National Rural Health Association

December 14, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

RE: CMS–9895–P; Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO–OP) Program; and Basic Health Program.

Submitted electronically via regulations.gov.

Dear Administrator Brooks-LaSure,

The National Rural Health Association (NRHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services' (CMS) Notice of Benefit and Payment Parameters for 2025. We appreciate CMS' continued commitment to the needs of more than 60 million Americans that reside in rural areas and urge the agency to support these communities in the final rule.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Since Congress passed the Affordable Care Act (ACA) in 2013, rural areas saw a decrease in uninsurance and increase in individuals covered by Medicaid.[1] Overall, rural residents under age 65 continue to be more likely to be uninsured and more likely to rely upon public coverage via Medicaid or Medicare than their urban counterparts.[2] Higher uninsurance among rural residents highlights the need to continue to strengthen Marketplace plan availability as well as access to other sources of coverage. In 2021, rural counties have an average of 2.6 issuers offering Marketplace plans while urban areas have 3.4.[3] These numbers also vary greatly by region, with the Midwest seeing a lower-than-average number of issuers in rural counties at 2.4 and the Northeast sitting above average at 3.7.[4] **NRHA supports proposals from CMS to strengthen and expand coverage to Marketplace plans for rural residents**, particularly because they are less likely to have employer-sponsored coverage than urban residents, and thus rely upon the Marketplace for health insurance.[5]

[1] Timothy McBride, et al., *An Insurance Profile of Rural America: Chartbook*, Rural Policy Research Institute, University of Iowa College of Public Health (Oct. 2022), 12, https://rupri.public-health.uiowa.edu/publications/other/Rural%20Insurance%20Chartbook.pdf.
[2] *Id.*
[3] *Id.* at 46.
[4] *Id.*
[5] *Id.* at 12.

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III. Provisions of the Proposed Regulations.

B. 42 C.F.R. Parts 435 and 600.

1. Increase State Flexibility in the Use of Income and Resource Disregards for Non-MAGI Populations.

CMS proposes to provide states with more flexibility to adopt income and resource disregards when determining financial eligiblity for subgroups of individuals that are exempt from meeting modified adjusted gross income (MAGI) requirements for Medicaid. The result would be to extend Medicaid eligibility to specific populations in order to best meet their needs. **NRHA supports policy proposals that increase access to Medicaid coverage to ensure rural residents have affordable health care. As such, we support CMS' proposal to increase state flexibility when determining eligibility for targeted non-MAGI populations.** This is especially important for non-MAGI populations, which are aged, blind, disabled, or otherwise medically needy populations that are some of the most complex and costly patients.

D. 45 CFR Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act.

19. Establishment of Exchange Network Adequacy Standards (§ 115.1050).

CMS proposes to align quantitative network adequacy standards for State Exchanges with those for Federally Facilitated Exchanges (FFEs). **NRHA supports network adequacy standards that ensure rural consumers have adequate access to in-network providers**, thus limiting unaffordable out-of-network care or forgoing care altogether due to cost. Network adequacy standards must assure participation by essential rural providers and reimbursement levels that both adequately reflect the costs incurred by these providers and offer the financial incentives necessary to assure access to care in rural communities. For rural patients, network adequacy standards should aim for a goal of ensuring primary care services within 30 minutes from the patient's home where possible. Additionally, network adequacy standards for plans in rural counties should support more than one network to provide competition among plans, foster reasonable wait times for appointments, and reduce geographic barriers.

E. 45 CFR Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges.

3. Provision of EHB (§ 156.115).

Currently, plans may not include routine non-pediatric dental services as an essential health benefit (EHB). CMS is revisiting its reading of the Affordable Care Act to remove the prohibition on offering routine adult dental services as an EHB. **NRHA strongly supports the proposal to allow plan issuers to include dental services as an EHB.** Offering dental coverage for rural adults that rely upon the Marketplace for health insurance is critical to helping address the oral health disparities between rural and urban residents. Rural residents are less likely to have employer-sponsored

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coverage and therefore more likely to be enrolled in Marketplace plans.[6] Therefore rural residents have been disadvantaged in accessing dental services compared to their metropolitan counterparts.

In 2019, just over half of adults in rural areas indicated that they saw a dentist in the past year, compared to 66% of metropolitan adults.[7] In terms of health outcomes, rural populations have higher percentages of those living with partial edentulism compared to urban populations.[8] Rural residents also self-report fair or poor oral health at higher rates than suburban or urban residents.[9] While factors such as geographic isolation and a lack of dental providers in rural areas may contribute to worse oral health outcomes for rural populations, a lack of dental insurance and inability to pay are also factors. When rural residents delay care because of the latter two issues, overall health may *also* decline as it is *well documented as being* connected to oral health.[10]

NRHA applauds CMS for taking steps to improve dental insurance coverage in rural communities. Access to coverage is one important tool for improving affordability of dental care and closing oral health disparities.

NRHA thanks CMS for the opportunity to provide comments on this proposed rule. We look forward to continuing our work together to ensure access to quality care for rural beneficiaries. If you have any questions, please contact NRHA's Regulatory Affairs Manager, Alexa McKinley at amckinley@ruralhealth.us.

Sincerely,

Alan Morgan
Chief Executive Officer
National Rural Health Association

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[6] *Id.* at 12.
[7] National Center for Health Statistics, *Health, United States, 2020 – 2021*, Table DentAd: Dental visits in the past year among adults aged 18 and over, by selected characteristics: United States, selected years 1997–2019, 2023, https://www.cdc.gov/nchs/data/hus/2020-2021/DentAd.pdf.
[8] Jordan Mitchell, Kevin Bennett, & Amy Brock-Martin, *Edentulism in high poverty rural counties*, 29 J. RURAL HEALTH 30, 33 (2012) https://pubmed.ncbi.nlm.nih.gov/23289652/.
[9] Paige Martin, et al., *Still Searching: Meeting Oral Health Needs in Rural Settings*, CAREQUEST INSTITUTE FOR ORAL HEALTH, 5 (Nov. 2023) https://www.carequest.org/system/files/CareQuest_Institute_Still-Searching_11.6.23.pdf.
[10] National Advisory Committee on Rural Health and Human Services, *Improving Oral Health Care Services in Rural America*, 3, (Dec. 2018), https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/2018-oral-health-policy-brief.pdf.

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