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Office of the Assistant 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

VIA ELECTRONIC MAIL – HHSPlan@hhs.gov

Attn: Strategic Plan Comments

Community Catalyst respectfully submits the following comments to the Department of Health and Human Services in response to its request for input on its 2018-22 Strategic Plan, released on September 27, 2017.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers and foundations, providing leadership and support to change the health care system so it serves everyone - especially vulnerable members of society.

We greatly appreciate the opportunity to provide comments on the draft 2018-22 Strategic Plan, as well as the Department's dedication to addressing important topics relevant to our nation's healthcare system, such as affordable health coverage, high-quality care, healthy individuals living to their full potential and safe, thriving communities. While we overall support the Department's chosen strategic goals and objectives, we feel the plan is missing key components and other components are sufficiently lacking in content. Therefore, we feel the draft plan does not meet the requirements of its authorizing legislation, the Government Performance and Results Modernization Act of 2010 (GPRMA), and should be significantly revised before it can be considered final and complete.

We provide general comments and recommendations for the first three strategic goals within this plan as well as specific comments organized by health care-related areas and impacts on specific populations. The main areas we address are the plan's implications for children's health, health equity, oral health, women's health and individuals with disabilities, as well as the prevention and services to address substance use disorders.

The Strategic Plan is Not Compliant with its Authorizing Legislation

The Government Performance and Results Act (GPRA)¹ and GPRA Modernization Act of 2010² require agencies to develop a performance plan that expresses performance goals for each strategic objective “in an objective, quantifiable, and measurable form.”³ Performance goals must include “clearly defined milestones” and “provide a basis for comparing actual program results with the established performance goals.”⁴ In its 2014-18 Strategic Plan, HHS included performance goals beneath every objective within each of the five overarching strategic goals. For example, the 2014-18 strategic plan included the objective: “Reduce the prescription drug coverage gap (the “donut hole”) for those receiving the Medicare Prescription Drug benefit,” and the corresponding performance goal was to “[r]educe the average out-of-pocket share of prescription drug costs while in the Medicare Part D Prescription Drug Benefit coverage gap for non-Low-Income Subsidy Medicare beneficiaries who reach the gap and have no supplemental coverage in the gap.” In contrast, the current version of the strategic plan contains no performance goals to measure whether or how the plan's objectives are being achieved.

The GPRA and GPRA Modernization Act also require HHS to consult with members of Congress while developing its strategic plan, and include in its plan “a description of how the goals and objectives incorporate views and suggestions obtained through congressional consultations.”⁵ However, the current draft of the strategic plan admits this consultation has not taken place, and the only scheduled attempt to do so is through this public comment period. HHS writes in the “Stakeholder Engagement” section of the plan that “HHS will update this section to reflect input received from public and Congressional consultation conducted in the fall 2017.”⁶ We feel that a public comment period is insufficient to meet this requirement and the strategic plan cannot be considered compliant unless and until HHS consults with the appropriate members of Congress.

The Strategic Plan Fails to Mention Key Populations and Public Health Programs

¹ P.L. 103-62

² P.L. 111-352

³ 31 U.S.C. 1115(b)(2)

⁴ 31 U.S.C. 1115(b)(6)-(7)

⁵ 5 U.S.C. 306(d)

⁶ Lines 104-07

One of the most notable differences between the 2014-18 HHS Strategic Plan and the 2018-22 plan is that the current plan makes no reference to the Affordable Care Act (ACA), a program that has expanded coverage to more than 20 million individuals and provided protections within private health insurance to millions more. The plan also fails to mention the Children's Health Insurance Program (CHIP), which ran out of funding on September 30th. It is concerning that the main agency charged with administering all of the country's public health insurance programs has decided to write a strategic plan that fails to even reference two core components of our nation's system of health care coverage (the Affordable Care Act and CHIP), rather than strategically contemplate ways to build upon their successes and address their shortcomings.

In addition, the current strategic plan does not include any references to lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ) individuals. For example, the prior strategic plan contained strategies to: “[s]upport research that will increase our understanding of the health and health status of population subgroups such as racial and ethnic minorities, persons with disabilities, the reentry population, rural populations, and lesbian, gay, bisexual, and transgender (LGBT) populations, as well as to “[s]upport the safety, well-being, and healthy development of children and youth, including children and youth who have been maltreated, who have disabilities, who are integrating into U.S. society, and who are experiencing homelessness, including lesbian, gay, bisexual, and transgender (LGBT) youth and other vulnerable populations.” While the 2018-22 Strategic Plan contains references to other key populations such as children, older adults, individuals with disabilities and individuals with substance use disorders, there are no references to LGBTQ individuals or the LGBTQ population.

Similarly, there are no references to individuals and families with immigration statuses other than refugee status. In contrast, the prior strategic plan contained strategies such as to: “[p]rovide online and technological resources to help refugees, other immigrant populations, and service providers connect with mainstream resources to achieve self-sufficiency,” as well as to “[p]rovide supportive services, including health and behavioral health services and supports, and wraparound services like employment, housing, caregiver support, and peer recovery supports, to reduce and eliminate barriers to community living for vulnerable populations, including individuals with disabilities, older adults, the lesbian, gay, bisexual, and transgender (LGBT) community, refugees and immigrants, and individuals at risk for homelessness.”

Overall, in order to have a more healthy and productive society, we believe health care policies and public health programs, such as those created, administered and monitored by HHS, must have missions, strategies and performance measures inclusive of and responsive to the diverse and varied needs of individuals and families living the United States. Overall, we are concerned that the explicit removal of references to these populations signifies that understanding the health and health status of these populations is no longer a priority for HHS or the Administration. We strongly believe our health care system must serve and be inclusive of all individuals and urge

the Department to revise this plan so that its goals and strategies are more representative of all of the populations it serves.

References to prioritizing working with faith-based organizations and removing barriers for individuals with religious beliefs and moral convictions to participate in HHS programs

Another significant departure from the previous strategic plan is the frequent reference to working with faith-based organizations⁷ when carrying out the Department’s goals and strategies, as well as administering programs, policies and procedures that do not impose barriers for individuals with religious and moral convictions.⁸ We are certainly supportive of partnering with faith-based organizations when providing outreach and education to individuals regarding access to health coverage and services⁹, as well as advancing health and wellness and promoting preventive care. However, we’re concerned that certain strategies and goals involving “removing barriers” for individuals with religious beliefs and moral convictions will lead to barriers to care for patients, such as the strategy to “[t]est new payment models on alternative approaches to end-of-life care that incentivize patient and family-centered preferences while respecting religious beliefs and moral convictions.”¹⁰ Overall, prioritizing the ability of religious providers to practice in accordance with their religious beliefs signals a departure from evidence-based care, even though the Department mentions prioritizing evidence-based care throughout the strategic plan.

We’re further concerned that these provisions may lead to barriers to accessing certain health care services and health information, particularly regarding reproductive, sexual health, gender identity-related and end-of-life care. Patients who do not receive full information cannot make fully-informed healthcare decisions, which may adversely affect their health outcomes all together. We believe additional efforts to remove barriers or better allow religious providers to deliver care in accordance with their beliefs unnecessarily prioritizes the beliefs of religious providers over their duty to provide quality medical care to all individuals, and to the detriment of the health of their patients. Therefore, we recommend requiring all religious providers and faith-based organization to provide evidence-based, unbiased and non-discriminatory information and services.

Strategic Goal #1: Reform, Strengthen and Modernize the Nation’s Health Care

Overall, we support all of the objectives contained within Strategic Goal #1, including supporting and promoting preventive care and services, strengthening and supporting informed consumer-decision making, and promoting health care that is high quality, effective in improving

⁷ Lines 189-90, 230-33, 316-17, 332-34, 350-52, 375-77, 388-91

⁸ Lines 169-72, 359-64, 365-70, 371-74, 399-403, 435-36, 474-78

⁹ Lines 350-52, 388-91

¹⁰ Lines 169-72

health, and efficient. Our comments on specific goals and recommendations for improving them are below.

Strengthen the individual private insurance market

Overall, we support the Department's intention to help strengthen the individual insurance market by both encouraging enrollment by uninsured individuals,¹¹ including younger and healthier individuals, as well as helping currently enrolled individuals maintain their coverage. To best incentivize enrollment and continued participation in the individual market, we believe HHS should continue to implement the ACA's consumer protections, such as continuing to prohibit pre-existing condition exclusions and annual and lifetime caps. We also believe that individual market stability can best be achieved if there are robust outreach and education efforts to educate the public about opportunities to enroll in the marketplaces and obtain financial assistance. We particularly support the goals around creating and improving health literacy resources and other decision-support tools to help individuals make informed health plan selections as well as learn how to use their coverage to access care. We therefore urge HHS and the Administration to support bipartisan Congressional efforts to ensure a stable individual market going forward and also aid HHS in achieving many of these objectives.

Ensure stability of Medicaid & CHIP

Together, Medicaid and the Children's Health Insurance Program (CHIP) provide the foundation for access to health care for many children and families. Medicaid, as distinct from CHIP, further provides a foundation for children's health by creating opportunities for innovation in payment and delivery while improving health outcomes. Without this foundation, many of HHS's important priorities would be undermined. As noted earlier, we were concerned to see no references to CHIP in this strategic plan and urge HHS to work with Congress to ensure continued adequate federal funding for Medicaid and quickly extend funding for CHIP. Additionally, to preserve the coverage gains that have been achieved over the last few years and continue to improve access to care, we believe HHS should continue to support states that have expanded Medicaid as well as assist and encourage those who have not yet expanded.

Support innovative models of care that focus on improving outcomes, particularly for those with complex needs

We appreciate HHS' focus on prevention and interest in addressing health care costs. We emphasize the importance of ensuring that the policies adopted by HHS do not have negative consequences for consumers that have the most complex care needs. We believe that it is important to recognize that consumers with serious chronic illness, who are low-income, or have other health or social challenges are particularly harmed by policies that impose financial or administrative burdens on consumers.

¹¹ Lines 174-75

We appreciate the mention of patient-reported data and the use of patient experience and outcome measures. We would like the Department to focus more strongly on identifying, reporting and addressing the profound disparities in health in our country, including those related to race. We are particularly troubled that this document omits almost any mention of race or racial disparities.

While we appreciate there are several mentions of the integration of physical health services with others, oral health is largely left out of strategies and language around integrated care. We recommend including oral health along with physical and behavioral health integration as part of a strategy to make care more comprehensive and reduce costs.¹²

Continue to improve access to coverage and care

We also appreciate the Department's stated goal to promote the use and inclusion of midlevel providers such as dental therapists, as a means of expanding access to low-cost preventive care.¹³ Along with providing education and preventive services, dental therapists are also able to perform common dental procedures such as filling cavities and, in limited cases, removing teeth. Additionally, through the off-site supervision of a dentist, dental therapists can deliver care in settings that better meet the needs of underserved communities such as rural areas, remote clinics, schools and senior centers. Extensive evidence shows that dental therapists provide safe, effective dental care¹⁴, enable dentists to see more patients,¹⁵ increase access to care - particularly for underserved communities - and increase the productivity of the dental team while decreasing costs to the practice.¹⁶ Dental therapists also offer a culturally competent model of care. As of 2017, 78% of dental therapist work in their village or region of origin. These communities report the cultural connection allows them to establish a high level of trust with patients improving their experiences and outcomes.¹⁷

New evidence also shows 47 million people currently live in federally-designated dental professional shortage areas.¹⁸ Therefore, we believe HHS should play an instrumental role in expanding access to and use of midlevel providers who can provide basic levels of care. We urge

¹² Snyder, Andrew; Oral Health and the Triple Aim: Evidence and Strategies to Improve Care and Reduce Costs: <http://nashp.org/wp-content/uploads/2015/04/Oral-Triple-Aim.pdf>

¹³ Lines 182-83.

¹⁴ Nash DA, Friedman JW, Mathu-Muju KR, Robinson PG, Satur J, Moffat S, Kardos R, Lo ECM, Wong AHH, Jaafar N, van den Heuvel K, Phantumvanit P, Chu E, Naidu R, Naidoo L, McKenzie I, Fernando E. A review of the global literature on dental therapists. *Community Dent Oral Epidemiol* 2013.

¹⁵ Minnesota Department of Health. (2014). Early Impacts of Dental Therapists in Minnesota. Report to the Minnesota Legislature 2014: <http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf>

¹⁶ See *id.*

¹⁷ Presentation by Dr. Mary Williard, DDS, Director, Dental Health Aide Therapist Training Program: <http://anthc.org/dental-health-aide/>

¹⁸ Health Resources & Services Administration; Shortage Areas: <https://datawarehouse.hrsa.gov/topics/shortageAreas.aspx>

HHS to support initiatives that increase the accessibility of dental therapy training by supporting the education model for dental therapists authorized by the Council on Dental Accreditation (CODA) in 2015.¹⁹ Making this education accessible ensures new students can be recruited from shortage areas and are able to return to their communities quickly and cost effectively, creating a new professional workforce within under-employed communities.

Improve access to dental care

In general, mentions of dental care and oral health are few and far between. We recommend more comprehensive inclusion of oral health, stressing its importance for overall health and improving coverage and access to integrated health care that includes oral health. We support the inclusion of oral health as part of a holistic approach to overall health and wellbeing. There is an existing, robust evidence base that provides empirical strategies for improving access to affordable insurance coverage. We recommend prioritizing putting this evidence into action by protecting and expanding Medicaid, CHIP and Medicare and financial support for private coverage.

In addition, we encourage the Department to expand dental coverage for adults in publicly-funded health insurance programs including Medicare and Medicaid and to protect dental benefits for children. The connection between oral health and overall health is undeniable, yet Medicaid continues to classify dental benefits for adults as optional and the Medicare program does not offer a dental benefit at all. We also recommend more specificity around strategies to address dental provider shortages, for example licensing dental therapists, promoting the use of teledentistry, and increasing Medicaid reimbursement rates. We also believe that prevention is key – continuing to mandate a dental benefit for children is critical. Additionally, we recommend support for school-based dental services and other opportunities for screening and treating children’s oral health needs in school settings to promote prevention. As stated above, we applaud the interest of HHS in expanding the availability of dental therapists throughout the United States and the particular attention paid to the ability of dental therapists to provide safe, effective care in community-based settings. A recent study showed that over ten years, residents in Alaska Native communities where dental therapists spent more time had fewer instances of invasive procedures and more preventive care visits than residents in communities with less access to dental therapists.²⁰ This adds to the already extensive evidence²¹ that dental therapists have provided safe, quality, affordable care to underserved communities for over 90 years. We

¹⁹ Commission on Dental Accreditation; Accreditation Standards for Dental Therapy Education Programs: <http://www.ada.org/~media/CODA/Files/dt.pdf>

²⁰ Chi D, Et al. Dental Utilization for Communities Served by Dental Therapists in Alaska’s Yukon Kuskokwim Delta: Findings from an Observational Quantitative Study, 2017. <http://faculty.washington.edu/dchi/files/DHATFinalReport.pdf>.

²¹ Nash DA, Friedman JW, Mathu-Muju KR, Robinson PG, Satur J, Moffat S, Kardos R, Lo ECM, Wong AHH, Jaafar N, van den Heuvel K, Phantumvanit P, Chu E, Naidu R, Naidoo L, McKenzie I, Fernando E. A review of the global literature on dental therapists. Community Dent Oral Epidemiol 2013

therefore urge HHS to provide guidance to states on how to provide supervision for dental therapists, to ensure commitment to the goal of providing care outside the dental office.

Focus on health equity

We recommend that health equity be the department's overarching priority. We firmly believe our health care system should be accessible to all individuals, regardless of race, ethnicity, language, immigration status, age, disability, sex, gender identity and sexual orientation. As a result, we are strongly supportive of many of the Department's goals regarding health equity, including promoting strategies for delivering culturally-competent and linguistically appropriate care, promoting the use of dental therapists, researching the role of social determinants of health in improving health outcomes and collecting and analyzing data to improve access to care.²² However, we urge HHS to continue to identify and address health disparities with the ultimate goal of eliminating them.

HHS should also consider collecting, analyzing, applying and disseminating data broken down by various demographic factors including but not limited to race and ethnicity. We further encourage HHS to engage in efforts to increase transparency, uniformity and quality by working in partnership with states to ensure that all individuals, children and families have the opportunity to be healthy and succeed.

Strategic Goal #2: Protect the Health of Americans Where They Live, Learn, Work and Play

We appreciate the Department's comprehensive approach to addressing substance use disorders through prevention, early intervention, treatment and recovery supports. Overall, this section promotes strategies supported by consumers, individuals in recovery, and treatment providers and employs evidence-based practices stemming from the most current addiction research. Our comments on specific goals and recommendations for improving them are below.

Include youth-prevention and care integration in efforts to address substance use disorders

We applaud HHS for including a robust plan for youth-focused prevention. Young people are in a critical window of vulnerability to addiction. We support efforts to identify substance use through verbal or written screening and intervene early, particularly through the use of SBIRT (screening, brief intervention and referral to treatment) in schools and community-based settings. We are also encouraged to see the integration of substance use, mental health, physical health care and long-term services and supports included as a priority area in several of the plan goals. Efforts to co-locate services and improve the coordination among providers minimizes many logistical barriers experienced by consumers and can significantly improve quality of care.

²² Lines 283-302, see also lines 545-51

Expand early intervention services to include those that reduce harm for people continuing to use substances

The plan refers repeatedly to the full continuum of services needed for people with substance use disorders. We recommend adding explicit mention of the importance of expanding services that reduce harmful effects of continued drug or alcohol use among those who are not ready for or interested in abstinence. These services will help reduce co-occurring illnesses.

Promote pre-arrest diversion programs to address addiction

We ask that HHS elevate pre-arrest diversion programs a key strategy for addressing addiction and related health and human service needs. A majority of individuals in the criminal justice system have a mental health or substance use disorder. Pre-arrest diversion programs create an alternative path for people who are at risk of arrest or incarceration for offenses related to their illnesses. People are diverted to a broad range of coordinated community services, from housing supports to job counseling to treatment for mental illness and substance use. This helps both the individuals and their communities and prevents states and localities from wasting resources on unnecessary incarceration costs for people who need services, not jail time.

Prioritize privacy concerns of consumers with substance use disorders

While we support the Department's goal of leveraging technology to improve care and improving care coordination, we urge HHS to prioritize the privacy concerns of consumers with substance use disorders. We appreciate the challenges of balancing enhanced information sharing to improve care coordination with the critical issue of protecting the privacy rights of consumers. We recommend meaningful and effective participation of consumer representatives in all decision-making by the Department related to the exchange of health information.

We believe that addiction treatment records must be protected and consumers must retain the power to decide when and to whom their records are disclosed. Failure to do so will deter many individuals from seeking care. For example, if patient records can be easily accessed in order to criminally investigate or prosecute an individual, deny them a job or be used against them in a divorce or child custody proceeding, many individuals will be afraid to enter treatment.

Improve monitoring and enforcement of federal parity law

While parity is mentioned as important to consumer access to services in goals 1.3 and 2.3 , we recommend HHS expand cross-agency oversight and enforcement of the parity law, as required by the 21st Century Cures Act. In addition, HHS should help state regulators by issuing additional guidance, such as use of market conduct surveys and parity audits, and concrete examples and tools state regulators can use. The Department could build out an easy-to-use consumer complaint portal and issue guidance to states on how to simplify the process for submitting complaints, clearly outlining what consumers need to file and to whom in order to make it easier for consumers to get help.

We are encouraged by HHS' commitment to preventing addiction and overdose deaths and supporting consumers with substance use disorders and we believe the suggestions outlined above will further strengthen the Department's efforts.

Strategic Goal #3: Strengthen the Economic and Social Well-being of Americans Across the LifeSpan

We are concerned HHS states at the beginning of this strategic goal that a “core component of HHS mission is our dedication to serve all Americans *from conception to natural death*” (emphasis added). The belief that life and personhood begins at conception is contrary to U.S. law,²³ medical evidence and standards of care. Additionally, incorporating this view into HHS's policies and programs will only serve to undermine women's health and the ability of women to make healthcare decisions for themselves. Elevating a fetus to the status of a legal person would interfere with a woman's ability to make healthcare decisions with her provider, including the decisions to both use contraception and have an abortion, which would likely worsen health outcomes for women. Again, prioritizing one specific religious belief and incorporating it into medical practice is a concerning and significant departure from standard, evidence-based medical care.

We are also concerned by the references in this strategic goal to assisting and encouraging individuals “who are at risk of being unemployed or underemployed,” with finding employment and becoming self-sufficient, including youth and people with disabilities. For example, one of the Department's stated strategies is to “[i]ncrease the number of employed people with disabilities by encouraging and assisting integration into the greater community's workforce.”²⁴ While we don't object to the Department wanting to assist individuals with finding work and building an employable skillset, we strongly believe that work requirements shouldn't come with the consequence of denying individuals health coverage or care if the requirements aren't met. We therefore urge the Department not to penalize individuals who do not succeed in finding employment and allow them to continue to receive health care even when not working.

Continue to Improve Children's Health

Strategic goal #3 contains many references to addressing and improving children's health. Overall, we applaud HHS's effort to address care across the lifespan including pre and post-natal care. Research shows that investing in Medicaid benefits children in future generations. We urge HHS to ensure that all children and their families have access to the health services they need including well-child care, the full range of reproductive health services, and mental and behavioral health care.

²³ *Roe v Wade*, 410 U.S. 113, 153 (1973); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 856 (1992).

²⁴ Lines 906-07

We also urge HHS to identify and utilize opportunities to address the social determinants of health within children's health, such as access to safe housing, robust education, nutritious food and adequate transportation. For example, health issues can impede children's ability to learn and may lead to chronic absenteeism. Addressing underlying health issues will improve children's educational opportunities and help them more fully participate in their community as adults. One such opportunity HHS can leverage would be to encourage states to draw down Medicaid funding to cover health services in schools. Lastly, we applaud HHS's commitment to addressing adverse childhood experiences (ACEs) and intergenerational trauma. We encourage HHS to utilize community-wide initiatives to reduce exposure to trauma and ACEs and fully integrate trauma-informed care into pediatric primary care.

Overall, we urge HHS to consider the aforementioned recommendations and issues when finalizing the strategic plan. Thank you for your consideration of our input.

Respectfully submitted,



Robert Restuccia
Executive Director
Community Catalyst