

## NOSORH Comments – CMS Proposed Rule on Benefit and Payment Parameters for 2023

### **Overview:**

On January 5, 2022, the Department of Health and Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS) issued a Proposed Rule (CMS-9911-P) with updated guidance for issuers offering qualified health plans (QHPs) in 2023 through Federally-Facilitated Exchanges (FEEs) and State-based Exchanges on the Federal platform (SBEs).

In this communication, the National Organization of State Offices of Rural Health (NOSORH) addresses specific proposed provisions in this proposed rule which could have significant impact on rural health systems and rural health. NOSORH was established in 1995 to assist State Offices of Rural Health (SORHs) in their efforts to improve access to, and the quality of, health care for nearly 57 million rural Americans. All 50 states have a SORH, and each SORH helps their state's rural communities to build effective health care delivery systems. NOSORH also convenes SORHs to explore important rural health policy issues. This provides an important state-level perspective for rural health policy development.

NOSORH is encouraged by the proposed requirements related to *QHP network adequacy and standardized QHP options*. NOSORH believes that effective implementation of these requirements could have a positive effect on the availability of affordable QHPs in rural areas and the accessibility of QHP provider networks for rural residents. These comments address that potential impact and include recommendations for how the requirements could be improved to maximize that impact. NOSORH and its member SORHs stand ready to assist CMS in the implementation of these new requirements.

### **NOSORH Perspective on Standardized QHP Options**

**Comment:** NOSORH strongly supports the proposed requirements for standardized option plans. This would assure consistency in offerings in all service areas, rural and urban. NOSORH is particularly supportive of establishing a robust set of *pre-deductible co-pay standards* for these plans. This approach to requiring affordable, pre-deductible co-pays for key services has been used successfully by several states, including New York and California. These requirements will assure affordability of key services for all QHP enrollees, and can be used to incentivize the use of services that improve health and reduce the preventable cost of delayed health care.

### **Recommendation:**

***NOSORH recommends that CMS examine state models for how to structure successful standardized options.*** NOSORH believes that state models provide an indication of where pre-deductible benefits can have the most impact on health and

preventable costs. ***NOSORH also recommends that CMS consider what additional pre-deductible benefits might be included in the Federal requirements.*** NOSORH suggests that pre-deductible benefits for the following services can have a beneficial impact:

- **Preventive care** – including services beyond those currently mandated by Federal guidance;
- **Primary care** – including coverage for more than a limited number of visits;
- **Outpatient specialist care** - including routine visits needed to manage chronic disease and disability;
- **Maternity care** – including prenatal, delivery and in-patient and home-based post-partum services;
- **Core laboratory and radiologic services** – including those procedures needed to diagnose and manage disease; and
- **Generic and lower-price brand name drugs** – including those needed to prevent, treat and manage acute and chronic illness.

NOSORH suggests that CMS consult with states to examine what level of pre-deductible co-pays and co-insurance is reasonable, and does not create undue barriers to essential care.

***NOSORH also recommends that the CMS requirements for standardized plans direct insurers to offer some coverage of and pre-deductible benefit for out-of-network providers for those enrollees located in health professional shortage areas and where a QHPO does not meet network adequacy requirements.*** This provision would eliminate a potential coverage penalty faced by enrollees in these areas where the underlying issue is QHP provider network deficiency. See additional recommendations related to network adequacy in the following section of these comments.

## **NOSORH Perspective on QHP Network Adequacy**

**General Comments:** ***NOSORH strongly supports the use of quantitative network adequacy standards for QHPs proposed by CMS.*** NOSORH believes that a *county level approach to time and distance standard-setting*, similar to that required for Medicaid Advantage (MA) plans is useful. NOSORH also supports the creation of *waiting time standards* for key services. NOSORH notes that the MA standards include separate specifications for Metropolitan, Micropolitan, and Rural counties, as well as for Counties with Extreme Access Considerations (CEACs). NOSORH believes that this four-category approach is useful, and will improve network adequacy in non-metropolitan areas.

More detailed comments and recommendations on network adequacy are presented below.

## **Issue - Network Adequacy Standards in Shortage Areas**

**Discussion:** Many rural areas are in locations with shortages of primary care and other medical and dental services. This includes rural locations within geographic Health Professional Shortage Areas (HPSAs) – areas designated by the Health Resources and Services Administration (HRSA) as having a critical shortage of primary care services. These are, generally, areas where available primary care supply falls below 50% of the primary care needed by the local population. Many rural and frontier HPSAs are county-wide. In these shortage locations it will be difficult for QHPs to meet network adequacy standards.

NOSORH believes that several steps can be taken to expand access and network adequacy in shortage areas. These are included in the following recommendations:

- **Recommendation - Contracts with Essential Community Providers (ECPs) in areas with an inadequate supply of services:**

***NOSORH recommends that CMS require insurers offering QHPs in areas with an inadequate supply of services to contract with all ECPs in those areas.*** ECPs covered by this requirement should include Federally-Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Sole Community Hospitals (SCHs), Disproportionate Share Hospitals (DSHs), Critical Access Hospitals (CAHs) and all others included in CMS ECP definitions.

***NOSORH further recommends that QHPs be required to contract with ECPs at a reimbursement level no lower than the established rate at which they are compensated under Medicaid or Medicare.*** This will assure that ECPs have a financial incentive to participate.

- **Recommendation - Telehealth services in areas with an inadequate supply of services:**

***NOSORH recommends that CMS expand its network adequacy requirements to assure appropriate availability of telehealth services in areas with an inadequate supply of services.*** While not all services can be provided through telehealth, many can be. NOSORH believes that a QHP should maximize the availability of its overall health care network capacity through telehealth in areas with an inadequate supply of services. NOSORH also believes that appropriate telehealth services should be coordinated through the local health system – for example, with telehealth specialist services coordinated through local primary care providers.

- **Recommendation - Coverage for out-of-network services for enrollees in areas with an inadequate supply of services:**

***NOSORH recommends that CMS establish requirements for QHPs to cover out-of-network services for enrollees in areas with an inadequate supply of services.*** This would assure that enrollees in these areas will not be penalized for the use of accessible services when QHPs have failed to include available local providers in their provider networks.

- **Recommendation - Provider network expansion in areas with an inadequate supply of services.**

NOSORH notes that CMS proposes permitting QHPs to submit information justifying why they can't meet network adequacy standards in certain counties. After review, CMS would exempt them from meeting applicable standards. NOSORH believes that this type of exemption would provide no incentive to QHPs to take steps to improve network adequacy in these areas.

***NOSORH recommends that that CMS require QHPs to take reasonable steps to expand the network adequacy in areas with an inadequate supply of services and provide adequate documentation of these steps.*** These steps could include payment incentives for services in these areas – as is done by Medicare for its Physician Shortage Area Bonus arrangements – as well as through enhanced provider 'circuit-riding' arrangements, wherein providers in other areas could travel to provide part-time services in underserved areas.

#### **Issue – Quantitative Network Adequacy Standards for Non-Metropolitan Counties:**

**Discussion:** NOSORH notes that the Medicare Advantage network adequacy standards currently in use for CEAC, Rural and Micropolitan counties appear to be, in several instances, in conflict with *other* Federal minimum access standards. For example, in its HPSA guidance, HRSA defines *reasonable access* for primary medical, dental and behavioral health services as 30 minutes/30 miles. Any primary care service beyond this limit is considered *inaccessible*. In contrast, several of the current MA standards, particularly for CEAC counties, are substantially less stringent and would permit travel times for these services of an hour or more.

#### **Recommendation - Consistent definitions of service accessibility in non-metropolitan counties:**

***NOSORH recommends that CMS consult with HRSA – particularly with the Bureau of Health Workforce, Bureau of Primary Care, Maternal and Child Health Bureau and the Federal Office of Rural Health Policy – to develop appropriate and consistent time and distance standards for key services in non-metropolitan areas.***

#### **Issue - Abandonment of Service Areas with Inadequate Healthcare Capacity:**

**Discussion:** NOSORH notes that, in most states, insurers can choose *not* to offer QHPs statewide, and can select the specific sub-state insurance service areas where they will provide coverage. In many states, non-metropolitan counties are isolated in a single 'balance of state' service area. Some insurers, faced with the challenges of building provider networks in the non-metropolitan areas, have chosen to ignore the needs of those areas, operating exclusively in metropolitan and micropolitan counties. In some states, this resulted in an abandonment of some rural and frontier counties. Several states have needed to intervene, providing financial subsidy and underwriting to insurers in efforts assure QHP offerings in more remote counties.

The implementation of QHP network adequacy standards could exacerbate the abandonment of rural and frontier service areas with inadequate healthcare capacity. Insurers could choose not to do business in these markets, rather than engage the difficulties of working in those underserved areas.

NOSORH notes that several states have established requirements which increase the likelihood of statewide QHP offerings. For example, New Mexico requires that, for each metal level, any insurer offering a plan in one service area must offer at least one plan statewide. NOSORH believes that CMS should consider implementing similar approaches as part of its nationwide QHP requirements.

Any requirement for statewide offering of coverage must be accompanied by a requirement that assures coverage affordability. For example, New Mexico requires that, for each metal level, the premium for a plan in one service area cannot exceed 125% of the premium for that plan in any other service area. This assures a reasonable cost of coverage in rural and underserved areas.

**Recommendation – Statewide QHP offerings:** *NOSORH recommends that CMS require insurers to offer at least one QHP statewide for each metal level at which they offer coverage.* This might be done most simply by requiring that standardized options be offered statewide. *NOSORH further recommends that CMS require the premiums of statewide offerings to be set within an acceptable range in all insurance service areas.*

#### **Issue - Monitoring Insurer Provider Network Adequacy:**

**Discussion:** NOSORH believes that network adequacy standard-setting *without* adequate monitoring will not achieve desired provider network adequacy. Regular studies conducted for the Nevada Medicaid Program on provider networks have underscored the importance of effective monitoring. One recent ‘secret shopper’ study of Medicaid managed care network providers showed that while Medicaid provider networks nominally met quantitative network standards established by the state, actual access to providers was woefully inadequate. In the study, fewer than 50% of attempts to set a primary care appointment on a timely basis were successful. An even lower percentage of attempts to set a timely prenatal care appointment were successful.

In addition, assessments conducted in California and other states uncovered numerous inaccuracies in published QHP provider network listings. In several instances, a significant number listed providers no longer participating in the network. NOSORH believes that CMS should support active monitoring of network adequacy to assure that compliance with network adequacy requirements is sustained throughout the program year.

**Recommendation – CMS support for monitoring efforts:** *NOSORH recommends that CMS provide financial support for the monitoring of insurer network adequacy.* This should include support for efforts to *monitor waiting time for key services* as well as support for the *periodic verification of provider network listings*. NOSORH believes that an entity in each state should be given responsibility and funding to conduct appropriate

monitoring of insurer network adequacy. This agent should likely be the state insurance commissioner or superintendent of insurance.

NOSORH notes that HRSA maintains Federal/State partnerships that could be utilized for these purposes. HRSA partners with State Offices of Rural Health and Primary Care Offices who already engage in some surveying for special shortage designations. With additional support they could expand their efforts to include insurer provider network availability. These state partners would be appropriate collaborators with the state insurance commissioner in this effort.

#### **Issue - Network Adequacy Enforcement:**

**Discussion:** NOSORH believes that QHP remediation/decertification procedures will be needed to respond to any circumstance where an insurer is unable to assure adequate provider network adequacy. Enforcement should be based upon the results of monitoring, as described previously. Enforcement procedures will need to include both progressive sanctions and positive incentives to help insurers meet all requirements.

**Recommendation - CMS Non-Compliance Procedures:** ***NOSORH recommends that CMS establish a detailed sequence of responses for managing QHPs that fail to meet network adequacy standards.*** This sequence should include progressive sanctions as well as opportunity for QHPs to implement a remediation plan. Any set of procedures should be based upon a clearly defined and appropriate *timetable* for the completion of each procedural step.