Dear Secretary Burwell:

We are writing on behalf of the HIV Health Care Access Working Group (HHCAWG) – a coalition of more than 100 national and community-based HIV service organizations representing HIV medical providers, public health professionals, advocates, and people living with HIV who are all committed to ensuring access to critical HIV-related health care and support services. As CMS reviews Indiana’s and other state waiver requests, we urge you to consider the ACA’s intent to increase access to meaningful health care coverage, particularly for individuals living with HIV and other vulnerable populations who are largely dependent on Medicaid for health care.

Medicaid is currently a lifeline for at least fifty percent of people with HIV who are in care – a percentage that is growing with the implementation of the Medicaid expansion in many states. If every state were to expand their program, nearly 50,000 people with HIV in care would gain access to Medicaid, not including the additional numbers of individuals who are likely to be eligible but who are not yet connected to care. To this end, we support state efforts to expand their Medicaid programs to the full extent allowed under the ACA, and understand that states may take different approaches to the expansion process.

However, as CMS reviews expansion proposals it is important to hold firm to the comprehensive coverage standards and critical protections that have been a hallmark of the Medicaid program. These standards and protections were established through robust legislative and regulatory processes to protect the country’s most vulnerable residents. In particular, we urge CMS to maintain high standards with respect to:

- protecting the medically frail,
- preserving established premium and cost-sharing limits,
• maintaining comprehensive benefits, including adequate wrap-around services in premium assistance models,
• requiring robust provider networks, and
• ensuring a fair and just appeals process that maintains consumer protections.

While 1115 waivers are designed to encourage state innovation, such innovation cannot come at the expense of eroding the program’s most important features and jeopardizing access to care. We are writing to reiterate key recommendations that we urge you to consider in reviewing all state waiver proposals and with specific recommendations and concerns regarding the Healthy Indiana Plan (HIP 2.0).

KEY RECOMMENDATIONS/CONCERNS

• CMS should advise against proposals that would increase the complexity of Medicaid program that is already complicated by different eligibility groups and benefit structures in addition to significant variations by state. **We are particularly concerned by the complexity of HIP 2.0 that will create serious confusion among enrollees and providers in addition to making administration and monitoring extremely challenging.** The structure of who is eligible for which benefits package; who is charged co-payments versus premiums (“POWER” account contributions) on top of the implications for failure to pay premiums are difficult for health policy experts to follow let alone individuals new to Medicaid and to health insurance (in addition to the fact that many are dealing with other health and life challenges).

• CMS should require detailed information about state processes to identify and educate the medically frail to ensure that all medically frail enrollees are enrolled in the coverage that best meets their medical needs. At a minimum, anyone living with HIV should automatically qualify as medically frail. **In the HIP 2.0 proposal, it is noted that the Medically Frail will be identified through the information included in the application and this group will maintain the state plan benefits and cost sharing requirements. We urge you to ensure that the Medically Frail criteria are appropriately and clearly outlined in the application and that the enrollment process includes the appropriate dedication of resources and outreach to support education and identification of this population.**

• CMS must not permit states to increase enrollee premiums and cost-sharing beyond the established limits. Even minimal cost sharing can present a significant barrier to care, particularly for people living with HIV and other chronic conditions who utilize the health care system more than the general population. We have a number of concerns with the HIP 2.0 application of premiums through POWER account contributions. We urge CMS to:
  
  o **Deny Indiana’s proposal to charge premiums through POWER account contributions to individuals below 100% of the federal poverty line.** This policy would set a
dangerous precedent and undermine the viability of the Medicaid program as a safety-net program for individuals with very low incomes.

- **Reject the proposal to delay coverage until premium payments are made and also reject the proposal to impose a 6-month lock out for failure to pay premiums.** The cost-sharing and premium protections established for the Medicaid program reflect the fiscal realities for low income individuals who must make very difficult choices to meet their basic living needs, i.e., food, clothing, shelter and health care. Delaying coverage or locking individuals of coverage for failure to pay premiums is counter to the intent of the Medicaid program, and for people with HIV and others with complex, chronic conditions, the decision can have serious and costly health consequences.

- CMS must ensure access to comprehensive benefits for all individuals in Medicaid, including adequate wrap-around services for individuals in premium assistance plans. We urge CMS to:

  - **Ensure the HIP Basic coverage meets the minimum Alternative Benefits Plan standard and does not limit access to key services, such as prescription drugs through narrower formularies or utilization management.** People with HIV and others with complex chronic conditions who have a greater medical need for robust benefit packages are also likely to face greater challenges making the “POWER” account or premium contributions. Many of them will not have a real choice between HIP Basic and HIP Plus.
  - **Deny Indiana’s request to waive non-emergency medical transportation for the newly eligible low income adults.** Non-emergency transportsations is an important benefit to people with HIV and particularly in rural areas can often make the difference in their ability to access medical care.

- CMS must ensure that individuals in Medicaid and premium assistance plans have access to adequate provider networks and should require states to provide detailed information on plan networks, including geographic access and inclusion of Ryan White Program and other specialty providers. **With regard to HIP 2.0, CMS must ensure that if there are only the current three “Managed Care Entities” providing medical benefits under HIP 2.0 that there is sufficient provider capacity to meet the medical needs of the existing and new enrollees in a timely and geographically accessible manner. In addition, we urge you to specifically monitor for access to specialty providers, such as HIV and mental health providers.** We also note that the state received several comments regarding provider network adequacy during its public process.

Thank you for your consideration of our comments, and for your continued efforts to ensure that Medicaid will continue to meet the needs of its most vulnerable enrollees. Please contact the HHCAWG Co-Chairs Andrea Weddle with the HIV Medicine Association (aweddle@idsociety.org); Robert Greenwald with the Treatment Access Expansion Project (Rgreewa@law.harvard.edu); or Amy Killelea
with the National Association of State and Territorial AIDS Directors (Akillelea@nastad.org) with questions.

Respectfully submitted by the HIV HealthCare Access Working Group Steering Committee,