May 6, 2013

SUBMITTED VIA ELECTRONIC TRANSMISSION

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Mail Stop C4-26-05

7500 Security Boulevard

Baltimore, MD 20144-1850

Attention: **CMS-9955-P**

**Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel**

Dear Sir/Madam:

Thank you for the opportunity to comment on CMS–9955–P, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel” (hereinafter referred to as “the proposed rule”).

The Center for Children and Families is based at Georgetown University’s Health Policy Institute with the mission of improving access to health care coverage among the nation’s children, particularly those in low-income families. As such, we have a long history of conducting analysis, research and advocacy on issues relating to children’s enrollment in Medicaid, CHIP and other health insurance programs.

We are including detailed comments on the proposed rule below. However, to start, we wanted to address HHS’ request for public comments on the number of navigator grantees or the number of non-Navigator assistance personnel and project leads expected, as well as the number of consumers expected to receive assistance.

***Consumer assistance funding in states accessing only federal navigator grant allocations is strikingly inadequate.***

Information is just beginning to emerge from the states with state based (SBE) or consumer partnership (SPE) exchanges relative to their projections for the number of navigators and assisters needed in 2014. California expects to assist 1,090,258 people in accessing coverage in 2014 with an estimated $57.9 million paid to 25,000 navigators and assisters. In New York, 560,000 are expected to enroll in the individual exchange, and the state will spend $27.2 million annually on consumer assistance for the next five years. Contrast that to Texas, the state getting the largest share (15%) of the federal navigator pie ($8.1 million of $54 million), where 7.35 million are uninsured of which the Urban Institute estimates a reduction of 2.5 million if the state does not expand Medicaid and 3.8 million if Medicaid is expanded.

Looking at smaller states, New Hampshire anticipates spending more than $2 million to serve 83,500 and will receive another $600,000 for navigators, while Vermont will spend $2 million on navigators and assisters and expects to enroll 266,500. Contrast that to Kansas, where 336,885 people are uninsured and Urban estimates an 80,000 reduction in the uninsured; the state will receive only $600,000 for federal navigators.

These examples illustrate that the assistance resources in states that are able to tap 1311(a) funds for in-person assistance (state-based and consumer partnership exchange states) is strikingly different than states where only federal navigator grants are available. It is critical that HHS identify additional resources to fund navigators in this first critical year of exchange coverage.

As additional states reveal the details of their consumer assistance numbers, HHS should be able to glean a formula for projecting the number of navigators and project leads needed based on 1) the number of uninsured, 2) the percentage expected to enroll in the first year, 3) the average number of individuals on each application, 4) the proportion that will need or want assistance, 5) the period of time for open enrollment and 6) the average number of applications a navigator might assist given their other duties, including conducting outreach and public education. Such a formula could include a range of projections but would quickly reveal that the level of funding for federal navigator grants is strikingly inadequate to meet the needs of consumers for enrollment assistance. Given that fact, we would like to highlight in this cover letter several other ways to strengthen the navigator and non-navigator assistance program.

***There are several steps HHS can take to better support and strengthen the availability of assistance:***

1. ***Allow section 1311(a) funds to be used to provide consumer assistance in full FFE states:*** We appreciate the clarification that section 1311(a) exchange establishment grants can be used to support the cost of navigator training, grants management and oversight in SBE states. As a transition policy, HHS is allowing an SBE to delay the implementation of its state-funded navigator program until it is self-sustaining at the end of its initial year of operation. Section 1311(a) funds can be used in the interim to fill any gaps in its navigator program and ensure that the full range of services that the navigator program will provide in subsequent years are available during the initial year. Likewise section 1311(a) funds can be used in consumer assistance partnership exchanges to supplement the limited amount of funding that will support navigators in 34 states with a federally facilitated (FFE) or SPE exchange.

HHS has not indicated that section 1311(a) funds can be tapped by states with an FFE to supplement the navigator funding. Yet, such funds have been made available to several FFE states (OH, NE, KS and MT) to conduct marketplace plan management functions, and recently HHS announced that 1311(a) funds can be used for marketing and outreach with specific conditions. The Secretary’s Q&A on exchanges, market reforms and Medicaid dated December 10, 2012 suggests that it is permissible to more broadly use 1311(a) funds in FFE states. It outlines in the answer to question 9, that states may choose to seek section 1311(a) exchange establishment funding for "activities necessary to support the effective operations of a federally-facilitated exchange." Additionally, the CCIIO Q&A dated February 20, 2012 indicates that states can use 1311(a) funding for evaluation of plan management activities without submitting an exchange blueprint. Extending this funding to consumer assistance activities, including in-person assistance, necessary to support the FFE would extend the capacity of states with an FFE to assist consumers.

1. ***Clarify how private support can leverage federal Medicaid matching funds to provide enrollment assistance.*** HHS has indicated that state navigator funds can be eligible for Medicaid match. Recently, the California Endowment pledged millions of dollars to support Medicaid enrollment and retention that will leverage federal Medicaid match. It would be helpful for HHS to clearly articulate the circumstances and process for private funds to qualify for federal Medicaid match.
2. ***Establish a dedicated technical assistance unit and helpline in the FFE to support navigators and assisters:*** Highly skilled and knowledgeable eligibility, enrollment and system experts are needed to appropriately support the work of navigators and assisters who uncover more complex issues and barriers to coverage, or who are helping a consumer resolve an eligibility problem. Providing an adequate level of easily accessible expert technical assistance is considered a best practice in Medicaid, and Medicare counselors have identified the dedicated counselor line as one of the most important tools they use to assist consumers. Providing access to expert staff who have the ability to resolve eligibility issues has proven to add value by reducing consumer calls to the call center, providing an effective loopback mechanism to pinpoint system issues and other recurring problems, and identifying gaps in training.
3. ***Establish a web-portal with enhanced functionality for navigators and assisters.*** An enhanced portal goes beyond tracking applications by assister. It would allow assisters to check the status of applications and enrollment and provide other functionality such as reporting the birth of a child or other changes in circumstances or checking the status of needed verifications. It could also facilitate reporting of problems directly associated with a specific application or account that would provide a more effective and efficient means of identifying and troubleshooting problems. A dedicated portal for assisters provides a key consumer protection by clearly identifying when data and other changes are submitted by assisters rather than consumers themselves. Otherwise, there is the likelihood that assisters will access consumer accounts on their behalf, effectively “impersonating” individuals, which should be avoided.
4. ***Provide key resources needed by navigators through the FFE so that limited navigator grants can be dedicated to direct consumer assistance.*** Specifically, the FFE call center will rely on language translation services to supplement bi- or multi-lingual staff. Such services should be directly available to federal navigators so that their grants can be used to provide a higher level of direct services. Furthermore, access to assistive technologies to help individuals with disabilities, including sensory impairments, should be made available. Pooling the purchasing power of the federal government will make these key services more cost-effective and enable federal navigators to use their limited grant funds for personnel to provide direct assistance.
5. ***Release final regulations regarding certified application counselors (CACs) as soon as possible and clarify that states are not prohibited from funding CACs.*** In states where only an FFE will operate, certified application counselors will be a key resource for consumers needing assistance. The sooner the regulations are finalized, the sooner states can begin the implementation process. We also believe that states should not be barred from providing much needed resources to community-based organizations and safety-net providers that can help fill the assistance gap as suggested by proposed regulations released on January 12, 2013. Those proposed rules pointed out that the difference between CACs and navigators and brokers is that CACs are not funded by the exchange, either through grants or directly. While we understand that HHS is not offering the use of federal funds under section 1311(a) of the ACA or otherwise, we believe clarification will ensure that states have the flexibility to fund CACs.

**Detailed comments on requests for information and the proposed regulations:**

We acknowledge the comments in the NPRM preamble that state-based exchanges and state partners in consumer partnership exchanges may use section 1311(a) exchange establishment grants to fund non-navigator assistance programs consistent with the following discussion. Furthermore, as long as section 1311 funds are available to states, a state-based exchange is not required to be self-sustaining in the first year of operation. Thus, as a transitional policy and to ensure that the full range of navigator services is available in the initial year of operation, a state-based exchange may use a non-navigator (in-person assister) assistance program to supplement or substitute for its navigator program. It is important these states use the initial year of operation to develop a transition plan to ensure adequate availability of navigators to meet the need for consumer assistance in 2015 and beyond. In doing so, it is advantageous to build on the experience of the non-navigator entities and assisters rather than create new programs from scratch.

**Recommendation: Require states using section 1311 funds for non-navigator assisters to develop a plan that transitions their 1311 funded assistance programs into fully functioning navigator programs.**

**§155.210 Navigator program standards.**

We appreciate that the proposed rule clarifies that state licensing, certification and other standards prescribed by the state or exchange must not prevent the application of the provisions of Title I of the Affordable Care Act, including the navigator program. It will be critical for HHS to monitor state requirements to ensure that they do not impede Navigators’ ability to perform all of the functions required of them under the law, including helping people through the entire eligibility process, facilitating the consumer’s selection of an exchange plan and assisting with enrollment. In addition, we agree that any state licensing or certification program for navigators should not prevent at least two different types of entities from serving in this capacity, including at least one entity that is a community and consumer-focused non-profit group. In order to encourage the largest pool of navigator applicants, it is urgent that HHS reassures prospective navigators that the agency will intervene when necessary so navigators and assisters are not caught in the middle of any potential conflict between federal and state standards.

**Recommendation: Assure prospective navigator applicants and actively monitor, and intervene as necessary, when state licensing, certification and other requirements interfere with navigators’ ability to fulfill all of their legal responsibilities.**

**§155.215(a) Conflict of interest standards.**

We support the inclusion of stop loss insurance issuers among the types of entities that are prohibited from serving as navigators, as well as prohibiting navigators from receiving consideration directly or indirectly from stop loss insurers for enrollment in a QHP or non-QHP. We also support the clarification that receiving consideration from a health plan or stop loss insurance issuer includes trailer commissions. The role of navigators is to provide consumer assistance through the entire eligibility and enrollment process, including facilitating plan selection. Thus, receiving referral fees from insurance brokers and agents should also be prohibited.

**Recommendation: Amend §155.215(a)(1)(i)(D) and §155.215(a)(2)(ii)(D) to as follows: “Will not receive any consideration directly or indirectly from any health insurance issuer, any issuer of stop loss insurance, or any licensed insurance agent or broker in connection with enrollment or referrals for enrollment of any individuals or employees in a QHP or non-QHP.”**

The preamble to the NPRM requests comments on whether the conflict of interest standards should be applied to certified application counselors CACs. We support this. However, if it is determined that the full set of standards should not be applied, we strongly urge HHS to minimally apply the standards prohibiting receipt of consideration for enrollment (as amended above), requiring assisters to provide information on the full range of QHPs and requiring CACs to make specific disclosures to the exchange and consumers. That said, we also recognize that consumers may not fully understand the implications of disclosed relationships. [A study at Georgetown University](http://www.georgetown.edu/news/sunita-sah-conflicts-of-interest.html), “The Burden of Disclosure: Increased Compliance with Distrusted Advice,” published in the [*Journal of Personality and Social Psychology*](http://psycnet.apa.org/journals/psp/104/2/289/) suggests that consumers may be influenced by disclosures in a negative way. Advisees who received disclosure were aware that the advice may be biased and trusted it less. Yet they also were more likely to comply with their advisor’s recommendation and be less satisfied with their choice. Thus, it will be important for this phenomenon to be explored in FFE monitoring.

**Recommendation: Extend the conflict of interest standards at §155.215(a)(1) or §155.215(a)(2) (as amended above) to certified application counselors.**

**Alternative recommendation: HHS to minimally apply the standards at 1) §155.215(a)(1)(i)(D) and §155.215(a)(2)(ii)(D) (as amended above) relating to prohibition on receiving consideration for enrollment, 2) at §155.215(a)(1)(iii) and §155.215(a)(2)(D)(iv) requiring that assisters provide information on the full range of QHPs and 3) at §155.215(a)(1)(iv) and §155.215(a)(2)(v) regarding disclosure to the exchange and consumers.**

**§155.215(b) Training standards for Navigators and Non-Navigator Assistance Personnel carrying out consumer assistance functions.**

We generally support the certification and annual re-certification standards at

§155.215(b)(1) for navigators and non-navigator assistance personnel. We believe that state-based exchanges (SBE) and state consumer partnership exchanges (SPE) may wish to create and administer their own training programs and therefore support that the proposed regulations allow SBEs and SPEs to do so. We encourage HHS to release further guidance and provide an opportunity for comment on the criteria that will be used to receive HHS approval for state-based training.

§155.215(b)(1)(iv) requires continuing education and recertification, at least on an annual basis. We support these provisions. We also believe that continuing education should include routine opportunities for the exchange of information between the FFE and navigators and assisters, as well as the sharing of best practices among all assister types. Such forums should actively promote two-communications and networking among assisters, and serve as a key loopback mechanism that enables HHS to assess how outreach, marketing, communications, systems, eligibility and enrollment procedures and virtually all aspects of FFE operations and access to the coverage continuum is working on the ground level for real people. This type of feedback has proven to play a critical role in pinpointing systemic and recurring problems and identifying opportunities for quality improvement over time.

**Recommendation: Ongoing education should include routine opportunities for exchange of information, sharing of best practices and expertise, and feedback from the field through regular conference calls, webinars and face-to-face meetings.**

§155.215(b)(1)(v) indicates that navigators and non-navigator assistance personnel be prepared to serve both the individual exchange and SHOP. We believe this will limit the pool of applicants for navigator grants and disagree with CCIIO’s interpretation of the law and subsequent regulations. The preamble of the latest proposed rule indicates HHS has “inferred” from ACA section 1311(i)(2)(B), which states an entity must demonstrate it has existing relationships, or could readily establish relationships, with employers and employees and the inclusion of Small Business Administration resource partners among entities that are eligible for navigator grants, that navigators must serve both exchanges. We agree that the ACA requires there to be navigators serving the SHOP. We also acknowledge the law requires SHOP navigators and that small employers, particularly those that are minority owned, may be best served by navigators who can provide culturally and linguistically competent services. A particularly large proportion of SHOP participants will be immigrant employers and employees, as many immigrants are small business owners and are employed by small businesses. Many of these individuals are limited-English proficient (LEP), and live in mixed-status families that include eligible and ineligible household members, thus the SHOP presents an opportunity for many immigrant workers and entrepreneurs and their families to obtain affordable coverage.

However, we do not agree that all navigators, as well as all non-navigator assisters (as the training standards also apply to them), should be required to serve both exchanges. Both the ACA and navigator regulations finalized on March 23, 2012 state that to be eligible to receive a grant under paragraph (1), an entity shall demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), ***or*** self-employed individuals likely to be qualified to enroll in a qualified health plan. The use of “or” rather than “and” could also be inferred to mean that eligible navigators must have one or more, but not all, of the relationships noted. Thus, we urge you to reconsider this provision. We believe there is still time to update the federal funding opportunity announcement that parallels this proposed rule to give priority to applicants that indicate they will serve both exchanges but eliminate the requirement that all applicants must serve both exchanges.

**Recommendation: Strike the provision at §155.215(b)(1)(v) but ensure that navigator resources are available to assist eligible employers in the SHOP throughout each state.**

**§ 155.215(b)(2) Training module content standards.**

It appears that the range of training topics listed in § 155.215(b)(2)(i) – (xv) largely incorporates the broad content that is needed to ensure that navigators and other assisters have the training and skills necessary to provide reliable, effective assistance to consumers. We urge HHS to work with knowledgeable stakeholders to review and comment on more detailed training materials in order to ensure that all the critical content areas and best practices are incorporated.

**Recommendation: Provide an opportunity for stakeholders to review and comment on detailed training materials in order to ensure that the most comprehensive content and best practices are incorporated.**

§155.215(b)(2)(i) describes the type of QHP information that will be included in the training. It is important that the training emphasize the requirement that navigators and non-navigator assistance personnel provide information on the full range of QHPs and be trained on the importance of providing guidance on factors to consider in choosing a plan without recommending a specific plan.

In regard to QHP information, issues regarding pediatric dental benefits, which are essential for children’s healthy development, may be especially complex. Having expertise in QHPs must include a clear understanding of the impact of stand-alone dental plans on accessing pediatric dental benefits, premium tax credits and consumer protections.

Additionally, this section of training should include the process for referring appeals, complaints and grievances to state health ombudsman or consumer assistance programs (CAPs), and how to ensure a successful handoff.

**Recommendation: Ensure that training includes a thorough understanding of the implications of pediatric dental benefits accessed through stand-alone plans.**

**Recommendation: Ensure that the training incorporates how to make effective referrals to other consumer assistance programs for grievances and complaints.**

§155.215(b)(2)(ii) addresses training on the range of insurance affordability programs. The duties of navigators require that they maintain expertise in eligibility, enrollment and program specifications for all of the insurance affordability programs. Yet, it is not clear to what extent state-specific content, such as Medicaid and CHIP eligibility levels or eligibility and enrollment requirements in states that will not be using the FFE to make Medicaid determinations, will be included in the training. While we appreciate the challenges and time constraints in developing 34 versions of the training for each of the FFE states, it is very important that training include state-specific content so that navigators can fulfill their duty to assist with all coverage options. We note that Medicaid and CHIP eligibility levels and state verification requirements will be available to HHS through the Centers for Medicaid and CHIP Services. These resources should be used to provide state-by-state details on eligibility levels and procedures that should be included in navigator resource materials and linked in the web-based training.

**Recommendation: Compile state-by-state data on final MAGI-equivalence levels for Medicaid and CHIP and use state verification plans to detail enrollment procedures as resources for navigators and non-navigator assisters to ensure they have expertise in Medicaid and CHIP eligibility, enrollment and program specifications.**

By definition, certain members of mixed-status families will not be eligible for the Exchange, Medicaid, or CHIP. Research has shown that when some in the family cannot access health care, others in the family are less likely to use medical coverage or services for which they may be eligible. It is vital that navigators be able to connect uninsured family members to coverage and care. If navigators fail to provide effective help to the uninsured, an important opportunity will be lost to improve the health and well being of vulnerable, hard to reach families. An invaluable resource in this regard would be the development of post-ACA fact sheets or guidance with detailed information about safety net providers and services that are convenient and open to all, regardless of immigration status, including Medicaid emergency services.

**Recommendation: Provide fact sheets or guidance with detailed information about safety net providers and services.**

§155.215(b)(2)(iii) requires training on the tax implications of enrollment decisions, which we believe is critical for navigators and assisters to understand and be able to clearly articulate to consumers.

**Recommendation: Training on tax implications of enrollment decisions should include an understanding of the tax reconciliation process so that navigators and assisters are able articulate how tax credits are reconciled after the fact through the federal tax filing process for the applicable coverage year.**

**Recommendation: The training should also cover the availability of tax credits for small business that provide health insurance to their employees.**

§155.215(b)(2)(iv) addresses eligibility requirements for premium tax credits and cost-sharing reductions, and the impacts of premium tax credits on the cost of premiums. As noted in our comments on §155.215(b)(2)(ii), the ACA and regulations finalized on March 23, 2012 require navigators to also have expertise in the eligibility requirements for Medicaid and CHIP. It is therefore, critical, that training cover eligibility requirements for all the insurance affordability programs.

§155.215(b)(2)(v). We strongly support requiring that training include contact information for appropriate public agencies in order for navigators and other assisters to provide information to consumers regarding health care options not offered through the Exchange. The health care safety net for uninsured individuals, including immigrants, is comprised of a number of state- and county-funded programs as well as the network of FQHCs, public hospitals, and other essential community providers that can connect family members to health care. These families will heavily rely on the knowledge of navigators and other assisters about additional providers that are available as sources of care, when they are not eligible for the Exchange, Medicaid and CHIP. Minimally, the training should provide guidance on how to compile an extensive list of safety net resources for this purpose, as noted in our comment at §155.215(b)(2)(ii).

§155.215(b)(2)(vi) addresses the basic concepts of health insurance, the benefits of having it and the individual responsibility to do so. We support the this provision but want to ensure that it incorporates detailed information on who is subject to and exempt from the individual responsibility requirement, and the process for obtaining an exemption. In particular, it is important for navigators to help people not eligible for minimum essential coverage under the ACA understand that though the mandate applies to eligible members of their families, it does not apply to them and they will not incur a tax penalty for failing to have coverage.

**Recommendation: Training should include detailed information on who is subject to the individual responsibility** **requirement, as well as who may be exempt and the process for securing an exemption.**

We recommend that sub-regulatory guidance also require navigators to understand predatory practices in marketing and issuing plans and benefits that are exempt from federal regulations and ACA standards. A [recent report by Kaiser Health News](http://www.kaiserhealthnews.org/Stories/2013/April/22/insurance-scams.aspx) explored the growing accounts of scams where vulnerable seniors are offered “fake health coverage, stripped down policies masquerading as real coverage…(including) fake Obamacare coverage.” Consumers are likely to be confused by the individual responsibility, and particularly those barred from participation in ACA coverage options but exempt from the mandate, could be targets of such scams. It will be important for navigators to clearly educate consumers and caution them about such practices.

§155.215(b)(2)(vii) references eligibility and enrollment procedures, including how to appeal an eligibility decision. We support this provision and want to reiterate our comments on §155.215(b)(2)(ii) that such training incorporate eligibility and enrollment procedures for the full range of insurance affordability programs, including Medicaid and CHIP.

§155.215(b)(2)(viii) requires training on culturally and linguistically appropriate services. The importance of this training cannot be overemphasized. For immigrant communities and mixed-status families especially, culturally-appropriate services includes specific understanding of the special concerns of these families which have arisen from their experience living in America. Parents in many mixed-status immigrant households are afraid to apply for and enroll their family members in health coverage. In the past, immigrants have experienced hostility, language barriers, harassment and threats when seeking services from federal, state, and local government agencies. At times, benefits agencies have reported immigrants to immigration enforcement, resulting in deportation of a family member, separating families.

Mixed-status families face especially complex and confusing eligibility rules, difficulty completing the application process due to language barriers, and concerns about adverse “public charge” determinations, that may impair their application for a green card due to receiving assistance from a government agency. Navigators and assisters should be sensitive to these issues and provide reassurances that overcome these barriers for mixed-status families.

Understanding and addressing these concerns will help ensure that all eligible persons are enrolled, and that states comply with civil rights and privacy laws, while helping states reduce administrative errors and costs. At a minimum, assisters must be trained to avoid creating barriers to participation. Goals for assister training should include creating a gateway to health care for mixed-status immigrant families that is welcoming, informative, credible, and secure.

**Recommendation: Navigators and assisters should be well versed in the common concerns and anxiety faced by mixed immigration families and trained to provide reassurances to help mixed immigration status families overcome barriers to coverage.**

§155.215(b)(2)(ix) accessibility

§155.215(b)(2)(x). We support that navigators and assisters should understand the differences among health plans in order to help consumers fully understand their choices. In doing so, it is critical to provide fair, accurate and impartial information on the full range of QHP options.

§155.215(b)(2)(xi) notes that the training will include the section §155.260 privacy and security standards, which is critical to ensuring the safeguard of personally identifiable information for everyone. For immigrant families, privacy and security is even more important. Confidentiality concerns of parents in mixed-status families are paramount and should be addressed directly by navigators and other assisters. A threshold requirement for navigators and assisters is to understand which family members are applicants and which are non-applicants in order to gather needed information without deterring participation.

**Recommendation: Training in privacy standards must include specific applicability to mixed-status households. For example, direct and clear messages for immigrants to help address their confidentiality needs, presented at a timely point in the application process, should clearly communicate information such as the following:**

* Only citizen and lawfully present members of immigrant families are eligible for services, but ineligible adults are encouraged to file applications on behalf of eligible family members.

* Ineligible, non-applicant family members will never be required to provide their citizenship or immigration status in order to apply for others in their family. There should be no indirect questions asked for use as a proxy for immigration status such as inquiring about a non-applicant’s place of birth.
* Requests for Social Security numbers (SSNs) are *always* optional for non-applicants and never required for determining the eligibility of family members who are applying for benefits. The SSN of a non-applicant who chooses to provide the number, will be used only for the administration of the health care program and not for immigration enforcement purposes.
* Any information regarding immigration status and SSNs that is required of applicants will be used solely for administration of the health care program and not for immigration enforcement purposes.
* Questions about SSNs, race, ethnicity and primary language are asked in order to help insure equity and are never used to discriminate; answering these questions is voluntary and declining to answer will not affect the application or an eligibility determination.

§155.215(b)(2)(xii). We support that navigators and assisters must be able to work effectively with individuals with limited English proficiency, people with a full range of disabilities, and vulnerable, rural and underserved populations. Such expertise and effectiveness is gained over time through experience, training and sharing of best practices. While training can describe the issues and barriers to coverage that the people described in this provision face, building skills in working effectively with these consumers is developed through hands-on experience. As a starting point, it is critical that navigators and assisters with proven track records in working effectively with these populations be selected. Equally important is facilitating the sharing of best practices and networking among navigators and assisters through regular forums as recommended at §155.215(b)(1)(iv).

§155.215(b)(2)(xiii) We support that the training will include customer service standards and skills. Any sub-regulatory guidance should address the importance of, but not be limited to, 1) active and emphatic listening; 2) using clear, plain language communication; 3) promoting the value of coverage 4) efficiency and follow-up and 5) providing reassurances regarding privacy and confidentiality.

§155.215(b)(2)(xiv) We support that training should cover outreach and education methods and strategies. Much has been learned about effective outreach and public education through Medicaid, CHIP, consumer assistance programs (CAPs) and the Massachusetts health reform experience. It is important for HHS to identify strategies that worked well in the past, as well as those that didn’t, to help navigators and assisters be optimally effective. Equally important, will be assessing the most effective outreach strategies in reaching targeted populations as the ACA is fully implemented and sharing those best practices. As noted in our comment at §155.215(b)(2)(xii), it is also important that navigators and assisters with a proven track record of effective outreach and public education be selected, as these skills are also developed and enhanced through experience.

§155.215(b)(2)(xv) Clearly navigators and assisters will need to understand the administrative procedures and processes, as well as be competent in using systems, in order to execute their duties efficiently and effectively. Ideally, the FFE will build a specific navigator/assister portal that includes enhanced functionality for all assisters to be more effective. Such a portal should enable navigators to check the status of applications, submit changes on behalf of the people they serve and other tasks that offload administrative responsibilities from the FFE call center and technical assistance staff. Such a portal should have the ability for navigators to report, and the FFE collect, analyze and act on, system issues and other barriers to coverage.

**Recommendation: Launch a navigator/assister portal with enhanced functionality as soon as possible.**

**§155.215(c) Providing culturally and linguistically appropriate services.**

We support the inclusion of the CLAS Standards in the proposed rule and their regulatory application to Navigator and non-Navigator training. The CLAS Standards have long been helpful and exemplary guidelines, and this inclusion in federal regulation elevates them by giving them the force and effect of law, making the standards enforceable for the first time.

We note that the CLAS Standards are being revised by HHS, and recommend review of revised standards as a possible revision to this rulemaking in the future.

**§155.215(d) Standards ensuring access by persons with disabilities.**

**§ 155.215(e) Monitoring.**

Monitoring of navigators and other assisters will be key to ensure that the best interests of consumers are well served and that navigators and assisters are effective and efficient. It is important that information collected on performance metrics be shared with navigators and assisters so they can learn from each other. Proposed performance indicators could include:

* Number and type of outreach activities; estimated number of consumers reached;
* Number and type of public education activities; estimated number of consumers reached;
* Analysis of the outreach partnerships that navigators and assisters regularly engage;
* Number of applications facilitated; number of applicants enrolled in QHPs, Medicaid or CHIP (or referred to Medicaid/CHIP);
* The rate of completed enrollments relative to applicants assisted;
* The demographic breakdown of facilitated applications and enrollments, particularly the targeted populations;
* The proportion of applications submitted online;
* Number of referrals to social services programs such as the Supplemental Nutrition Assistance Program (SNAP) or the Women, Infants and Children (WIC) program;
* Positive data from customer satisfaction surveys; post-enrollment surveys should be deployed to seek consumer feedback on their enrollment experience;
* Enrollment patterns (to ensure consumers are not being steered to one plan or another).

Thank you for your consideration of these comments. If you have follow-up questions, please contact Tricia Brooks at pab62@georgetown.edu or 202.365.9148.