



October 6, 2016

Centers for Medicare & Medicaid Services

SUBJECT: Issuer Payment and Benefit Parameters for 2018 NPRM CMS-9934-P.

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. Our mission is to work with the fifty State Offices of Rural Health to improve health in rural America. State Offices of Rural Health are anchors of information and neutral observers and conveners for rural health. They support collaboration, information dissemination and technical assistance to rural communities and health care providers across the nation including critical access hospitals, certified rural health clinics, oral health and other providers.

NOSORH submits these comments are to ensure rural Americans have financial access to care in the community based facilities by the care providers dedicated to serving their needs. Thank you for the opportunity to comment. If we can provide additional information on the impact of proposed regulations for rural and underserved communities and the providers who serve them please feel free to email teryle@nosorh.org or call for assistance.

Sincerely,

Teryl E. Eisinger, MA
Executive Director
National Organization of State Offices of Rural Health

Draft NOSORH Comments on the Proposed Rule Affecting Issuer Payment and Benefit Parameters

Introduction

The Notice of Proposed Rulemaking (NPRM) CMS–9934–P published by the Centers for Medicare and Medicaid Services (CMS) on September 6, 2016 proposes new and revised provisions related to Issuer Payment and Benefit Parameters for 2018. Several of these provisions will have impact on health service providers in rural communities. In this communication the National Organization of State Offices of Rural Health (NOSORH) makes specific comment on how the proposals in the NPRM would affect these rural providers and submits recommendations on how the requirements can be implemented in a way which does not create unanticipated problems for the nation’s rural health system.

Specific Comments and Recommendations:

NOSORH sees potential in the direction signaled by CMS in several provisions of the proposed rule. NOSORH’s comments and recommendations on specific NPRM sections follow:

- **Section 155.20 Standardized Options**

Overview: The proposed rule establishes revised Standardized Options for Bronze, Silver and Gold Qualified Health Plans (QHPs). The Standardized Options provide cost-sharing guidelines for these plans. The proposed rule also establishes new cost-sharing guidance for High Deductible Health Plans - low benefit plans eligible for Health Savings Accounts.

Comment: While the Standardized Options are a suggestion, not a requirement, the framework provided in these guidelines is useful for states as a model for local regulation. It provides reasonable cost-sharing standards that states could implement. This type of regulation is needed.

NOSORH conducted analysis of QHP cost-sharing in Federally Facilitated Marketplaces in each of the last three years and has concluded that a very large number of Bronze and Silver plans offered in rural counties have unacceptably high cost-sharing requirements. More than half of Bronze plans offered in rural counties report no pre-deductible benefits for primary care, specialist visits, generic drugs or hospitalization. This means that, absent state regulation, enrollees must pay for all basic care until the deductible level is reached. This means that plans are little better than catastrophic coverage.

QHPs with no pre-deductible benefit have a negative impact on the rural health care system. Lower income individuals will expend a significant portion of their health care budget on plan premiums, leaving smaller amounts to cover the cost of basic primary care, chronic disease management or unplanned hospitalizations. They may not be able to pay for all the care they need before reaching the plan deductible. This can lead to increases in provider and hospital uncompensated care. For a fragile rural health care system the burden of uncompensated care from QHP enrollees can be a serious problem.

High deductible plans with no pre-deductible benefits for basic care have another important impact. Low income individuals enrolled in these plans will often postpone seeking care until a health problem becomes more acute. This delay in seeking care can lead to higher costs than if the individual had received care earlier. It can result in poorer individual health.

Some states have responded to this issue by requiring all plans to have pre-deductible benefits for a minimum set of basic care services. NOSORH believes that this approach is needed, and that it will contribute substantially to the achievement of the Affordable Care Act's triple aims in rural areas. NOSORH also believes that CMS should take the same approach to assure a common nationwide approach to the problem.

Recommendation: NOSORH recommends that CMS require QHPs to include Standardized Options with a minimum level of pre-deductible benefits for basic care services. NOSORH recommends that all plans have appropriate pre-deductible benefits for primary care, specialist visits, generic drugs, outpatient behavioral health, laboratory services and hospitalizations.

- **Section 153.235 Essential Community Providers (ECPs)**

Overview: The draft rule seeks to clarify the current requirements for satisfaction of minimum Essential Community Provider (ECP) participation. It specifies that:

"Multiple providers at a single location will count as a single essential community provider toward both the available essential community providers in the plan's service area and the issuer's satisfaction of the essential community provider participation standard."

It also specifies that the same enumeration approach will be used to satisfy ECP requirements for areas of health professional shortage or high poverty.

Comment: This enumeration approach codifies the enumeration of facilities, not the number of actual clinical providers at a facility, as the basis for meeting ECP requirements. This approach, while pragmatic, can create problems. Consider the hypothetical example of a service area where there are two Federally Qualified Health Centers (FQHCs) – one center employing two physicians and a second center employing six physicians. Under the proposed rule, an issuer could meet ECP requirements by contracting with the smaller center. This would mean, however, that only 25% of the FQHC physicians in the local market were under contract – an inadequate number for meeting local needs.

It should be noted that the standard for inclusion of ECPs under current guidance is very limited. An issuer can meet the standard by contracting with 30% of the available ECPs in a service area. This is a very minimal requirement, particularly in areas of health professional shortage. The requirement applies to all ECPs, and does not assure that there is an appropriate representation of different categories of ECP. NOSORH believes that this standard should be raised substantially. The State of Montana has established a state standard for ECP participation of 80%. This more accurately reflects the need to assure access to services, both in shortage areas and

other rural areas. A standard which assures that different types of ECPs be under contract is also needed.

Current rules also require that issuers must offer contracts in good faith to at least one ECP in each of six specified categories in each county in the service area. It should also be noted that a “good faith contract offer” is defined as offering contract terms that a “willing, similarly-situated, non-ECP provider would accept or has accepted.” The phrase “similarly-situated” is open to some interpretation, and could be construed to include providers in other counties in a service area. For rural communities an interpretation of this sort could be problematic. There are many different types of rural communities ranging from small frontier settlements of a few hundred people to small towns with populations in the tens of thousands. A contract rate acceptable to a provider in a small town with no health professional shortage could be far less than what would be needed to support a provider in a frontier shortage area. There is a need to clarify the meaning of “similarly situated” to assure that good faith offers are truly comparable.

Recommendation: NOSORH recommends that CMS revise the ECP participation standard to assure that contracts are executed with providers representing a majority of the ECP provider capacity in a service area, and with representatives of each ECP category. NOSORH also recommends that CMS revisit the current standard for ECP participation to assure that **all** ECPs in each category in a service area/county be given good faith contract offers. Finally, NOSORH recommends that CMS clarify the definition of ‘similarly-situated’ in current rule to assure that good faith offers are truly comparable in different size rural communities.