NASTAD

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Medicaid 1115 Waivers

Exemptions for People Living with HIV and Hepatitis

Introduction

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve demonstration or "waiver" projects that promote the objectives of the Medicaid program. These waivers offer states an opportunity to respond to the needs of low-income individuals by improving and expanding the Medicaid program. However, many pending and recently approved waivers include provisions that would make it more difficult for consumers to enroll in Medicaid or access necessary benefits—for example, by placing limits on benefits or imposing burdensome eligibility requirements. Under recently proposed and approved waivers, people with chronic conditions will be subject to work requirements and other provisions that jeopardize access to Medicaid services. This means that people living with HIV and hepatitis could lose access to affordable medications and care for months at a time. To read more about the details of pending and approved waivers and the implications for people living with HIV and hepatitis, see NASTAD's fact sheet: *Medicaid 1115 Waivers: Considerations for HIV and Hepatitis Programs*.

When a state uses an 1115 waiver to offer a new set of benefits or to place restrictions on services, individuals with higher health needs, including people who are determined to be "medically frail," may have the option to enroll in the standard Medicaid benefits package instead. These rules, established by federal regulations, ensure that consumers with complex medical conditions have access to benefits packages that are adequate for their needs. In the context of 1115 waivers, these rules can also protect medically frail individuals from provisions that could disrupt their care and treatment. This fact sheet will provide background on Medicaid medically frail exemptions, explain why these exemptions are important for people living with HIV and hepatitis, examine medically frail exemption policies in four states that have received approval for 1115 waivers imposing work requirements, and propose opportunities for health departments and other stakeholders to shape state exemption policies that ensure people living with HIV and hepatitis maintain access to Medicaid. For questions, please contact Dori Molozanov.

ACTION STEPS

- ☑ Monitor state and federal public comment opportunities for Medicaid State Plan Amendments and 1115 waiver proposals.
- ☑ Work with Medicaid counterparts to ensure medically frail exemptions policies include adequate protections for people living with HIV, hepatitis, and other chronic conditions.
- ☑ Engage in outreach and education to support consumers as they navigate the exemptions process in their state.

Overview of Medically Frail Exemptions

Federal law requires that medically frail Medicaid enrollees who gain eligibility through Medicaid expansion under the ACA have the option choose between two Alternative Benefit Plans (ABPs): the ABP that is equivalent to the state's traditional Medicaid benefits package (often referred to as the State Plan benefits), or the benefits package that is usually mandatory for the Medicaid expansion group. Some states used ABPs, often referred to as benchmark plans, prior to the ACA because this offered states flexibility to develop innovative health coverage plans. However, ABPs now play a larger role in delivering health care to low-income individuals because the ACA requires that adults in the Medicaid expansion population receive benefits through an ABP. The medically frail exemption is intended to ensure that individuals with higher health needs are not placed into ABPs that may be less generous than the traditional state plan.

Federal regulations require that certain "exempt" individuals with higher health needs, including people who are determined to be "medically frail," have the option to enroll in the standard Medicaid benefits package. CMS policy specifically requires that all medically frail individuals are exempt from work requirements.

The medically frail exemption now has additional significance in the context of Medicaid waivers authorizing provisions such as work requirements and premiums that can lead to loss of coverage. In January 2018, the Centers for Medicare & Medicaid Services (CMS) announced that states seeking to implement Medicaid work requirements through 1115 waivers must exempt medically frail individuals from these requirements. Some states—for example, expansion states that have not aligned their Medicaid expansion ABPs with their State Plan benefits, and states that have ABPs in place for other populations—already exempt medically frail individuals from mandatory participation in ABPs and certain waiver programs. These states should have existing processes for identifying medically frail individuals, providing benefits counseling, and offering enrollees the option to enroll in the State Plan benefits package instead of the ABP. However, many states will need to develop a process for exempting medically frail individuals from work requirements.

This creates an opportunity for health department staff, consumer advocates, and other stakeholders to participate in developing exemptions policies that account for the unique needs of people living with HIV and hepatitis. However, even in states that already have exemptions processes in place, stakeholders can still play a role in ensuring that people living with HIV and hepatitis are adequately protected.

States with proposed or approved work requirements that are already required to have medically frail exemptions	*AR, ID, KS, MT*
States with proposed or approved work requirements that are not currently utilizing medically frail exemptions process	*GA, MS, OK, SD, TN*

Why Are Medically Frail Exemptions Important for People Living with HIV and Hepatitis?

The January 2018 CMS policy announced the agency's commitment to helping states implement work requirements for Medicaid, while also explicitly requiring states to exempt medically frail individuals from work requirements. CMS withdrew this guidance in February 2021 and is reevaluating previously approved work requirements in a number of states. However, the importance of medically frail exemptions is not limited to work requirements. Many approved and pending waiver applications include a number of provisions such as premiums, lifetime caps on benefits, prior authorization, closed formularies, lockouts for failing to comply with new requirements, and other policies that could disrupt access to care and treatment by making it more difficult to access Medicaid services. Even individuals who can satisfy the new requirements may be disenrolled and locked out of coverage for failure to comply with confusing and complex administrative processes in place for reporting and tracking member compliance. Exemptions are important protections for people living with HIV and hepatitis because these waiver provisions jeopardize consistent access to affordable medications and care that are essential to the health and well-being of low-income individuals with chronic conditions.

A Look at Medically Frail Exemptions in States With Approved Work Requirements

Though there are many waiver provisions for which a medically frail exemption is relevant, this section will focus on how the states that have been approved to implement a work requirement have approached the medically frail definition and exemption process. A number of states have received approval from CMS to impose work requirements on the ACA expansion population. Georgia has received approval to apply work requirements to other eligibility categories, including low-income parents and caretakers. Mississippi, Oklahoma, South Dakota, and Tennessee have similarly proposed to apply work requirements to other eligibility categories, but these proposals are still pending CMS approval.

Although Medicaid waivers authorizing work requirements vary somewhat in their details, the result is similar: clients who fail to meet work requirements (defined broadly as engagement in a variety of work, education, community service, and other activities defined by the state) will lose access to coverage for some amount of time. In most states with approved work requirements, enrollees who fail to comply will have their coverage terminated or suspended, and may be barred from reapplying for up to a year. Medically frail exemptions processes vary widely by state, and it is important that individuals and entities working directly with consumers understand the policies in place in their state.

How do states define medically frail? Federal regulations allow states substantial flexibility to define "medically frail." Federal law requires states to exempt individuals with "serious and complex medical conditions" from work requirements, but states must decide how to interpret and implement this requirement.

Very few states with approved work requirements have passed laws or regulations defining "medically frail" in more specific terms than the definition established by federal regulations. Some state Medicaid agencies have narrowed "medically frail" somewhat by developing guidance with non-exhaustive condition lists for exemptions. In some states, individuals who have a condition included on the list may be automatically exempted and bypass the usual medically frail determination process altogether. Other states may require additional review before making a determination. Only Arizona, Indiana,

Maine, Michigan, Nebraska, and Virginia specifically exempted or proposed to exempt people living with HIV from work requirements (work requirement waivers in these states have since been withdrawn, either by the state or by CMS).

Even in states that do not have such condition-specific exemptions, people living with HIV and hepatitis may still seek an exemption based on the standard medically frail determination process. Alternatively, they may meet a different exemption criteria that is not directly related to being medically frail—for example, states have exemptions on the basis of age, homelessness, enrollment in school, or "hardship."

How are people identified as medically frail?

SELF-REPORTING. One way for people to be identified as medically frail is to self-report. This can be done at the time of Medicaid application, generally by answering screening questions. Enrollees who do not self-identify on their initial Medicaid application can still request a medically frail determination at any time. Self-identification may be enough to have someone automatically determined medically frail in some states; in others, it may trigger a review process where the state or Managed Care Organization (MCO) reviews claims, medical data, documentation from medical providers, or other sources of information to determine whether someone is medically frail. However, some state Medicaid applications include screening questions that are unlikely to capture the vast majority of people living with HIV, hepatitis, or other complex medical conditions. Providers and health department staff should educate clients about their option to self-report and should be prepared to support clients in documenting eligibility for an exemption or pursuing appeals if they are denied exempt status.

MCO REVIEW OF CLAIMS DATA. MCOs may assess enrollees to determine if a person has past medical claims that qualify them for medically frail status. This may be done continuously or at regular intervals, such as annually. MCOs may use an automated process to monitor claims data and data from medical professionals, such as lab results, in order to identify and confirm medically frail status.

PROVIDER ATTESTATION. Medical providers may be able to attest to a patient's medically frail status by notifying the state or MCO on the client's behalf. This is especially important for patients with conditions that cannot be easily identified through claims and encounter data, as well as for patients who lack claims history because they are new enrollees or are not receiving care. Providers should understand the documentation requirements and be prepared to discuss medically frail exemptions with patients. For example, the Nebraska Medicaid agency has developed a Provider Attestation form which includes a list of conditions, including HIV, that qualify for medically frail status.

DATA-SHARING WITH MEDICAID. A few states are matching health department HIV data from the Ryan White HIV/AIDS Program with Medicaid data to identify people with confirmed HIV diagnoses and automatically exempt them, although this may not necessarily capture all people living with HIV in the state.

Health Department Considerations

Monitor state and federal public comment opportunities for Medicaid State Plan Amendments and 1115 waiver proposals. Every waiver application must undergo state and federal comment periods before it can be approved. Health department staff can advocate for clients' interests by submitting comments on the state and federal level about exemption policies that protect people living with HIV and hepatitis, and by attending any public hearings or forums held by state agencies.

Work with Medicaid stakeholders to ensure exemptions policies include adequate protections for people living with HIV, hepatitis, and other chronic conditions. Ryan White program staff work directly with people living with HIV, and are therefore uniquely positioned to advocate for exemptions from harmful waiver provisions that protect clients while still remaining sensitive to their unique needs and challenges. It is important to advocate for clear, comprehensive, and inclusive rules surrounding exemptions in your state.

While some states, may provide for automatic exemptions for people living with HIV or hepatitis, other states may require additional documentation before a medically frail exemption is granted. For example, under Indiana's policies, medically frail status is confirmed by utilizing the Milliman Underwriting Guidelines. Once the MCO determines that the member has a condition included on the state's medically frail condition list, the MCO must analyze claims data to determine whether the member meets a "points" threshold. The MCO may also use supplemental data, such as lab results and physician notes, indexed to the Guidelines. Medically frail status must be redetermined every 12 months. If the MCO denies medically frail status, the member may appeal this decision. Health department staff can educate MCOs in the state about the importance of consistent access to treatment, and advocate for automatic and lifelong exemptions for certain chronic conditions such as HIV and hepatitis.

Policies should be clearly set forth on the state's Medicaid website so that enrollees, consumer advocates, and medical providers know exactly what the process is for claiming and documenting an exemption. Consumer notices and application materials should be comprehensive but easy to understand, Medicaid screening tools such as online questionnaires should be consumer-friendly, and screening questions should not be so narrow that people living with HIV and hepatitis are discouraged from self-identifying as medically frail. Additionally, Medicaid churning can impose a significant administrative burden on Ryan White programs; formal data-sharing agreements with Medicaid can facilitate identification of medically frail individuals and, if needed, smooth client transition between programs.

Note that advocacy strategies are very state-specific, and what works in one state may not work in another. For example, there are states where an exemption means switching health plans, but this may not be the best option for every client. In these states, the best policy may be one that leaves clients with a choice as to whether they want to be exempted. Every state's Medicaid program is unique, and there is no one-size-fits-all approach to developing Medicaid policy. HIV and hepatitis advocates seeking to influence policy should work closely with Medicaid stakeholders in their state to ensure exemption policies do not have unintended consequences.

Engage in outreach and education to support consumers as they navigate the exemptions process in their state. Talking to clients about exemptions can be challenging, especially in states where the policies are confusing, complex, or unclear. Here are some tips for talking to clients about medically frail exemptions:

- *Talk to clients about what "medically frail" does and does not mean.* Clients may be confused by the term "medically frail," especially since most states do not provide comprehensive definitions in notices sent to consumers. Let consumers know that "medically frail" is not limited to health conditions that qualify as a disability or limit ability to engage in daily activities—it is a protection for Medicaid enrollees that have higher

health needs, including people living with chronic illnesses such as HIV and hepatitis. An exemption from work requirements or premiums does not mean that a client is unable to work or make timely payments. Instead, exemptions ensure that people with higher health needs can enroll in a benefits package that is adequate for their needs and avoid burdensome requirements that may result in loss of access to life-saving medications and treatment.

- *Work with clients to ensure they understand how to obtain an exemption.* Although states are required to provide Medicaid enrollees with information about applying for exemptions, consumer notices are not always easy to understand. Support clients as they navigate exemptions by explaining requirements for self-identification and provider documentation, helping consumers understand notices they receive from the state, and ensuring clients know what to expect at every stage of the process. Clients should also know about how to appeal MCO or Medicaid agency decisions if their request for a medically frail determination is denied.
- *Explain how clients' coverage may be affected if they are determined medically frail.* The State Plan benefits package is generally more comprehensive than the ABP benefits package in non-aligned states, but some states may offer benefits through the ABP that are not available through the State Plan. Additionally, states with non-aligned ABPs may require medically frail individuals to switch delivery systems—for example, states that expand Medicaid through Premium Assistance by enrolling consumers in Marketplace plans may require medically frail individuals to enroll in Medicaid managed care plans instead. It is important to talk to consumers about how these changes may impact their coverage and to remember that switching plans may not be the best option for everyone, even if it means needing to comply with work requirements and other waiver provisions.

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Resources

- NASTAD: *Medicaid Waivers: Considerations for HIV and Hepatitis Programs*.
- Community Catalyst: Leveraging "Medically Frail" Medicaid Rules to Help Consumers: Advocacy in States with Existing Policies.
- Community Catalyst and National Council for Behavioral Health: Promoting Effective Identification of Medically Frail Individuals Under Medicaid Expansion.
- National Council for Behavioral Health: Lessons from the Field: Effective Identification and Enrollment of Medically Frail Individuals.