



October 19, 2022

Submitted via the Federal Medicaid.gov Portal

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: New York State Medicaid Section 1115 Proposed Waiver Amendment

Dear Administrator Brooks-LaSure:

We are writing on behalf of the Federal AIDS Policy Partnership - HIV Health Care Access Working Group (HHCAWG). 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-related health care and support services. We are writing to express our support for New York's proposed Medicaid 1115 waiver amendment.

Many people living with HIV rely on Medicaid as a main source of coverage. Forty-two percent of adults living with HIV are covered by Medicaid, compared to just 13% of the general population.¹ Ensuring access to effective HIV care, treatment, and support through the Medicaid program is important to the health of people living with HIV and to public health. When HIV is effectively managed and individuals stay engaged in treatment and virally suppressed, there is no risk of sexual transmission.² HHCAWG therefore writes to express our support for several of New York's innovative proposals that are aimed at promoting health equity and reducing interruptions to care among Medicaid beneficiaries, including the proposals to provide pre-release coverage to certain individuals in carceral settings, to invest in infrastructure and digital literacy to improve access to telehealth, to improve mechanisms to track and support social determinants of health, and to invest in workforce training and development.

¹ Kaiser Family Foundation, *Medicaid and HIV* (Oct. 1, 2019), <https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/>.

² R. Eisinger, C. Dieffenbach, A. Fauci, *HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittable*, 321 JAMA 451 (2019), doi:10.1001/jama.2018.21167.

1. CMS should approve New York’s proposal to provide pre-release coverage to certain individuals in carceral settings.

We support New York’s proposal to extend Medicaid coverage to certain individuals in jails or prisons, including people living with HIV, hepatitis C, and other chronic conditions, for up to 30 days prior to their release. The proposal will help facilitate transitions in medical care for these individuals, including the streamlining of service and medication delivery, to promote better health outcomes post-incarceration such as reduced emergency room visits, hospitalizations, and overdose deaths.

Individuals in carceral settings are five to seven times more likely to have HIV than the general population.³ Many people learn of their HIV diagnosis for the first time while they are in prison or jail.⁴ Furthermore, HIV infection in carceral settings reflects the same racial disparities that we see both in the HIV epidemic more broadly and in the criminal justice system: Black men are five times more likely to be diagnosed with HIV in prison compared to white men.⁵ Timely access to HIV care post-release is critical but often lacking because of insurance issues and poor linkages to care, resulting in poor health outcomes over time.⁶

Appropriate access to care in the initial weeks and months following release is especially crucial. People are in a period of significant transition and the likelihood of disruption is high. Despite Medicaid being, as explained by the Department’s Assistant Secretary for Planning and Evaluation, “a key source of coverage for this high needs, high risk population, facilitating access to much needed physical and behavioral health services,”⁷ justice-involved individuals face complex barriers to accessing care upon release. Medicaid enrollment and coverage reinstatement delays, provider shortages, difficulties establishing care, and challenges relaying medical histories are common. Health risks are further exacerbated by difficulties meeting basic health-related social needs, such as housing. Research shows that newly released individuals with HIV present to emergency rooms in far higher numbers than the general population, for reasons that may be preventable through outpatient care.⁸

Extending Medicaid coverage to incarcerated individuals 30-days prior to release has the potential to improve continuity of care post release in several ways. First, it will allow for the resolution of administrative issues related to enrollment and reinstatement of care prior to release and, therefore, the first day that care in the community is needed. Second, it will allow transitions of care to be more streamlined and timely, thereby minimizing harmful disruptions in care and treatment. And,

³ The Center for HIV Law and Policy, *Prisons and Jails*, <https://www.hivlawandpolicy.org/issues/prisons-and-jails>.

⁴ *Id.*

⁵ Shufang Sun, Natasha Crooks, Rebecca Kemnitz & Ryan P. Westergaard, *Re-entry experiences of Black men living with HIV/AIDS after release from prison: Intersectionality and implications for care*, 211 *Social Science & Medicine* 78 (2018), doi: 10.1016/j.socscimed.2018.06.003.

⁶ Benjamin Ammon, et al., *HIV Care After Jail: Low Rates of Engagement in a Vulnerable Population*, 95 *J of Urban Health* 288 (2018), doi:10.1007/s11524-018-0231-0; David Alain Wohl & David Loren Rosen, *Inadequate HIV care after incarceration: case closed*, 5 *The Lancet E64* (2018), doi:10.1016/s2352-3018(17)30210-2.

⁷ Jhamirah Howard, et al., *ASPE Issue Brief: The Importance of Medicaid Coverage for Criminal Justice Involved Individuals Reentering Their Communities*, 6 (2016), https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/146076/MedicaidJustice.pdf.

⁸ Alfredo G. Puing, Xilong Li, Josiah Rich & Ank E. Nihawan, *Emergency department utilization by people living with HIV released from jail in the US South*, 8 *Health & Justice* (2020), doi:10.1186/s40352-020-00118-2.

it will allow community providers and coordinators to establish relationships with members, thereby facilitating members' access to critical health and treatment information prior to release. New York's proposal includes provisions that are well-designed to leverage these advantages of pre-release enrollment, since New York's proposed amendment includes targeted care for incarcerated individuals who are in their first 30 days in county jails to avoid care disruptions during what are usually brief periods in correctional facilities.

We are aware that CMS is currently working on guidance required under the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018⁹ that will impact CMS's review of New York's proposal. In issuing this guidance and reviewing the proposal, we urge CMS to consider the advantages of extending Medicaid enrollment to all eligible individuals who are within 30 days of release from incarceration—not just those who are already living with chronic conditions. While HHCAWG supports New York's proposal, we note that extending pre-release coverage to HIV-negative individuals would facilitate access to critical prevention tools, like HIV pre-exposure prophylaxis (PrEP), that may not otherwise be available in correctional settings. PrEP is one of the best ways to prevent HIV for people at high risk; when used as prescribed, PrEP reduces the risk of contracting HIV from sex by about 99% and from injection drug use by at least 74%.¹⁰ As of 2019, HIV prevention medication had not been integrated into any correctional setting.¹¹ Research suggests, however, that people leaving prison may be especially vulnerable to HIV infection.¹² We therefore encourage CMS and New York to consider permitting individuals to enroll in Medicaid and commence PrEP prior to leaving incarceration.

Pre-release coverage has the potential to greatly improve continuity of care for individuals living with HIV and hepatitis C post-release. We therefore encourage CMS to approve New York's proposal.

2. CMS should approve New York's proposals to invest in digital health and telehealth infrastructure.

We support New York's efforts to reduce barriers to care by creating an Equitable Virtual Care Access Fund to assist providers to make investments in telehealth. These proposals would enable less-resourced providers—providers that also often care for disproportionate numbers of complex, lower income patients—to provide high quality telehealth, and patients to access that care. In turn, the initiatives have the potential to reduce barriers to care for people living with HIV, improve care quality, increase access to PrEP, and bridge the digital divide that often prevents members of systematically marginalized groups from benefitting from telehealth availability. However, as telehealth becomes a permanent feature of health care delivery in New York and elsewhere, we urge CMS to ensure that various safeguards referenced below are also in place.

⁹ See Pub. Law No. 115-271 § 5032(b).

¹⁰ Centers for Disease Control and Prevention, *How effective is PrEP?*, <https://www.cdc.gov/hiv/basics/prep/prep-effectiveness.html>.

¹¹ Lauren Brinkley-Rubinstein, et al., *The Path to Implementation of HIV Pre-exposure Prophylaxis for People Involved in Criminal Justice Systems*, 15 *Current HIV/AIDS Reports* 93 (2018), doi:10.1007/s11904-018-0389-9.

¹² Jack Stone, et al., *Incarceration history and risk of HIV and hepatitis C virus acquisition among people who inject drugs: a systematic review and meta-analysis*, 18 *Lancet Infect. Dis.* 1397 (2018), doi:10.1016/S1473-3099(18)30469-9.

Expanding access to care via telehealth services is particularly important for people living with HIV, for whom consistent access to care is essential. Increased access to telehealth services can remedy barriers to care such as lack of transportation and time constraints associated with traveling to in-person appointments, which have been linked to interruptions in HIV care.¹³ Some people seeking HIV prevention or treatment have also expressed a preference for telehealth appointments out of concern for privacy.¹⁴ By reducing barriers to care such as transportation, time constraints, and exposure to stigma, telehealth makes care for HIV and any co-occurring conditions more easily accessible.

Increased availability of telehealth can also help prevent HIV transmission, as telehealth has been successfully used to facilitate delivery of PrEP and related services.¹⁵ Despite PrEP's effectiveness, PrEP use remains low among individuals at risk of HIV, particularly young men who have sex with men (MSM) of color and MSM living in rural areas.¹⁶ Low uptake of PrEP has been attributed to a variety of barriers to care, including geographic distance to a provider, cost, and stigma that increased access to telehealth services can ameliorate.¹⁷ Therefore, expanding access to telehealth, when combined with investments in digital and telehealth infrastructure in underserved areas, is one promising approach to help close the gap in PrEP access and reduce HIV transmission.

The diffusion of telehealth supported by the Equitable Virtual Care Access Fund may also improve the quality of care available to people living with HIV. First, in some circumstances, telehealth has helped people living with HIV to become more open with their providers; in one study, more than half of individuals surveyed expressed feeling less intimidated and more open to disclosure in a telehealth environment.¹⁸ Where proper consents are in place, telehealth can also allow a provider to assess a patient's living conditions and to engage caregivers, family members, and other members of a patient's care team, both of which may contribute to a more holistic approach to treatment.¹⁹

Without the proposed investments in telehealth and digital infrastructure and literacy to reduce the digital divide, telehealth has the potential to widen existing health disparities. HIV disproportionately affects racial, ethnic, and gender minorities, and nearly half of people with HIV today are over the age of 50.²⁰ These groups also face barriers in accessing telehealth

¹³ Dima Dandachi et al., *Integration of Telehealth Services in the Healthcare System: with Emphasis on the Experience of Patients Living with HIV*, 67 *Journal of Investigative Medicine* 815 (2019), <https://perma.cc/22SR-K7KJ>.

¹⁴ *Id.*

¹⁵ Rebecca Touger & Brian R. Wood, *A Review of Telehealth Innovations for HIV Pre-Exposure Prophylaxis (PrEP)*, 16 *Current HIV/AIDS Reports* 113 (2019), available at: <https://perma.cc/NL83-BBXX>.

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ Titilola Labisi et al., *HIV Care Meets Telehealth: A Review of Successes, Disparities, and Unresolved Challenges*, 19 *Current HIV/AIDS Reports* 446 (2022), <https://perma.cc/WY4P-FCC6>; Dini Harsono, *Experiences with Telemedicine for HIV Care During the COVID-19 Pandemic: A Mixed-Methods Study*, 26 *AIDS and Behavior* 2099 (2022), <https://perma.cc/U87H-VMBP>.

²⁰ Titilola Labisi et al., *supra* note 19.

technologies.²¹ We therefore applaud the proposal’s efforts to reduce barriers to telehealth access, including by providing tablets to providers and enrollees who lack the necessary technology to participate in telehealth services; outfitting community health workers with backpacks that include technology to boost internet connectivity; and providing telehealth kiosks in at least three homeless shelters in each county. This last proposal is especially promising, given the disproportionately high rates of HIV among homeless individuals.²²

Finally, while we support New York’s proposal for the reasons discussed, we urge CMS to ensure that the proposal does not in any way reduce opportunities for in-person appointments for those who would be better served in that setting or who prefer in-person care. Building trust between patients and providers is important for effective, patient-centered HIV care, and some providers have reported more difficulty establishing a connection with their patients when providing telehealth services.²³ And telehealth can decrease visibility of body language, or eliminate it completely in the case of audio-only visits, and can leave more room for misinterpretation of verbal communication.²⁴ In one study involving older individuals living with HIV, participants reported various communication challenges in telehealth visits, including technological problems and the sense that telehealth visits were shorter and less open-ended.²⁵ These types of concerns are particularly important for people who are initiating HIV care, as early clinical experiences have been found to significantly impact retention in care.²⁶ Further, telehealth can be associated with unique privacy concerns, such as when patients have not disclosed their HIV status to household members and/or lack a private space in their living environment in which to meet with an HIV care provider.²⁷ Therefore, we urge CMS to ensure that New York’s proposals are not implemented in a manner that may push Medicaid beneficiaries toward telehealth appointments in circumstances where in-person appointments would promote better health outcomes.

3. CMS should approve proposals supporting the delivery of social care.

We strongly support New York’s proposals designed to advance health equity by promoting social care, including the creation of Social Determinants of Health Networks (SDHN), value-based payment (VBP) initiatives, the inclusion of a uniform social needs assessment, and the Enhanced Transitional Housing Initiative (collectively referred to here as the “Social Care Proposals”).

The Social Care Proposals hold significant promise to improve health outcomes for people living with HIV. Effective treatment access and viral load suppression are severely undermined by social

²¹ *Id.*; see Abigail Baim-Lance et al., *Challenges and Opportunities of Telehealth Digital Equity to Manage HIV and Comorbidities for Older Persons living with HIV in New York State*, 22 *BMC Health Services Research* 609 (2022), available at: <https://perma.cc/37HM-9G3E>.

²² Kinna Thakrar et al., *Homelessness, HIV, and Incomplete Viral Suppression*, 27 *Journal of Health Care for the Poor and Underserved* 145 (2016), <https://perma.cc/W8RH-CZBP>.

²³ Ofole Mgbako et al., *COVID-19, Telemedicine, and Patient Empowerment in HIV Care and Research*, 24 *AIDS and Behavior* 1990 (2020), <https://perma.cc/L5AG-ZAN9>.

²⁴ Melissa Grove et al., *Employing Telehealth within HIV Care: Advantages, Challenges, and Recommendations*, 35 *AIDS* 1328 (2021), <https://perma.cc/7S3V-A2LJ>.

²⁵ Abigail Baim-Lance et al., *supra* note 21.

²⁶ Dima Dandachi et al., *supra* note 13.

²⁷ *Id.*; Melissa Grove et al., *supra* note 24.

risk factors including housing instability,²⁸ food insecurity,²⁹ and unemployment³⁰—social risk factors disproportionately pervasive among people living with HIV.³¹ In a recent systematic review, for example, homelessness was associated with worse HIV medical outcomes such as increased viral load and increased mortality in 94% of studies.³² Moreover, when individuals living with HIV receive supportive housing placements, they are twice as likely as those without such supports to have an undetectable viral load after 12 months of treatment.³³ Medically-tailored food supports, such as medically-tailored meals, have been shown to decrease hospitalizations by ten percentage points and increase medication adherence from a baseline of 47% up to 70% for people living with HIV.³⁴

We appreciate that the Social Care Proposals seek to address health-related social needs (HRSN) through a continuum of interventions: beneficiaries will be consistently screened for unmet HRSN; care coordination will be managed and carried out by SDHNs; and responsive services will be provided by community-based organizations (CBOs) and other entities. Each such element of the proposal is critical, as is investment in infrastructure development and capacity-building to achieve the desired impact and scale. We urge CMS to approve the waiver in a manner that promotes robust design. We note that the establishment of a validated social needs assessment tool aligns with several recent instances of CMS rulemaking, including as pertaining to dual-eligible individuals.³⁵ Spending for catalyzing systems-level development that will underpin the delivery of social care supports are similar to 1115 waiver initiatives approved in states like Massachusetts (in connection with the Flexible Services Program), North Carolina (in connection with the Healthy Opportunities Pilots), and Oregon (as part of the new Oregon Health Plan demonstration).

Finally, housing, food, and other essential supports must be able to meet people living with HIV and other New Yorkers where they are. We urge CMS to promote rigorous standards development, monitoring, and evaluation of the waiver’s social care initiatives that support the presence of Medicaid member voices at the table from design through implementation, consumer choice, dignity, and empowerment.

²⁸ Kinna Thakkar et al., *supra* note 22.

²⁹ Food insecurity is highly prevalent among people living with HIV, even in well-resourced cities. Aranka Anema, et al., *Food insecurity and HIV/AIDS: current knowledge, gaps, and research priorities*, *Curr HIV/AIDS Rep.* 2009;6(4):224-231. doi:10.1007/s11904-009-0030-z; Seth C. Kalichman, et al., *Health and treatment implications of food insufficiency among people living with HIV/AIDS*, Atlanta, Georgia. *J Urban Health*, 2010;87(4). doi:10.1007/s11524-010-9446-4.

³⁰ People living with HIV are disproportionately likely to be unemployed. Liza M Conyers, et al., *A Critical Review of Health, Social, and Prevention Outcomes Associated With Employment for People Living With HIV*, *AIDS Educ Prev*, 2017 Oct;29(5). doi: 10.1521/aeap.2017.29.5.475.

³¹ Kinna Thakkar et al., *supra* note 22; Aranka Anema, et al., *supra* note 29; Liza M Conyers, et al., *supra* note 30.

³² Angela A. Aidala, et al., *Housing Status, Medical Care, and Health Outcomes Among People Living With HIV/AIDS: A Systematic Review*, *106 Am J Pub Health*, e1, e5 (2016). doi:10.2105/AJPH.2015.302905.

³³ David Buchanan, et al., *The health impact of supportive housing for HIV-positive homeless patients: a randomized controlled trial*, *Am J Public Health*. 2009 Nov; 99 Suppl 3(Suppl 3): S675-80. doi: 10.2105/AJPH.2008.137810.

³⁴ Kartika Palar, et al., *Comprehensive and Medically Appropriate Food Support Is Associated with Improved HIV and Diabetes Health*, *J Urban Health*, 94(1), 87–99 (2017). <https://doi.org/10.1007/s11524-016-0129-7>.

³⁵ Rachel Landauer et al., *Medicare’s Current Strategy for Health-Related Social Needs Is Necessary But Not Sufficient*, *Health Affairs Forefront* (2022). doi: [10.1377/forefront.20220901.523201](https://doi.org/10.1377/forefront.20220901.523201).

4. CMS should approve New York’s proposal to invest in workforce training and development.

HHCAWG supports New York’s proposal to invest in workforce training and development, including expanding the number of community health workers, care navigators, and peer support workers (particularly drawing from low-income and underserved communities) and training staff about implicit bias, cultural sensitivity, and community-specific needs.

Non-clinical health workers play a pivotal role in helping people living with or at risk of HIV get connected to and continuously engage with care. For example, the integration of community health workers in HIV primary care can result in improved patient outcomes, including engagement with primary care, having an active antiretroviral prescription, and being virally suppressed.³⁶ Furthermore, a workforce that reflects the communities being served (e.g., race/ethnicity, living with HIV, sexual orientation, gender identity) is not only critical in efforts to achieve health equity, but also in efforts to end the HIV epidemic in the United States.³⁷ Common lived experience may lead to increased trust and rapport with patients/clients.³⁸

Training staff members about implicit bias, cultural sensitivity and community-specific needs is especially important when working with individuals who come from marginalized or underserved communities. Implicit biases held by health care workers can result in poor care expectations and experiences.³⁹ This is particularly true for many people of color and LGBTQIA+ people.⁴⁰ Investment in cultural sensitivity trainings can better equip health care workers to treat diverse

³⁶ Mari-Lynn Drainoni et al., *Integrating Community Health Workers into HIV Care Teams: Impact on HIV Care Outcomes*, 19 J. HIV/AIDS & Soc. Serv. 204, 213 (2020) (describing a study that found that “clients who enrolled in a [Community Health Worker] program had statistically significant improvement in viral load suppression, being prescribed [antiretroviral therapy], and appointment attendance”) <https://bit.ly/3TbmY6S>.

³⁷ See, e.g., Amanda Y. Hammack et al., *A Community Health Worker Approach for Ending the HIV Epidemic*, 61 Am. J. Prev. S26, S30 (2021) (describing the effectiveness of a pilot community health worker program, representative of target populations, in East Baton Rouge Parish, Louisiana) (“[T]he CHWs provide linkage to an array of resources and services in the community, including transportation, job readiness, insurance enrollment, and housing assistance”) <https://perma.cc/9SFJ-CRLE>; Linda Martinez et al., “Part of Getting to Where We Are Is Because We Have Been Open to Change” *Integrating Community Health Workers on Care Teams at Ten Ryan White HIV/AIDS Program Recipient Sites*, 21 BMC Public 1 (2021) <https://perma.cc/ZQP2-7ZG5>.

³⁸ S. Alexandra Marshall et al., *Acceptability of a Community Health Worker Program to Link High-Risk People in Jail to HIV Pre-Exposure Prophylaxis*, 33 J. Health Care Poor & Underserved 149, 159 (2022) (quoting an interviewee “If you’re talking to somebody that you know has been there and been through some of the things you’ve been through, then you can relate to them a lot better. It allows you to open up better”) <https://muse.jhu.edu/article/847204/pdf>; Martinez et al., *supra* note 37 at 4 (“In addition, CHWs who were peers had a nuanced understanding of treatment and disclosure, which facilitated their ability to build rapport with patients, especially in the case of newly diagnosed patients.”).

³⁹ See, e.g., Michele Andrasik et al., *Stigma, Implicit Bias, and Long-lasting Prevention Interventions to End the Domestic HIV/AIDS Epidemic*, 110 Am. J. Pub. Health 67, 67 (2020) (“For HIV populations, bias is implicated in experiencing delays in initiating HIV care, being denied care, challenges linking to care, lower likelihood of being prescribed antiretroviral therapy (ART), lower adherence to ART, verbal harassment, and being refused treatment.”) <https://perma.cc/22EZ-LNU7>.

⁴⁰ Bani Saluja & Zenobia Bryant, *How Implicit Bias Contributes to Racial Disparities in Maternal Morbidity and Mortality in the United States*, 30 J. Women’s Health 270 (2021) <https://perma.cc/FZ96-39D2>; Michal J. McDowell et al., *Strategies to Mitigate Clinician Implicit Bias Against Sexual and Gender Minority Patients*, 61 Psychosomatics 655 (2020) <https://www.sciencedirect.com/science/article/pii/S0033318220301523>.

Medicaid beneficiaries by improving provider knowledge, motivation, approach, and practice of appropriate care.⁴¹ Health care workers have identified such training needs in published literature, including trainings focused on cultural humility, trauma-informed care, and community-specific skills and knowledge (e.g., holistic HIV care and care specific to people with substance use disorder).⁴²

Investing in workforce cultural competency will also aid in the engagement of justice-involved individuals in care. A review of initiatives targeting justice-involved individuals under Section 1115 waivers in Illinois, Texas, and Washington identified that “hiring and training culturally competent staff, who understand the cultural diversity and the realities of the populations being served, is vital to the successful implementation of a program.”⁴³ The review noted that some programs used peer supports or community health workers who had lived experience with the criminal justice system or who come from communities impacted by the justice system, while others implemented extensive training and ongoing support for staff members to increase confidence and reduce turnover.⁴⁴ Even if approval of New York’s proposal to provide targeted Medicaid services for certain incarcerated individuals 30 days prior to release is delayed due to the forthcoming SUPPORT Act guidance from CMS, preparing health care workers and other patient-facing service providers to better understand and address the needs of justice-involved individuals will improve their capacity to support continuity of care.

We have included numerous citations to supporting research, including internet links. We direct CMS to each of the materials we have cited, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If CMS is not planning to consider these materials part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies and articles into the record.

Thank you for the opportunity to provide feedback and for your thoughtful consideration of these comments. If you have further questions, please reach out to HHCAWG co-chairs Maryanne Tomazic (mtomazic@law.harvard.edu) with the Center for Health Law and Policy Innovation and Rachel Klein (rklein@tmail.org) with The AIDS Institute.

⁴¹ See, e.g., Paul J. Hershberger et al., *An Interactive Game with Virtual Reality Immersion to Improve Cultural Sensitivity in Health Care*, 6.1 Health Equity 189 (2022) <https://perma.cc/A49K-KECK>; Tam C. Phan et al., *LGBTQ+ Cultural Sensitivity in Pharmacy Education: A Co-curricular Training Event to Improve Pharmacy Students’ Knowledge and Motivation in Caring for Sexual and Gender Minorities*, 5 J. Am. Coll. Clin. Pharm. 1075 (2022) <https://bit.ly/3yKWaJj>.

⁴² See, e.g., Serena Rajabiun et al., *Using Implementation Science to Promote Integration and Sustainability of Community Health Workers in the HIV Workforce*, 90 J. AIDS S65, S70-S71 (2022) (also noting the importance that community health workers and people living with HIV be involved in developing training resources).

⁴³ State Health Access Data Assistance Center, University of Minnesota, *Targeting Justice-Involved Populations Through 1115 Medicaid Waiver Initiatives: Implementation Experiences of Three States* 14 (2019) <https://perma.cc/MSY9-2FHL>.

⁴⁴ *Id.*

Respectfully submitted by the undersigned organizations:

AHF

AIDS Alabama

AIDS Alliance for Women, Infants, Children, Youth & Families

AIDS Foundation Chicago

American Academy of HIV Medicine

APLA Health

Center for Health Law and Policy Innovation

Community Access National Network - CANN

Community Research Initiative, Inc. (CRI)

Georgia AIDS Coalition

HealthHIV

HIV Dental Alliance

HIV Medicine Association

iHealth

International Association of Providers of AIDS Care

NASTAD

Positive Women's Network-USA

Prevention Access Campaign

San Francisco AIDS Foundation

The AIDS Institute

Vivent Health