

VERMONT LEGAL AID, INC.

OFFICE OF THE HEALTH CARE ADVOCATE

264 NORTH WINOOSKI AVE. - P.O. Box 1367

BURLINGTON, VERMONT 05402
(800) 917-7787 (VOICE AND TTY)
FAX (802) 863-7152
(802) 863-2316

OFFICES:

BURLINGTON
RUTLAND
ST. JOHNSBURY

OFFICES:

MONTPELIER
SPRINGFIELD

Via email to HHSPan@hhs.gov

October 26, 2017

Office of the Assistance Secretary for Planning and Evaluation
Strategic Planning Team
Department of Health and Human Services
200 Independence Ave. S.W.
Room 415F
Washington, D.C. 20201

RE: Request for Comments on the Draft Department Strategic Plan for FY 2018-2022 (HHS-2017-20613)

To Whom It May Concern:

Thank you for the opportunity to comment on HHS' draft strategic plan.

The Office of the Health Care Advocate (HCA) provides consumer assistance to individual Vermonters on questions and problems related to health insurance and health care. The HCA handles over 4,000 cases per year and assists individuals regardless of their income or insurance status. The HCA also engages in a wide variety of consumer protection activities on behalf of the public, including before the Green Mountain Care Board, Vermont Health Connect, other state agencies, and the Vermont legislature.

We have organized our comments by thematic area and then provided specific edits on objectives and strategies. The main areas we address are the Strategic Plan's implications for reproductive health, people with disabilities, health equity, and people with substance use disorders. We also provide additional general comments.

1. Development of Strategic Plan.

The Government Performance and Results Act (GPRA) Modernization Act of 2010 (P.L. 111-352) requires agencies to develop a performance plan that expresses performance goals for each strategic objective "in an objective, quantifiable, and measurable form" unless otherwise authorized by the Office of Management and Budget.¹ Performance goals must include "clearly defined milestones."²

¹ 31 U.S.C. § 1115(b)(2), § 1115(c).

² 31 U.S.C. § 1115(b)(5)(B).

The performance plan must also establish a balanced set of performance indicators to be used in measuring or assessing progress toward each performance goal, including, as appropriate, customer service, efficiency, output, and outcome indicators,” and “provide a basis for comparing actual program results with the established performance goals.”³ Unfortunately, much of HHS’ plan fails to contain performance indicators and instead moves to include political goals – such as focusing on life beginning at conception rather than birth – rather than focusing on the requirements for a strategic plan.

Furthermore, HHS has omitted “a description of how the goals and objectives incorporate views and suggestions obtained through congressional consultations.”⁴ When developing a strategic plan, HHS “shall consult periodically with the Congress, including majority and minority views from the appropriate authorizing, appropriations, and oversight committees, and shall solicit and consider the views and suggestions of those entities potentially affected by or interested in such a plan.”⁵ Congress also has the ability “to establish, amend, suspend, or annul a goal of the Federal Government or an agency.”⁶ The current strategic plan cannot be considered compliant unless and until HHS consults with the appropriate members of Congress and a public comment period is insufficient to meet these requirements.

2. Implications for Reproductive Health

We object to the statements within the strategic plan that promote the religious belief that life begins at conception. This language amounts to political grandstanding and it is contrary to both the Establishment Clause and the Free Exercise Clause of the U.S. Constitution. The language inserts the abortion debate into public health policymaking, where it has no place. The idea that “life begins at conception” is not relevant to public health policy. Rather, it is a specific religious view that is contrary to the beliefs of many Americans. Free speech and religious liberty are concepts that cannot be limited to one specific view; those who do not believe that life begins at conception are entitled to the same free exercise of religion, and any language to the contrary is discriminatory. The decision to obtain any health service, including reproductive health care, should remain with the individual.

Second, one of the basic functions of government is to ensure the health and well-being of its population. Privileging embryos and fetuses over people threatens the capability of HHS to fulfill this function, and would deprive women of health care benefits that medical and health care experts recognize as critical to their health and wellbeing.⁷ Elevating the status of a fetus over the health needs of pregnant women would result in poorer maternal health and poorer birth outcomes.⁸ Such policies will impede the ability of HHS to cultivate and inform best practices for women’s health, and in turn, interfere with the ability of providers, particularly those who offer reproductive health services, to provide quality care to their patients.

³ 31 U.S.C. § 1115(b)(6)-(7).

⁴ 5 U.S.C. § 306(a)(5).

⁵ 5 U.S.C. § 306(d).

⁶ Pub. L. 111–352, §15, Jan. 4, 2011, 124 Stat. 3883.

⁷ AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, COMMITTEE OPINION: INCREASING ACCESS TO ABORTION (2014), <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co613.pdf?dmc=1&ts=20171019T1538434634>.

⁸ CENTER FOR REPRODUCTIVE RIGHTS AND IBIS REPRODUCTIVE HEALTH, EVALUATING PRIORITIES: MEASURING WOMEN’S AND CHILDREN’S HEALTH AND WELL-BEING AGAINST ABORTION RESTRICTIONS IN THE STATES (2017), <https://ibisreproductivehealth.org/sites/default/files/publications/Evaluating%20Priorities%20August%202017.pdf>.

Third, the language undermines consumer choice and patient empowerment. Consumer choice and empowerment must be driven by fully informed, patient-centered decision making. We oppose all efforts to limit the provision of health information, including but not limited to when it concerns the full range of contraceptive options including sterilization, abortion, and LGBT-inclusive sexual health information. Elevating a fertilized egg to equal status with a person is contrary to U.S. law and establishes a policy framework that would undermine the ability of women and others to make the best decisions for themselves and their families, including decisions impacting their health and wellbeing, and their ability to participate in public life.⁹

Moreover, adopting policies that give health rights to fetuses would also undermine a woman's constitutional right to access abortion, and interferes with the patient-provider relationship by limiting the information, counseling, referral and provision of abortion services that a woman can receive, despite the fact that these are part of the standard of care for a range of common medical conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer. The language is overly broad, confusing, and subject to misuse and abuse by creating a federal health care framework that invites HHS to refuse to participate in the orderly delivery of evidence-based health care services.

Finally, we believe that HHS' goal to remove barriers for health care providers with religious beliefs or moral convictions is unnecessary and could potentially reduce access to care for vulnerable populations including women, adolescents, and LGBT communities. While we appreciate HHS' desire to strengthen and expand the healthcare workforce, federal law provides ample protections and religious exemptions, such as the Church Amendments, for health care entities and individuals who object to providing certain services based on their religious beliefs. The Strategic Plan cites no evidence that further protections are needed. Additional provisions to shield these providers from delivering evidence-based, quality medical and health-related services that meet the standard of care would be unnecessary and restrictive.

We offer the following additional comments:

- We strongly support expanding resources, supports, and information for adolescents so that they can make the best decisions for their health and well-being. However, programs and information supported under this strategic plan must include age, developmentally and culturally appropriate, medically accurate, evidence-based sexual and reproductive health information to ensure that adolescents have the tools they need to make informed and healthy decisions throughout their lives.
- We support comprehensive sexual and reproductive health counseling and services from LGBT-competent providers, and discourage use of faith-based partners that shame LGBT individuals and communities based on specific ideological beliefs.
- We object to the draft plan's references to a "natural" death. This language inappropriately incorporates religious views about suicide into governmental health policy.

⁹ Roe v. Wade, 410 U.S. 113, 153 (1973); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 856 (1992).

3. Implications for People with Disabilities

HHS's strategic plan appropriately addresses issues related to individuals with disabilities throughout the entire plan, recognizing that accessibility, community-integration and self-determination are implicated in almost every aspect of health care. Our comments below seek to clarify and strengthen HHS' strategies to promote the following four goals: expansion of access to services in the context of behavioral and physical health collaborative models; promotion of community-integration and inclusion; protection of the right to person-centered services and self-determination; and protection of all other individual rights.

We appreciate HHS' commitment to promoting collaborative models of behavioral and physical health care. Such collaboration has the potential to both address shortages of behavioral health professionals via consultative models, and to address unmet physical health care needs of individuals receiving behavioral health care services. To the extent these models focus on the former by expanding the reach of behavioral health professionals via screening, telemedicine, and/or other consultative models, HHS should ensure that such approaches are coupled with an explicit commitment to expanding and integrating essential community-based behavioral health support services. Essential community-based services include, but are not limited to, Peer Support Services, Assertive Community Treatment, Mobile Crisis Intervention, and various other intensive community-based services.

Last, we appreciate HHS' acknowledgment that some of the barriers to treatment pursuant to HIPAA may be "perceived barriers." As HHS investigates such barriers, we encourage HHS to promote solutions that protect individual privacy while promoting self-direction and advanced planning. Advance directives for behavioral health care (also known as psychiatric advanced directives) are one such legal tool which allow individuals to designate types of treatment and settings in which they want to receive care, and allow them to designate certain individuals or providers that should be notified regarding treatment needs.

Here are some additional comments related to these issues:

- We appreciate that HHS has included a section regarding improving Home and Community-Based Services (HCBS), and that HHS makes explicit mention of the well-established and crucial right to community integration and inclusion in numerous sections of the strategic plan. While we encourage the development of additional community supports to enhance community integration, we caution against relying on such supports in place of paid supports.
- Choice of providers for mental health and substance use treatment services is often quite limited. Care must be taken to ensure that all individuals are able to access care free of discrimination.
- HHS' commitment to protecting individual rights and addressing abuse and neglect should be clarified to ensure it is clearly applicable in all facilities where individuals with disabilities receive services, not just in traditional health care settings.
- Protection from abuse and neglect must be built into emergency planning. People with disabilities and older adults too often bear the brunt of poor disaster planning, and may need additional assistance to safely survive emergencies.

- We object to HHS' characterization of a lack of "personal responsibility" as the barrier to employment for returning citizens, without acknowledgement of discriminatory hiring practices, disability and/or trauma and restrictive conditions of release as major reasons for unemployment. Reentry support should be a long-term investment that addresses both structural and individual barriers to work.

4. Implications for Health Equity

HHS must continue to undertake activities to identify and address health disparities with the ultimate goal of eliminating them. In activities spanning the Office for Civil Rights, Office of Minority Health, Office of Women's Health as well as the Centers for Medicare & Medicaid Services, all of HHS' endeavors must ensure that disparities are not heightened but are prevented. We appreciate recognition of the need to address disparities within the Strategic Plan but believe that HHS must strengthen these sections to ensure all individuals can achieve their health equity.

Further, the Strategic Plan should ensure that all of HHS' activities are undertaken in a culturally competent manner. Providing culturally competent services is critical to ensure that services are client/patient centered and are appropriate for not just the particular program at issue but also for the clients/enrollees served. We urge HHS to include more specific and measurable goals and strategies to address cultural competency in a holistic manner including race, ethnicity, language, immigration status, age, disability, sex, gender identity and sexual orientation.

Here are some additional comments on ways to improve health equity:

- We support HHS' recognition of the need for health literacy tools. We suggest HHS specifically recognize the need to provide culturally competent tools such that all individuals, regardless of their background, can benefit from these tools.
- We recommend additional requirements to specifically address collecting, analyzing and applying demographic data.
- We appreciate HHS's mention of the need to reduce disparities. We believe this includes not merely racial and ethnic health disparities but also disparities based on language, age, sex, sexual orientation, gender identity, and disability. We recommend HHS include a broad definition of health care disparities in its strategic plan.
- We note that alternative payment models must not be implemented in such a way that they create incentives to stint on needed care or avoid costlier patients. We believe that HHS should focus on models that prioritize primary care (for example, that include strong PCMH requirements). Furthermore, we recommend that if HHS uses financial incentives, those incentives should be focused on improving outcomes and not to reducing costs.
- We appreciate the recognition of the need to provide programs that improve the quality of care and increase access. To that end, we recommend that such programs be developed and implemented in a culturally competent manner.
- We strongly support the inclusion of the strategy "Reduce disparities in quality and safety" as it is critical to ensure that our health care system is accessible to all individuals,

regardless of race, ethnicity, language, immigration status, sex, gender identity, sexual orientation, age and/or disability.

- To the extent HHS recognizes the need for providing materials in non-English languages, HHS should also recognize the need for providing materials in formats that will be accessible to individuals with disabilities who have communication needs. This would include large print format and audio or video recordings for those who cannot access written materials.
- We are concerned that the plan fails to mention other federal civil rights laws and Executive Orders which are relevant to providing healthcare options that are responsive to consumer demands. These include Executive Order 13166, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, the Age Discrimination Act, and Section 1557 of the Affordable Care Act. All of these laws must be fully implemented and enforced by HHS to ensure that HHS' programs and activities, and those it supports with federal funds, are responsive to consumer demands.
- We do not agree with HHS' statement that removing barriers to and promoting participation in HHS programs by persons and organizations with religious beliefs or moral convictions is a solution to assisting targeted populations. Rather, HHS should remain religiously and morally neutral in its funding and activities to ensure that individuals do not feel proselytized by providers or receive access to a limited scope of services due the moral or religious nature of an organization.
- We appreciate the role HHS has in preparing for and responding to public health emergencies. We believe that much of this work, especially in the provision of tools to states and providing public health communications must be done in a culturally competent manner.
- We support the recognition of the need to improve collaboration with State, Local, Tribal and Territorial (SLTT) partners. We recommend that these strategies also specifically recognize the need to provide information in a culturally competent manner.
- We support the objective to optimize information technology investments to improve process efficiency and believe HHS should ensure that efforts to identify and address healthcare disparities are sufficiently recognized and address with regard to information technology investments.

5. Implications for LGBT Individuals

People who are lesbian, gay, bisexual, or transgender (LGBT) are considered a vulnerable population as it concerns their health. LGBT people face higher rates of HIV/AIDS, depression, an increased risk of some cancers, and are twice as likely as their heterosexual peers to have a substance use disorder. Transgender people in particular are at higher risk for a range of poor health outcomes. For example, the 2015 U.S. Transgender Survey,¹⁰ a national study of nearly 28,000 transgender adults, found that respondents were nearly five times more likely to be living with HIV than the general population, with even higher rates for some populations: for example, nearly one in five

¹⁰ THE NATIONAL CENTER FOR TRANSGENDER EQUALITY, 2015 U.S. TRANSGENDER SURVEY (2016), available at <http://www.ustranssurvey.org/>

(19%) Black transgender women living with HIV, more than 63 times the rate in the general population. Transgender respondents were nearly eight times more likely than the general population to be living with serious psychological distress based on the Kessler 6 scale, with higher rates correlating with experiences of discrimination, violence, and rejection. The medical community and scientific research has repeatedly demonstrated that the poor health outcomes that LGBT people face are not associated with any inherent pathology, but rather high rates of poverty, discrimination in the workplace, schools, and other areas, and barriers to nondiscriminatory health care that meets their needs. Recognizing these disparities and the impact they have on LGBT people, improving the health, safety, and well-being of LGBT people was made a goal of Healthy People 2020. LGBT people were included in a number of other health objectives including mental health and mental illness, tobacco use, usual source of care, and health insurance coverage, and the National Institute of Health (NIH) formally designated sexual and gender minorities as a health disparity population in 2011 for NIH research.¹¹

A major factor in these health disparities is the discrimination that LGBT people face when trying to access health care. While the Affordable Care Act has significantly increased the percentage of LGBT people with insurance and has helped prohibit discrimination against LGBT people in coverage and care, LGBT people are still more likely than non-LGBT adults to lack insurance and LGBT people still face discrimination. A recent survey found that transgender respondents were over 5 times more likely to avoid doctor's offices just to avoid the risk of experiencing discrimination than their cisgender counterparts. Additionally, the 2015 U.S. Transgender Survey found that, just in the past year, 33% of those who saw a health care provider faced some form of mistreatment or discrimination because of being transgender, such as being refused care, harassed, or physically or sexually assaulted, and 23% avoided seeing a doctor when needed due to fear of discrimination. We expect HHS to continue serving LGBT people and believe the strategic plan is an ideal opportunity for HHS to show that it plans to engage in targeted efforts to ensure that vulnerable populations like LGBT communities get the healthcare they need.

As a population that experiences the significant disparities related to health care access, essential services, and economic security described above, LGBT individuals should be specifically mentioned in relevant portions of the Strategic Plan. In previous strategic plans, HHS included explicit references to the LGBT population when discussing goals related to providing access to quality, competent care, improving data collection, supporting the healthy development of youth, and expanding access to culturally competent services, among other goals. We recommend that the needs of the LGBT population be explicitly mentioned in some of the following key goals:

- Collect additional data, identify barriers to access, facilitate consumer engagement, and promote evidence-based practices to improve access to physical and behavioral health services.
- Measure and report on healthcare quality and disparities at the national, state, local, and individual provider level to facilitate improvement in the healthcare system.
- Identify individuals and populations at risk for limited health care access and assist them to access health services, including prevention, screening, linkages to care, clinical

¹¹ Kellan Baker, "Open Doors for All" (Washington: Center for American Progress, 2015), available at <https://www.americanprogress.org/issues/lgbt/reports/2015/04/30/112169/open-doors-for-all/>.

treatment, and relevant support services, including through mobilization of faith-based and community organizations.

- Health promotion and wellness strategies supported by HHS are often focused on specific populations at risk for poorer health outcomes, such as older adults, people with disabilities, racial and ethnic minorities, American Indian and Alaska Native populations, people with low socioeconomic status, children, and people with limited English proficiency.
- Produce and promote patient-centered health care delivery methods and interventions that improve care quality, promote healthcare access, reduce disparities, and address social determinants of health among populations at risk for poor health outcomes.
- Support research to identify, implement, and evaluate interventions to reduce health disparities and improve the health of populations at risk for poor health outcomes.

We recommend HHS revisit the Strategic Plan taking into consideration the large body of research demonstrating the need for specific and competent inclusion of LGBT people in all aspects of efforts to improve the health of Americans.

6. Impact on People with Substance Use Disorders

We appreciate HHS' recognition of the importance of expanding the entire spectrum of interventions, from prevention through recovery, as well as the importance of public health approaches to preventing, identifying, and treating substance use disorders. We also support the emphasis on a collaborative approach that involves both governmental and non-governmental organizations. We caution, however, that some faith-based and "community" organizations rely on outdated and non-evidence-based approaches to mental and substance use disorders, many of which do not reduce the incidence and prevalence of these disorders and some of which can be harmful to vulnerable individuals and communities.

We urge HHS to engage in education and outreach to ensure that both governmental and non-governmental organizations are aware of and are utilizing modern, evidence-based, non-stigmatizing approaches to substance use disorders. We also urge HHS to ensure that "community" organizations are inclusive of people who use drugs (PWUD), including harm reduction organizations.

7. Additional Comments

We believe HHS' strategic plan must specifically mention and address HHS' legal responsibility to uphold the laws of the United States, including the Affordable Care Act and Medicaid. Without robust implementation of the ACA and adherence to Medicaid's governing statute and regulations, many of the goals and strategies outlined in this plan will be unobtainable. Further, we appreciate the recognition that consumers and enrollees should have choice but that choice must come with sufficient knowledge and information to make informed choices. The recent actions by the Administration to cut funding for navigators and open enrollment outreach are contrary to the stated ability to provide consumers with choices that they actually can understand. Health insurance is extremely complicated, and the terminology involved in comparing plans and understanding benefits is difficult for consumers to understand. Navigators in particular play a critical role in

informing consumers about their eligibility for health insurance, helping them enroll, explaining how to use health insurance, and connecting them with health care.

We thus suggest adding a new “strategy” bullet that would read as follows:

Implement and enforce the ACA

- Ensure sufficient resources to maintain and improve healthcare.gov and its Call Center.
- Provide sufficient financial support to FFM navigators to ensure they can operate in all counties in all FFM states and throughout the entire calendar year.
- Conduct outreach activities commensurate with the need to educate and inform individuals about the marketplaces, public health insurance programs (including Medicaid, CHIP and Medicare), their health insurance options, and how to enroll.
- Ensure compliance with all statutory and regulatory requirements regarding the Affordable Care Act and Medicaid.

Thank you for considering these comments. If you have any questions or need any further information, please contact Christine Speidel at cspeidel@vtlegalaid.org or Kaili Kuiper at kkuiper@vtlegalaid.org.

Sincerely,

/s/ Michael Fisher

Michael Fisher
Chief Advocate

Vermont Legal Aid’s Office of the Health Care Advocate