

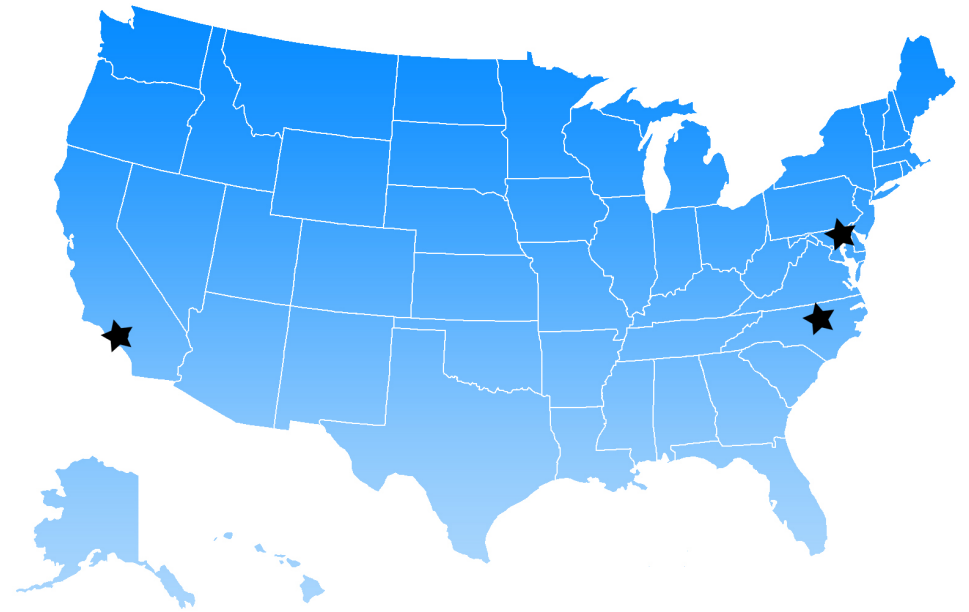
Medicaid, incarcerated persons, and hepatitis C treatment

Wayne Turner, Senior Attorney



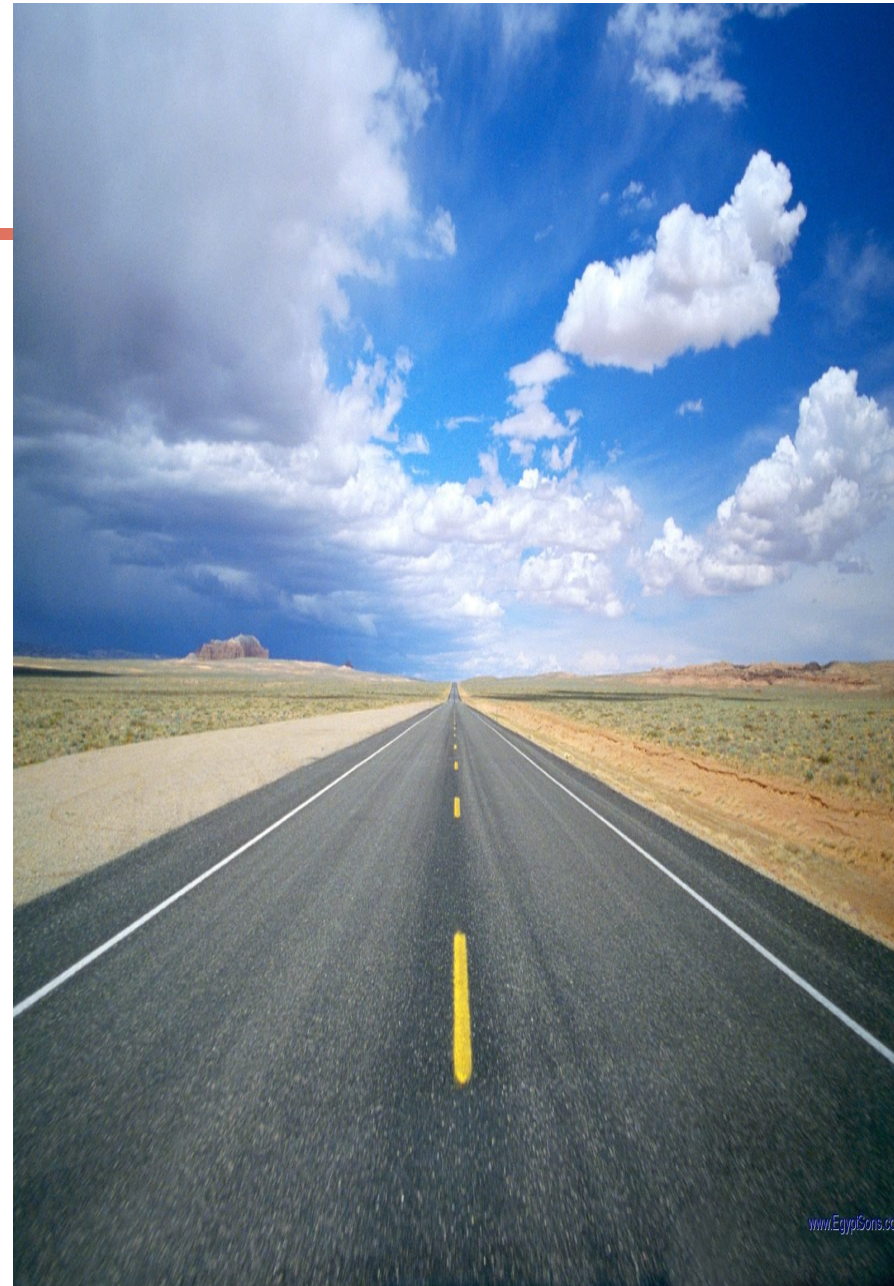
About NHeLP

- National non-profit committed to improving health care access and quality for low income and underserved individuals and families
- State & local partners:
 - Disability rights advocates – 50 states + DC
 - Poverty & legal aid advocates – 50 states + DC
- Offices: CA, DC, NC
- Join our mailing list at www.healthlaw.org
- Follow us on Twitter @nhelp_org



Roadmap

- Medicaid 101
- Coverage for incarcerated persons
- Rx access in Medicaid
- HCV treatment in Medicaid
- Advocacy and litigation



The Medicaid Promise

- Federal-state partnership –
 - states pay part of the costs
 - on average 63% paid by the federal government, but up to 75% in states with lowest per capita income
 - Enhanced federal match for system upgrades, services for newly eligible adults, family planning, preventive services
- No caps or waiting lists (except for some waiver programs)
- As an “entitlement” Medicaid is a “property interest” under the Constitution and cannot be taken away without due process

Medicaid “inmate exclusion”

- Federal law prohibits use of federal Medicaid funds to provide medical assistance to an “inmate of a public institution”
 - Applies to adults and juveniles
 - Exception for in-patient services in a “medical institution”
 - e.g., services provided in an outside hospital
- Person “living in a public institution” over which government exercises administrative control” See 42 C.F.R. § 435.1010
- Includes federal, state, and local jails, prisons, and other penal settings (boot camps, wilderness camps)

Who is an inmate?

Parole or probation?	No
Residential Reentry Center	Yes
Home confinement	No
Halfway House	<p>Depends</p> <ul style="list-style-type: none">• Can the individual work outside the facility and use community resources?• Curfews and other restrictions ok

Termination vs. Suspension

- Incarcerated persons can remain eligible for Medicaid while incarcerated, states just cannot use federal funds for services
- States fail to bill Medicaid for in-patient services
- Suspending and reinstating Medicaid eligibility is easier/faster than reapplying
- Best practices include
 - discharge planning
 - linking individuals to medical home
 - managed care case management and other services

See KFF, *STATE MEDICAID ELIGIBILITY POLICIES FOR INDIVIDUALS MOVING INTO AND OUT OF INCARCERATION* (Aug. 2015),
<http://kff.org/medicaid/issue-brief/state-medicaid-eligibility-policies-for-individuals-moving-into-and-out-of-incarceration/>

Recent changes in Medicaid inmate exclusion

- Requires states to suspend rather than terminate Medicaid for youth under 21 and former foster care up to 26
 - applies whether they are in adult or juvenile prison
 - those eligible are enrolled upon release
- Requires stakeholder group to recommend best practices "for ensuring continuity of health insurance coverage or coverage under the State Medicaid plan"
- Within 1 year, CMS must issue a Dear State Medicaid Director letter on using §1115 authority to "to improve care transitions for certain individuals who are soon-to-be former inmates."

Example: Florida



- Managed care contracts require plans to:
 - “make every effort...to provide medically necessary community-based services for enrollees who have justice system involvement”
 - Provide psychiatric services w/in 24 hours of release
 - Ensure enrollees are linked to care and routine services w/in 7 days of release
 - Conduct outreach to enrollees “at-risk of justice system enrollment” to assure services are accessible
 - Work with correctional facilities to anticipate and plan for release



Medicaid Expansion: Helps State Budgets

Year	State Share	Federal Share
2016	0%	100%
2017	5%	95%
2018	6%	94%
2019	7%	93%
2020+	10%	90%

Medicaid Due Process

Medicaid applicants and recipients have rights to notice and administrative hearings when claims for assistance are denied or not acted upon with reasonable promptness.

- Constitutionally protected
 - *Goldberg v. Kelly*, 397 U.S. 254 (1970)
 - “brutal need”
- Forums for enforcement
 - Administrative Fair Hearing
 - State Courts
 - Federal Courts



Cite: 42 U.S.C. 1396a(a)(3)

Outpatient prescription drugs

- Optional service but all states + DC cover
- All FDA-approved medications w/ rebates
 - Medically accepted indications
 - Off label uses (supported)
 - No experimental
- Prior authorization ok, but limits/restrictions must be reasonable

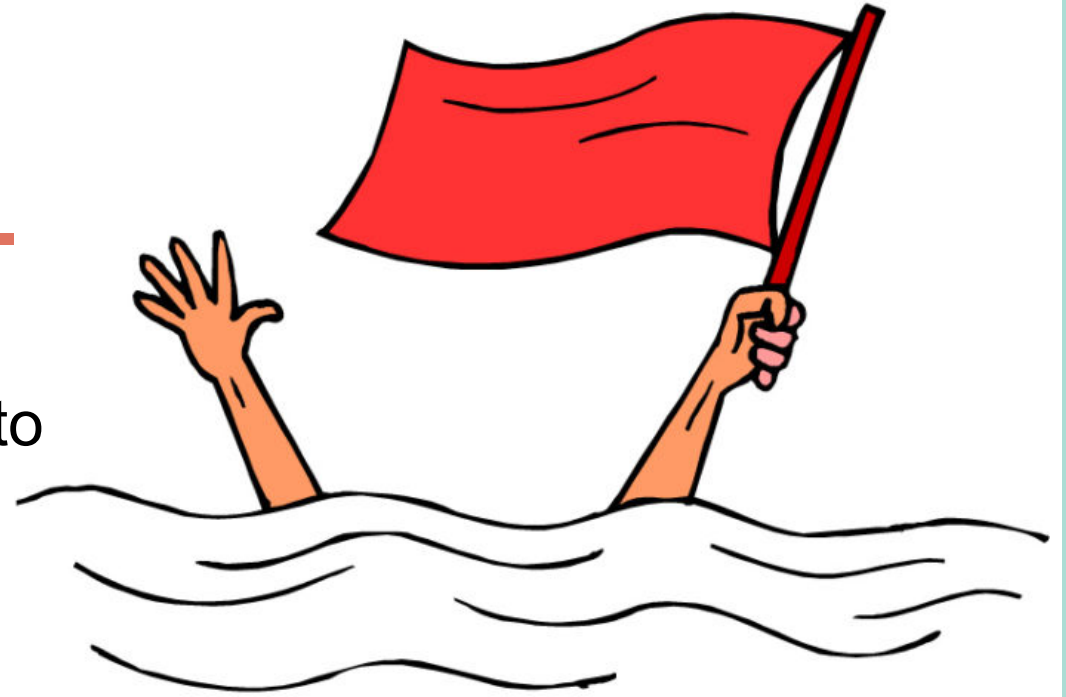


Rx “grace period”

Medicaid Access and Payment Commission (MACPAC) recommending legislative change to allow states to exclude newly approved drugs from Medicaid coverage for up to 180 days

Rationale – state Pharmacy and Therapeutics committees need time to establish prior authorization criteria

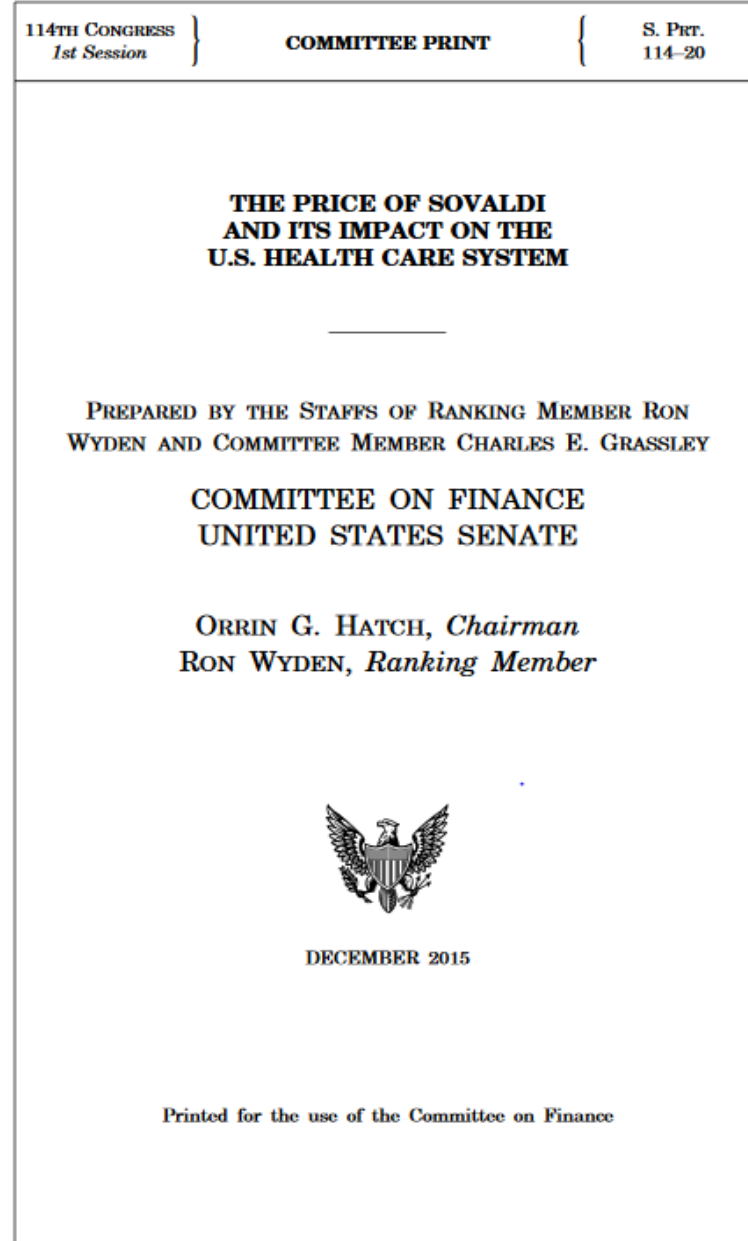
Harm to patients – must wait for breakthrough therapies with no clear exceptions process



HCV treatment in Medicaid

- Direct Acting Anti-retrovirals (DAAs)
- \$80,000 - \$100,000 treatment regimen
➡ \$30,000 – \$40,000
 - Supplemental rebates, competition, advocacy
- *“ending the requirement that states cover every FDA-approved drug...the option to exclude a drug from the formulary will be critical to the ability of states to successfully negotiate pharmaceutical prices.”*

Govs. Kasich, Snyder, Sandoval, Hutchinson, Letter to Speaker Ryan and Majority Leader McConnell (March 16, 2017)



State restrictions on DAAs

- high fibrosis score
- abstinence from drugs and alcohol
- mandatory SUD treatment
- only specialists can prescribe
- policies on when you can replace lost or stolen pills
- limits on people with treatment compliance issues (mental or behavioral health issues)

HHS guidance on HCV treatment

CMS is concerned that some states are restricting access to [HCV] drugs contrary to the statutory requirements [...] by imposing conditions for coverage that may unreasonably restrict access to these drugs.

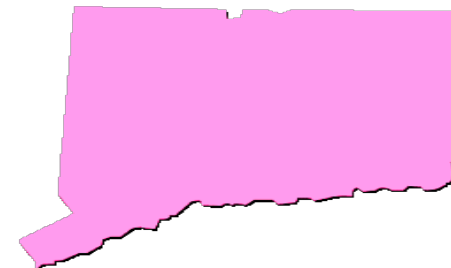
Centers for Medicaid and CHIP Services, *Medicaid Rebate Program Notice No. 172*
(Nov. 5, 2015)

Strategies for HCV DAA access

- Advocacy
- Administrative hearings (Medicaid due process)
- Litigation

Advocacy at state level

- **California** – Legal services providers teamed up with HIV/HCV advocates (Health Consumer Alliance, Project Inform) – letter to state Medicaid agency and meeting, involved providers – raised in a stakeholder meeting announced policy – removed all restrictions
- **Connecticut** – New Haven Legal Assistance, consumer coalition, providers – demand letter and sign on



Florida – administrative hearing

- Florida Legal Services had case in fair hearing process
 - fibrosis score
 - drug testing requirement
- Notice to the state that policy unlawful
- Client obtained and completed treatment
- State updated policy

Legal aid attorneys push Florida Medicaid to cover cure for hepatitis C .

📅 POSTED ON NOVEMBER 1, 2016 📁 CATEGORIES: FALL 2016, HEALTH CARE, SPEAKING OF JUSTICE, STORIES OF JUSTICE

💬 NO COMMENTS YET

For two years Vickie Goldstein filed appeals and wrote letters trying to get Florida's Medicaid program to pay for a drug with the potential to cure her of the viral infection that was slowly destroying her liver.

For two years she got the same answer: You have to get sicker first.

"I talked to a couple of attorneys who specialized in insurance law, and they all said to me, 'We can't make any money suing the government,' so they didn't want any part of it," said Goldstein, who at 57 had been living with hepatitis C for more than a decade.

Finally, in December 2015, her Internet search hit upon Florida Legal Services Inc. staff attorney Miriam Harmatz, a health law expert whose work is supported by The Florida Bar Foundation.



Vickie Goldstein of Delray Beach is finally free of hepatitis C after her legal aid attorneys compelled Florida Medicaid to cover her treatment. She had been denied access to a potential cure for two years based on a policy that required she first have at least stage three liver fibrosis.

Litigation

- Washington state – preliminary injunction/settled
- Colorado – settled
- Indiana – settled in February (No fibrosis score no specialists equal access to all DAAs)
- Delaware – settled
- Missouri – PI issued, settled
 - Treatment is medically appropriate regardless of fibrosis score – no reason to delay treatment under current standard of care
- Not the best strategy in every state



Enforceability of Medicaid Rx

SCOTUS case with dicta that suggests that r-8 is not privately enforceable

– *Astra v. Santa Clara*, 131 S.Ct. 1342 (2011)



Rx claims based upon other Medicaid provisions with strong enforcement record:

- Availability provision – state has an obligation to provide medically necessary treatment – 42 U.S.C. § 1396a(a)(10)
- Comparability – advance stages of the disease vs early stages – 42 U.S.C. § 1396a(a)(10)(B)
- Reasonable promptness – making people wait until disease progresses – 42 U.S.C. § 1396a(a)(8)



Event dates

San Francisco: September 10, 2019

Los Angeles: October 3, 2019

Washington DC: November 12, 2019

North Carolina: October-November, 2019



THANK YOU

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