



October 4, 2010

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: OCIO-9989-NC
P.O. Box 8010
Baltimore, MD 21244-8010

Via Electronic Transmission

Dear Mr. Angoff,

Medicaid Health Plans of America appreciates the opportunity to comment on the Office of Consumer Information and Insurance Oversight's request for comments on the Planning and Establishment of State-Level Exchanges and Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act published in the *Federal Register* on August 3, 2010, at 45 CFR Part 170.

Medicaid Health Plans of America (MHPA) is a national trade association and not-for-profit organization representing 23 health plans with 14 million members in the Medicaid and CHIP programs in 35 states and the District of Columbia. MHPA represents both non-profit and for-profit health plans, ranging from large multi-state insurance corporations to small community-based health plans. For more about MHPA members, go to www.mhpa.org. Our comments will be confined to interaction between Medicaid and the Exchange and the policies affecting the Medicaid health plan business and the low-income Medicaid beneficiaries they serve.

The mission of MHPA is to develop and advance public policy that controls costs and improves access and delivery of quality health care to Medicaid members. MHPA supports the principle that every American should have access to affordable health coverage.

Our comments will primarily be centered around four areas:

- Streamlining enrollment processes
- Maintaining continuity of coverage
- Medicaid health plan participation in Exchanges
- Encouraging consumer choice

Streamlining Enrollment Processes

The Affordable Care Act provides for the state Exchanges to serve an eligibility determination and enrollment function for the Medicaid and CHIP programs, in addition to determining eligibility for subsidies and enrollment in the Exchange. We believe this will be a valuable tool in identifying eligible but un-enrolled individuals and getting them enrolled into the correct program, whether that's Medicaid, CHIP, or the Exchange.

We support efforts to simplify the enrollment process for the individual. We would encourage national protocols around sources of income and citizenship verification data such that states have access to IRS, SSA, and other federal data necessary to make eligibility determinations rapidly. Individuals seeking to determine eligibility and to enroll should have access to real time or near-real time enrollment.

A central web-based portal is a great tool the states should use for Medicaid, CHIP, and Exchange eligibility and enrollment. We would encourage federal standards for the state portals that include a consumer-friendly interface, easy navigation, only the necessary set of consumer information requirements, and availability in multiple languages. OCIO should provide states with a template to standardize enrollment procedures through the web portals and provide the software necessary to ensure consistent eligibility determinations nationwide. Although these web portals will serve an important function in eligibility and enrollment, we believe other traditional enrollment methods will still be required.

Maintaining Continuity of Coverage

MHPA believes that maintaining continuity of coverage, reducing churning, and eliminating disruptions in coverage should be overarching goals of the enrollment policies in the Exchange. To achieve these goals, we have the following suggestions:

1. Require states to adopt continuous eligibility in Medicaid and CHIP for some period of time that corresponds to open enrollment periods in the Exchange; we suggest 12-month continuous eligibility and redetermination in Medicaid synced with annual open enrollment periods in the Exchange. This would eliminate frequent shifts between Medicaid and the Exchange for the individual that could result from changes in income of just a few dollars.
2. Ensure that the system is set up to support and encourage individuals to be continuously enrolled. With today's information technology networks and access to real-time data, states can ensure that there are no gaps in coverage as people move from Medicaid to the Exchange. There should not be disincentives built into the system such as unnecessary paperwork, extra income verifications, or other roadblocks to coverage.

Medicaid Health Plan Participation in Exchanges

MHPA believes Medicaid health plans are well-positioned to serve individuals in the Exchange, particularly lower-income populations in the Exchange and in the Basic Health Plans, should states choose to establish them. While we believe Medicaid health plans should have the option of providing coverage to individuals in the Exchange, we do not believe they should be required to do so. Likewise, we do not believe plans that offer coverage in the Exchange should be required to also participate in Medicaid and CHIP. There are other ways to support the goal of continuity of coverage, such as 12-month continuous enrollment and transition periods.

Medicaid health plans and commercial health plans operate under a very different set of rules and requirements, and have a very different business model, including different provider networks. Many providers refuse to contract with Medicaid health plans, much like they refuse to see traditional Medicaid fee-for-service patients. Many Medicaid health plans specialize in the Medicaid business, which means contracting primarily with community and safety-net providers. Provider networks even vary between the Medicaid and commercial plans provided by the same company, if the company provides business in both Medicaid and the commercial market in the same geographic area.

If the goal of requiring health plans to operate in both Medicaid and the Exchange is to ensure continuity of providers regardless of which program the individual is in, doing so would not achieve the stated goal. Another way to ensure more seamless transitions between Medicaid and the Exchange would be to establish a transition period where beneficiaries can complete treatments in progress for an allotted period of time, allowing a smoother transition between plans and maintaining access to care.

Many smaller Medicaid-focused health plans are simply not equipped to provide coverage in the commercial market as they lack the necessary back-office capabilities of larger, more diversified health plans such as premium collection, marketing and other administrative functions related to offering a commercial product. They have missions to serve the Medicaid population and have never desired to offer a commercial product. According to the latest CMS Medicaid Managed Care Enrollment Report from 2009, there are 159 Medicaid-only managed care organizations.

State insurance departments regulate commercial health plans and Medicaid health plans quite differently. Medicaid health plans have different capital reserve and solvency requirements, and are subject to additional state and federal requirements as outlined in the Social Security Act. The benefits mandated in Medicaid and in commercial plans by states are also different, and should, for good policy reasons, continue to be different under the Affordable Care Act. The Medicaid appeals process and quality reporting requirements are also different. In short, the Medicaid health plan model has worked because Medicaid plans can specialize in the needs of low-income populations. A requirement that they now also serve populations in the Exchange would likely cause them to rethink their business and result in market consolidation and less competition.

Careful consideration needs to be given to any requirements that affect the underlying Medicaid managed care programs, rules, waivers, or state plan amendments that have created a strong competitive and quality environment for Medicaid.

While we believe Medicaid health plans are well-positioned to be Qualified Health Plans and offer commercial plans in the Exchange, we do not believe they should be required to participate in the Exchange. We would urge OCIIO and CMS to examine the differences in the markets and fully analyze the impact of such a requirement. Furthermore, we would urge you to consider issuing guidance to states specifically advising them that health plans participating in Medicaid should not be required to also offer coverage in the Exchange, recognizing the differences between the programs and the populations served. This would help ensure that each population receives access to the coverage that best fits their needs.

Encouraging Consumer Choice

The establishment of state Exchanges where consumers select coverage among competing certified plans based on cost and quality also offers a new opportunity and platform for Medicaid beneficiaries to make the same choice among competing Medicaid health plans contracting with the state.

If applicants are determined eligible for Medicaid through the Exchange, we believe states should be encouraged to allow them to choose among competing Medicaid plans available in their area to the greatest extent possible. They could then enroll directly in the plan they select, without being assigned a plan by the state or first being enrolled in traditional Medicaid. We believe this would also promote continuity of coverage and add an element of consumer choice in the Medicaid program not available in many areas.

Conclusion

Thank you for the opportunity to present our views. We would be happy to work with OCIIO and CMS as you develop the standards and regulations around development of the State Exchanges. We would recommend you consult with Medicaid health plans among other stakeholders as you develop new procedures for Medicaid outreach and enrollment. Please feel free to contact Joe Moser, MHPA Director of Federal Affairs at (202) 857-5724 or jmoser@mhpa.org if you have any questions regarding our comments.

Sincerely,



Thomas L. Johnson
President and CEO