

ELECTRONIC TRANSMITTAL (Submitted via Regulations.gov)

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The Medicaid Health Plans of America (MHPA) is the leading national trade association focused solely on the universe of Medicaid health plans. MHPA works on behalf of 165 commercial and nonprofit plans that serve 28 million Medicaid enrollees in 39 states. We are grateful for the opportunity to comment to the Centers for Medicaid and Medicare Services (CMS) request for information (RFI) regarding concerns about health care providers and provider-affiliated organizations steering people eligible for receiving Medicare and/or Medicaid benefits to an individual market plan for the purpose of obtaining higher payment rates.

MHPA is particularly concerned with regards to steering practices that might disenfranchise Medicaid beneficiaries of the benefits provided by our plans. The potential steering of beneficiaries not only has programmatic effects on Federal expenditures, but also can result in the disruption of care for vulnerable populations, as well as cost-sharing uncertainty. For example, generally Medicaid-eligible individuals generally would have more expansive benefits and lower cost-sharing (if any) through Medicaid than what they would receive from the individual market. Moreover, as CMS notes in the RFI, enrollment decisions should be made, without influence, by the individual based on their specific circumstances, and health and financial needs.

A survey of our members has corroborated some of the reports that presumably served as the impetus for CMS's request for information; third party payment have been an issue primarily as related to dialysis providers, residential treatment facilities for substance abuse and mental health conditions, and closely-related organizations. We would note that some plans also have concurrent open investigations underway within their Special Investigation Units (SIUs) targeting these type of practices.

These third party assistance programs are often operated by special interest groups under the guise of assisting beneficiaries with access to care. In fact, some of these programs are merely a de facto workaround to attempt to secure higher reimbursement for the same services that are provided to a beneficiary.

It is apparent that many beneficiaries claim to receive a benefit from certain non-profit third parties with regards to premium assistance, and are advocating for their inclusion as approved entities. However, in behooves CMS as the stewards of public programs such as Medicare and Medicaid to reconsider the parameters related to steering and the potential "cross-over" impact on other markets (i.e. federally-state facilitated marketplaces/"Exchanges") and should explore revisions to Medicare and Medicaid provider conditions of participation and enrollment rules, etc.

For example, there has been anecdotal evidence that steering practices may be helping to contribute to adverse selection in the public exchanges and maybe connected to evidence of extraordinary specialty spending in that market. We would suggest that CMS leverage its data capacity to identify outliers and trends, as well work with other Federal agencies (e.g. IRS) to assure the integrity of public programs.

We thank you for this opportunity to provide commentary to supplement the comments we anticipate from our member plans.