NOSORH

National Organization of
State Offices of Rural Health

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Overview

On December 21, 2022, the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (DHHS) released, for comment, a proposed rule [CMS–9899–P] to be applied to qualified health plans (QHPs) offered by issuers through the Federally Facilitated Marketplace (FFM) – including Federally-facilitated Exchanges (FFEs) and State-based Exchanges on the Federal platform (SBE–FPs). Several of the provisions of the proposed rule will have implications for health care in rural and frontier areas of the nation. In this communication, the National Organization of State Offices of Rural Health (NOSORH) makes specific comments and recommendations related to selected provisions in the proposed rule.

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 over 60 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 believes that the needs of non-metropolitan communities – rural and frontier - are distinct from those of urban communities. NOSORH feels that several of the proposed provisions could be modified to help FFEs/SBE-FPs better met the needs of these communities. Changes in the guidance could increase the enrollment of rural/frontier residents in QHPs. Changes could also assure that the provider networks of QHPs are adequate to provide reasonable access in rural/frontier areas.

NOSORH's comments and recommendations are detailed below.

Comments and Recommendations

Issue: Facilitated enrollment provisions

Background: Residents of rural/frontier communities face multiple barriers to the health insurance enrollment process. Many health exchanges emphasize online comparison shopping and enrollment. The lack of broadband access in rural communities is well documented. This places rural/frontier residents at a disadvantage when it comes to understanding, choosing and enrolling in health exchange offerings. Targeted outreach, education and enrollment assistance will be important to assure equitable participation of rural residents in health plan enrollment/re-enrollment.

Rural/frontier communities generally do not receive the same special outreach and enrollment efforts as do urban communities. Some rural/frontier essential community providers, including FQHCs and sole community hospitals, participate in outreach and enrollment efforts, but this is not universal. While this is useful, it does not necessarily provide help to rural/frontier residents who do not actively utilize the services of these providers. Frontier and rural residents residing at a distance from local towns face significant accessibility problems, even for the services of these providers. This is a particular issue for residents living on diffusely settled native nations, such as the Navajo and Lakota nations.

Federal rules currently prohibit navigators, certified application counselors, and non-navigator assistance providers from going door-to-door or using unsolicited means to provide enrollment assistance to consumers. The proposed rules will eliminate this prohibition and allow more energetic outreach to consumers. This could be particularly useful in efforts to reach frontier and rural residents. Targeted support campaigns for rural and frontier health plan enrollment can now be mounted without restriction.

Recommendation: **NOSORH strongly supports the proposed lifting of current limits on navigators, certified application counselors and non-navigator assisters**. NOSORH believes that the elimination of these restrictions will facilitate improved enrollment of rural and frontier residents in health plans.

Issue: Minimum percentage of ECPs required to be part of a provider network

Background: Under current rules, marketplace plan networks must include a minimum number of essential community providers (ECPs) in marketplace plan networks. There are six categories of ECPs:

- Federally Qualified Health Centers (FQHC)
- Ryan White Program Providers
- Family Planning Providers
- Indian Health Care Providers
- Inpatient Hospitals
- Other ECP Providers (defined to include Substance Use Disorder Treatment Centers, Community Mental Health Centers, Rural Health Clinics, Black Lung Clinics, Hemophilia Treatment Centers, Sexually Transmitted Disease Clinics, and Tuberculosis Clinics).

Issuers in the FFM must have 35 percent of available ECPs participating in their plan networks. In addition, QHPs must offer a contract in good faith to at least one provider in each ECP category in each county in the plan's service area.

The proposed rules would create two new and distinct ECP categories: *Mental Health Facilities* and *Substance Use Disorder (SUD) Treatment Centers*. These providers would be removed from the "Other ECP Providers" category. Creating these two new categories would require issuers to attempt to contract with at least one SUD Treatment Center and at least one Mental Health Facility. The proposed rules would also add Rural Emergency Hospitals as a provider type in the *Other ECP Providers* category.

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NOSORH believes that the proposed changes would be helpful for rural/frontier areas. The addition of the REH as an enumerated ECP in the *Other* category is particularly helpful. It will help assure that this new provider classification can be part of issuer networks. Despite its name, a REH is not an inpatient facility, and would not automatically be included in the *Inpatient Hospital* category.

NOSORH, similarly, believes that the separation of Mental Health Centers and Substance Use Disorder Treatment Centers is a positive change. This will give these facilities separate consideration at contracting time. It will separate them from the broader set of facilities classed as *Other*.

NOSORH finds, however, that the current, as well as the proposed guidance related to ECPs is very limited. It provides small assurance that ECPs in rural/frontier communities will be part of provider networks. This creates the possibility of inadequate essential services in these communities.

NOSORH believes that the 35% minimum standard is particularly weak. There is the possibility that an issuer could meet the requirement with provider contracts exclusively in urban locations of the plan area. This would completely isolate rural/frontier enrollees from accessible care. Time and distance standards help address this issue but are not sufficient to assure rural/frontier resident access.

NOSORH also believes that the guidance requiring issuers to *offer a contract in good faith to one provider in each category in each county* is also a very weak standard. Participation of ECPs in provider networks will not be assured if an ECP is offered a contract with a proposed reimbursement less than that of other payors. NOSORH notes that many rural/frontier ECPs, such as Critical Access Hospitals (CAHs), FQHCs and RHCs, have payment rates under Federal and state programs that are calculated in a manner which helps assure the financial stability of these providers. Despite this, it is not unusual for rural/frontier ECPs to be offered reimbursement rates by QHPs at a level that is half of the governmentally established rate. These low payment rates might be considered a 'good faith' offering from the QHP if they are equivalent to rates paid to urban providers. The rates, however, do not reflect the actual costs of providing care in rural/frontier, low-volume locations. A stronger standard would be preferable – one which addresses both the rate of reimbursement offered ECPs as well as the number of ECPs actually contracting the issuer to be part of the provider network.

It should also be noted that many rural/frontier counties are huge. For example, Rio Arriba County in New Mexico is more than 80 miles from North to South. There are FQHCs and RHCs located throughout the county. Requiring a contract with a single FQHC in Espanola – in the far South of the county - does very little to assure access to services in the remainder of the county. A different standard would be more effective.

<u>Recommendations</u>: **NOSORH recommends that CMS**:

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- **Require QHP contracting with *all* those ECPs in the plan area *with Federal or State established reimbursement rates***. Further, **NOSORH recommends that QHPs contract at those Federally established rates unless a different rate is negotiated.**
- **Require a *higher minimum percentage* of ECPs – including those without governmentally established rates - be part of a QHP's provider network**.
- **Require the higher minimum ECP participation percentage to be achieved separately in rural/frontier and urban parts of the plan service area.**

Issue: Wait Time Standards and reporting

Background: The proposed rules call for issuers to demonstrate compliance with the wait times standards established in the PY 2023 Payment Notice. This Notice established three maximum wait times for enrollees:

- Primary Care (Routine) – 15 business days,
- Specialty Care (Non-Urgent) – 30 business days, and
- Behavioral Health – 10 business days.

The proposed rules for PY 2024 directs issuers to collect the necessary data to assess appointment wait times and determine if their provider network meets the wait time standards detailed in the 2023 Letter to Issuers. The proposed rules indicate that CMS will begin conducting reviews of issuer attestations in PY 2024.

NOSORH believes that there is a need for more robust wait times standards, and that compliance with these standards should be evaluated in a more systematic way than issuer attestation. NOSORH believes that wait times are a direct indicator of provider network adequacy and should be a key measure used to evaluate each issuer's ability to meet the needs of its enrollees.

NOSORH feels that additional wait time standards should be established for several important types of care, including:

- Maternity Care: including maximum wait time it takes for pregnant mothers to schedule a first prenatal visit and the maximum wait time for required follow-up visits;
- Emergency/Urgent Medical Care: particularly for those patients with chronic illness requiring care for changes in their conditions; and
- Emergency/Urgent Behavioral Health Care.

NOSORH believes that these and other national health priority areas should be reflected in the wait time standards.

Multiple studies have demonstrated the significant differences between the provider network capacity *reported* by health plan issuers and the *actual* network capacity available. NOSORH believes that this is a particular problem in rural and frontier counties. NOSORH bases this opinion on experiences with QHPs and state Medicaid programs.

There is a well-documented problem with the accuracy with QHP provider directories:

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- https://www.highpointsolutions.com/accuracy-in-provider-directories-2/

These inaccuracies persist in the face of both CMS and state efforts to address the problem. The inaccuracies can mask the actual adequacy of QHP provider networks. Some of the inaccuracies are so extensive and continuing that lawsuits and enforcement actions have been brought against insurers. Inadequate networks directly result in unacceptable wait times.

Provider network inaccuracies can be a major challenge in rural and frontier counties. Total numbers of providers are typically smaller in these counties and inaccurate reporting of one or more providers could misrepresent a higher percentage of providers than in urban counties with a larger provider pool. These inadequate rural/frontier provider networks can create wait times for rural/frontier enrollees that are longer than wait times for urban enrollees.

Medicaid programs in several states have conducted *independent* evaluations of Medicaid managed care wait times as a measure of provider network adequacy and accessibility. Of note are the efforts of the Nevada Department of Health and Human Services to conduct regular assessments of the accessibility of reported Medicaid managed care networks.

- http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/MCandQ/APlantoMonitorHealthcareAccessv16.1.pdf

These assessments, conducted by contracted researchers, use a 'secret shopper' approach where providers are contacted by surveyors purporting to be Medicaid enrollees seeking to schedule appointments. The assessments have uncovered numerous problems in network adequacy where multiple providers in the network listing are no longer participating, may not actually be located in the area or have capped the numbers of their Medicaid patient panel, removing themselves from the network for new patients. Finally, some providers are so oversubscribed that Medicaid enrollees cannot be scheduled for appointments for weeks or months, effectively becoming inaccessible. In Nevada, the evaluation research has shown that these network adequacy problems are particularly acute in rural and frontier areas.

NOSORH believes that it is likely that these types of accessibility problems exist in rural/frontier areas nationwide. It recommends that CMS expand required, independent evaluation of wait times linked to inadequate QHP provider networks. NOSORH suggests that these evaluations include special assessment of accessibility problems in non-metropolitan counties.

Recommendations: NOSORH recommends that CMS require regular, independent evaluation of QHP wait times for key services. The aim of these evaluations should be to assure QHP compliance with established maximum wait time standards. Evaluations should include targeted evaluation of network adequacy in rural and frontier areas. **NOSORH also recommends that CMS expand the number of maximum wait time standards** to include maternity care and other national priority services.

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We appreciated the opportunity to submit comments on these important conditions of participation and hope you find value in the outlined recommendations.

Let me know if you have questions, would like discussion, or if I may be of assistance. Thanks so much.

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