January 14, 2019

Centers for Medicare & Medicaid Services
Department of Health and Human Services,
P.O. Box 8016
Baltimore, MD 21244-8013

Attention: CMS-2408-P

Re: RIN 0938-AT40 Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care

The HIV Health Care Access Working Group (HHCAWG) appreciates the opportunity to comment on the proposed rule "Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care." 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 health care and treatment that keeps them healthy and able to contribute to society 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] HHCAWG is concerned about the Centers for Medicare and Medicaid Services' (CMS) proposals to roll back information and network adequacy protections that enable people living with and at risk of HIV to access medically necessary care in treatment. To provide meaningful access to care for people living with HIV, we urge CMS to consider the recommendations and comments detailed below.

[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.

NETWORK ADEQUACY STANDARDS (§ 438.68)

We oppose the proposed changes to this rule and urge CMS to reconsider adopting them. In particular, we oppose removing the requirement that states establish network adequacy standards for the Managed Care Organizations (MCOs) in their jurisdiction.

MCOs now serve over 80% of Medicaid beneficiaries nationwide.[4] Further, as compared to privately insured individuals, Medicaid enrollees experience more barriers when accessing services and providers.[5] Consistent access to expert HIV care is particularly important for people living with HIV as it is well documented that people living with HIV who are managed by HIV experts have better outcomes and receive more cost effective care.[6] Ensuring uninterrupted access to effective HIV care and treatment is important to both the health of people living with HIV and to public health.[7] When HIV is effectively managed, the risk of transmitting the virus drops to near zero.[8]

Under current rules, states are already given significant flexibility to set time and distance standards with no boundaries set by CMS. Further, implementation of time and distance standards has been varied across states, contributing to already-existing geographic disparities in the adequacy of provider networks and access to care. Instead of rolling back these already lax protections, we urge CMS to consider strengthening the current standard to move towards national network adequacy standards. A minimum national standard that includes geographic access, provider-patient ratios, and timely access thresholds will provide consistency and continuity for enrollees.

For people living with HIV, establishing a relationship with a trusted, culturally competent provider is critical for retention in care. Finding such a provider is often difficult given increasingly narrow networks in addition to the stigma surrounding HIV, particularly for individuals of color.[9] Therefore, we urge CMS to align the MCO standards with the baseline

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[4] https://www.kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[5] *See, e.g.,* Medicaid & CHIP Payment & Access Comm'n, *Medicaid Access in Brief: Children's Difficulties in Obtaining Medical Care* 1 (2016) ("[C]hildren in Medicaid or CHIP are more likely than those with private coverage to report difficulties accessing medical care; these difficulties include finding a provider who will accept their insurance, obtaining a timely appointment, and obtaining a referral to a specialist."), https://www.macpac.gov/wp-content/uploads/2016/11/Adults-Experiences-in-Obtaining-Medical-Care.pdf.

[6] Horberg, et al. Influence of provider experience on antiretroviral adherence and viral suppression. HIV AIDS (Auckl) 2012;4:125-133.

[7] 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.

[8] Cohen, MS., et al. Antiretroviral Therapy for the Prevention of HIV-1 Transmission. N Engl J Med 2016; 375:830-839. September 1, 2016.

[9] National Medical Association and HealthHIV, *African-American Physicians Believe Stigma Remains Significant Barrier To Routine HIV Testing: HealthHIV & National Medical Association Release Survey Findings in Recognition of National Black*

Qualified Health Plan (QHP) and Medicare Advantage requirements. It is particularly important for the QHP and MCO standards to be in alignment given the churn between Medicaid and QHP coverage for individuals whose incomes fluctuate annually. In particular, we suggest CMS incorporate a requirement for MCOs to contract with Essential Community Providers (ECPs). A majority of Medicaid beneficiaries with HIV are likely to have received care from Ryan White-funded providers, who are designated ECP providers. Ryan White providers offer expert HIV care management as well as comprehensive care and services such as case management, which facilitate and support successful treatment of HIV and has been documented to improve clinical outcomes.[10] Therefore, access to ECPs for MCO enrollees living with HIV is crucial. CMS could either require MCOs to contract with all ECPs as is the policy in some states (e.g., Minnesota[11]) or, at a very minimum, apply the standards set for the QHPs. Incorporating an ECP standard will better ensure the Medicaid MCO population has access to providers with the appropriate expertise to meet their medical needs in addition to promoting continuity of care given the Medicaid to QHP churn experienced by this population.

In addition, we strongly recommend that the final rule encourage states to adhere to the National Association of Insurance Commissioners' (NAIC) Health Benefit Plan Network Access and Adequacy Model Act.[12] The model guidelines were developed by a diverse stakeholder coalition, including insurance commissioners, providers and health policy experts and advocates. Most states do not have the resources or bandwidth to support such a thoughtful and deliberative process. In addition, following the model guidelines would help to align Medicaid MCO requirements with other insurers.

In addition to adopting relevant standards from other health programs, we also recommend that CMS set baseline provider standards to inform the state developed network adequacy standards. Specifically, we urge CMS to develop maximum time and distance standards and patient to provider ratio standards to set a national floor for provider networks. For the time and distance standards, we suggest CMS set an access standard that ensures access to primary care in urban areas within 30 minutes or 10 miles and for rural areas within 30 minutes or 30 miles with exceptions for states with documented issues in meeting this standard. For specialty care, we recommend a general standard of 30 minutes or 30 miles with exceptions for states with documented issues in meeting this standard. We recommend these standards based on a review of Medicaid state access standards compiled by the Kaiser Family Foundation.[13]

HIV/AIDS Awareness Day (Washington, D.C.: National Medical Association and HealthHIV, February 6, 2012), available at: http://www.healthhiv.org/modules/info/files/files_4f31915141746.pdf.

[10] Bradley, H, et al. Ryan White HIV/AIDS Program Assistance and HIV Treatment Outcomes. Clin Infect Dis. 2016 Jan 1; 62(1): 90–98.

[11] See Minnesota Department of Health. Essential Community Providers. Available at: http://www.health.state.mn.us/divs/hpsc/mcs/ecpmain.html.

[12] National Association of Insurance Commissioners. *Health Benefit Plan Network Access and Adequacy Model Act*. 2015, available online at https://www.naic.org/store/free/MDL-74.pdf.

[13] Kaiser Family Foundation. *Medicaid MCO Access Standards: Primary Care*. Available at http://kff.org/other/state-indicator/medicaid-mco-access-standards-primary-care/. *See also* Kaiser Family Foundation. Medicaid MCO Access Standards: Specialty Care. Available at http://kff.org/other/state-indicator/medicaid-mco-access-standards-specialty-care/.

We believe that it is important to consider both time and distance and patient to provider ratios. Relying on only one of these factors would lead to untenable results; being promised the next available appointment with a provider means nothing if the provider is overloaded with patients or the distance to the provider is too far to travel.

INFORMATION REQUIREMENTS (§ 438.10)

Ensuring full access for people with disabilities and Limited English Proficiency (LEP) is critical to ensuring that a state's Medicaid program provides appropriate services to all participants, including managed care enrollees. Disability and language-related barriers to access may severely limit an individual's opportunity to access medical care, assess options, express choices, and ask questions or seek assistance. Managed care plans especially need to protect and promote access because they often have limitations, such as limited networks of providers, which may mean that people with disabilities and LEP are not able to obtain the care they need.

In addition, considering the impact of these proposed changes specifically to people living with or at risk of HIV, it is important to note the reality of this epidemic on people with disabilities and those with LEP. According to the CDC, HIV continues to be a serious threat to the health of Hispanic/Latino communities. In 2016, Hispanics/Latinos accounted for 26% of new HIV diagnoses in the United States and 6 dependent areas.[14] Also, among all Hispanics/Latinos with HIV in 2015, only 59% received HIV treatment, 49% were retained in HIV care, and 50% had a suppressed viral load. In 2015, of all Asian Americans living with HIV, only 80% had received a diagnosis, which is lower than any other population.[15] Significantly, both groups are the most likely to have LEP, with Hispanics/Latinos comprising 63% of the LEP population and Asians making up 21%.[16] While these statistics demonstrate a clear need to improve viral suppression rates amongst Hispanics/Latinos living with HIV, they also illustrate the many barriers to care that this specific population faces. Changing much-needed protections for this and other LEP populations, after just two years of enactment of the 2016 Final Rule, would ultimately lead to limiting access to health services for persons with LEP and persons with disabilities, including people living with and at risk of HIV. We urge CMS to reconsider.

Access for persons who are visually impaired

Current regulations require taglines in large print no smaller than 18 point font (42 C.F.R. § 438.109d)(2)). In 2016, CMS explained that it based this standard on guidance from the American Printing House (APH) for the Blind (81 Fed. Reg. 27724). The APH established standards for print documents, including the minimum of 18 point font for large print, to allow

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[14] Centers for Disease Control and Prevention. *HIV and Hispanics/Latinos*. Available at https://www.cdc.gov/hiv/group/racialethnic/hispaniclatinos/index.html (accessed Jan 2019).

[15] Centers for Disease Control and Prevention. *HIV Among Asians*. Available at https://www.cdc.gov/hiv/group/racialethnic/asians/index.html (accessed Jan 2019).

[16] Zong, J. and Batalova, J. The Limited English Proficient Population in the United States. Migration Policy Institute, July 8, 2015.

"optimal usability for persons with low vision."[17] The APH developed its standards for large print and other features for print document readability based on "research that originated from the study of the impact of print characteristics on readers."[18]

However, CMS now proposes to replace this evidence-based standard with a vaguer requirement that taglines be "conspicuously visible." We oppose this change. CMS provides no information or description of what constitutes a "conspicuously visible" tagline; nor does CMS provide any evidentiary basis for how persons with low vision would be able to access health information under this new standard. The potential harm to persons with low vision under an ambiguously defined "conspicuously visible" standard far outweighs any possible benefit for insurers in reducing paperwork. CMS should withdraw this ill-advised proposal.

Limiting information access through taglines

Taglines are an effective and cost-efficient manner of informing persons with disabilities and LEP individuals and will help assist plans in determining in which languages additional materials should be provided. CMS proposes to limit use of taglines to written materials that "are critical to obtaining services." This standard is not only vague, but CMS fails to specify who decides whether information is critical to obtaining services.

For example, some plans or state Medicaid agencies might not consider information on plan performance and quality to be "critical to obtaining services," yet such information is vitally important to potential enrollees engaged in the process of plan selection.

Further, MCOs, PIHPs, PAHPs, and PCCM entities must provide potential enrollees with information about Medicaid benefits not covered by the entity, including family planning services and supplies and abortion services not covered by a plan due to religious objections. If potential enrollees know that a particular plan does not cover certain services, and obtaining these services through the plan is important to them, they can choose a plan that does cover the services. It is unclear whether information "critical to obtaining services" would include services that a plan does not provide.

Moreover, as all of the entities governed by this provision receive federal funds, they are all subject to Section 1557 of the Affordable Care Act, the ACA's nondiscrimination requirements. Under the final regulations implemented by the HHS Office for Civil Rights, these "covered entities" must provide taglines on all "significant" documents. CMS should not create a competing standard that would make it difficult with which for entities covering both private markets and Medicaid to comply with. Moreover, CMS should not redefine the requirements for MCOs under Section 1557 in a manner that directly conflicts with the Final Rule issue by the Office of Civil rights.

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[17] J. Elaine Kitchel, Low Vision Project Leader, APH Guidelines for Print Document Design, American Printing House for the Blind, https://www.aph.org/research/design-guidelines/ (accessed Dec. 23, 2018).

[18] *Id.*

Finally, this ill-conceived proposal opens the door to adverse selection whereby plans discourage enrollment by persons with significant health needs. Limiting information access for enrollees and potential enrollees will have harmful consequences, particularly for persons living with disabilities, with LEP, or those living with or vulnerable to HIV.

§ 438.10(h) - Provider directories

Provider access begins with having accurate, up-to-date provider directories available to enrollees and potential enrollees. This is especially important for those living with or at risk for HIV since the reality is that not all providers who care for Medicaid managed care members have the expertise, experience and competency needed to care for this population. However, instead of strengthening federal standards, CMS proposes to weaken them. CMS seeks to change requirements for provider directories by allowing MCOs to update printed directories quarterly, instead of monthly, if the MCO also provides a mobile-enabled electronic directory.

CMS cites data on cell phone use by low-income persons to justify this change (83 Fed. Reg. 57278), but provides no information on enrollee use of printed directories. U.S. Census data shows that low income persons are less likely to have access to broadband and internet services. For example, more than one in five Virginian households (21.4%) lack broadband internet access.[19] Nationwide, half of households with incomes under $25,000 have either no computer or no broadband at home.[20]

In the absence of additional research on enrollee preferences for print versus mobile/electronic formats and accessibility, we believe it would be premature to ease current requirements for updating provider directories.

The HHS Office of the Inspector General (OIG) identified significant shortcomings in provider access in its 2014 report, Access to Care: Provider Availability in Medicaid Managed Care.[21] However, issues and deficiencies regarding provider access remain. Instead of "encourage[ing] managed care plans to perform direct outreach to providers on a regular basis to improve the accuracy of their provider data," CMS should maintain current standards and engage in active compliance monitoring and enforcement actions when plans fail to meet those minimum standards.

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[19] Camille Ryan & Jamie Lewis, American Community Survey Reports, *Computer and Internet Use in the United States: 2015* 8 (2017), https://www.census.gov/content/dam/Census/library/publications/2017/acs/acs-37.pdf.

[20] *Id.* at 9; Rachel Garfield et al., Kaiser Family Found., *Implications of Work Requirements in Medicaid: What Does the Data Say?* (Jun. 12, 2018), http://files.kff.org/attachment/Issue-Brief-Implications-of-Work-Requirements-in-Medicaid-What-Does-the-Data-Say

[21] OIG, Access to Care: Provider Availability in Medicaid Managed Care, OEI-02-13-00670 (Dec. 2014), available at http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf.

Thank you for the opportunity to offer comments to this proposed rule. For the reasons detailed above, we urge CMS to reconsider these proposals. Please contact HHCAWG Co-Chairs Amy Killelea with the National Alliance of State and Territorial AIDS Directors at akillelea@nastad.org, Phil Waters with the Center for Health Law and Policy Innovation at pwaters@law.harvard.edu, or Ramon Gardenhire with the AIDS Foundation of Chicago at rgardenhire@aidschicago.org.

Respectfully submitted by the undersigned organizations:

ADAP Educational Initiative
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.
Communities Advocating Emergency AIDS Relief (CAEAR)
Community Access National Network (CANN)
Equality California
Georgia AIDS Coalition
Harm Reduction Coalition
HealthHIV
HIV Medicine Association
Housing Works
Human Rights Campaign
iHealth
Lambda Legal
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
Treatment Action Group (TAG)
Thrive Alabama