jennifer Kates, *Insurance Coverage and Viral Suppression Among People with HIV*, 2018, KFF, Sept. 4, 2020, https://www.kff.org/hiv-aids/insurance-coverage-and-viral-suppression-among-people-with-hiv-2018/ ("*Insurance Coverage and Viral Suppression*").

[5] Elizabeth Hamlyn et al., *Plasma HIV Viral Rebound Following Protocol-Indicated Cessation of ART Commenced in Primary and Chronic HIV Infection*, PLOSOne, 2012; Gerald Friedland & Ann Williams, *Attaining Higher Goals in HIV Treatment: The Central Importance of Adherence*, 13 AIDS S61, 1999.

[6] HIV.gov, *Aging with HIV*, Sept. 8, 2025. https://www.hiv.gov/hiv-basics/living-well-with-hiv/taking-care-of-yourself/aging-with-hiv.

[7] Nari Rhee, Medicaid Cuts—Including Work Documentation Requirements—Harm Older Adults, UC Berkeley Labor Center, June 23, 2025., https://laborcenter.berkeley.edu/medicaid-cuts-including-work-documentation-requirements-harm-older-adults

[8] *E.g.*, Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 Fed. Reg. 42,160, 42,233 (July 15, 2013) ("We agree with the commenters that illnesses such as HIV/AIDS, viral hepatitis, cancer and end stage renal disease are all serious chronic medical conditions."); Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program, 88 Fed. Reg. 78,818, 78,938 (Nov. 16, 2023) ("Examples of a serious, high-risk condition/illness/disease include,

"medically frail" under previous work requirement proposals or exemptions to the Medicaid Alternative Benefit Plan rules.[9] Most recently, Nebraska has included HIV on its list of diagnosis codes that will trigger eligibility for the serious or complex condition exemption to the work requirement under H.R. 1.[10] We understand that numerous other states have planned for that, as well.

We therefore urge you to adopt a definition of the "serious or complex medical condition" subcategory of medical frailty or special medical needs that encompasses all people living with HIV. It is a medical condition that lasts for a lifetime and requires consistent, uninterrupted access to care.

### III. Many People with HIV Qualify for Medicaid Only Through Medicaid Expansion

Medicaid expansion has been a lifeline for many people living with HIV. Prior to Congress's passage of Medicaid expansion, eligibility for Medicaid was limited to those who met financial eligibility requirements and fell into one of the traditional Medicaid categories, such as people with disabilities, people over the age of 65, children, and pregnant people. Low-income people living with HIV could not qualify for Medicaid unless they met one of the existing eligibility categories or had already developed advanced disease due to HIV. This created a "catch-22" for many people with HIV, whereby they could not access comprehensive health insurance—which could help them stave off severe disease—until after their health had substantially deteriorated.[11] Many people with HIV in states that have not expanded Medicaid remain uninsured for this reason.[12]

Today, 42 percent of people living with HIV who are enrolled in Medicaid access the program through Medicaid expansion.[13] These individuals may not qualify for any of the categorical

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but are not limited to… HIV/ AIDS"); Centers for Medicare & Medicaid Services, CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 12461 (Jan. 18, 2024) https://www.cms.gov/files/document/r12461cp.pdf ("[I]f the practitioner is furnishing ongoing care related to a patient's single, serious and complex condition, e.g., … HIV, then the add-on code G2211 could be billed. The add-on code G2211 captures the inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship.").

[9] *E.g.*, ARIZONA SECTION 1115 WAIVER AMENDMENT REQUEST: AHCCCS WORKS WAIVER, 9 (Dec. 19, 2017), https://www.azahcccs.gov/shared/Downloads/News/AHCCCSWorks1115WaiverAmendmentRequest.pdf (those with HIV/AIDS would be considered "medically frail," qualifying for exemption under proposed work requirement); Indiana State Plan Amendment: IN-15-0025-HIP Plus ABP, ABP 2a (Oct. 29, 2015), https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IN/IN-15-0025.pdf ("All individuals with an active disability determination by the Social Security Administration *or* a confirmed diagnoses of HIV/AIDS from the Indiana State Department of Health will be confirmed medically frail without having to self report their frail status" (emphasis added).

[10] Nebraska Medicaid Work Requirements, Medically Frail Exemption Conditions Index, p. 4, https://dhhs.ne.gov/Documents/Nebraska%20Medicaid%20Work%20Requirements%20-%20Medically%20Frail%20and%20SUD%20Conditions.pdf.

[11] Jennifer Kates and Lindsay Dawson, *Insurance Coverage Changes for People with HIV Under the ACA*, KFF (Feb. 14, 2017), https://www.kff.org/affordable-care-act/insurance-coverage-changes-for-people-with-hiv-under-the-aca/.

[12] *See Insurance Coverage and Viral Suppression*, supra note 4.

[13] Lindsey Dawson, Priya Chidambaram & Jessica Mathers, *5 Key Facts About Medicaid Coverage for People with HIV*, KAISER FAM. FOUND. (Apr. 1, 2025), https://www.kff.org/medicaid/5-key-facts-about-medicaid-coverage-for-people-with-hiv/

eligibility pathways for traditional Medicaid, including eligibility for people who are disabled. That is because Medicaid based on disability generally requires a person to meet the Supplemental Security Income (SSI) definition of disability, which requires significant impairment in an individual's ability to work.[14] Many people living with HIV do not meet this definition *because* the treatment they are able to get through Medicaid keeps them healthy enough to avoid worsening illness or disability. For them, continuous health coverage and access to care is an essential support that helps them maintain their health so that they can continue to work or otherwise participate in their communities.

## IV. Allowing Verifiable Self-Attestation of Serious or Complex Chronic Illness is Necessary

Congress recognized the importance of continuous coverage for people living with HIV and other serious or complex conditions when it incorporated the "serious or complex medical condition" exemption subcategory into H.R. 1 *in addition* to people with disabilities and other concerns. We urge the federal government to fully implement this exemption in its forthcoming guidance and to permit verifiable self-attestation as a sufficient basis for the exemption. Because H.R. 1 does not require states to verify exemption status, states can and should accept self-attestation integrated directly into the Medicaid application—without requiring separate forms or affidavits.[15]

We understand that implementing the community engagement requirement and other aspects of H.R. 1 is a complex job that requires balancing many different considerations. We look forward to working with you to ensure that these important decisions do not undermine the goal we share with President Trump: achieving once and for all an end to the HIV epidemic in the United States. Please reach out to Rachel Klein, Deputy Executive Director at The AIDS Institute at rklein@taimail.org or (202) 815-2973 to arrange a time to meet.

Sincerely,

Elizabeth Kaplan, Director of Health Care Access, Center for Health Law and Policy Innovation
Rachel Klein, Deputy Executive Director, The AIDS Institute
Dori Molozanov, Senior Manager of Health Systems Integration, NASTAD
Leslie McGorman, Senior Director of Policy and Strategy, AIDS United
Terri Wilder, Manager of Health & Economic Security Policy, SAGE

[14] MACPAC, *People with disabilities* (July 30, 2025), https://www.macpac.gov/subtopic/people-with-disabilities/.

[15] National Alliance on Mental Illness (NAMI) and Legal Action Center. *Work Reporting Requirements and Mental Health: Recommendations to Protect Individuals with Mental Health Conditions from Losing Medicaid.* November 2025. Available at: https://www.nami.org/wp-content/uploads/2025/11/2025-Work-Reporting-Requirements-and-Mental-Health.pdf.