College of Public Health – N232A
105 River Street
Iowa City, IA 52242
(319)-384-3832
http://www.rupri.org/panelandnetworkviewer.php?id=9
Keith-mueller@uiowa.edu

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Centers for Medicare and Medicaid Services Department of Health and Human Services
Attention: CMS-9937-P
P.O. Box 8012
Baltimore, MD 21244-8016
By electronic submission at http://www.regulations.gov

Re: 80 FR 75487 [CMS-9937-P] Proposed Rule: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017

To Whom It May Concern:

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal policy makers. The Panel is pleased offer comments regarding the Proposed Rule regarding HHS Notice of Benefit and Payment Parameters for 2017, particularly the section on Network Adequacy.

The Panel understands that CMS will receive comprehensive comments from a wide variety of sources. Thus we will limit our comment to rural-specific issues.

The Panel appreciates the opportunity to address concerns about network adequacy in these comments. Network adequacy guidelines are important for ensuring access to providers in rural areas. But if network adequacy guidelines are too onerous for health plans to meet in rural areas, they can constrain the availability of QHPs in rural markets. Because of rural health workforce shortages and geographic dispersion of the rural population, health plans may find it unusually difficult to assemble provider networks that offer a complete range of services, a full continuum of care, and timely, convenient access to rural beneficiaries. Therefore, it is important to strike a balance in network adequacy guidelines that will provide access to rural providers without discouraging the full participation of QHPs in providing necessary coverage and care in rural areas.

Proposed Rule: § 156.230 proposes network adequacy standards for states and anticipates incorporating "prospective time and distance standards at least as stringent as the FFE standard" and "prospective minimum provider-covered person ratios for the specialties with the highest utilization rate for the state."

Comment: The Panel recommends CMS consider emphasizing travel time over distance. Travel time incorporates other factors such as road status and geography that are of particular concern to rural beneficiaries. The Panel suggests the combination of travel time and provider ratios into a single standard for primary and specialty care services. The Medicare Advantage program includes standards that we believe are appropriate in this regard. The Medicare Advantage program is also flexible, allowing QHPs assistance to meet access standards.

The Panel has concerns about the proposed highest utilization rate standard in the proposed rule. CMS should clarify this standard, as the Panel is concerned that historical utilization rates may not reflect the actual need for services in rural areas, particularly if rural beneficiaries have not had access to those specialties in the past.

Further, the Panel suggests that CMS consider other methods of access such as telehealth as a supplement to rural health systems in providing beneficiary access. Telehealth should only be used to supplement and support a rural health system, not replace it.

Proposed Rule: § 156.230 implements a federal default network adequacy standard consisting of a time and distance standard.

Comment: The Panel once again recommends a standard with multiple components such as time/distance as well as provider ratios. Further, the Panel reiterates that a time-based standard is more effective than a standard based on distance. CMS's reference to the Medicare Advantage system is important and supported by the Panel. As discussed in the comment above, the Medicare Advantage standards are appropriate for both QHPs and rural beneficiaries.

Proposed Rule: § 156.230 proposes new rules regarding notification of discontinued providers in QHPs. In particular, this standard requires QHPs to provide enrollees who are seen on a regular basis or receive primary care from a provider with notice of a discontinued provider at least 30 days before the effective date of the change.

Comment: The Panel recommends a longer notification period for beneficiaries. 30 days is an inadequate amount of time to find a replacement provider in rural areas. Insurers should continue coverage for 6 months after termination at previously negotiated rates. Further CMS should adopt a standard for "regular basis" and should consider defining this as any beneficiary who has had a visit to the provider within 12 months.

Proposed Rule: § 156.230 proposes requirements for continuity of care after provider termination and states: "we propose to require the issuer, in cases where the provider is terminated without cause, to allow an enrollee in active treatment to continue treatment until the treatment is complete, or for 90 days, whichever is shorter, at in-network cost sharing rates." The proposed rule also includes treatment for a "life-threatening condition" and an "ongoing course of treatment for a serious acute condition" in the definition of active treatment.

Comment: The Panel is concerned that the proposed 90-day standard is too short, particularly in rural areas where a replacement provider may be difficult to access. In addition, the panel proposes clarifying the definition of active treatment by proposing a definition for "life-threatening condition" and by adding **"an ongoing course of treatment for a serious acute physical or mental health condition"** to the second part of the definition of active treatment.

Proposed Rule: § 156.230 proposes to require counting of "cost sharing paid by an enrollee for an EHB provided by an out-of-network provider in an in-network setting under certain circumstances towards the enrollee's annual limitations on cost sharing."

Comment: The Panel supports this proposal, as it will benefit patients in rural areas.

Proposed Rule: § 156.230 indicates CMS is considering requiring a network resilience policy for disaster preparedness.

Comment: Although the Panel agrees that it is important for QHPs to consider disaster preparedness, requiring specific guidelines for disaster preparedness policies may be burdensome for some rural providers. As long as this proposed rule does not place too high a burden on rural providers, the Panel supports this initiative.

Proposed Rule: § 156.230 addresses wait time variation between providers and whether there should be state standards implemented on wait times. This proposed rule also addresses provider surveys to gather data on whether "a sufficient number of network providers are accepting new patients."

Comment: Wait times for appointments and new patient acceptance are important access measures. These data should be measured and compared as enrollees assess QHP options. The Panel recommends CMS also consider how to address lack of provider supply, particularly in rural areas. Perhaps one option to consider is GME support of community provided care. The Panel supports the requirement that issuers be required to survey all contracted providers on a regular basis to determine if a sufficient number of network providers are accepting new patients.

Proposed Rule: In § 156.230 CMS seeks comments on issuer standards and transparency, particularly how standards should require selecting and tiering of participating providers for QHPs.

Comment: Ideally provider participation should depend on clinical quality, patient experience and access, and cost. However, some QHPs may overly emphasize cost. Therefore, to settle provider inclusion disputes, the standards should be transparent.

Proposed Rule: In § 156.230 CMS requests input on whether the standards on notification and continuity of care should be extended to all QHPs or only QHPs in FFEs.

Comment: The Panel recommends that these standards be applied to all QHPs.

Proposed Rule: In § 156.230 the proposed rule considers providing ratings for QHPs on HealthCare.gov.

Comment: The Panel agrees in principle with the rating system suggested by CMS as it would provide consumers with transparency. However, the Panel is concerned about the practicality of offering these ratings. QHPs and providers can change frequently and the Panel is concerned that it would not be possible to gather up to date information for accurate ratings. Further, state by state differences in the scope of practice of non-physician providers is an inhibitor of standardized measures of access especially in rural areas in states where physician oversight requirements might make access more difficult.

Sincerely,

The Rural Policy Research Institute Health Panel

Keith J. Mueller, PhD – Chair

Andrew F. Coburn, PhD

Jennifer P. Lundblad, PhD, MBA

A. Clinton MacKinney, MD, MS

Timothy D. McBride, PhD

Charlie Alfero