February 7, 2019

Submitted via the Federal Medicaid.gov Portal

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: TennCare II Demonstration Amendment 38

To Whom It May Concern:

The HIV Health Care Access Working Group (HHCAWG) appreciates the opportunity to comment on Tennessee's TennCare II Demonstration Amendment (the "Tennessee Application") under Section 1115 of the Social Security Act. HHCAWG is a coalition of over 100 national and community-based HIV service organizations representing HIV medical providers, public health professionals, advocates, and people living with HIV who are all committed to ensuring access to critical HIV- and Hepatitis C (HCV) related health care and support services.

The Medicaid program is a critical source of health coverage for life-saving care for people living with HIV. More than 40 percent of people living with HIV in care count on the Medicaid program for the healthcare and treatment that keeps them healthy and productive.[1] Ensuring uninterrupted access to effective HIV care and treatment is important to the health of people living with HIV and to public health.[2] When HIV is effectively managed, the risk of transmitting the virus drops to near zero.[3] While HHCAWG understands and supports the value of work, Tennessee's proposals imposing work requirements on vulnerable populations threaten to

[1] Kates, Jennifer and Lindsey Dawson. Insurance Coverage Changes for People with HIV Under the ACA. Kaiser Family Foundation. February 2017.
[2] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. Available at http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL. pdf.
[3] Cohen, MS., et al. Antiretroviral Therapy for the Prevention of HIV-1 Transmission. N Engl J Med 2016; 375:830-839. September 1, 2016.

reverse the progress in providing access to prevention, care, and treatment and reducing health care costs. For the reasons discussed in detail below, we strongly oppose the Tennessee Application and urge the Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS) to reject it.

I. Tennessee's proposed work requirement would violate the core objective of the Medicaid program and would thus be unlawful

If approved, the Tennessee Application would violate the basic conditions required for approval of a section 1115 waiver. Section 1115(a) of the Social Security Act, codified at 42 U.S.C. § 1315(a), allows a federal waiver to facilitate a State's "experimental, pilot, or demonstration project" that, "in the judgment of the Secretary, is likely to assist in promoting the objectives" of the Medicaid program. One of the primary objectives of Medicaid, as explained by § 1901 of the Social Security Act, is to enable each State to furnish "medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and costs are insufficient to meet the costs of medically necessary services."[4] This core objective was re-affirmed in the recent *Stewart v. Azar* decision vacating approval of Kentucky's waiver that would similarly condition eligibility on satisfying a work requirement: the court stated that the central objective of Medicaid is to provide health coverage to low-income people.[5] The work requirement, enforceable premiums, and related lockout penalties would achieve the exact opposite result intended by this objective, resulting in more individuals losing access to health coverage and medically necessary services.

Tennessee has not provided any estimates as to the number of individuals that would be subject to a work requirement, nor has it provided any information about expected disenrollment in its budget neutrality estimates. Instead, Tennessee dedicates a brief paragraph in the Application to vague statements that the state is continuing analyses to determine member impact and simply states that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." It is noteworthy that the court in *Stewart v. Azar* focused heavily on HHS' deficiencies in considering the impact of approving a waiver on coverage for Medicaid enrollees.[6] In this case, because Tennessee has refused itself to consider this impact, HHS has no way to adequately consider the waiver's impact on coverage for the affected population.

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[4] 42 U.S.C. § 1396-1.
[5] *Stewart v. Azar*, 313 F. Supp. 3d 237, 260-61.
[6] *Id.*

However, experience from Arkansas, the first state to implement a work requirement is instructive: the Arkansas demonstration has resulted in over 18,000 individuals losing coverage. A work requirement that will inevitably lead to otherwise eligible individuals being removed from the Medicaid rolls cannot be reconciled with the core purpose of Medicaid to furnish medical assistance.

In order to find that the project is likely to promote the objective of the Medicaid act, HHS must consider the impact of the project on the populations that Medicaid was designed to protect.[7] Medicaid was designed to provide "medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services."[8] As the state has not expanded eligibility to childless adults, Tennessee's proposal would primarily apply to low-income parents and caretakers of dependent relatives. These populations will be the most at risk of losing coverage due to this proposal, thus undermining access to care for the exact populations that the Medicaid program is designed to protect.

Tennessee's application could even end up keeping people from gaining employment, because without health services, it will be more difficult for them to find and hold a job. Ohio's Department of Medicaid found that three-quarters of Medicaid expansion enrollees who were looking for work reported that Medicaid made it easier to do so, and more than half of those who were working said that Medicaid made it easier to keep their jobs.[9] It is precisely *because* Medicaid meets enrollees' health needs that they are able to focus on finding and keeping employment. An analysis of Tennessee's Medicaid enrollees reveals the majority of enrollees in the program already work: 77% of non-SSI, nonelderly enrollees live in working families, 37% work full-time, and 20% maintain part-time employment.[10] Further, among non-SSI, nonelderly enrollees who are not employed, most face some significant barrier to work, with 41% citing an illness or disability as reasons for not working.[11] These individuals depend on consistent access to care and treatment in order to stay healthy and lead productive lives. The policies contemplated by the Tennessee Application will place access to these services in jeopardy, worsening health outcomes for those affected and removing any chances of economic mobility.

Approving policies that cause coverage losses, increase the number of uninsured individuals, and leave vulnerable individuals without access to health services cannot be justified as a lawful

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[7] *Newton-Nations*, 655 F.3d at 1074.

[8] 42,U.S.C.S. § 1396-1

[9] Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

[10] Rachel Garfield, Robin Rudowitz, Anthony Damico, Kaiser Family Foundation, *Understanding the Intersection of Medicaid and Work* (http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work (Updated Jan. 2018)

11 Id.

and proper use of Section 1115's waiver authority. Medicaid is a lifeline for many individuals living with HIV and other chronic health conditions, and losing Medicaid coverage would be particularly harmful for these individuals.

II. Work requirements threaten to disproportionately harm individuals living with HIV and other chronic health conditions

Individuals living with chronic illnesses stand to be disproportionately harmed by this proposal. Many individuals who live with a chronic illness that makes maintaining employment impossible are not considered "disabled" by Medicaid standards, and would be subject to the work requirement. Chronic illnesses can produce symptoms or disabilities that are not visible, yet serve as impediments to steady employment. Additionally, some chronic conditions like multiple sclerosis produce periods of inability to work due to medication side effects or symptom flare-ups; employees with these conditions require flexible work arrangements that can be hard to find or keep. Episodic disabilities can produce an uneven work history, which in turn can make it more difficult for a person to find consistent employment. These burdens particularly affect people living with chronic illnesses or disabilities, as consistent access to medical care is key to the management of symptoms and overall long-term wellness.

While the Tennessee Application ostensibly notes 9 enrollee categories that will be exempt from the work requirement, the state gives little clarity as to who would qualify in many of the categories. For example, the Application notes that individuals "medically certified as physically or mentally unfit for employment" will be exempt, but does not specify what kinds of conditions would qualify, how difficult it will be to obtain medical certification, or how long an exemption lasts. Further, Tennessee purports to exempt "medically frail" individuals, however this designation was designed for the Medicaid expansion population and Tennessee has not yet defined the scope of their medically frail exemption nor designed a process by which individuals are identified as medically frail. At a minimum, people living with HIV should not be forced to re-certify that they are HIV positive and therefore should qualify for an exemption once secured.

Further, the complexity involved in tracking and applying exemptions is likely to prove unduly burdensome and has the potential to disrupt coverage for individuals that require continuity of care. The history of administering exemptions to work requirements in other public benefits program shows that states often make mistakes and end up sanctioning beneficiaries that are not formally subject to the requirement. The administrative challenges associated with implementing work requirements would be more pronounced in Medicaid than in the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy

Families (TANF) programs, which have struggled with implementation. SNAP and TANF require substantial interactions with participants, including interviews and frequent reporting. States have encountered numerous obstacles to accurately applying these policies. States' administration of these policies in the SNAP program was error prone, applied inaccurately, and led to eligible individuals being denied benefits.[12] When first implemented, a U.S. Food and Nutrition Service analysis found that policies were "difficult to administer and too burdensome for the States." One of the biggest shifts was tracking benefit receipt over time, rather than circumstances in a single month, which was a fundamental change to program administration.[13] Historical analysis of state experience implementing work requirements in TANF suggests that adding similar requirements to Medicaid could cost states thousands of dollars per beneficiary.[14]

Tennessee has not adequately considered the disproportionate effect these harmful policies will have on individuals living with chronic health conditions, despite numerous state comments speaking directly to this issue. Accordingly, Tennessee has not satisfied the requirement that issues raised during the public notice procedure are considered during development of the final application.[15] It is clear from this Application that Tennessee is not adequately protecting the health needs of its most vulnerable citizens.

We appreciate the opportunity to provide comments on the Tennessee Application. Our comments include numerous citations to supporting research, including direct links to the research for HHS' benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments and the attached report be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

For the reasons described above, we urge HHS to reject the Tennessee Application in order to ensure that the 1115 waiver program promotes, rather than undermines, the objectives of the Medicaid program, and that vulnerable populations retain access to crucial medications and health care services. Please contact HHCAWG Co-Chairs Phil Waters with the Center for Health

[12] USDA Office of Inspector General, FNS Controls over SNAP Benefits for Able-Bodied Adults Without Dependents, September 2016, https://www.usda.gov/oig/webdocs/27601-0002-31.pdf.
[13] Mathematica Policy Research, Inc., Imposing a Time Limit on Food Stamp Receipt: Implementation of the Provisions and Effects on Food Stamp Participation (2001).
[14] Gayle Hamilton et al., "National Evaluation of Welfare-to-Work Strategies: How Effective Are Different Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs," Manpower Demonstration Research Corporation, December 2001, Table 13.1.
[15] 42 C.F.R. § 431.412(a)(1)(viii).

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Respectfully submitted by the undersigned organizations:

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AIDS Alabama
AIDS Action Baltimore
AIDS Alliance for Women, Infants, Children, Youth & Families
AIDS Foundation of Chicago
AIDS Research Consortium of Atlanta
AIDS United
American Academy of HIV Medicine
APLA Health
AIDS Resource Center of Wisconsin
Bailey House, Inc.
Black AIDS Institute
Communities Advocating Emergency AIDS Relief (CAEAR)
Community Access National Network (CANN)
Georgia AIDS Coalition
Harm Reduction Coalition
HealthHIV
HIV Medicine Association
Housing Works
Legal Council for Health Justice
Michigan Positive Action Coalition
Minnesota AIDS Project
National Alliance of State and Territorial AIDS Directors
National Latino AIDS Action Network
NMAC
Positive Women's Network - USA
Project Inform
Rocky Mountain CARES
San Francisco AIDS Foundation
SisterLove
Southern AIDS Coalition
Southern HIV/AIDS Strategy Initiative

St. Louis Efforts for AIDS
The AIDS Institute
Treatment Access Expansion Project
Thrive Alabama