ACAP
Association for Community Affiliated Plans

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John Lovelace, Chairman | Margaret A. Murray, Chief Executive Officer

November 9, 2015

Claudia Adams
Office for Civil Rights
Office of the Secretary
Department of Health and Human Services
200 Independence Ave. S.W.
Washington, D.C., 20201

Re: RIN 0945-AA02

Submitted via http://www.regulations.gov

Dear Ms. Adams,

The Association for Community Affiliated Plans (ACAP) thanks you for the opportunity to comment on proposed guidance published September 8, 2015, **Nondiscrimination in Health Programs and Activities**.

ACAP is an association of 61 nonprofit and community-based Safety Net Health Plans (SNHPs) located in 24 states. Our member plans provide coverage to approximately 15 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP), Medicare Special Needs Plans for dually-eligible individuals, and Qualified Health Plans through the Marketplaces. Nationally, ACAP plans serve roughly one-third of all Medicaid managed care enrollees, including around one-third of all enrollees in the Medicaid-Medicare demonstrations. ACAP plans are committed members of their communities, partnering with states to improve the health and well-being of their members who rely upon the Medicaid and CHIP programs.

ACAP supports the intent of the proposed rule to prohibit discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. While many of these requirements already apply to publicly-funded programs, we agree that the proposed regulations will serve to harmonize protections across programs and activities. However, we do have some concerns with the application of specific requirements as currently proposed.

The effective date of the rule is noted as 60 days after the final rule is published. However, this rule may require significant operational and potential rate setting changes that will take longer than 60 days to effectuate, therefore we request that implementation period be extended to at least 180 days.

Section 92.7 proposes that a covered entity with more than 15 employees must designate a responsible employee and adopt grievance procedures including appropriate due process standards. ACAP supports that the designated person can be the same person as required by other

existing laws and regulations as long as the scope of duties is specifically modified to include duties related to 1557.

Section 92.8 requires that covered entities must take steps to notify beneficiaries, enrollees, applicants or members of the public about the requirements and that the notices must include taglines to address limited English proficient individuals. The proposed rule also requires that the notice be posted in significant communications and the plan website, but allows the use of links and taglines on the health plan's home page. Finally, the rule allows existing stock of materials to be exhausted before having to incorporate these changes into written materials. We believe this is an appropriate and adequate way to address this issue. We also support having OCR provide notice samples that combines the content of the required notice in the top 15 languages to ensure consistency and support compliance.

Section 92.101 asks for comments on whether sex-specific distinctions in programs and services, such as women's health clinics, should be allowable. ACAP strongly supports having sex-specific programs to allow medical and health education needs to be addressed in an appropriate manner. To disallow such programs would reduce the availability of effective and targeted health programs and would be a disservice to population health efforts.

ACAP supports the requirements of Section 92.201 which provides that language assistance must be free of charge, accurate and timely. However, concerning the use of bilingual health plan staff to serve as an interpreter, we believe that health plans should be able to have staff fluent in a specific language to serve in that role, especially as it relates to health plan functions such as case management and care coordination. We believe that any required training on issues such as ethics can be incorporated into training on other critical compliance issues. ACAP does not support more stringent requirements such as mandated statewide population thresholds and the need for an advanced planning process.

Section 92.206 notes that covered entities are required to provide individuals equal access to their health programs or activities without discrimination on the basis of sex and that covered entities treat individuals consistent with their gender identity. There is an exception if treating an individual based on gender identity would deny or limit health services (for example, pap smear for an individual who identifies as transgender male). While we support the intent of this provision, we are concerned that there may operational issues that have not been adequately addressed. For example, publicly funded health plans are required to apply a system of claim edits to avoid inappropriate payments and prevent fraud and abuse. Many of these edits are related to the member's sex (for example, not paying a claim for a hysterectomy for a male.) While health plans should be able to deal with any denials for appropriate services for a transgender individual through an exception process (i.e., grievance and appeals), we believe it would be ill-advised to eliminate the edits given their important purpose.

Concerning the exclusions related to gender dysphoria and gender transition, ACAP requests that the final guidance provide more clarity as to how this will apply. Specifically, the proposed regulations states that an explicit, categorical or automatic exclusion of coverage for all health services related to gender transition is unlawful on its face. However, the proposed rule then

states that the proposed rule does not affirmatively require covered entities to cover any particular procedure or treatment for transition-related care. To support these efforts and facilitate compliance, we believe more clarity is need on how these statements operate together as it relates to specific examples. *Previously, some State Medicaid programs explicitly excluded coverage for such services that Medicaid managed care plans will now be required to provide. ACAP emphatically requests that CMS and states work to ensure rates paid to health plans are actuarially sound, including mid-year rate changes upon adoption of the rule.*

ACAP thanks you for the opportunity to share our comments on this proposed regulation. If you have any additional questions or comments, please do not hesitate to contact Deborah Kilstein (202-341-4101 or dkilstein@communityplans.net).

Sincerely,

Margaret A. Murray
Chief Executive Officer