NATIONAL ASSOCIATION OF Community Health Centers

January 2, 2024

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program (CMS–9895–P)

The National Association of Community Health Centers (NACHC) is the national membership organization for federally qualified health centers (also known as FQHCs or health centers). Health centers are federally funded or federally supported nonprofit, community-directed provider clinics that serve as health homes for over 31 million people, including 1 in 6 Medicaid beneficiaries and over 3 million elderly patients. It is the collective mission and mandate of nearly 1,400 health centers around the country to provide access to high-quality, cost-effective primary and preventative medical care as well as dental, behavioral health, and pharmacy services and other "enabling" or support services that facilitate access to care to individuals and families located in medically underserved areas, regardless of insurance status or ability to pay.

Health centers serve a critical role in the success of Marketplaces in every state. They serve as the medical home for millions of Americans who are eligible for reduced-cost coverage through Federal and State marketplaces. Twenty percent of health center patients have private insurance, and 48% have Medicaid coverage, some of whom receive coverage through Medicaid expansion.[1] These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions. Additionally, health centers are a key source of outreach and enrollment (O&E) assistance nationally. With support from the Health Resources and Services Administration (HRSA), and often from CMS programs, FQHCs helped over 4 million individuals seeking coverage in 2022.[2] This assistance includes assisting individuals to enroll in Medicaid, CHIP, Medicare, or the Marketplace; it also includes assisting individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance.

NACHC welcomes the opportunity to comment on the 2025 Notice of Benefit and Payment Parameters. We appreciate that many of the proposals mirror and aim to better align enrollee experience on the Marketplace side, like items in the proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes." Our comments are broken into four sections:

[1] https://www.nachc.org/wp-content/uploads/2023/07/Community-Health-Center-Chartbook-2023-2021UDS.pdf
[2] https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=ODE&year=2022

I. Streamlining Network Adequacy Standards Between State Exchanges & FFMs; II. Reducing Barriers to Enrollment/Financial Assistance; III. Increasing Health Insurance Enrollee Protections; and IV. Enhancing Essential Health Benefits.

In brief, we appreciate CMS considering the following proposals below:

- NACHC supports CMS' proposal at § 155.1050 to require that State Exchanges and State-based Marketplace-Federal Platform (SBE-FPs) establish and impose quantitative time and distance network adequacy standards for qualified health plans (QHPs) that are at least as stringent as the Federally-facilitated Exchange's (FFEs) network adequacy standards established for QHPs under § 156.230.
- NACHC strongly supports CMS' proposal that State Exchanges and SBE–FPs be required to conduct quantitative network adequacy reviews before QHP certification and that they conduct them consistent with network adequacy reviews undertaken by the FFEs under § 156.230.
- NACHC appreciates CMS' intent to gather input from the public regarding any potential future enforcement of appointment wait time standards.
- NACHC supports CMS' proposal requiring all issuers seeking certification of plans offered as QHPs to submit information to the respective State Exchanges or SBE-FPs about whether network providers offer telehealth services.
- NACHC recommends publishing this information in the provider directory.
- NACHC supports deleting paragraph d(4) at § 435.601 to allow States flexibility in disregarding income and/or resources for the non-MAGI population for Medicaid eligibility purposes.
- NACHC supports CMS' proposals at §§ 155.205(b) and 155.302(a)(1)) to require Exchanges to operate a centralized enrollment and eligibility platform on its website and make all eligibility determinations to streamline the process for all enrollees.
- NACHC appreciates the proposal at §155.335(j) to include catastrophic coverage plans into the auto re-enrollment hierarchy.
- NACHC supports changes at § 155.400(e)(2), which clarifies allowing Exchanges to implement premium payment requirements on all insurance premium payments, such as the requirement to trigger a grace period to enrollees receiving APTC if enrollees fail to pay premiums timely.
- NACHC supports the Administration's proposal (§ 155.305(f)(4)) not to deny an enrollee APTC based on Internal Revenue Service (IRS) data that a consumer failed to pay their previous year's APTC unless the enrollee has failed to do so in the past two years.
- NACHC supports amending §155.315(e) to allow for self-attestation and electronic verification of an HHS-approved data source to verify an enrollee's incarceration status.
- NACHC supports the proposal at § 155.410, which aligns open enrollment periods for all Exchanges, Federal and State, beginning January 1, 2025.
- NACHC appreciates CMS' efforts to ensure effective coverage dates begin on the first day of the month after the selection of health insurance at § 155.420(b) beginning January 1, 2025.
- NACHC supports the proposed minimum standards at § 155.205 for Exchange and State call centers.

- NACHC supports CMS' proposal to amend §155.220(j)(2)(ii) to ensure web brokers operating in State Exchanges meet existing HHS standards that already apply in FFEs and SBE-FPs.
- NACHC supports allowing enrollees who retroactively enroll in Medicare Part A or B to terminate their Marketplace coverage, effective on the day before Medicare coverage begins (§ 155.430).
- NACHC supports revising language around the special enrollment period for Advanced Premium Tax Credit individuals under 150% FPL, regardless of whether their premiums are effectively zero (§ 155.420(d)(16)).
- NACHC supports requiring the Exchanges to conduct periodic checks twice a year to check for deceased enrollees to maintain program integrity (§ 155.330(d)).
- NACHC supports CMS' proposal at § 156.122 to codify that prescription drugs in excess of those covered by a State's EHB-benchmark plan are considered EHB.
- NACHC strongly supports CMS' proposal at § 156.115 to remove the regulatory prohibition on issuers from including routine non-pediatric dental services as an EHB.
- NACHC encourages CMS to remove the regulatory prohibition at § 156.115(d) prohibiting issuers from including routine adult eye exam services as an EHB.
- NACHC supports CMS' proposal at § 156.122 to update Pharmacy and Therapeutics (P&T) membership standards to require the P&T committee to include a consumer representative as part of its membership.

I. Streamlining Network Adequacy

NACHC supports CMS' proposal at § 155.1050 to require that State Exchanges and State-based Marketplace-Federal Platform (SBE-FPs) establish and impose quantitative time and distance network adequacy standards for QHPs that are at least as stringent as the FFEs network adequacy standards established for QHPs under § 156.230. The Affordable Care Act (ACA) requires QHPs offered through the Marketplace to ensure a sufficient choice of providers and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers.[3] This is particularly important when applied to FQHC patients. FQHCs provide all the necessary health services to help ensure their patients can live healthier lives and increase their overall well-being. Accordingly, because FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations, it is imperative that time and distance standards are applied when determining whether participating providers are geographically accessible to plan enrollees. While we acknowledge that Congress created the Essential Community Provider provision of the ACA[4] to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, like FQHCs, HIV/AIDS clinics, and family planning health centers, time and distance standards are a crucial component of patient access.

Problems arise when patients cannot find local in-network providers and must either pay more for out-of-network care if that's even an option in their plans or travel farther for in-network care.[5] In

[3] https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/
[4] Section 1311(c)(1)(C)
[5] https://www.npr.org/sections/health-shots/2023/04/05/1168088923/the-big-squeeze-aca-health-insurance-has-lots-of-customers-small-networks

fact, time and distance standards range from 15 to 90 minutes for a primary care provider (average, 44.7 minutes in rural areas, 28.9 minutes in urban areas) to 30–135 minutes for a cardiologist (average, 72.1 minutes in rural areas, 40.4 minutes in urban areas).[6] Studies have also shown that patients living further away from healthcare facilities had worse health outcomes.[7] For this reason, it is essential to investigate additional avenues that will help decrease time and distance standards for health center patients.

To ensure State Exchanges and SBE–FPs meet FFE network adequacy standards, NACHC strongly supports CMS' proposal that State Exchanges and SBE–FPs be required to conduct quantitative network adequacy reviews before QHP certification and that they conduct them consistent with network adequacy reviews undertaken by the FFEs under § 156.230. Both states and the federal government oversee Marketplace plan adequacy. Still, enforcement has been criticized as weak.[8] A recent government report found that 243 out of 375 plan issuers on the Federal Exchanges were not complying with network adequacy standards for the 2023 plan year.[8] Additionally, it has been determined that one of the most common areas of network adequacy noncompliance was plan issuers' failure to meet time and distance standards. Those standards are meant to ensure providers are geographically accessible to plan members and require payers to make at least one provider available for various specialties within a certain driving distance. Although this proposal offers insurers the opportunity to justify any deficiencies and potentially earn certification, NACHC recommends CMS enforce this requirement to prohibit State Exchanges and SBE–FPs from accepting an issuer's attestation as the only means for plan compliance with network adequacy standards. Enforcement of this requirement will create greater accountability and uniformity across health plans and reduce their ability to define and monitor their performance without review. This, in turn, will help to alleviate the shortage of providers in certain areas — especially rural areas — a vulnerable FQHC population.

While CMS deferred the appointment wait time standards to PY 2025, NACHC appreciates CMS' intent to gather input from the public regarding any potential future enforcement of appointment wait time standards. However, with the reality of workforce shortages, meeting these wait time standards can be challenging. A 2022 NACHC survey found that 68% of health centers lost between five and twenty-five percent of their workforce, with a majority citing financial opportunities at a large healthcare organization as the main reason for departure.[9] Nurses represent the highest category of workforce loss, followed by administrative, behavioral health, and dental staff. Workforce challenges can adversely affect patients and their health, contributing to longer wait times, decreased hours of operation for health centers, and reduced appointment availability.

With a shortage of behavioral health staff, meeting the 15-day appointment wait time standard for SUD/mental health would be particularly difficult for health centers. A survey conducted by the Association of American Medical Colleges projects that the United States will face a shortage of

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9236159/
[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5178808/#:~:text=77%25%20of%20the%20included%20studies,than%20those%20who%20lived%20closer.
[8] https://www.healthcaredive.com/news/cms-proposes-state-aca-provider-adequacy-time-distance-standards/699999/
[9] The National Association of Community Health Centers. (2022, March). Current State of the Health Center Workforce. Pandemic Challenges and Policy Solutions to Strengthen the Workforce of the Future. https://www.nachc.org/current-state-of-the-health-center-workforce/

up to 124,000 physicians by 2034, including 48,000 primary care clinicians.[10] Besides dealing with the workforce shortage, health centers have dealt with long delays in getting their providers credentialed, further contributing to the appointment wait time issue.

However, programs such as HRSA's Teaching Health Center Graduate Medical Education (THCGME) Program have helped communities grow their health workforce by training physicians and dentists in community-based settings with a focus on rural and underserved communities.[11] This unique training model changes the physician training paradigm by providing the majority of training in community-based outpatient settings where most people receive their health care. The program also aims to increase physicians and dentists trained in community-based settings, improve health outcomes for members of underserved communities, and expand healthcare access in underserved and rural areas. Last year, THCGME residents treated over 792,000 patients during more than 1.2 million patient encounters, significantly enhancing access to primary care in underserved areas.[12] To continue addressing workforce needs, NACHC encourages CMS to work with HRSA to grow the THCGME program, which works towards building a stronger primary care workforce that better supports the communities served, resulting in reduced wait times.

NACHC also supports CMS' proposal requiring all issuers seeking certification of plans offered as QHPs to submit information to the respective State Exchanges or SBE-FPs about whether network providers offer telehealth services. Using technology to deliver health care has several advantages, including cost savings, convenience, and the ability to provide care to people with mobility limitations or those in rural areas who don't have access to a local doctor or clinic.[12] Rural communities have long experienced health care workforce shortages with too few primary care providers choosing to practice in rural areas.[13] One way health centers are addressing workforce shortages is through telehealth, a cost-effective way to increase access to care when providers are long distances apart.[14] Rural health centers have led the way in telehealth, and today, nearly half (49%) of rural health centers offer services through telehealth technologies.[15]

NACHC appreciates CMS' intent to help inform the future development of telehealth standards. As CMS has stated, a state that heavily relies on telehealth in some regions may find that a healthcare provider-to-enrollee ratio is more useful in measuring meaningful access to all services without unreasonable delay. The time it would take the enrollee and the distance the enrollee would have to travel to access the provider in person could be well beyond applicable time and distance standards. However, the enrollee may still be able to access many different providers easily and quickly on a virtual basis. A recent NACHC survey assessed patient satisfaction with telehealth in CHCs. The survey results found that almost 9 of 10 respondents agreed or strongly agreed that

[10] https://www.aamc.org/media/54681/download
[11] https://bhw.hrsa.gov/funding/apply-grant/teaching-health-center-graduate-medical-education
[12] https://www.health.harvard.edu/staying-healthy/telehealth-the-advantages-and-disadvantages
[13] National Rural Health Association. Health Care Workforce Distribution and Shortage Issues in Rural America. January 2012.
[14] NACHC. 2018. The Health Center Program is Increasing Access to Care Through Telehealth.
[15] 2007 & 2017 Uniform Data System. Bureau of Primary Health Care, HRSA, DHHS. Note: Federally-funded health centers only. Health Centers self-identify as rural or urban, and comparisons to non-health center rural populations are an approximation.

telehealth addressed their needs, was suitable for interaction with their clinician, and they were generally comfortable and satisfied with care via telehealth.[16]

To ensure that patients are aware if their provider offers telehealth services, NACHC recommends publishing this information in the provider directory. Collecting more data on telehealth usage is relevant to State Exchange and SBE-FP analysis of whether a QHP meets network adequacy standards. Specifically, gathering telehealth data aligns with CMS' goal to further advance health equity and ensure patients have access to the care they need. However, we urge CMS to take a step further and ensure that patients are aware of which providers offer telehealth, which can promote access. For rural areas especially, this will increase trust in the local healthcare systems and provide additional funding for local health services with a remote patient population.[17] As rural health centers continue to grow and serve more rural communities, the collection of data concerning whether network providers offer telehealth services will support improving health.

II. Reducing Barriers to Enrollment/Financial Assistance

NACHC supports deleting paragraph d(4) at § 435.601 to allow States flexibility in disregarding income and/or resources for the non-MAGI population for Medicaid eligibility purposes. This population – older adults, those with disabilities or blindness, or people eventually being assessed as medically needy – often are at a disadvantage for Medicaid eligibility because of the "asset tests," as stated in the proposed rule, and have to "spend down" their savings before being deemed eligible. For instance, health centers served 1.28 million dually eligible patients in 2022.[18] Dually-eligible individuals traditionally experience more barriers when seeking care due to the combination of complex chronic conditions and social drivers of health (SDOH). Dually-eligible people, as well as people with disabilities, should have access to comprehensive health insurance, and this proposal would grant states more leeway to do so. States would be allowed to target income and/or resource disregards for individuals in the same Medicaid eligibility group as long as the subpopulation is reasonable and does not violate other Federal statutes. Some states have already pursued this, like California, which was able to eliminate the asset test for non-MAGI individuals through the passage of a state plan amendment in August 2023.[19] In comparison to the "all-or-nothing approach" required by the current regulation, this proposal would allow states to target specific expansions of Medicaid coverage and help improve the lives of some of the most vulnerable patients.

NACHC supports CMS' proposals at §§ 155.205(b) and 155.302(a)(1)) to require Exchanges to operate a centralized enrollment and eligibility platform on its website and make all eligibility determinations to streamline the process for all enrollees. While there is no explicit regulatory or statutory requirement for this centralized enrollment and eligibility platform, this would codify existing policies and practices that many Exchanges already utilize. This will enhance a seamless enrollment experience and eligibility determination for all enrollees. No matter

[16] https://www.nachc.org/wp-content/uploads/2023/07/Assessing-Patient-Satisfaction-with-Health-Center-Telehealth-Services-A-Policy-Brief_2023.pdf
[17] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8590973/
[18] https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=Full&year=2022
[19] https://www.mcknightsseniorliving.com/home/news/state-becomes-first-to-strip-medicaid-asset-limit/

if the person is eligible for the Marketplace or Medicaid/CHIP, they should easily be able to obtain health insurance regardless of whether it's in-person, online, by mail, or through an Exchange call center.

In the spirit of this proposal, NACHC also supports ideas for the future interoperability of State/Federal Exchanges with other types of public assistance programs, like the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Supplemental Nutrition Assistance Program (SNAP). We understand that many states are already trying to coordinate and share data to maximize the uptake of these programs by consumers who may be unaware of their eligibility. A recent study showed that at least 34 WIC state agencies have a written agreement on coordination or data sharing with Medicaid or SNAP. Furthermore, at least 30 WIC state agencies periodically (anywhere from daily to annually) receive data on Medicaid and/or SNAP enrollees.[20] NACHC is supportive of positive steps forward like these; eventually having one platform that could perform eligibility determinations on financial assistance programs will allow enrollees to get all the benefits for which they are eligible and contribute to the betterment of their lives.

NACHC appreciates the proposal at §155.335(j) to include catastrophic coverage plans into the auto re-enrollment hierarchy. With 90% of health center patients living under 200% FPL, many can benefit from enrolling in catastrophic plans if they qualify.[21] While these plans have high deductibles, they have low monthly premiums and still cover the essential health benefits, making it an affordable way to protect patients against worst-case scenarios, like serious sickness or injury.[22] Instead of going without insurance, people can spend a smaller amount on a monthly premium and have peace of mind with their health insurance coverage. Enrollees can put money saved towards food, housing, or improving their quality of life and not avoid care due to being uninsured. Finalizing this proposed change will positively impact people by ensuring insurance coverage continuity for enrollees by auto-enrolling them in a similar catastrophic coverage plan if their old plan is no longer available.

NACHC supports changes at § 155.400(e)(2), which clarifies allowing Exchanges to implement premium payment requirements on all insurance premium payments, such as a requirement to trigger a grace period to enrollees receiving APTC if enrollees fail to pay premiums timely. As currently written, Exchanges could interpret this section as grace period flexibilities *only applying to the binder (first) payment for health insurance*; rewriting this section to allow Exchanges to be flexible with enrollees clearly can help better ensure consumers' continuity of coverage and assure access to health care services. Health center patients are lower-income and experience more SDOH, which could impact their ability to make timely payments. Factors like unstable housing or lack of reliable broadband access could negatively impact a patient's ability to pay on time or receive notice about a late payment. This seemingly small clarification will make a significant impact by allowing Exchanges to grant enrollees leniency in the case of a late payment.

[20] https://www.cbpp.org/research/food-assistance/wic-coordination-with-medicaid-and-snap-0
[21] People under 30 or people age 30 or older with either a hardship or affordability exemption (if Marketplace or job-offered coverage is unaffordable) qualify.
[22] https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/what-is-a-catastrophic-health-plan/

NACHC supports the Administration's proposal (§ 155.305(f)(4)) not to deny an enrollee APTC based on Internal Revenue Service (IRS) data that a consumer failed to pay their previous year's APTC unless the enrollee has failed to do so in the past two years. We appreciate that this change, initially made in the CY24 Notice of Benefit and Payment Parameters, will extend to all Exchanges, including State Exchanges. Especially given the backlog experienced at the IRS and many other governmental agencies during the pandemic, this slight administrative change lends heightened protection to more financially vulnerable enrollees who are supposed to qualify for APTCs. Furthermore, the Inflation Reduction Act and American Rescue Plan Act extended APTCs (2021-2022 and 2023-2025, respectively)[23] to new populations who may be unfamiliar with the reconciliation process in their taxes at the end of the year. In 2022, around 80 million people waited until the last minute to file their taxes, with 21% of respondents stating "general confusion" around all the different tax credits.[24] With the median U.S. household income reported at $74,580 in 2021,[25] having access to APTCs can be crucial to affording comprehensive coverage. NACHC appreciates the Administration allowing leniency for first-time recipients of this tax credit.

NACHC supports amending §155.315(e) to allow for self-attestation and electronic verification of an HHS-approved data source to verify an enrollee's incarceration status. Health centers play a crucial role in caring for patients with complex and chronic health conditions, such as formerly incarcerated individuals, who are at higher risk for adverse health outcomes. Some health centers have partnerships with their local jails to begin developing care relationships and are ready to engage with them upon release as well.[26] Incarcerated individuals are not allowed to acquire insurance through the individual Marketplace.[27] However, upon release, individuals do seek out health insurance coverage.

Almost two-thirds (64%) of people in jail and over half (54%) of people in state prisons report a mental health concern,[28] making it imperative they can access health coverage insurance upon release. Unfortunately, in 2018, approximately 4.4 million people were under community supervision from 2015 – 2019, and about one quarter (26%) of those adults under community supervision were uninsured.[29] Current rules allow consumers to assert their incarceration status, but then Marketplaces are directed to confirm their status using an HHS-approved data source. Furthermore, applicants must provide documentation to show that they are no longer incarcerated. We appreciate CMS changing the process to allow self-attestation, which will remove at least one barrier that justice-involved individuals face when they exit the justice system. According to an internal HHS study, a large majority—over 96 percent—of these data-matching issues were

[23] https://www.cms.gov/marketplace/technical-assistance-resources/aptc-csr-basics.pdf
[24] https://www.cbsnews.com/newyork/news/expert-confusion-reigns-supreme-as-americans-wait-until-the-last-minute-to-file-their-tax-returns/
[25] https://www.census.gov/library/publications/2023/demo/p60-279.html
[26] https://nhchc.org/wp-content/uploads/2019/08/csh-nhchc_health-centers_justice-involved-pops_final.pdf
[27] https://www.healthcare.gov/incarcerated-people/
[28] https://www.apa.org/monitor/2014/10/incarceration#:~:text=Mental%20illness%20among%20today%27s%20inmates,health%20concerns%2C%20the%20report%20found
[29] https://www.macpac.gov/wp-content/uploads/2021/08/Access-in-Brief-Health-Care-Needs-of-Adults-Involved-with-the-Criminal-Justice-System.pdf

resolved in favor of the consumer attestation.[30] This easy fix will continue to maintain program integrity while decreasing administrative costs and, most importantly, allowing equal access to health insurance.

III. Increasing Health Insurance Enrollee Protections

NACHC appreciates the Administration's continued investment in the outreach and enrollment (O&E) workforce. The $98.6 million that CMS granted to 57 returning Navigator for plan year 2024 and $5 million for a pilot to conduct rural-focused outreach and health insurance enrollment activities will significantly help the O&E community, like FQHCs, better reach more enrollees. These investments will also help consumers understand new coverage options and find the most affordable coverage that meets their healthcare needs in federally facilitated or State Partnership Marketplaces.[31] Funding for this workforce is important for health centers and our patients. While outreach and enrollment services are built in the 330 grant that health centers receive, outreach and enrollment (O&E) work is not covered as "billable providers" and reimbursable services, making the continued funding from the Administration crucial so that health centers can reach more patients. This funding has also provided health centers with the necessary resources to assist patients undergoing Medicaid redeterminations. States have been conducting Medicaid redeterminations since April 1; an estimated 10 million have lost Medicaid coverage. With many states still in the redetermination process,[32] there are myriad enrollees who are seeking assistance with acquiring health insurance.

NACHC appreciates the Administration holding user fees stable—2.2% for FFE and 1.8% for SBE-FP— given the high volume of Medicaid redeterminations and the resources needed to help consumers maintain consistent coverage. The marketplace user fee — a fixed percentage of premium revenue paid by insurers — supports critical functions, including operating and improving the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. HealthCare.gov, the Marketplace call center, and these consumer-facing functions are critical for health centers across the country because they ultimately impact patient outcomes; more funding leads to a strengthened outreach and enrollment workforce providing services that help increase enrollment in health insurance.

Health centers have utilized marketing and outreach funding under the ACA by incorporating Community Health Workers (CHWs) into their patient care teams. CHWs and enrollment assisters are public health workers who are trusted members of or are closely connected to a community. They provide unbiased enrollment assistance and facilitate access to services that improve the quality of care for patients. Unlike CHWs and enrollment assisters funded by the user fees, private navigators and assisters are often paid commissions by a third party. This third party incentivizes private navigators and assisters to direct consumers to certain private products rather than promoting consumer utilization in a neutral manner. Given that user fees fund these core

[30] https://www.federalregister.gov/documents/2023/11/24/2023-25576/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2025#footnote-155-p82573
[31] https://www.cms.gov/newsroom/fact-sheets/marketplace-plan-year-2024-open-enrollment-fact-sheet#:~:text=CMS%20invested%20%2498.6%20million%20in,application%2C%20and%20enroll%20in%20coverage.
[32] https://www.statnews.com/2023/11/03/medicaid-disenrollment/

marketplace functions, we appreciate no changes to user fees to continue to allow consumers to access accurate and comprehensive eligibility information for Medicaid and related programs associated with HealthCare.gov.

We urge CMS to continue to invest in O&E. We know that from 2016 to 2019, when outreach and enrollment experienced significant budget cuts, unsubsidized enrollment decreased by 2.8 million people.[33] We continue to advocate for further investment in enrollment assistance programs, as this would reduce the burden on the safety net and generally ensure better public health because having health insurance is associated with increased access to health services and better health monitoring.[34, 35, 36] States may need additional funding, given the resources necessary to help consumers impacted by Medicaid redeterminations. Health centers will continue playing a crucial role in helping enrollees understand their new coverage, and adequate funding will help bolster the workforce.

NACHC supports the proposal at § 155.410, which aligns open enrollment periods for all Exchanges, Federal and State, beginning January 1, 2025. Having a 6-week open enrollment beginning on November 1 and ending no earlier than January 15 will help enhance consumer knowledge even in the event of moving out of state with a new insurance exchange. We also appreciate the option to extend the open enrollment period beyond January 15. Over 16 million people enrolled in the Marketplaces for CY2023, with over 3.5 million being new consumers.[37] With an overwhelming number of plans to choose from in some Marketplaces and varying guidelines for financial assistance eligibility, implementing a longer open enrollment period can help better reach new enrollees and give them more time to overcome any challenges when signing up for Marketplace coverage, especially because open enrollment occurs around the busy holiday season.[38]

NACHC appreciates CMS' efforts to ensure effective coverage dates begin on the first day of the month after the selection of health insurance at § 155.420(b) beginning January 1, 2025. One in five adults delay seeking medical care due to lack of insurance.[39] The time of the month a person seeks insurance should not put them at a disadvantage in acquiring Marketplace coverage, resulting in a delay in coverage. Health center enrollees are more likely to have chronic

[33] https://www.cms.gov/newsroom/press-releases/unsubsidized-enrollment-individual-market-dropped-45-percent-2016-2019-0
[34] Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., ... & Finkelstein, A. N. (2013). The Oregon experiment — effects of Medicaid on clinical outcomes. New England Journal of Medicine, 368(18), 1713–1722.
[35] McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2003). Impact of Medicare coverage on basic clinical services for previously uninsured adults. JAMA, 290(6), 757–764.
[36] Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. Medical Care Research and Review, 62(1), 3–30.
[37] https://www.cms.gov/newsroom/fact-sheets/marketplace-2023-open-enrollment-period-report-final-national-snapshot
[38] https://www.kff.org/policy-watch/signing-up-for-marketplace-coverage-remains-a-challenge-for-many-consumers/
[39] https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/#:~:text=One%20in%20five%20uninsured%20adults,health%20conditions%20and%20chronic%20diseases.

conditions and desperately need coverage. Studies continue to show that people without insurance are less likely to seek preventive care and services for significant health conditions and chronic diseases than those with insurance[40] due to concerns about cost. No matter the type of Exchange an enrollee signs up for health insurance, it is important that coverage begins the first day of the month after health insurance is selected.

NACHC supports the proposed minimum standards at § 155.205 for Exchange and State call centers. Ensuring that a live call center representative is accessible to consumers during the Exchanges' hours and available to assist enrollees with anything related to their QHP application is crucial to enhancing enrollees' understanding and setting them on the path toward successfully enrolling in a health insurance plan. We understand that CMS does not intend to implement more stringent standards for call centers, such as wait times. Wait times widely vary between states; in August, they ranged from 1 minute to 46 minutes. Furthermore, while the average call center wait time was approximately 12 minutes, enrollees reported that call center wait times do not accurately reflect actual wait times. Call centers often have "tier systems," so an initial call might be answered quickly but then transferred to other tiers, sometimes multiple times, and therefore, the wait time is much longer than what gets reported.[41] We understand workforce issues persist at the state level and fully staffing; however, we urge CMS to consider implementing wait time standards so enrollees can be helped promptly to resolve health insurance issues.

One remedy CMS could implement is mandating call centers to offer a call-back option. Around 40% of businesses do this, granting enrollees back time in their day and decreasing time they spend waiting on the phone.[42] As of August, more than half of states (31) call centers already offer a call-back option.[43] If all 50 states had a call-back option for enrollees, this could help alleviate the workforce issue while simultaneously helping shorten wait times for consumers.

NACHC supports CMS' proposal to amend §155.220(j)(2)(ii) to ensure web brokers operating in State Exchanges meet existing HHS standards that already apply in FFEs and SBE-FPs. By requiring web-broker non-exchange websites to display standardized QHP comparative information, disclaimer language, information on eligibility for APTC/CSRs, operational readiness, standards of conduct, and access by web-broker downstream agents and brokers apply to web-brokers across all Exchanges, enrollees will have access to the same QHP comparative information whether they decide to use the Exchanges website or a web brokers' website. Since brokers and agents are commission-based, unlike Navigators trained to provide unbiased opinions, this additional protection will better empower consumer knowledge by helping simplify the plan selection process and enhancing their knowledge of plan benefits and costs, especially given that these interactions are often web-based. While many health center patients seek enrollment assistance from health center outreach and enrollment staff, adding these standards to web brokers in State Exchange will enhance web-brokers' integrity and protect enrollees, like health center patients, who choose to use their services. Similarly, NACHC supports requirements

[40] https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/#:~:text=One%20in%20five%20uninsured%20adults,health%20conditions%20and%20chronic%20diseases.
[41] National Health Law Program Call Center Report (December 2023)
[42] https://www.forbes.com/sites/christopherelliott/2019/11/22/call-back-systems-rise/?sh=3ad9dd9973de
[43] National Health Law Program Call Center Report (December 2023)

at § 155.221 to ensure Direct Enrollment (DE) Entities' websites prominently display and reflect Healthcare.gov changes within a specific time frame. Because many web brokers operate on these sites, this information must be updated timely to reflect any updates on Healthcare.gov accurately.

Additionally, NACHC supports:

- **Allowing enrollees who retroactively enroll in Medicare Part A or B to terminate their Marketplace coverage, effective the day before Medicare coverage begins (§ 155.430).** This is the first time enrollees on the Federal Exchange can retroactively disenroll from their plan, which will decrease the administrative burden on behalf of the enrollee and the Exchange.
- **Revising language around the special enrollment period for Advanced Premium Tax Credit individuals under 150% FPL, regardless of whether their premiums are effectively zero (§ 155.420(d)(16)).** This proposal will hopefully ensure the special enrollment period continues to be available for states and consumers following the expiration of these enhanced tax credits after 2025.
- **Requiring the Exchanges to conduct periodic checks twice a year to check for deceased enrollees to maintain program integrity (§ 155.330(d)).** Aligning with current Federal policy on the Exchanges, it also will help avoid overpayment of APTCs and Cost-Sharing Reductions.

IV. Enhancing Essential Health Benefits

NACHC supports CMS' proposal at § 156.122 to codify that prescription drugs in excess of those covered by a State's EHB-benchmark plan are considered EHB. Current rules say that plans must offer at least one drug per U.S. Pharmacopeia (USP) category and class or the number of drugs in the EHB-benchmark plan.[44] Prior preamble language indicated that individual market and small group market plans are permitted to go beyond the number of drugs offered by the benchmark plan, with all covered drugs considered EHBs. However, CMS has become aware of some plans that are unclear about this flexibility, and even plans that have developed programs to provide some drugs as "non-EHB," meaning the annual limitation on cost sharing would not apply, and they would not be subject to the annual and lifetime dollar limits.

Some health plans and pharmacy benefit managers (PBMs) have partnered with third-party companies to distribute their specialty medications. In doing so, these third-party companies determine that certain specialty medications are considered non-EHBs. When health plans and PBMs adopt one of these programs, patients prescribed specialty medications are told they will have very low copayments of $0-$5 if they enroll in the third-party specialty medication program. However, the plan artificially inflates the patient's copay to ensure it collects all copayment assistance available to the patient—essentially operating as a copay maximizer.[45] The coercive nature of these programs places patients in a position in which they have no option but to enroll in

[44] https://manattonhealth.manatt.com/health-insights/premium-insights/regulatory-and-guidance-summary/Documents/CMS%20Proposed%202025%20Notice%20of%20Benefit%20and%20Payment%20Parameters%20Focuses%20on%20State-Based%20Marketplace%20Rules/Manatt%20on%20Health_CMS%20Proposed%202025%20Notice%20of%20Benefit%20and%20Payment%20Parameters%20Focuses%20on%20State-Based%20Marketplace%20Rules_2023.11.20.pdf

[45] https://aimedalliance.org/wp-content/uploads/2022/07/Aimed-Alliance-Non-EHB-Fact-Sheet-FINAL-1.pdf

the third-party program. Because these programs define specialty medications as non-EHBs, patients are forced to pay thousands of dollars more per year before reaching their deductible and annual out-of-pocket limit.[46]

Many health center patients who experience several SDOH would benefit from CMS' proposal. Health centers reported that nearly 790,000 patients screened positive for financial strain.[46] Requiring prescription drugs over those covered by a State's EHB-benchmark plan to be considered EHBs could help improve medication adherence for more vulnerable patients. Similarly, the U.S. House of Representatives recently took important steps to broaden healthcare price transparency systemwide by passing *the Lower Costs, More Transparency Act*, which ensures that patients pay the same price for the same drugs regardless of where those drugs are administered.[47]

However, among low-income individuals, regardless of insurance type, medication cost is a well-established barrier to medication adherence. Spending less on basic needs to pay for medication is a particularly concerning cost-coping strategy and may be associated with worse health outcomes. About three in ten (29%) of all adults report not taking their medicines as prescribed at some point in the past year because of the cost.[48] Although an exception would arise if the state mandates coverage of the prescription drug, making it considered to be "in addition to" EHB, benefits that are "in addition to" EHB are still subject to state defrayal of their cost.[49] Therefore, codifying that prescription drugs in excess of those covered by a state's EHB benchmark are considered EHB can address many challenges faced by health center patients.

NACHC strongly supports CMS' proposal at § 156.115 to remove the regulatory prohibition on issuers from including routine non-pediatric dental services as an EHB. FQHCs serve as a point of care for over 31 million patients annually, many of whom are uninsured and living in poverty. These SDOH create chronic conditions, including a disproportionate burden of oral disease, within a vulnerable patient community. Although 81% of community health centers provided on-site dental services in 2017, a 30% increase since 2010, low-income adults are still twice as likely to experience tooth decay and gum disease and have unmet oral health needs.[50]

NACHC appreciates CMS' proposal to remove regulatory and coverage barriers to expand access to routine non-pediatric dental benefits for those plans that must cover EHB. This proposal would allow states to work to improve adult oral health and overall health outcomes, which are disproportionately low among marginalized communities such as people of color and people with

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[46] https://publichealth.gwu.edu/three-out-four-community-health-centers-assess-social-determinants-health-improve-patient-health

[47] https://www.congress.gov/bill/118th-congress/house-bill/5378

[48] https://www.kff.org/health-costs/press-release/poll-nearly-1-in-4-americans-taking-prescription-drugs-say-its-difficult-to-afford-medicines-including-larger-shares-with-low-incomes/

[49] https://manattonhealth.manatt.com/health-insights/premium-insights/regulatory-and-guidance-summary/Documents/CMS%20Proposed%202025%20Notice%20of%20Benefit%20and%20Payment%20Parameters%20Focuses%20on%20State-Based%20Marketplace%20Rules/Manatt%20on%20Health_CMS%20Proposed%202025%20Notice%20of%20Benefit%20and%20Payment%20Parameters%20Focuses%20on%20State-Based%20Marketplace%20Rules_2023.11.20.pdf

[50] https://www.nachc.org/wp-content/uploads/2020/08/NACHC_DQP_VBC-FQHC_FINAL_8.31.2020.pdf https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784602

low incomes. Coverage for dental services is one of the few options for low-income adults to access and receive dental care.[51] Without adult dental coverage, low-income adults are left seeking care at emergency departments, which is unsustainable and costly. In addition, visiting emergency departments does not promote optimal oral health, as patients are often given antibiotics and pain medication and not definitive treatment for their dental problems. Uninsured adults are three times more likely to visit the emergency department for dental emergencies than privately insured adults.[52] Lifting this prohibition and allowing individual and small group market plans to offer the same services as EHB that people are accustomed to for employer-sponsored coverage aligns with CMS' Oral Health Cross-Cutting Initiative, which aims to implement policy changes and consider opportunities through existing authorities to expand access to oral health coverage.

NACHC also encourages CMS to remove the regulatory prohibition at § 156.115(d) prohibiting issuers from including routine adult eye exam services as an EHB. Significant barriers exist for Americans seeking eye health and vision care at community health centers, with less than 3% of patients receiving such services.[53] Nearly 1 in 7 patients treated at FQHCs have diabetes, with 1 in 3 of those patients exhibiting uncontrolled diabetes.[54] Unfortunately, these populations face significant health-related disparities that impact patients' access to and uptake of health care, such as patients of Hispanic or African descent being twice as likely as Caucasians to go blind from diabetic retinopathy or glaucoma.[54] FQHCs are uniquely positioned to help improve access to eye health and vision care because of their reach in underserved communities and their emphasis on providing integrated, whole-person care to underserved populations. However, because FQHCs are often the only source of eye care available to these populations and other low-income individuals, plan members have limited access to routine adult eye exams. Removing regulatory prohibitions at § 156.115(d) and including routine adult eye exam services as an EHB will bolster plan members' access and counter anticipated financial challenges due to lack of coverage.

NACHC supports CMS' proposal at § 156.122 to update Pharmacy and Therapeutics (P&T) membership standards to require the P&T committee to include a consumer representative as part of its membership. As CMS has stated, P&T committee decisions can impact a consumer's overall quality of life and encompass important elements of care and cost for the consumer. The P&T committee develops a formulary of medications and medication-associated products accepted in a healthcare organization. [54] However, the selection of items to be included in the formulary should be based on an objective evaluation of their relative economic, clinical, and humanistic outcomes based solely on economic factors.[55] To assist in addressing potential safety concerns for each medication that is considered for inclusion in the formulary, a consumer

[51] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784602
[52] Akinlotan MA, Ferdinand AO. Emergency department visits for nontraumatic dental conditions: a systematic literature review. *J Public Health Dent*. 2020;80(4):313-326. doi:10.1111/jphd.12386
[53] https://www.aoa.org/news/clinical-eye-care/public-health/federally-qualified-health-centers-address-underserved-community-eye-care?sso=y
[54] https://www.ashp.org/-/media/assets/policy-guidelines/docs/statements/pharmacy-and-therapeutics-committee-and-formulary-system.ashx#:~:text=The%20P%26T%20committee%2C%20on%20an,and%20other%20health%20care%20experts
[55] https://www.ashp.org/-/media/assets/policy-guidelines/docs/statements/pharmacy-and-therapeutics-committee-and-formulary-system.ashx#:~:text=The%20P%26T%20committee%2C%20on%20an,and%20other%20health%20care%20experts

representative should be included as part of the P&T committee. The consumer representative will provide relief for many consumers who otherwise felt as though their voice was not heard concerning the value of different treatments and medications for patients. For example, the consumer representative will be able to represent the consumer perspective on issues and actions before the P&T committee, serve as a liaison between the committee and interested consumers and consumer organizations, and facilitate dialogue with the P&T committee on issues that affect consumers.

Including a consumer representative offers the opportunity to provide insight into real consumer experiences that P&T committees may be unaware of. In turn, this will help the committee better understand consumer challenges related to medication use and assist them in exploring solutions to these challenges during the formulary development process. Additionally, this ensures that any potential safety concerns consumers have are addressed if the medication is added to the formulary or used in the health system. NACHC also supports CMS' proposal that the consumer representative should have a background in more than one condition or disease to represent a diverse population's concerns sufficiently. Representation from someone with a clinical background who has been involved in activities related to healthcare consumer advocacy will ultimately allow consumer perspectives to be adequately represented to the fullest.

The provisions in this proposed rule will positively impact health center patients' access to high-quality, affordable health coverage and care through enhanced access to services and streamlined enrollment in coverage. We greatly appreciate the opportunity to provide comments on this proposed rule. Should you have any questions about our comments, please feel free to contact Vacheria Keys, Associate Vice President of Policy and Regulatory Affairs, at vkeys@nachc.org.

Sincerely,

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