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November 29, 2022

Carole Johnson, Administrator
Health Resources and Services Administration
Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857

Re: HHS Notice of Request for Public Comment on Proposed Update to the Bright Futures Periodicity Schedule as Part of the HRSA-Supported Preventive Services Guidelines for Infants, Children, and Adolescents

The National Health Law Program (NHeLP) is a public interest law firm that protects and expands the health rights of individuals who have low incomes or are underserved. We appreciate the opportunity to provide these comments on the Department of Health and Human Services Health Resources and Services Administration (HRSA) proposed rule to update the Bright Futures Periodicity Schedule as part of the HRSA-Supported Preventive Services Guidelines for Infants, Children, and Adolescents. As discussed below, we support the changes.

<u>Young People in the 18-21 Year Age Range Would Benefit from this Screening Based On the Prevalence of HIV in this Population.</u>

Raising the upper age range of HIV screening to 21 years old would better align the Bright Futures Periodicity Schedule with the risks posed by the current HIV/AIDS epidemic in the United States. In 2020, 30,635 people in the United States received an HIV diagnosis, but still 13% of individuals in the United States with HIV do not know their status.[1] This is particularly troubling, as the CDC has found that knowledge of status is one of six

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indicators of ending the HIV epidemic.[2] The impact of the epidemic disproportionately impacts Black, Latine, and LGBTQIA+ communities. As of 2019, the HIV infection rate for the Black population was eight times higher than for the white population; the infection rate for the Latine population was four times higher.[3] Additionally, 69% of new diagnoses were among gay and bisexual men.[4] Based on this data, increasing access to HIV screening would help increase awareness and treatment, allow transmission rates to decrease, and address health disparities.

When HIV screening was first added to comprehensive preventative services, a limited understanding of the disease led medical professionals to believe that only people participating in "high risk" activities should be screened.[5] The medical field has greatly improved its understanding of HIV and, as a result, the CDC has noted the diminished efficacy of limiting HIV screening only to people participating in activities labeled "high risk."[6] Instead, the CDC and the US Preventive Services Task Unit (USPST) recommend incorporating HIV screening as a normal part of medical practice for adolescents and adults aged 15 to 65 years.[7]

Raising the upper age range of HIV screening to age 21 would more effectively screen 18 to 21 year olds, a group that has an increased proportion of HIV infections.[8] The prevalence of HIV among youth between the ages of 13 and 24 accounted for 21% of new diagnoses in 2018, and that number rose to 23% in 2019.[9] This population is often unaware that they have the disease. One report found that the HIV infection remained undiagnosed in 45% of those

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[1] Ctrs. for Disease Control & Prevention, *HIV in the United States and Dependent Areas* (Sept. 2, 2022) https://www.cdc.gov/hiv/statistics/overview/ataglance.html; Ctrs. for Disease Control & Prevention, *Knowledge of Status* (Sept. 2, 2022) https://www.cdc.gov/hiv/statistics/overview/in-us/status-knowledge.html.
[2] Ctrs. for Disease Control & Prevention, *Knowledge of Status*, *supra* note 1.
[3] Ctrs. for Disease Control & Prevention, *Estimated HIV Incidence and Prevalence in the United States, 2015–2019: HIV Surveillance Supplemental Report* (May 2021) https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-26-1.pdf.
[4] Ctrs. for Disease Control & Prevention, *HIV and Gay and Bisexual Men* (Sept. 2021) https://www.cdc.gov/hiv/pdf/group/msm/cdc-hiv-msm.pdf.
[5] Bernard M. Branson et al., Centers for Disease Control and Prevention, *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings* (2006).
[6] *Id*.
[7] United States Preventive Services Task Force, *Final Recommendation Statement: Human Immunodeficiency Virus (HIV) Infection: Screening* (June 11, 2019).
[8] Branson, *supra* note 5.
[9] Ctrs. for Disease Control & Prevention, *HIV by Age: HIV Diagnoses* (July 1, 2022) https://www.cdc.gov/hiv/group/age/diagnoses.html.

aged 13 to 24.[10] Delays in diagnosis can have devastating results, as it leads to delayed treatment. Untreated HIV and AIDS result in significant morbidity, mortality, and transmission.[11] By contrast, successful early diagnosis and treatment can gain patients years of life that might otherwise be lost.[12]

Amending the Bright Futures Schedule Would Be Particularly Beneficial for Medicaid Enrollees.

Given the large number of young people enrolled in Medicaid and the high number of states that recommend using Bright Futures for screening content and periodicity, implementing this amendment to the Bright Futures schedule would particularly benefit Medicaid enrollees.

Medicaid ensures coverage of prevention and early intervention services for low-income youth under age 21 through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit established at 42 U.S.C. §§ 1396a(a)(10), 1396a(a)(43), 1396d(a)(4)(B), and 1396d(r). According to the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies must ensure coverage for screening services consistent with reasonable standards of medical and dental practice, including the nationally recognized Bright Futures, developed by the American Academy of Pediatrics (AAP).[13] Bright Futures provide evidence-driven guidance for pediatric preventive care screenings and health supervision visits through age 21.[14]

In 2018, a total of 37 states, including the District of Columbia, used Bright Futures (4th edition) as their EPSDT pediatric preventive care screening recommendations.[15] An additional 8 states used preventive care recommendations that are very similar to Bright Futures, leaving only 6 states with the greatest divergence from Bright Futures.[16] If the additional 8 states with very similar recommendations to Bright Futures are counted, 45 states used or closely

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[10] Branson, *supra* note 1; *see also* Katherine Hsu & Natella Rakhmanina, *Adolescents and Young Adults: The Pediatrician's Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis*, 149 American Academy of Pediatrics 1, 2 (January 2022).
[11] Roger Chou, US Preventative Services Taskforce, *Screening for HIV Infection in Asymptomatic, Nonpregnant Adolescents and Adults* E1 (2019).
[12] Branson, *supra* note 5.
[13] *EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*. Baltimore: Centers for Medicare and Medicaid Services, June 2014.
[14] Margaret McManus, *Bright Futures and EPSDT: A National Review* (August 26, 2018) https://downloads.aap.org/DOFA/NationalEPSDTReport.pdf.
[15] *Id.*
[16] *Id.*

followed the AAP's current pediatric preventive care screening recommendations.[17] In 2020, there were approximately 35 million youth and young people enrolled in Medicaid.[18] Based on this data, it can be inferred that a majority of those enrolled in Medicaid would benefit from expanding the Bright Futures HIV screening schedule to the 21-year visit.

Amending the Bright Futures Schedule to Expand the Age Range Would Also Make Coverage More Affordable.

By the Bright Futures schedule expanding the age range for youth and young people to receive an HIV screening, it would make coverage more affordable because, as a preventive screening service, it would not be subjected to cost sharing under Medicaid or ACA plans. 42 U.S.C. §§ 1396o/13960-1 specify that services furnished to children under age 18 (and, at state option, individuals under 21, 20, or 19 years of age) must be excluded from payments of deductibles, copayments, and similar charges. Likewise, Section 2713 of the Public Health Service Act requires coverage without cost sharing of certain preventive health services.[19] This means that amending the Bright Futures schedule to expand the age range would make these vital screenings more affordable.

Conclusion

Our comments include citations to support research and documents for the benefit of HHS in reviewing our comments. We direct HHS to each of the items cited and we request that HHS consider these, along with the full text of our comments, part of the formal administrative record on this proposed rule. If you have any questions, please contact Jane Perkins, perkins@healthlaw.org, or me, Jasmine Young, jyoung@healthlaw.org. Thank you for the opportunity to comment on this important issue.

Sincerely,

Jasmine Young
Policy Analyst

[17] *Id.*
[18] Unduplicated number of children enrolled in Medicaid in FY 2020 from Statistical Enrollment Data System (SEDS) Reporting (As of 06/23/2021) https://www.medicaid.gov/chip/downloads/fy-2020-childrens-enrollment-report.pdf.
[19] Section 2713, the Public Health Service Act (PHS Act).

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