



On November 4, 2022, 24 patient and consumer organizations submitted the following recommendations to the Centers for Medicare and Medicaid Services in response to the Request for Information: Make Your Voice Heard. CMS sought feedback on accessing healthcare and related challenges, understanding provider experiences, advancing health equity, and assessing the impact of waivers and flexibilities provided in response to the COVID-19 Public Health Emergency (PHE)

Topic 1: Accessing Healthcare and Related Challenges: CMS wants to empower all individuals to efficiently navigate the healthcare system and access comprehensive healthcare. We are interested in receiving public comment on personal perspectives and experiences, including narrative anecdotes, describing challenges individuals currently face in understanding, choosing, accessing, paying for, or utilizing healthcare services (including medication) across CMS programs.

Key Challenges

Our organizations represent millions of individuals facing serious, acute, and chronic conditions across the country. There are key challenges for accessing health coverage and care that exist in the Medicaid program, the Marketplace, and the private market that we hope you will address through some of our recommendations that follow.

Access to needed care for low-income individuals is exacerbated by limited night and weekend office hours among health providers, perceived or real cost of care, confusion about covered benefits and service denials, and, in turn, reluctance to seek needed care that could unknowingly incur added cost. Added financial challenges such as lack of access to childcare, and the added stress that has persisted after the pandemic make trying to navigate a confusing health care system more overwhelming. People in rural communities face geographical barriers to accessing needed care, or, if available, Internet access to use telehealth services. The evidence of systemic racism in American health care has only added to the existing mistrust of the medical establishment among many underrepresented communities. Further, variation in state health policy choices also means that where a person resides directly impacts what coverage and care they are able to access.

Enrollment

Millions of uninsured individuals are eligible for coverage through Medicaid or for financial assistance through the Marketplace but are not enrolled in these programs.¹ We appreciate this Administration's investments in outreach and enrollment, but additional efforts are needed, particularly to reach individuals from marginalized and underserved groups. These individuals make up a significant share of individuals who are eligible for coverage in the marketplaces or Medicaid but not yet enrolled, which suggests greater investments will improve health equity by reducing barriers to coverage.

End of the Public Health Emergency

The continuous coverage requirement for states will sunset with the end of the Public Health Emergency (PHE) and millions of eligible individuals may lose insurance according to the HHS Assistant Secretary. People of color are most at risk of losing coverage due to administrative barriers. Income fluctuations, address changes, and employment turnover are situations individuals with low-income regularly experience and have only been exacerbated during the pandemic.

Non-ACA Compliant Plans

We are deeply concerned that short-term limited duration insurance (STLDI) plans and other coverage exempt from the ACA's strong consumer protections continue to be marketed to consumers, often with deceptive and aggressive tactics.² Consumers shopping for comprehensive coverage are instead directed to plans that can discriminate based on pre-existing conditions, leaving the patients we represent exposed to crippling costs for the care they need.³

The end of the PHE will give insurers and brokers selling non-ACA-compliant plans enhanced opportunity to mislead consumers into buying sub-par coverage. An estimated five to six million people are projected to be disenrolled from Medicaid and eligible for a marketplace plan with subsidies.⁴

Standards for Web-brokers and Other Direct Enrollment Entities

Insurance agents and brokers, including web-brokers are subject to inherent conflicts of interest that are simply not present for Navigators or the marketplaces themselves.⁵ Agents and brokers generally have no duty to act in the best interest of consumers and are compensated in ways that typically do not align with consumer interests.

Network Adequacy

We reiterate to the Departments the importance of strengthening network adequacy requirements and ensuring timely, sufficient access to health services and accurate information on providers for the patients and consumers we represent. Networks that exclude or severely limit a category or categories of specialists have the effect of limiting or denying access to these providers' services, raising discrimination concerns. Networks must ensure access to culturally appropriate care that reflects the diversity of enrollees' backgrounds and is attuned to traditionally underserved communities, including people of color, immigrants, and LGBTQI+ individuals.

¹ <https://www.kff.org/uninsured/issue-brief/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip/>

² <https://georgetown.app.box.com/s/mn7kgnhibn4kapb46tqmv6i7putry9gt>

³ https://www.lls.org/sites/default/files/National/undercovered_report.pdf

⁴ https://www.urban.org/sites/default/files/publication/104785/what-will-happen-to-unprecedented-high-medicaid-enrollment-after-the-public-health-emergency_0.pdf

⁵ <https://www.urban.org/sites/default/files/publication/39571/2000091-Insurance-Brokers-and-the-ACA.pdf>

Recommendations

- **Address STLDI and the proliferation of non-ACA compliant plans.** HHS should restore the 3-month duration limit, limit renewability and stacking of multiple plans, ban sales during open enrollment, limit internet and phone sales, prohibit plan rescissions, improve disclosures, and prohibit marketing of non-ACA-compliant plans at the end of the PHE.
- **Develop standards for web-brokers and other direct enrollment entities.** HHS should prohibit agents and brokers from marketing non-ACA compliant products during open enrollment and require brokers to act in the best interest of consumers. They should be required to screen consumers for Medicare and Medicaid and be required to disclose the amount of their commissions.
- **Make improvements to Healthcare.gov.** HHS should improve consumer support tools and information display. For example, the total cost estimator should offer the option to further customize anticipated care use. The health plan highlights interface should more prominently display information regarding mental health services, formularies, and utilization management. Outreach and advertising at the end of the PHE should direct consumers to silver plans. Healthcare.gov should send notice of the availability of cost-sharing help to those who are eligible but don't enroll in silver plans.
- **Continue to improve outreach and enrollment.** HHS should prioritize help for individuals from underserved groups who are disproportionately eligible but not enrolled. HHS should assess cultural and language barriers to enrollment, including accessibility of materials. HHS should reinstate the community- and consumer-focused program requirements that were previously eliminated and consider more standards to protect the assister-consumer relationship. HHS should prohibit Navigators from referring individuals to debt collection. Finally, HHS should conduct a robust education campaign on the No Surprises Act.
- **Ensure states are offering enrollment and renewal through all modalities.** States must allow individuals to apply and renew Medicaid coverage through four modes: online, by telephone (with telephonic signature), in-person, and by mail. A handful of states are not in compliance.⁶
- **Encourage states to use texting and phone calls to share information and remind enrollees if action is required to retain coverage.** Texts and automated calls can be low-cost and easy to implement. Using these modes can improve the response rate for change in circumstance or at renewal.
- **Encourage states to use enrollment assister portals with enhanced features.** Full-service portals like Kynect, Kentucky's combined eligibility system, can help assisters support enrollment with functions like providing alerts when a client needs to take action. Portals also allow states to monitor the effectiveness of assisters.
- **Encourage use of multi-benefits applications.** Joint applications (preferably with dynamic questioning) simplify the process for applicants and states. States can offer a multi-benefit application that transfers information to separate eligibility systems. Multi-benefit applications provide families with access to other benefits, including supporting health-related social needs.

⁶ <https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey/>.

- **Encourage states to adopt or expand certified application counselor (CAC) programs.** CMS should promote best practices for CAC programs and issue guidance on federal funding for states. CMS should emphasize identifying gaps in geographic access and cultural, linguistic, and accessibility needs.
- **Promote best practices for community-based assistance networks.** For example, Massachusetts and New York support a “hub and spoke” approach by working with organizations to provide grants and support to a network of community-based assisters. Assisters are a valuable resource when states implement system changes.
- **Conduct state-level surveys or expand the Medicaid CAHPS survey.** CMS should fund state-level surveys of people who recently applied or renewed coverage to understand the barriers that individuals face, with sufficient samples to stratify data by demographic factors. Alternatively, CMS could broaden the CAHPS survey.
- **Engage healthcare providers in outreach and retention.** CMS should consider granting the same flexibility for states to engage providers as it has for MCOs. Healthcare providers consistently update patient contact information and will often inform an enrollee that they have lost coverage.
- **Implement and strengthen network adequacy standards.** We strongly support the Department’s decision to establish a robust set of quantitative, time and distance standards for assessing network sufficiency beginning in the 2023 and appreciate your commitment to implementing appointment wait time limitations in 2024. When wait time standards do come into effect, we request that the Department take affirmative steps to test plans’ compliance in addition to complaint reporting.

Despite the federal obligation for marketplace plans to maintain adequate networks, the standards and compliance regimes for ensuring network adequacy vary substantially across the states. We therefore support extending federal baseline quantitative standards to all marketplaces, federal and state-run alike. States could retain flexibility to apply and enforce standards that are more stringent than the federal minimum.

Topic 3: Advancing Health Equity: CMS wants to further advance health equity across our programs by identifying and promoting policies, programs, and practices that may help eliminate health disparities. We want to better understand individual and community-level burdens, health-related social needs (such as food insecurity and inadequate or unstable housing), and recommended strategies to address health inequities, including opportunities to address social determinants of health and burdens impairing access to comprehensive quality care.

Identifying Policies to Advance Health Equity

First, we would like to thank CMS for Section 1557 Proposed Rule, which would realign Section 1557 nondiscrimination regulations with the statute and federal nondiscrimination law. Our organizations support the strong nondiscrimination provisions to remove barriers that have historically made access to adequate health care harder for individuals, particularly people of color, people with disabilities, immigrants, individuals with limited English proficiency (LEP), people with low incomes, and LGBTQIA+ individuals.

Additionally, our organizations have urged HHS to prioritize access to culturally and linguistically competent care, to include:

- **Enforce and/or establish digital accessibility standards for state Medicaid, MCO, and Marketplace websites consistent with the Department of Justice’s recommended strategies for developing multilingual digital services.** We urge HHS to strongly enforce the existing accessibility requirements for the Marketplace under 45 CFR 155.205(c) for written translations, language services for individuals with LEP, taglines in non-English languages, and accessible web sites for those with disabilities; CMS should also establish, improve upon, and enforce the similar standards for state Medicaid and MCO websites under 42 CFR §§ 435.905(b) and 435.1200(f). Websites should indicate when all important information, like disclaimers, are not translated online and direct people with LEP to where they can find that information. Any telephonic consumer assistance should offer non-English voicemail menus, and customer service representatives should have access to qualified interpreters. Managed care provider directories should be accessible to people with LEP and indicate which providers are multilingual.
- **Encourage states to adopt language access policies that explicitly require translation and interpretation services for LEP and disability populations.** Under Title VI of the Civil Rights Act and Section 1557 of the Affordable Care Act, states are required to ensure LEP individuals can meaningfully access Medicaid and CHIP benefits. While all states have passed laws protecting language accessibility for health care services, only a limited number of states require the comprehensive translation and interpretation services that would be necessary for meaningful access to care. Medicaid enrollment has increased in states with enacted comprehensive language access laws – CMS’s guidance should strongly recommend their use.
- **Recommend cultural competency training for interpreters and providers.** At least six states—California, Connecticut, Iowa, New Mexico, Oklahoma, and Oregon—have passed language access laws addressing the need for cultural competency in health care or mandating cultural competency training for translators and some health professionals. CMS should promote these policies as ways to expand access and improve care for LEP and immigrant Medicaid beneficiaries. CMS can leverage the managed care contract review process to accomplish this.

Data are crucial for identifying disparities and where policy interventions are needed to address inequities. We recommend:

- **Scrutinize networks for their ability to provide culturally- and linguistically-competent care; and physically and programmatically accessible care.** We urge CMS to collect data on time and distance standards and appointment wait times, as well as data on whether providers are equipped to serve beneficiaries with LEP, have received diversity and inclusion training and in serving LGBTQ+ populations, and whether provider offices are accessible to people with disabilities. CMS should use collected data to assess whether networks provide culturally appropriate care that reflects the diversity of enrollees’ backgrounds and is attuned to traditionally underserved communities, including people of color, immigrants, people with disabilities, and LGBTQIA+ individuals.
- **Improving collection and reporting of race/ethnicity/language, sexual orientation and gender information, disability status (beyond eligibility category), and other enrollment data.** CMS should study and lift up the examples of states that have worked to improve their data collection and reporting. For example, although race/ethnicity is an optional question on Medicaid applications, there are many improvements that states could make to increase response

rates and accuracy, including adding more subgroups (such as Middle Eastern/North African) and training navigators and assisters on the importance of answering this question.

- **Reporting TMSIS, Child and Adult Core Set, EPSDT-416** and other care access data by race, ethnicity, age, geographic location, and plan wherever possible to more systematically understand gaps and variations in access to care.

Finally, CMS should:

- **Issue updated guidance and provide technical assistance to states on community-based billing for eligible Medicaid services adjacent to the clinically-focused health system.** In addition to adequate payment and reimbursement, providers that lie outside of the traditional health system, like doulas and schools and community-based organizations, face more costly administrative barriers learning medical codes and processes that are commonplace among larger clinical settings. These administrative hurdles can mean fewer culturally appropriate and community-linked supports for beneficiaries. As more states adopt strategies to broaden community-based providers, CMS should monitor provider uptake and access to services among underrepresented beneficiaries to identify lessons learned or opportunities for improvement in policies, systems and billing practices.

Understand effects of community providers leaving community or participation in CMS program

CMS will never achieve health equity if underserved communities do not actually have timely access to health care providers to meet their needs. We recommend that CMS commit to improving network adequacy in Medicaid, including access to community providers.

- **Develop minimum quantitative standards for network adequacy in Medicaid managed care.** CMS regulations at 42 CFR 438.206(b) require that states develop a “quantitative network adequacy standard” for each of seven different provider types (if covered under the state’s contracts with MCOs). The purpose of these standards is to ensure that MCO provider networks are sufficient to provide access for all enrollees to all services covered under the state’s contract with the MCO. CMS should develop minimum quantitative standards, including time-and-distance and appointment wait time, and revise its regulations to require that states enrolling beneficiaries in MCOs require those MCOs to meet or exceed the CMS minimum standards. The CMS minimum standards for Medicaid network adequacy should be at least as protective of beneficiary access as those developed for QHPs in the Marketplace under the January 5, 2022 Notice of Benefit and Payment Parameters. CMS should also revise its regulations to expressly require that, in conducting readiness reviews, states determine whether an MCO’s provider network meets the minimum quantitative standards (or, if more protective of beneficiaries, the state’s quantitative standards) for network adequacy.

Topic 4: Impact of COVID-19 PHE Waivers and Flexibilities: CMS wants to understand the impact of waivers and flexibilities issued during the COVID-19 PHE, such as eligibilty and enrollment flexibilities, to identify what was helpful as well as any areas for improvement, including opportunities to further decrease burden and address any health disparities that may have been exacerbated by the PHE.

Impacts of COVID PHE waivers

Our organizations appreciate the updates that CMS made to its guidance to states regarding the resumption of routine state Medicaid operations at the end of the COVID-19 public health emergency,

and we have reached out to states to share our recommendations for how to ensure patients who remain eligible for Medicaid coverage maintain their access to care.

There are additional opportunities for CMS to improve continuity of coverage by sustaining positive policy changes that have been adopted during the PHE including:

- **Support state adoption of permanent telehealth options, which helped bolster access to care during the pandemic.** As many states worked quickly to offer telehealth options during the pandemic, it offers a new way to ensure a variety of ways to access care for patients, provided barriers to Internet access continue to be removed and personal information for each beneficiary can be protected. Our organizations believe telehealth can and should be used to increase patient access to care. For example, telehealth has utilized by individuals to receive mental health services; according to a GAO report, beneficiaries reported feeling more comfortable accessing behavioral health services at home by telehealth, and behavioral health services were among the most commonly delivered via telehealth in the first year of the pandemic.⁷ We ask that HHS keep in mind that network provider access through telehealth should supplement not supplant network provider access to in-person visits. In all cases, consumers must retain the right and ability to choose between receiving care in-person or via telehealth. We also note that audio-only visits have been important to expand access to individuals who lack the broadband or devices needed for video-enabled visits. However, access to video-enabled visits has not been equitable, and for some patients, audio-only visits may not provide care in an optimal clinical setting.⁸
- **Encourage states to permanently remove premiums and cost-sharing for families in Medicaid and CHIP as a barrier to care.** While many states waived premiums during the pandemic, removing cost sharing altogether can further remove a barrier to care beyond the pandemic.

Recommendations

As CMS prepares for the eventual unwinding of the continuous enrollment protection, significant efforts should be made to ensure Medicaid-eligible individuals maintain coverage and individuals no longer eligible are transferred to other sources of coverage without gaps.

To ensure successful transitions between Medicaid and the Marketplace during the unwinding and beyond, we recommend that CMS and CCIIO work together to:

- **Ensure that Marketplace plan coverage is effective on the first day of the month after a person losing Medicaid coverage enrolls, even if that person enrolls after the 15th of the month.** Completing the application process for Marketplace coverage can be burdensome and result in gaps in coverage as individuals collect needed paperwork. CMS and CCIIO can support continuity of coverage—which is of utmost importance to individuals with chronic conditions—by ensuring coverage is retroactive to the first day of the month in which an individual starts the application process.
- **Use every available opportunity to facilitate enrollment with applications pre-populated with information included in the file transfers.** In addition to just transferring data from Medicaid to the Marketplace, the Marketplace should use the data to pre-populate an

⁷ <https://www.gao.gov/products/gao-22-104700>

⁸ <https://pubmed.ncbi.nlm.nih.gov/30153920/>

application and ask the individual to verify the information included. CMS could provide technical and IT assistance in this endeavor.

- **Consider possibilities for auto-enrollment in \$0 premium plans.** CMS should work with federal and state legislators as well as IT vendors to craft an option allowing individuals to consent to enrollment in a \$0 premium plan. The agencies should consider appropriate guardrails, such as allowing individuals to change plans within a set timeframe if they face issues related to network access or prescription drug coverage.
- **Ensure that outreach and advertising during the transition directs people to silver level plans in order to obtain the cost-sharing assistance, if applicable.** For those who are eligible for cost-sharing reductions but who enroll in a bronze plan, healthcare.gov can send a notice of the availability of cost-sharing help and the opportunity to change plans if the enrollee is still within their special enrollment window and hasn't effectuated coverage.
- **Recognize challenges of transitioning to new coverage, particularly for those who transition mid-plan-year and who have substantial health care needs.** This would include allowing enrollees to maintain access to their provider with in-network cost-sharing under the new plan, having pro-rated cost-sharing for the partial-year coverage, and carrying over or guaranteeing expedited approvals for treatments covered under their Medicaid plan.
- **Require a minimal level of commissions for enhanced direct enrollment sites and brokers during special enrollment periods.** This change could help shift the incentives for EDEs and brokers who often push non-ACA compliant products which provide poorer coverage for the patient but are more lucrative for the EDE or broker.

The continuous enrollment protection and planning for its unwinding have also highlighted areas where CMS can take steps to reduce health disparities which have been widened by the COVID-19 pandemic. We recommend:

- **Provide technical assistance to states on policy options to smooth income fluctuations.** States may consider predictable changes in income, such as seasonal work, in determining eligibility. States may also project annual income through the end of the calendar year when processing a change in income. More technical assistance would help states apply and maximize the impact of these policies and determine ways to program systems to flag situations that require manual review.
- **Continue to approve section 1115 waiver proposals from states to provide continuous eligibility to adults and to children for multiple years.** We commend CMS for its recent approval in Oregon to provide multi-year continuous eligibility for young children and for two-year periods among all school-aged and adult beneficiaries, which will promote continuity of coverage by eliminating gaps in enrollment due to temporary changes or renewal difficulties. The policy can help improve health outcomes through higher rates of well-child visits, immunizations, as well as use of other preventive and routine care. Gaps in coverage are more likely to affect children of color and can be particularly detrimental for individuals with chronic conditions who need continuous access to treatments or prescriptions. Even temporary gaps can result in substantial medical debt for families.
- **Encourage states to apply the 90-day reconsideration period following a loss of coverage due to income.** When individuals are disenrolled for procedural reasons, states must provide a period of 90 days for individuals to submit needed information and have their eligibility reviewed

without completing a new application. This policy would also be helpful to individuals who lose coverage due to temporary changes. It would also reduce the state's administrative burden and cost in processing new applications associated with churn.

American Heart Association
American Kidney Fund
American Liver Foundation
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation of America
Cancer Support Community
CancerCare
Cystic Fibrosis Foundation
Epilepsy Foundation
Family Voices
Hemophilia Federation of America
Lupus Foundation of America
March of Dimes
Muscular Dystrophy Association
National Alliance on Mental Illness (NAMI)
National Eczema Association
National Hemophilia Foundation
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
The Leukemia & Lymphoma Society