NOSORH

National Organization of
State Offices of Rural Health

January 28, 2021

TO: Department of Health and Human Services

SUBJECT: HHS Teletracking COVID-10 Portal

The National Organization of State Offices of Rural Health (NOSORH) is the membership association of the fifty State Offices of Rural Health (SORH). 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, neutral observers and conveners for rural health.

Across the nation State Offices of Rural Health have taken a lead to support initiatives which ensure support for rural providers and communities working diligently to ensure the health and safety and appropriate care during the pandemic. The fifty SORH have been instrumental in reporting efforts and supporting rural community- based organizations, clinics and hospitals to understanding the resources available and reporting requirements for a large variety of federal and state programs during the pandemic and before the pandemic. These experiences have shaped the comments and provide recommendations to ensure the best outcomes for the efforts.

If we can provide additional information on the impact of reporting for rural facilities please feel free to email teryle@nosorh.org or call for assistance.

Sincerely,

Teryl Eisinger

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

www.nosorh.org

44648 Mound Road, #114 | Sterling Heights, MI 48314-1322 | TEL 586-336-4627 | FAX 586-336-4629

NOSORH Comments – DHHS Teletracking COVID-19 Portal

Introduction

On December 29, 2020 the Department of Health and Human Services (DHHS) released an Agency Information Collection Request (ICR) related to the DHHS Teletracking COVID–19 Portal. The referenced data collection system is used by hospitals and Critical Access Hospitals (CAHs) to report a large number of data elements related to each facility's response to the COVID-19 pandemic. In this communication, the National Organization of State Offices of Rural Health (NOSORH) provides comments and Identifies problems with that data collection system as it affects rural health care facilities.

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 is supportive of the efforts of DHHS to collect information about the COVID-19 related operations of health care providers. NOSORH believes that continuous assessment of health care provider capacity and activities is necessary for effective responses to the pandemic. NOSORH has found, however, that the current system has issues which need to be addressed. These issues have been particularly problematic for Critical Access Hospitals (CAHs) and rural acute care hospitals. NOSORH's comments also include recommendations that could be implemented to improve the DHHS reporting system.

NOSORH notes that, in addition to the question of reporting burden, there are problems posed by the sanctions used for failure to report completely. Full compliance with reporting – defined as all data elements for an entire week - is required as part of hospital and CAH Conditions of Participation for Medicare and Medicaid certification. Failure to reach full compliance with reporting over three consecutive weeks can lead to de-certification of facilities. NOSORH believes that this sanctioning is overly harsh and that it has led to confusion and consternation in the rural health care system. This concern goes beyond the narrow scope of the ICR, but NOSORH feels that it contributes significantly to the burden of the system.

Time Burden of Reporting

For most facilities the reporting system requires daily submission of a full slate of data elements and weekly submission of selected data elements. DHHS, in its ICR, estimates the daily time burden for reporting to be 1.75 hours per day. NOSORH notes that this estimate is approximately equal to 25% of a full-time equivalent staff member. This

estimated burden can be problematic for short-staffed CAHs and rural hospitals.

NOSORH and its member SORHs solicited input from CAHs and rural hospitals about the actual time burden of reporting. Many facilities indicated that the actual time for *data collection, analysis and reporting* ***significantly exceeded the ICR estimated burden***.

Part of the problem is the ***incompatibility*** of current data reporting systems in rural facilities with the set of required data elements. At the time the requirements were implemented, few rural hospitals and CAHs had data systems that could automatically produce the reports needed for the Teletracking system. This required some facilities to conduct manual data collection, analysis and reporting efforts in order to meet the requirements.

The excessive time burden for reporting was compounded by two additional problems – ***Data Portal Interface Deficiencies*** and ***Multiple Additions to Reporting Requirements***. These problems added significant additional time to the reporting burden. They are discussed separately below.

Data Portal Interface Deficiencies

Rural hospitals and CAHs have indicated to NOSORH that the Teletracking data entry interface has multiple usability problems. In particular, rural facilities have flagged two important issues - ***default value failures*** *and* ***skip logic failures***. These problems are serious. In addition to increasing reporting time burden, they have caused several rural facilities to be pushed to the verge of de-certification.

The portal interface displays default values for several data fields. For example, several data fields display a ‘0’ as the default value. In most data entry applications, data entry staff can accept the default values by clicking on the ‘Submit’ button on the bottom of a data entry page. Multiple hospitals and CAHs have indicated to NOSORH that the Teletracking Data Portal does not function in this standard manner. Rural facilities were surprised to receive non-compliance warning letters when they believed that they had reported fully.

Rural facilities discovered a work-around for this problem. They found that manually adding a response for each field, even if the response was the same as the default display, eliminated the problem. For example, although the default display for a field was ‘0’, the data entry staff person was required to enter a ‘0’ manually. Only then would the default value be recorded. Since many of the required daily data fields have a ‘0’ entry, this adds substantially to the time burden of reporting.

The portal interface has several data entry fields which could benefit from appropriate skip logic. For example, if a hospital reports that it has no *staffed inpatient ICU beds*, there is no need to answer subsequent questions about the number of *adult inpatient ICU beds*, the number of *occupied ICU beds* or the number of *occupied adult ICU beds*. A data entry

system with appropriate skip logic would automatically skip unnecessary data fields when a higher level '0' or 'NA' is entered.

CAHs and rural hospitals indicated that they, at first, skipped unnecessary data entry, assuming that the system would be logical enough to recognize when a previous '0' entry should cover subsequent responses. Unfortunately, several rural facilities were surprised to receive non-compliance warning letters when they believed that they had reported fully. They subsequently found a work-around by entering a response to each and every data field, whether or not it was an unnecessary repetition. The need for this duplicative data entry adds substantial time to the burden of reporting.

Multiple Additions to Reporting Requirements

The initial reporting requirements for CAHs and hospitals were implemented in early October 2020. Subsequent to that initial implementation, there have been multiple expansions of data elements required, including data related to influenza, monoclonal antibody treatments and, most recently, vaccinations. Each expansion of the reporting requirements has an impact on the time burden of reporting. Each change requires more than just increased data entry time. Rural hospitals and CAHs must modify their mechanisms for collecting, analyzing and reporting data to accommodate the changes.

NOSORH and SORHs have worked to inform rural hospitals and CAHs about these multiple changes to reporting requirements. There have been many instances where rural facilities have not been aware of the changes, leading to warnings from DHHS about being out of compliance. **Communication about changes could clearly be improved.** In addition, ***training and instructional materials related to changed reporting is also needed***. The multiple additions to reporting requirements in the few months since implementation of the system have added substantially to the time burden of reporting.

Recommendations

NOSORH suggests several changes, which could make the COVID-19 reporting burden for hospitals and CAHs more reasonable for rural facilities. These recommendations are listed below.

- **Reporting Frequency**: NOSORH believes that the current daily reporting requirements are unnecessarily burdensome, particularly for smaller rural facilities. ***NOSORH recommends that DHHS permit smaller hospitals and CAHs with fewer than 50 beds the option of reporting on a weekly basis.***

- **Data Portal Deficiencies**: The Teletracking Data Portal deficiencies, described previously, place an unnecessary time burden on reporting for rural facilities.

NOSORH recommends that DHHS fix these deficiencies, including default value failures and skip logic failures.

- **<u>Additions to Reporting Requirements</u>**: The multiple additions of new data elements to the reporting requirements have placed an unnecessary burden on rural facilities. With each addition, these facilities must retool their data collection, analysis and reporting. ***NOSORH recommends that DHHS perform a prospective systems analysis to identify what data might be needed in the future. Further, NOSORH recommends that DHHS use this analysis to implement subsequent additions to reporting at one time, provide training about the changes, and permit all facilities adequate time to modify their internal systems.***

Comments on CMS Proposed Rule Governing Benefit and Payment Parameters for 2020

Overview:
On January 24, 2019, the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services proposed a rule entitled ***Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2020 (CMS–9926–P)***. The proposed rule would provide direction for the operation of Federally-facilitated Exchanges (FFEs) and State-based Exchanges on the Federal Platform (SBE–FPs). In this communication, the National Organization of State Offices of Rural Health (NOSORH) makes specific comments related to this proposed rule. While the proposed rule covers multiple topics, NOSORH is limiting its comments to proposed changes related to ***Silver Loading, Automatic Re-Enrollment*** and ***FFE/SBE-FP User Fees***. NOSORH's observations and recommendations related to these issues are detailed below.

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NOSORH is supportive of the direction provided by the recently enacted ***CMS Rural Health Strategy***. In that document CMS commits to applying a 'rural lens' in the assessment of its programs and policies. The Strategy seeks to find ways to *improve service delivery and payment models in rural areas* and to *improve access to services and providers for residents of rural communities*. NOSORH provides these comments to help provide a rural perspective on the impact of the proposed guidance.

Issue - Silver Loading

Discussion: In the proposed rule, CMS discusses the challenges created by Silver Loading – increases in Silver plan premiums resulting from the failure of the Federal government to appropriate funds to reimburse insurers for Cost Sharing Reductions (CSR). Under Patient Protection and Affordable Care Act (PPACA) requirements, insurers must reduce Silver plan copays, coinsurance and deductibles for lower income enrollees. In the absence of Federal support, most insurers have incorporated the additional cost of CSRs in higher Silver plan premiums – 'loading' these premiums with those costs. CMS seeks comment on ways in which HHS might address Silver loading for potential action in future rulemaking. These additional rules would be applicable no sooner than plan year 2021.

In the absence of Federal appropriations, insurers must assume the full cost of Silver plan CSR requirements for lower income enrollees. It is appropriate for insurers to reflect the actual cost of Silver plans in the price of this tier of offering. It would be inappropriate to shift the cost of this product tier to other metal level offerings, as the price of those

offerings does not include CSR requirements. Requiring an insurer to shift costs to other products would be like requiring the Ford Motor company to raise the price of the subcompact Ford Fiesta to offset the higher production cost of a Lincoln Continental. NOSORH understands that a secondary effect of higher Silver plan prices is an increase the level of subsidized premiums for all tiers of health plan. This calculation is a requirement of the PPACA statute and regulations. The requirement was enacted with the understanding that Federal appropriations would be made allowing insurers to price their offerings appropriately.

NOSORH does not believe that CMS should require shifting of Silver plan CSR costs to other tiers of insurance plans in an attempt to reduce the level Advanced Premium Tax Credits (APTCs). Any such regulatory effort would be an artificial distortion of the health insurance market. The higher price of Silver plans is the direct consequence of the failure of Congress to appropriate enough funding for CSR requirements. NOSORH believes that reductions of APTC levels can best be achieved by Congress appropriating support for CSRs, as was originally intended under PPACA.

NOSORH notes that the higher levels of APTC resulting from higher Silver plan premium levels has had an important impact on the net cost of Bronze plans for lower income individuals. Recent studies have shown that higher APTCs permit these individuals to secure Bronze plan coverage for little or no cost – see the following link for one of these analyses:

https://www.kff.org/health-costs/press-release/some-can-get-marketplace-plans-with-no-premiumsthough-with-higher-deductibles-and-cost-sharing/

These low/no cost offerings are equally available in rural and urban counties. This improves the financial access of lower income Americans in rural communities to health care coverage.

Recommendation: NOSORH recommends that CMS refrain from issuing any requirements that would direct insurers to shift Silver plan CSR costs to other tiers of health plans.

Issue - Automatic Re-Enrollment

Discussion: The proposed rule seeks comment on the current automatic re-enrollment process for purchases of Qualified Health Plans (QHPs) on the FFE/SBE-FP marketplace. The proposal also seeks ways to improve enrollment policies and procedures to reduce eligibility errors. The proposal clarifies that comments would be considered in the development of future rulemaking, to be effective no sooner than plan year 2021.

NOSORH believes that automatic re-enrollment is an important process that facilitates the selection of QHPs for consumers. NOSORH also believes that such facilitation is particularly important for residents of rural communities where there is limited access to enrollment programs and online portals. NOSORH suggests that automatic re-enrollment be continued in future years and that additional steps in that process be considered to help reduce eligibility errors. This policy position is discussed in greater detail below.

The preface of the proposed rule details the key reasons for continuing automatic re-enrollment. Automatic re-enrollment significantly reduces issuer administrative expenses and makes enrolling in health insurance more convenient for the consumer. The practice is consistent with broader industry practices, most notably with the annual choice of Medicare supplemental policies and Medicare Advantage coverage. The significance of this practice is underlined by the fact that in the open enrollment period for 2019 coverage, 1.8 million people in states using the Federal platform were automatically re-enrolled in coverage.

The importance of automatic re-enrollment for rural consumer convenience cannot be overstated. There is a rural digital divide – evidenced by a significant disparity in broadband availability in rural and urban communities. This lack of availability requires rural consumers to take extra effort to gain access to online enrollment portals – access taken for granted by urban consumers. Rural communities also have more limited health coverage outreach and enrollment services, such as insurance navigator services. This lack of availability has been exacerbated by reductions of Federal funding for these services in the last few years. Finally, rural communities are served by fewer insurance brokers who might assist in the selection of health plans. Automatic re-enrollment allows rural consumers to maintain health coverage without extensive effort.

NOSORH recognizes that errors can occur with automatic re-enrollment. Some consumers may have gained other coverage and failed to cancel their previous coverage. This is not an overwhelming issue and is faced by other types of coverage where automatic enrollment is standard practice. The number of these instances is relatively small and can be resolved in a single billing period when no premium is paid on the previous policy.

Another type of problem can occur when consumers want to continue their previous coverage but have changes to their income. These individuals may need to alert the policy issuer of the changes to assure that APTCs are correctly calculated. NOSORH believes that the problem posed by this type of error is small compared to the overall benefit to consumers of automatic re-enrollment. NOSORH also believes that a few additional procedures can reduce these errors.

Many problems can be eliminated by requiring a mailed announcement to enrollees providing notice of the potential automatic re-enrollment. This is routinely done with Medicare supplemental and Medicare Advantage plans. This notice alerts consumers that they need to act if they wish to change coverage. Note that there is a mechanism within Medicare that alerts the issuers of any previous coverage when an enrollee has chosen other coverage. A similar mechanism can be created for enrollees on the QHP marketplace.

A mailed re-enrollment notification to consumers can also include a mail-back form for updating income information. Such a form could include the income information currently on file and make provision for submitting any changes. This would permit appropriate calculation of APTCs.

Recommendation: NOSORH recommends that CMS continue automatic re-enrollment as a practice for health plan coverage on the Federally-facilitated marketplace. NOSORH further recommends that CMS require insurers to implement an appropriate re-enrollment notification and update process to reduce coverage and eligibility errors.

Issue - FFE/SBE-FP User Fees

Discussion: In the proposed rule CMS seeks to reduce, for the 2020 benefit year, the FFE user fee rate to 3.0 percent of the monthly premium, and the SBE–FP user fee rate to 2.5 percent of the monthly premium. This action is proposed as a means of reducing overall premium cost for consumers.
NOSORH believes that this proposed reduction is premature. As a potential cost savings, a reduction of .5% of the premium is nominal at best. NOSORH also believes that proceeds from the current, higher user fee can be used in a way that significantly improves health coverage enrollment in rural areas. In the past, Federal funding for outreach and enrollment helped target the uninsured in rural communities. Funding for these efforts, however, has been all but eliminated in recent years. The result has been a leveling of health care coverage in some communities and an increase in uninsured rates in others. NOSORH believes that rural consumers would best be served by keeping user fees at the current level and using these revenues to support enhanced outreach and enrollment.

Recommendation: NOSORH recommends that CMS continue the current level of FFE/SBE-FP user fees and that CMS use a significant portion of those user fees to support enhanced outreach and enrollment efforts in areas with high uninsured rates. NOSORH recommends that special outreach and enrollment emphasis be placed on rural and frontier areas with high uninsured rates.