NOSORH

National Organization of
State Offices of Rural Health

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-9937-P,
P.O. Box 8016,
Baltimore, MD 21244-8016.

SUBJECT: **CMS-9937-P] RIN 0938-AS57**
Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017

To Whom It May Concern:

The National Organization of State Offices of Rural Health (NOSORH) is the membership association of the fifty State Offices of Rural Health. State Offices of Rural Health support collaboration, information dissemination and technical assistance to rural communities and health care providers across the nation including the Critical Access Hospitals across the nation. In addition, they are neutral conveners and observers of the impact of policy and program changes on rural communities, patients and the health care providers that serve them.

The provisions released in the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017 are crucial to the delivery of services and access to care for rural Americans. The attached comments have been compiled in order to provide insight into the unique challenges in rural America. .

The National Organization of State Offices of Rural appreciates the opportunity for comment. Please do not hesitate to contact us if you have questions or additional insight on these issues.

Sincerely,

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Comments on Proposed Rule - December 2, 2015
HHS Notice of Benefit and Payment Parameters for 2017

Overview of NOSORH Comments:
The Health Resources and Services Administration (HRSA) definition of health care access addresses three issues:

- Availability,
- Affordability, and
- Acceptability.

The proposed Centers for Medicare and Medicaid Services (CMS) rule addresses two of these areas in its provisions for Network Adequacy Standards (Availability) and Standardized Cost-Sharing (Affordability).

NOSORH recognizes the importance of creating a national baseline on in these areas and supports the attempt of CMS to create a set of minimum standards. NOSORH's comments will address specific considerations related to rural health improvement and will offer suggestions important for rural communities based upon relevant research.

Comments: Quantitative Network Adequacy Standards - (Section 156.230):
NOSORH supports the establishment by CMS of quantitative network adequacy standards for Qualified Health Plans (QHPs). In the current rule CMS has provided general guidance on network adequacy and deferred the establishment of more detailed requirements to the states. While this has been sufficient in some places, there have been many reports of locations where it hasn't been enough. Many of these reports have been received from rural and frontier communities.
Not all states have been able to implement the standard-setting and monitoring needed to assure health network adequacy. While the National Association of Insurance Commissioners (NAIC) is developing new model rules for use by the states, the latest version of its draft appears to exclude the use of quantitative standards. The usefulness of a Federal baseline is becoming more evident.
NOSORH makes the following specific comments:

- **Type of Framework**: The proposed rule indicates that CMS will establish network adequacy standards using the general framework used in Medicare Advantage standards. This approach sets provider/facility to enrollee ratios and time/distance to services for urban, rural and remote locations. Based upon these ratios specific minimum standards are established for all counties/parishes in the nation. **NOSORH supports this approach as being an effective and clear way of establishing a baseline.**

- **Alignment of Standards**: NOSORH notes that the specific standards established by CMS for Medicare Advantage appear to be somewhat at variance with standards established for other Federal and state programs. **NOSORH suggests that CMS consult with HRSA and its partners, including state partners, in the creation of specific enrollee ratios and distance/time requirements.** This will help create alignment of different service access standards. While complete convergence of these

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standards is unlikely, it is useful to have similar requirements for Federal and state programs to assure coordinated health policy goals.

- **Accurate Capacity Assessment**: A head count of providers in a QHP network does not provide an accurate measure of provider capacity available to enrollees. A given provider might only have a portion of his/her time assigned to a given QHP's enrollees, with the remainder assigned to patients covered by Medicare, Medicaid and other plans. For purposes of accuracy only the portion of the provider's time assigned to a plans enrollees should be counted. To prevent an over count of q network's capacity **NOSORH recommends that CMS require health plan issuers report the full-time equivalent (FTE) of providers assigned to its health plan enrollees.**

- **Monitoring of Network Adequacy**: Network capacity as reported by health plans does not always ensure that enrollees of the health plan have reasonable access. A recent study by the State of Nevada underscores this problem.

  In its report entitled ***State Fiscal Year 2014-2015 Provider Network Access Analysis*** the State of Nevada examined the adequacy of Medicaid health provider networks for both fee-for-service and managed care Medicaid eligibles. The full study can be found at:

  http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Members/BLU/2014-2015%20Network%20Adequacy%20Report.pdf

  The study concludes that while provider networks largely meet both provider ratio and distance requirements actual access to care is severely limited. Attempts were made on a sampled basis to schedule appointments. Nearly 50 percent of all outreach calls failed to secure appointments (47.6 percent); and of those calls that ended in an appointment, fewer than three-quarters (69.4 percent) were scheduled within contract standards.
  There is a need for similar monitoring efforts in all states to assure adequate access to the networks of QHPs. **NOSORH suggests that CMS support monitoring of provider availability in coordination with HRSA and its partners.** HRSA has multiple state-based partners, including State Offices of Rural Health (SORHs), capable of conducting surveys of the type conducted in Nevada. Primary Care Offices (PCOs), many of which are co-located with SORHs, routinely conduct surveys of this type related to primary care access for low-income populations.

- **Enforcement/Remedial Measures**: Decertification remains the ultimate sanction available for addressing the failure of QHPs to meet requirements, including inadequate network adequacy. This sanction may be an over-response if a QHP's non-performance can be remediated. **NOSORH suggests that CMS consult with NAIC and others to develop a full range of progressive sanctions to help meet the needs of QHP enrollees facing inadequate networks.**

  There are several approaches possible for meeting the needs of underserved QHP enrollees. These enrollees could be allowed to seek care with out of network providers. The cost of enrollee travel could also be reimbursed. It should be noted that a different

approach may be needed in provider/facility shortage and scarcity areas than in areas with adequate provider/facility capacity. A discussion of this issue follows.

- **Requirements for Shortage and Scarcity Areas**: The existence of geographic provider and facility shortage areas are a major challenge to assuring adequate provider networks for the nation. If an area has insufficient provider supply for the general population, it is unlikely that there will be sufficient supply for any subpopulation enrolled in a health plan. NOSORH suggests that CMS address this issue proactively; creating requirements for how health plans should meet the needs of enrollees in these areas. **NOSORH suggests that CMS consult with HRSA and its partners in the development of these requirements**, as these agencies and organizations, including state agencies, have several decades of experience in working with populations in shortage areas.

Comments on Standardized Cost-Sharing Requirements (Section 156.20):

NOSORH supports the establishment of Standardized cost-sharing requirements such as those proposed in Table 9 in the discussion section of the proposed rule. A study conducted for NOSORH of pre-deductible QHP benefits in 35 states shows that many plans offered on health insurance exchanges do not adequately reduce financial barriers to key services. Some of the findings of that study related to Bronze plans are summarized below.

Expenditure Barriers to Service - Bronze QHPs		
Federally-Facilitated and Hybrid Exchanges - 2014-2015		
	2014	2015
Average Individual Medical Deductible	$5,074	$5,187
Average Family Deductible	$10,379	$10,562
No PC Physician Benefit Before Deductible - PCT Plans	65%	64%
No Specialist Physician Benefit Before Deductible - PCT Plans	86%	81%
No Generic Drug Benefit Before Deductible - PCT Plans	76%	70%
No Preferred Drug Benefit Before Deductible - PCT Plans	91%	92%
No Inpatient Facility Benefit Before Deductible - PCT Plans	78%	84%

More than 60% of listed plans provide no primary care benefit prior to the deductible. This means that an enrollee must pay the entire cost of primary care until a high deductible is reached. This can lead lower income Bronze plan enrollees to postpone needed health care until a problem is more severe and costlier to the health system.

NOSORH suggests that CMS consult with HRSA and its partners, including SORHs, in the development of effective standardized cost-sharing requirements. As listed in the draft Table 9, the cost-sharing requirements still include significant financial barriers for lower income enrollees - particularly those enrollees with Bronze plan coverage. The limitation of pre-deductible primary care benefits to three visits a year is not consistent with efforts to improve health. Additionally, the use of 50% cost-sharing for primary care without a maximum co-pay amount runs the risk of making this care unaffordable.

HRSA and its partners have extensive experience with establishing payment schedules reflecting patient ability to pay. NOSORH believes that CMS rule-making would benefit from consulting with HRSA in this policy area.

Comments on Essential Community Providers (Section 156.235):

The proposed rule makes no major changes in the current rule covering Essential Community Providers (ECPs). The existing rule requires health plans to offer contracts in "good faith" to all Indian Health Service providers as well as at least one ECP from each of the six federally-established ECP categories in each county in the service area, where available. NOSORH believes that the current rule is problematic in provider shortage and scarcity areas.

In shortage/scarcity areas there is insufficient provider capacity to meet the needs of the general population. If there are multiple essential community providers in capacity deficient area it would be more logical to assure that all of them participate in a health plan's network. **NOSORH recommends that CMS modify the current rule to require that health plans offer contracts to all ECPs from each of the categories in each county that is in a shortage/scarcity area.** HRSA can be a resource in the identification of these areas.