



To: Amira Boland, Office of Management and Budget

From: Community Catalyst

Date: July 6, 2021

Re: Response to *Methods and Leading Practices for Advancing Equity and Support for Underserved Communities through Government* Request for Information

Submitted electronically via www.regulations.gov

Dear Ms. Boland:

We respectfully submit the following responses to some of the questions put forth in Areas 1-5 of the Request for Information (RFI). We deeply appreciate the Administration's commitment to advancing equity and racial justice as well as its interest in and willingness to receive input on how agencies can best demonstrate their commitment to and effectively implement Executive Order 13985, which directs the federal government to "pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized and adversely affected by persistent poverty and inequality." Our organization is similarly committed to advancing equity and racial justice and agrees that demonstrating this commitment involves a systematic approach, as well as the development of processes and policies that embed these goals within them.

Community Catalyst is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice. We partner with local, state and national advocates to leverage and build power so all people can influence decisions that affect their health. Health systems will not be accountable to people without a fully engaged and organized community. That's why we work every day to ensure people's interests are represented wherever important decisions about health and health care are made: in communities, state houses and on Capitol Hill.

At the time of this writing, the United States is only in the beginning phases of recovering from the COVID-19 pandemic, which both laid bare the structural racism found in many of our nation's policies and actions, as well as exacerbated the racial and ethnic health disparities caused by structural racism. The disproportionate impact of COVID-19 on Black, indigenous and other people of color (BIPOC) is clear evidence of past and present policy choices that have perpetuated structural racism and created and maintained racial inequity.

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We firmly believe the Biden-Harris Administration can and must start to dismantle structural racism within government policies and practices and applaud the steps they have taken so far to do so, including publishing this RFI and undoing many of the policies of the previous administration that were intended to and/or would have likely resulted in health inequities, such as its public charge test and its changes to the rules enforcing Section 1557 of the Affordable Care Act. We also deeply appreciate the steps the Administration has taken to protect the health coverage of millions of individuals and families by opening up a COVID-19 special enrollment period for the Affordable Care Act's marketplaces and defending the Affordable Care Act in *California v. Texas*. These steps, along with the recommendations we provide in our response below, are critical to advancing our vision of [health justice](#). We view health justice as having as its principal goal the establishment of health care as a basic human right, and the creation of a health system in which everyone has the opportunity to achieve the best health outcomes possible. Realizing this vision requires addressing structural injustices and disparities and ensuring the system is centered on people and grounded in the communities it serves. The movement we envision is also one that fully represents the power of all individuals and communities it serves and embodies shared values of equity and justice.

Community Catalyst has expertise working with individuals, communities and health care advocates who address barriers and burdens to accessing public health coverage programs such as Medicaid, the Affordable Care Act's marketplaces and Medicare, and therefore our responses are primarily focused on ways agencies can improve health coverage, health care and the overall health of individuals, families and communities. Additionally, some of our proposed solutions for advancing equity are actions that must be taken by Congress, and accordingly we note where this is the case and express our support for the Administration taking steps to support Congressional efforts as much as possible. Overall, our recommendations for identifying inequities, as well as for assessing and improving equity in government policies, practices and processes, are focused on meaningful community engagement with underserved individuals (using the definition of "underserved" provided in the RFI), requiring a health equity assessment in various forms of health care policy and decision-making, and removing barriers to health coverage and care that cause or contribute to health inequities, such as by making health coverage and care more affordable and improving access to providers who are known to improve health equity.

Area 1: Equity Assessments and Strategies

What are some promising methods and strategies for assessing equity, as well as identifying inequity, in internal agency practices and policies?

Meaningful Community Engagement

We believe meaningful engagement with underserved individuals and communities is the most crucial step government can take to advance equity. Meaningful community engagement is the process by which any entity with power and decision-making responsibility, such as policymakers, government officials, health insurers, plans and systems, and other leads, genuinely commits to [listening, reflecting and working together with individuals and communities](#) who have been directly affected by racism, discrimination, cultural incompetency

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and other factors that have led to inequity. We strongly believe that individuals and communities who have historically experienced inequity should be directly involved in the assessment of equity/inequities and the [development of solutions to address these inequities](#).

Meaningful community engagement involves several core values: 1) **transparency and inclusivity**, including open and welcoming communications strategies and ensuring opportunities for communication and participation are accessible to all, 2) **respect** for different cultures, including approaching collaboration with community members with humility and patience, drawing on community knowledge and power, and recognizing that communities are rich and diverse in this knowledge and power, 3) **investment of resources** and long-term commitment to relationship and power-building to ensure that individuals and communities can truly develop leadership and step into their power, and 4) **humility**, through doing more listening and less directing, addressing power imbalances, acknowledging the impact of discrimination and structural racism on individuals and communities and facing up to any harms caused by the government's past or present approach to research and policymaking.

More specific strategies for meaningful engagement can be found in our responses to questions in Area 5, below. Below are additional helpful resources on this subject.

- [Our Principles and Approaches to Consumer Engagement](#)

Require health equity assessments during agency policymaking and other decision-making

A second strategy for assessing equity and identifying inequities in health coverage and care is to require federal agencies that oversee health coverage programs to conduct a health equity assessment when issuing regulations, guidance or other forms of policymaking, as well as when deciding whether to approve or disapprove a proposed health industry transaction. A health equity assessment could require the agency to assess the impact that the proposed policy, model or transaction would have on populations who have historically or traditionally been marginalized, discriminated against and/or excluded from justice. The equity assessments should be conducted at the outset of any agency decision or process, and should be made public in order to facilitate transparency and accountability.

For example, the Centers for Medicare & Medicaid Services could conduct a health equity assessment when reviewing and approving Medicaid Section 1115 or 1915 waiver applications. Also, the Centers for Medicare & Medicaid Innovation could conduct a health equity assessment when determining whether to approve any alternative payment or value-based payment models for the Medicare and Medicaid program, and the Medicare-Medicaid Coordination Office could similarly conduct these assessments for any new integrated care programs for dually-eligible individuals. Additionally, the Internal Revenue Service could require that hospitals incorporate assessments of health equity in their community health needs assessments. The Federal Trade Commission and Justice Department could also incorporate a health equity and access assessment in their review of proposed mergers and acquisitions involving health care entities. Lastly, the federal government could take more action to require health equity as a condition of

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participation for hospitals receiving Medicare and Medicaid dollars by requiring that they meet standards of non-discrimination and health equity.

State Legislatures in both New York and Oregon have passed legislation this year designed to incorporate a health equity assessment into state regulatory review of proposed health industry transactions. New York's Health Equity Assessment bill (S.1451A) requires an independent health equity assessment of the likely impact of a merger, acquisition, downsizing, closing, new construction or change of ownership on medically-underserved individuals, including those who are low-income, uninsured, Medicaid-insured, racial or ethnic minorities, women, LGBTQ people, people with disabilities, older adults, immigrants and rural residents. The assessment must include meaningful engagement of affected people. The state Department of Health and the Public Health and Health Planning Council must take the assessment into account when deciding whether to approve, disapprove or attach conditions to approval of a transaction. Oregon's Equal Access to Care Act (House Bill 2362), which applies to transactions proposed by health entities over a certain dollar threshold of revenue, would allow the Oregon Health Authority to deny approval if the project would not address health inequities, reduce patient costs or increase access to certain reproductive health services.

How can community engagement or feedback from underserved individuals with lived expertise on a given policy problem be integrated meaningfully in an agency's use of equity assessment methods?

We firmly believe that [the people closest to any problem should also be closest to the solution](#). Specifically, we recommend that agencies integrate community feedback from the inception of equity assessment methods. It would be even more meaningful for community members to take an active role in the development, implementation and analysis of the assessment process. People most impacted by health inequities can help with asking the right questions in a survey, focus groups, etc. Additionally, we offer several best practices and strategies in our response to Area 5.

Area 2: Barrier and Burden Reduction

How can agencies address known burdens or barriers to accessing benefits programs in their assessments of benefits delivery?

The following are the types of burdens and barriers individuals experience when attempting to access or receive care from public health coverage programs such as Medicaid, Medicare and the Affordable Care Act's marketplaces, as well as our proposed solutions for addressing them based on our experience:

Provide more funding, training and technical assistance to health coverage enrollment assisters

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We recommend that the Department of Health and Human Services provide more training, technical assistance and (when possible) funding to community-based organizations and other entities that provide “consumer assistance,” or assistance with applying for public health insurance programs such as Medicaid, Medicare and the Affordable Care Act. Navigating the public benefits system, from finding out about the benefit and someone’s eligibility, to completing all of the required components of the application, to finally taking the steps needed to finalize enrollment once eligibility has been determined and/or time spent on a waiting list is completed, is an immensely overwhelming and time-consuming process for all individuals. In particular, dually eligible individuals, or individuals who are dually eligible for Medicaid and Medicare, are often faced with the daunting task of [needing to enroll in both programs](#) as well as [assess the pros/cons of different integrated care plans](#), or health plans that administer and coordinate both Medicaid and Medicare benefits. Moreover, application and enrollment processes are often not entirely accessible to many different populations and for many different reasons, ranging from language and disability access issues to cultural insensitivity and institutional racism.

To address the burdens and barriers of navigating the public benefits system, Community Catalyst firmly believes in and supports robust “consumer assistance,” or outreach, education and enrollment assistance that can be provided through grant funding from the federal government to community-based organizations and individuals (such as Navigator programs, Consumer Assistance Programs and Certified Application Counselors under the Affordable Care Act, as well as State Health Insurance Assistance Programs and various Ombudsman programs) to provide information, counseling and application/enrollment assistance for public benefits programs, including Medicaid, Medicare, integrated care plans, marketplace coverage with financial assistance, hospital financial assistance applications. Consumer assistance grants should also include trainings and technical assistance on cultural competency and implicit bias, funding to provide services in all primary languages and alternative formats, as well as training on how grantees can facilitate connections to resources that help address social needs such as food, housing and community safety.

Withdraw and disapprove restrictive health coverage eligibility and enrollment policies

Even with ideal consumer assistance, there are eligibility and enrollment policies to public benefits that by themselves serve as barriers and burdens. For public health coverage programs, Community Catalyst and our advocacy partners have long monitored and advocated against restrictive eligibility and enrollment policies that have been approved through Medicaid Section 1115 waivers, including work reporting requirements. While the Biden-Harris Administration has thankfully indicated it will no longer approve waiver applications seeking to impose work reporting requirements in Medicaid, the Supplemental Nutrition Assistance Program also contains work reporting requirements for what it deems “able bodied adults without dependents” that have impeded access to needed food and nutrition throughout states. Furthermore, many states continue to operate Medicaid Section 1115 waiver demonstrations containing burdensome cost-sharing and redetermination requirements, as well as lockouts from coverage for a certain period of time for not meeting these requirements. Our state advocacy partners worked with individuals and families who were subject to these requirements and experienced harmful gaps in health coverage and care as a result. To address these barriers and help overcome them, we

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recommend the Administration no longer approve these types of requirements in 1115 waiver applications and renewals.

There is also a federal lifetime ban on individuals with a past felony drug conviction from receiving Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF). Although Congress gave states the ability to opt-out as part of the 1996 ban, many states still bar individuals and impose onerous and costly requirements that create barriers to restoring assistance. The drug felony ban on SNAP and TANF imposed by Congress undermines efforts by individuals striving to transition successfully into the community and provide for their families. Moreover, due to our country's long legacy of racism and injustice towards Black and brown individuals through policies such as the war on drugs and immigration enforcement, 32% of the US population is represented by African Americans and Hispanics, but [56% of the US incarcerated population is represented by African Americans and Hispanics](#). Our proposed solution to address this cruel and unjust policy is for Congress to lift the ban as part of the American Jobs Plan, and we support any steps the Administration can take to support this effort.

Improve the affordability of health coverage and care, such as by:

a. Increasing financial assistance for Affordable Care Act marketplace coverage

While the Affordable Care Act (ACA) opened the door to health coverage for millions of people – many for the first time – it was only a first step to advancing a more equitable health care system. Unaffordable coverage and care remain a [widespread problem](#), continuing to disproportionately affect low-income people, especially people of color. Our country's reliance on tax-subsidized employer-sponsored insurance and our history of race-based employment discrimination, mean these groups are particularly likely to lack affordable coverage or be exposed to crippling medical debt. Congress has taken steps in the right direction. The American Rescue Plan Act (ARPA) includes some provisions to address the problem of affordability of health coverage for consumers by making significant improvements to the ACA affordability schedule and offering an important roadmap to increasing affordability, recognizing that more should be done, specifically around addressing cost-sharing as a corollary policy to the enhanced premium subsidies.

However, Congress must do more to address out-of-pocket costs, and affordability overall over the longer-term. To address affordability as a barrier to coverage, [we believe Congress should](#): 1) make the ARPA provisions permanent, including and enhanced premium subsidies along a progressive sliding scale, no premiums under 150 percent FPL and caps premium contributions to 8.5 percent of income; 2) address cost-sharing for marketplace plans by benchmarking premium subsidies to “gold”, 3) providing additional cost-sharing subsidies to individuals and families with income below 250 percent FPL, and 4) extending current cost-sharing subsidies to individuals and families with income up to 400 percent FPL.

For more information, see:

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- [Make Coverage Affordable for the Long Term](#)
- [Health Care Affordability and COVID-19](#)
- [Getting Premium Affordability Right in the ACA](#)

b. Protecting individuals from medical debt

Medical debt is also a barrier to affordable health care, arising from both aggressive billing and collections policies as well as surprise balance billing from health providers and systems. While it's increasingly become an area of concern in the United States, it's also been a [longstanding contributor too and piece of evidence of structurally racist policies](#) that have [disproportionately impacted](#) Black individuals and families and caused racial inequities in income and wealth. Nationally, [23 percent of working-age adults](#) have medical debt, and the number rises to 31 percent for Black people due to [unfair and discriminatory barriers](#) to health care. Medical debt not only impedes individuals' ability to pay for basic necessities, but it also has a lasting impact on both financial and physical health by ruining credit ratings and causing people to postpone getting the health care they need.

To address these inequities, we [recommend the following policies](#): 1) suspend medical debt collection policies during public health emergencies, including at least 60 days immediately after without accrual of fees or interest. Health care providers should also be mandated to work with consumers on forbearance and repayment options, 2) implement consumer friendly billing practices, including requiring hospitals to work with patients on determining eligibility for financial assistance and navigating financial assistance policies before invoking extraordinary collection actions, and 3) mandate hospitals to make disaggregated data on medical billing and collections publicly available. Aggressive debt collection in communities of color perpetuates systemic oppression by keeping credit scores down and deterring them from seeking health care. Publicly available disaggregated data by race and ethnicity should be mandated to create transparency on how certain communities are disproportionately affected by medical debt and the extraordinary collection actions that may result.

For more information on these topics, see the following resources:

- [Protect Consumers from Medical Debt](#)
- [Principles for Improving Community Economic Stability through Hospital Billing Policies](#)
- [Hospital Billing and Financial Practices: "First Do No Harm"](#)

c. Ensuring strong implementation of the *No Surprises Act*

A significant contributor to medical debt as well as making health care unaffordable are surprise medical bills and balance billing policies. [Surprise medical bills](#) have unfortunately become all too common. In the past two years, one in five insured Americans reported receiving at least one – usually [large](#) – surprise medical bill. [Poll](#) after [poll](#) shows surprise medical bills are what people fear most, more than they worry about prescription drug costs, premiums and other cost-sharing requirements, or other costs of goods and services (such as rent, food, utilities, and transportation).

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Fortunately, and thanks to bipartisan efforts, federal policy makers passed and signed into law the *No Surprises Act* that makes great strides in protecting consumers from the unfair and harmful practice of surprise medical billing. To continue to address the barrier and burdens of surprise billing, we recommend the Departments of Labor, Health and Human Services, and Treasury undertake a broad, well-funded education campaign to inform people of their new rights under the Act. Specifically, we urge these agencies to incorporate racial equity into the regulations, implement the law in a way that provides individuals and their families with clear, comprehensive protections against surprise bills, as well as ensure the dispute resolution process does not contribute to higher health care costs.

For more information on these topics, see the following resources:

- [Recommendations on the Implementation of the No Surprises Act](#)
- [Ending Surprise Balance Billing: Steps to Protect Patients and Reduce Excessive Health Care Costs](#)

Strengthen community engagement requirements within community health needs assessments

As mentioned earlier in our responses to questions in Area 1, government policymaking and processes need to directly involve the individuals and communities who will be most impacted by the policy or process, both in the identification of the problems that the policy/process is intended to solve, as well as the development of solutions to address the problem. However, due to lack of knowledge, skills, resources or willingness, sometimes health care policymakers, providers, insurers and systems do not always meaningfully engage with individuals and communities, which can then lead to barriers and burdens in accessing health care.

Specifically, the Administration could do more to [strengthen community engagement requirements](#) within community health needs assessments for hospitals. Under [federal law](#), nonprofit hospitals are required to provide community benefits in order to maintain their tax-exempt status. To help guide their investments, they must conduct a community health needs assessment every three years and develop an implementation strategy that responds to identified needs. However, there is little regulation on the extent to which community members must be involved in this process. Furthermore, while hospitals may identify health disparities in their communities, surprisingly few devote resources to address them. Therefore, we believe the Biden Administration can take further action.

For more information, see the following resource:

- [Hospital Community Benefit Dashboard – Advancing Health Equity and Community Engagement](#)

Assess the impacts that health system mergers and acquisitions have on health equity and provider access

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Another significant barrier to health coverage and care are the mergers of hospitals and health systems as well as the acquisition of private provider practices, which can often lead to individuals: 1) losing access to their providers as a result of changing provider networks, 2) experiencing geographic barriers to care as the result of closures or consolidations, and/or 3) experiencing other restrictions on care as the result of changing policies or practices. To address these barriers, we recommend the Federal Trade Commission and Justice Department assess the impact on equity and access to care when reviewing these mergers and acquisitions, both horizontal consolidations as well as vertical integrations. Specifically, and as mentioned above, we recommend the FTC review its merger and acquisition oversight standards and incorporate a health equity and access assessment in its review of these transactions.

Promulgate stronger provider network adequacy standards

Many Medicaid enrollees struggle to find access to primary care physicians, dental providers, specialists and other health care providers in private practices, in part because many providers do not accept Medicaid. Moreover, and as explained in the section below, Medicaid enrollees also experience difficulty accessing providers who are reflective and representative of the communities they serve, despite evidence that providers from these communities are more effective in improving overall health because of their ability to form relationships with, share lived experiences with and provide culturally appropriate services to enrollees. In addition, we note that some of the largest private non-profit health systems in the nation have policy-based exclusions of certain reproductive services and of gender-affirming care, causing unexpected denials of care and forcing enrollees to search for alternative providers or go without needed care. We therefore recommend that federal health agencies, and in particular the Centers for Medicare and Medicaid Services, assess the adequacy of provider networks and impose stronger network adequacy standards (e.g., time, distance and availability of comprehensive reproductive and LGBTQ-inclusive care) for access to multiple types of providers, including dental therapists, home care and direct care workers, doula and peer support specialists. In addition, CMS should assess the demographic representativeness of its provider networks for all public health care programs to improve the lack of representation of underserved communities.

Fund initiatives to increase the amount of health care providers of color

[Racial concordance](#) between patients and their providers has been shown to substantially contribute to the health and well-being of individuals and families. However, it is unfortunately not currently possible in the United States for Black and African American individuals specifically, due to our country's long history of racism and oppression towards these individuals that has contributed to the [underrepresentation](#) of Black providers in the U.S. healthcare workforce. Similarly, only about [4% of all U.S. dentists are Black](#), even though Black people make up about 12% of the U.S. population. Tribal communities and other people of color are [also underrepresented](#) in the dental workforce. To address this barrier to health, we recommend providing funding and support for workforce development and health professions trainings, as well as prioritizing [training and recruitment](#) of individuals from underserved communities as a

way to ensure that the health care provider workforce reflects the demographic makeup of the communities they serve.

For more information, see the following resource:

- [Congress Must Respond to Deep Health Inequities for Black People During COVID-19: Medicaid is the Lever](#)

Support efforts to expand eligibility for health coverage, such as by:

- **Closing the Medicaid coverage gap**

Twelve states continue to deny their low-income residents access to health care coverage by not adopting Medicaid expansion. As a result, 1.8 million low-income adults who would otherwise be eligible for Medicaid under Medicaid expansion are struggling to maintain their health care coverage with high premiums and out-of-pocket costs, while 2.2 million low-income adults remain without coverage entirely. These state decisions compound racial health disparities, as 60% of those in the coverage gap are people of color. While we have seen and appreciate the Administration's commitment to closing the Medicaid coverage gap through unprecedented incentives in the American Rescue Plan Act (ARPA), it is clear that political leaders in non-expansion states will continue to prioritize partisan and racist motives over the health of their constituents. As such, we urge Congress to pursue a Medicaid-like federal direct coverage option that would allow the federal government to provide Medicaid-like coverage with its demonstrated benefits directly to low-income residents in non-expansion states

- **Lifting the 5-year bar to Medicaid coverage for certain immigrants**

Access to health care for immigrants and their families has been undermined for decades due to arbitrary barriers to health care such as the five-year bar. Lawfully present nonelderly immigrants represent nearly a quarter of the nonelderly uninsured population with an estimated uninsured rate of 23%. [Immigrants](#) and their families have few options for affordable health care options during the five-year bar that often result in delayed, costly and fragmented care as a result of limited services at community health centers and high out-of-pocket costs associated with private health insurance. The five-year bar also causes confusion among mixed-status families and public benefit agency workers due to varying immigrant and citizenship statuses different family members may hold and varying eligibility requirements from state-to-state and from program-to-program. As such, our recommendation is for Congress to remove the five-year waiting period for Medicaid, CHIP, and all other federally-funded programs subject to the bar.

- **Providing clarifying information on the current status of the public charge rule**

The 2019 proposed public charge rule has further disincentivized [immigrants](#) and their families from seeking health care for fear and confusion of becoming a "public charge." Despite the fact that the proposed public charge rule is currently blocked, it has had a lasting impact on immigrant communities' comfort in seeking health care. Our recommendation is for the Administration to create strong, clear, consistent and accessible messaging for public benefit agencies to utilize and that can be distributed to community-based organizations to break down fears and confusion among immigrant communities and public benefit agency employees.

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Enact administrative policies to reduce churn, such as by:

Another barrier to health coverage is churn, or an individual's transition between forms of health coverage or on and off of health coverage. Individuals can churn on and off of coverage due to not meeting burdensome Medicaid application or eligibility requirements, including onerous paperwork requirements to verify identity or income or meet frequent redetermination requirements. Additionally, individuals may experience changes in life circumstances or income that can cause them to move into the Medicaid coverage gap, or from Medicaid coverage to marketplace coverage, but individuals may not know about or be able to complete the requirements needed to successfully and smoothly transition. Policies such as ex parte renewals and No Wrong Door systems and approaches can help protect against these often arbitrary and unnecessary churns that can lead to care disruptions and worse health.

a. Approving Medicaid Section 1115 waivers seeking continuous eligibility

The issue of churn could also be resolved with policies like continuous eligibility, a policy already instituted by 27 states for children in CHIP and by 25 states for children in Medicaid. Self-employment, seasonal work, unpredictable work schedules, and growth in contracting and temporary work arrangements all contribute to variable monthly income amounts that can exceed the monthly income threshold for Medicaid for any given month. Continuous eligibility allows beneficiaries to maintain their Medicaid coverage for 12 months regardless of monthly income changes. With [70 to 80 percent](#) of parents with young children working in hourly jobs with fluctuating hours, this could have a profound impact on both parents and children as evidence suggests that when parents are insured, [children are more likely to be insured](#). Continuous eligibility for children has been shown to promote continuity of coverage. Therefore, the Administration can encourage or approve Medicaid Section 1115 waivers that include continuous eligibility, and Congress should promote this same stability in coverage for adults as well by incentivizing states to extend this policy to adults.

b. Requiring a six-month “Medicaid deeming period” for integrated care plans

Dually-eligible individuals may churn on and off of integrated care plans, such as Medicare-Medicaid plans offered under the Financial Alignment Initiative of the Affordable Care Act, because Medicaid has stricter or more frequent redetermination requirements than Medicare. Requiring a uniform “Medicaid deeming policy” of about six months for all integrated care plans, which allows health plans to consider a dually-eligible as currently enrolled in Medicaid while they're taking steps to maintain their eligibility and renew their coverage, would help these individuals stay enrolled in integrated coverage. Additionally, HHS could designate, and [provide training and technical assistance to community-based organizations to provide information, counseling and application assistance to dually-eligible individuals about all of their integrated care plans](#).

c. Supporting Medicaid coverage for individuals undergoing re-entry

Individuals may also churn on and off Medicaid coverage as a result of becoming incarcerated. By law, Medicaid cannot cover services provided to people while they are in jail or prison, with the exception of inpatient hospital stays provided outside of carceral settings. This prohibition,

known as the [inmate exclusion policy](#), was established in 1965, when Congress first authorized Medicaid, to prevent cost-shifting from state and local governments to the federal government.

The inmate exclusion policy thus creates discontinuities in care for Medicaid beneficiaries as they lose Medicaid coverage during incarceration. Insufficient coordination between corrections providers and community providers frequently interrupts the services, medications, and treatments that individuals were receiving prior to detention. It also creates disruptions at release that make it difficult for people to obtain services that can support successful reentry and reduce recidivism.

To address this barrier to coverage, we support the Medicaid Re-entry Act and its passage as part of the American Jobs Act, which would change the Medicaid payment restrictions currently in place for incarcerated individuals to allow for Medicaid coverage for those eligible during the 30 days before release from incarceration. Starting health insurance pre-release ensures that individuals have coverage during their reentry to the community. This makes it easier for them to connect to health and social services they need in the 30 days before release, and after release, without delay. Health care is one of many obstacles during the reentry period as individuals are also trying to find a place to live, get a job, and reconnect with loved ones. By making sure people have health insurance upon release, formerly incarcerated individuals have one less barrier they need to deal with, making the entire reentry process more successful. Continuous health coverage is especially important for incarcerated individuals with substance use disorders, who are at increased risk of overdose upon release. People reentering the community are [129 times](#) more likely to die of an overdose than the general population, as many incarcerated people have a substance use disorder and are forced into withdrawal while in prison. If more people were able to have continuous health coverage and access to life-saving addiction treatment through Medicaid during reentry, fewer people would die. Reducing Medicaid eligibility churn during reentry would help with continuity of care, more successful reentry, and saving lives by increasing access to health services.

d. Approving Medicaid Section 1115 waivers seeking to extend postpartum coverage

Another type of churn that individuals experience with Medicaid coverage is with postpartum coverage, which currently is only required to be 60 days under federal law. The [Medicaid and CHIP Payment and Access Commission recently recommended](#) that Congress extend Medicaid postpartum coverage to one year, however, which could dramatically and equitably improve maternal mortality rates, as it means that postpartum people would have access to Medicaid coverage and services for their postpartum health issues across the entirety of that period. We support the Administration approving Medicaid Section 1115 waivers that propose extending postpartum coverage to one year.

For more information, see:

- [Health Insurance Churn: The Basics](#)

Provide training, funding and technical assistance to health care providers on offering culturally competent, appropriate and respectful care

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Especially given the structural racism that has led to difficulties in achieving racial concordance between patients and their providers, it's [vital to train providers in providing culturally respectful, appropriate and competent care](#). Defining what “culturally appropriate” is should involve meaningful community engagement and use the practice of cultural translation as described below. Not receiving this type of care is a harmful and unjust barrier to health. Cultural competency is also desperately needed to ensure that LGBTQ+ patients are not shamed, stigmatized or denied medically-indicated care, and instead treated with respect, dignity and awareness of their particular health needs. We therefore recommend that HHS provide ongoing training, funding and technical assistance to providers and health systems who accept federal funding on how to provide culturally competent, appropriate and respectful care.

Provide parity in financing between the states and territories such as Puerto Rico

Currently, Puerto Rico's Medicaid program is financed differently than the states. While each state receives open-ended funding based on a Federal Medical Assistance Percentage, Puerto Rico's Medicaid is capped at a certain amount, which [severely prevented it from being able to respond](#) in the ways it needed to economic downturns, public health emergencies like the Zika outbreak and the COVID-19 pandemic, and natural disasters like Hurricane Maria and earthquakes. To address the health disparities that this limited and unequal funding has caused, we recommend that Congress provide parity in funding for all Medicaid programs.

What data, tools, or evidence are available to show how particular underserved communities or populations disproportionately encounter these barriers?

There are certain types of data that we feel are particularly effective in demonstrating how underserved populations experience injustice from the health care system. Having a standardized way for health care providers and systems to collect self-reported race, ethnicity and language (REL) and sexual orientation/gender identity (SOGI) data from underserved communities and populations themselves can be an important step towards allowing policymakers and health systems to better understand structural racism and its impacts, as well as better identify health disparities and work towards addressing them. However, it important to recognize that REL and SOGI data by themselves will not solve health inequities. Rather, this type of data collection is a core component in a [broader strategy to achieve health equity](#) in the health care system and can provide key information to shape other work to address equity. Additionally, any time data is collected on the government's behalf, the government should be sure to be mindful of its history of traumatizing communities of color when collecting their data and using their data in oppressive, harmful ways, as well as the fears among some LGBTQ people of providing personal information that could expose them to physical harm, harassment and other traumatic experiences. To promote transparency, inclusivity and equity in its data collection, the government should actively involve the individuals who provided their data in the development of recommendations and solutions for addressing any inequities that their data helped uncover.

What types of metrics might be used to measure outcomes?

We recommend that federal agencies measure the outcomes, performance or effectiveness of a particular program or policy by using metrics that individuals and communities who will be impacted by the program or policy have identified as important to them. Too often, community

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members are excluded from important policy decisions that affect their lives, including what outcomes certain policies, processes or programs are intended to achieve and how those outcomes are measured. As a result, research or policy proposals aren't focused on what matters most to people, resulting in services that aren't always responsive to individuals' needs and don't achieve the best results. Community Catalyst believes strongly in centering the lived experiences and power of individuals and communities in the development and measurement of outcomes of research, policymaking and service delivery and using the metrics that individuals and communities have identified as important to them.

For more information on this topic and how to improve the quality of health services based on the outcomes prioritized by community members, see [Peers Speak Out](#).

For public health programs like Medicaid and Medicare, we recommend federal health agencies use metrics that assess the appropriateness of care and avoidance of adverse outcomes, such as the management of chronic conditions as well as incidence of emergency department visits for and receipt of follow-up care after presentation in hospital emergency rooms. The Centers for Medicare and Medicaid Services could also [incorporate equity and patient experience into its definition of "value"](#) so that impact on health disparities and structural determinants of health can be included as a goal, in addition to improved quality and lower cost.

Area 3: Procurement and Contracting

How do we achieve equity in a procurement system that must balance competing economic and social goals, including the need to conduct procurements in a streamlined and rapid manner?

To achieve equity through the procurement process, we recommend the federal government take into consideration whether vendors are committed to diversity, equity and inclusion and have demonstrated that commitment in some way, such as whether their leadership is diverse in membership or ownership. The procurement process should ensure that it includes a representative review of diverse applications, and provide more of an opportunity to small businesses to apply and compete.

Area 4: Financial Assistance

What are promising practices for equitable grantmaking and the administration of financial assistance programs that agencies should consider in the course of their equity assessments?

We recommend agencies carefully review and reconsider grant application requirements that may have elements of institutional or structural racism embedded into them, such as requirements for which certain levels or degrees of education may be necessary, or that may require certain amounts of financial resources, such as having a grant writer available to complete grant applications. The government could address these types of application requirements by considering verbal applications rather than written, for example. Additionally, the federal government should assess which types of databases are considered legitimate for research that certain grant programs may require, as these databases may also be embedded with

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or reflective of forms of institutional racism (such as being primarily funded or operated by white-led institutions of higher learning). The government could also make the application process more accessible and equitable by providing more training and technical assistance to community-based organizations around how to apply for federal grants.

Area 5: Stakeholder and Community Engagement

What processes should agencies have in place to engage proactively with the underserved individuals and communities that will be most affected by agency programs, policies, rules, processes, or operations?

As mentioned in our responses to Area 1, we believe meaningful consumer engagement is the key process for engaging proactively with underserved communities that will be most affected by agency programs, rules, processes and operations. In addition to the values we listed above, we also believe meaningful engagement needs to be accompanied by a willingness to shift the balance of power, to validate the experience, expertise and value of community members, and to acknowledge the painful historical legacies of discrimination and exploitation by the health care system. These efforts require a commitment to act on community recommendations that will require investing resources, shifting priorities and ceding power. Our team has over the years delved deeply into how to authentically engage patients, families and communities, and offer resources to assist in this effort.

For more information, see:

- Our [Change Package](#)
- [Meaningful Consumer Engagement in Pre-Arrest Diversion Programs](#)

How can agencies design and implement community engagement practices that are accessible to underserved communities? How might affected communities be engaged pro-actively and early to shape agency policy priorities and strategies?

Cultural Translation

Affected communities can be engaged proactively through intentional relationship-building, active listening, meaningful and ongoing engagement, and shared decision-making in identification of problems and development of solutions. The practice of [Cultural Translation](#), a concept created by the [Cultural Wellness Center](#), is also a critical part of meaningful community engagement, and is the key to achieving building intentional, long-term relationships with community members, with a focus on the values and skills such as cultural competency, cultural agility and cultural humility. The overall goal of Cultural Translation is to provide a brave and welcoming place from which individuals can both share knowledge as well as use collective knowledge to assess equity and develop solutions to addressing it.

Cultural Translation acknowledges that achieving equity is not just a learning process but is one that requires skill development. Although many policymakers, government officials and other leaders may be familiar with the theories of diversity, racial equity and inclusion, these theories

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often fail to include the practice of translating culture. With Cultural Translation, many individuals, organizations and systems and in positions of privilege and power can move from theory to practice with the understanding that while theoretical knowledge is important, we want to shift towards practicing, building, understanding, and working together.

Creating accessible, inclusive and effective community forums

Overall, making community engagement practices accessible involves ensuring that any forum or opportunity for community members to provide input and feedback are conducted in welcoming, inclusive and respectful ways, such as:

- Ensuring that meetings are held at times that can accommodate work, caregiving or services/support needs for community members
- If meetings are held in a physical location, ensuring those spaces are physically accessible, accessible via multiple forms of transportation and provide all necessary reasonable accommodations
- Compensating individuals for their time
- Providing a way for meeting attendees to be able to communicate with each other outside of the meetings
- Ensuring that meeting information is available in the languages spoken and alternative formats used by meeting attendees
- Not using identification policies (such as requiring meeting participants to show a driver's license or other government ID) that could discourage participation from some groups of people, such as undocumented immigrants or people whose official documents do not yet match their gender

Agencies that we have partnered with have found that Community Resident Councils are an especially effective and a meaningful way to engage community members most impacted by health inequities

For more information, see:

- [Consumer and Community Engagement Tip Sheet](#)
- [Supporting Meaningful Consumer Engagement through Consumer Advisory Councils](#)
- [Meaningful Consumer Engagement Toolkit](#)
- [Lift Up Your Voice! Advocacy Training](#)

What tools and best practices might agencies deploy to establish advisory boards, task forces, and commissions that are inclusive of underserved communities?

- [Consumer Engagement in Medicaid Accountable Care Organizations](#)
- Our [Consumer Engagement Hub](#)

Thank you again for your consideration.

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Respectfully submitted,

A handwritten signature in black ink, appearing to read "Emily Stewart". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Emily Stewart
Executive Director
Community Catalyst

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