V. Proposed Action

With the exception of interstate transport provisions pertaining to the contribution to nonattainment or interference with maintenance in other states and visibility protection requirements of section 110(a)(2)(D)(i)(I) and (II) (prongs 1, 2, and 4), EPA is proposing to approve Georgia's December 14, 2015, SIP submission, for the 2012 Annual $PM_{2.5}$ NAAQS for the above described infrastructure SIP requirements. EPA is proposing to approve Georgia's infrastructure SIP submission for the 2012 Annual $PM_{2.5}$ NAAQS because the submission is consistent with section 110 of the CAA.

VI. Statutory and Executive Order Reviews

Under the CAA, the Administrator is required to approve a SIP submission that complies with the provisions of the Act and applicable Federal regulations. *See* 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the CAA. Accordingly, this proposed action merely approves state law as meeting federal requirements and does not impose additional requirements beyond those imposed by state law. For that reason, this proposed action:

- Is not a significant regulatory action subject to review by the Office of Management and Budget under Executive Orders 12866 (58 FR 51735, October 4, 1993) and 13563 (76 FR 3821, January 21, 2011);
- does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the CAA; and
- does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, the SIP is not approved to apply on any Indian reservation land or in any other area where EPA or an Indian tribe has demonstrated that a tribe has jurisdiction. In those areas of Indian country, the rule does not have tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), nor will it impose substantial direct costs on tribal governments or preempt tribal law.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Intergovernmental relations, Nitrogen dioxide, Ozone, Particulate matter, Reporting and recordkeeping requirements, Volatile organic compounds.

Authority: 42 U.S.C. 7401 *et seq.*

Dated: August 9, 2016.

Heather McTeer Toney,

Regional Administrator, Region 4.

[FR Doc. 2016–20139 Filed 8–22–16; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 402, 420, and, 455

[CMS–6074–NC]

RIN 0938–ZB31

Request for Information: Inappropriate Steering of Individuals Eligible for or Receiving Medicare and Medicaid Benefits to Individual Market Plans

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Request for information.

SUMMARY: This request for information seeks public comment regarding concerns about health care providers and provider-affiliated organizations steering people eligible for or receiving Medicare and/or Medicaid benefits to an individual market plan for the purpose of obtaining higher payment rates. CMS is concerned about reports of this practice and is requesting comments on the frequency and impact of this issue from the public. We believe this practice not only could raise overall health system costs, but could potentially be harmful to patient care and service coordination because of changes to provider networks and drug formularies, result in higher out-of-pocket costs for enrollees, and have a negative impact on the individual market single risk pool (or the combined risk pool in states that have chosen to merge their risk pools). We are seeking input from stakeholders and the public regarding the frequency and impact of this practice, and options to limit this practice.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on September 22, 2016.

ADDRESSES: In commenting, refer to file code CMS–6074–NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–*6074*–NC, P.O. Box 8010, Baltimore, MD 21244–*8010.*

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–*6074*–NC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses:

a. For delivery in Washington, DC—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots

located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Morgan Burns, 301–492–4493.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

This is a request for information only. Respondents are encouraged to provide complete but concise responses to the questions listed in the sections outlined below. Please note that a response to every question is not required. This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal, applications, proposal abstracts, or quotations. This RFI does not commit the Government to contract for any supplies or services or make a grant award. Further, CMS is not seeking proposals through this RFI and will not accept unsolicited proposals.

Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request. Please note that CMS will not respond to questions about the policy issues raised in this RFI. CMS may or may not choose to contact individual responders. Such communications would only serve to further clarify written responses. Contractor support personnel may be used to review RFI responses. Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur cost for which reimbursement would be required or sought. All submissions become Government property and will not be returned. CMS may publically post the comments received, or a summary thereof.

I. Background

The Centers for Medicare & Medicaid Services (CMS) believes that when health care providers or provider-affiliated organizations steer or influence people eligible for or receiving Medicare and/or Medicaid benefits, it may not be in the best interests of the individual, it may have deleterious effects on the insurance market, including disruptions to the individual market risk pool, and it is likely to raise overall healthcare costs. Individuals eligible for Medicare and/or Medicaid benefits are not required to enroll in these programs.[1] However, individuals eligible for Medicaid or Medicare Part A benefits are generally ineligible for the premium tax credit (PTC), including advance payments thereof (APTC), and for cost-sharing reductions (CSR) for their Qualified Health Plan (QHP) coverage for the months they have access to minimum essential coverage (MEC) through the Medicare or Medicaid programs.[2]

We have heard anecdotal reports that individuals who are eligible for Medicare and/or Medicaid benefits are receiving premium and other cost-sharing assistance from a third party so that the individual can enroll in individual market plans for the provider's financial benefit. In some cases, a health care provider may estimate that the higher payment rate from an individual market plan compared to Medicare or Medicaid is sufficient to allow it to pay a patient's premiums and still financially gain from the higher reimbursement rates. Issuers are not required to accept such payments from health care providers or provider-affiliated organizations, as described below. Enrollment decisions should be made, without influence, by the individual based on their specific circumstances, and health and financial needs. CMS has established standards for enrollment assisters, including navigators, which prohibit gifts of any value as an inducement for enrollment, and require information and services to be provided in a fair, accurate, and impartial manner.[3] Additionally, CMS has established standards for insurance agents and brokers that register with the Federal Marketplace, including training about the interaction of Medicare and Medicaid eligibility with eligibility for individual market plans and financial assistance, and has remedies for insurance agents that provide inaccurate or incorrect information to consumers, such as misinformation about the impact of not enrolling in Medicare when an individual first becomes eligible, including termination of the Marketplace agreement, civil monetary penalties, and denial of right to enter agreements in future years.[4]

We believe there is potential for financial harm to a consumer when a health care provider or provider-affiliated organization (including a non-profit organization affiliated with the provider) steers people who could receive or are receiving benefits under Medicare and/or Medicaid to enroll in an individual market plan. The potential harm is particularly acute when the steering occurs for the financial gain of the health care provider through higher payment rates

[1] Individuals eligible to receive premium free Medicare Part A benefits may not decline Medicare Part A entitlement if they accept Social Security benefits.

[2] See 26 U.S.C. 36B. In general, an individual who is eligible for minimum essential coverage (other than coverage in the individual market) for a month is ineligible for the premium tax credit for that month. Medicare part A and most Medicaid programs are minimum essential coverage. See 26 U.S.C. 5000A(f) and 26 CFR 1.5000A–2(b).

[3] 45 CFR 155.210.

[4] 45 CFR 155.220.

without taking into account the needs of these beneficiaries. People who are steered from Medicare and Medicaid to the individual market may also experience a disruption in the continuity and coordination of their care as a result of changes in access to their network of providers, changes in prescription drug benefits, and loss of dental care for certain Medicaid beneficiaries. If an individual receives the benefit of APTC for a month he or she is eligible for minimum essential coverage, the individual (or the person who claims the individual as a tax dependent) may be required to repay some or all of the APTC at the time such person files his or her federal income tax return. Moreover, it is unlawful to enroll an individual in individual market coverage if they are known to be entitled to benefits under Medicare Part A, enrolled in Medicare Part B, or receiving Medicaid benefits. Importantly, those eligible for Medicare may be subject to late enrollment penalties if they do not enroll in Medicare when first eligible to do so—a monthly premium for Part B may go up 10 percent for each full 12-month period an individual could have had Part B, but did not sign up for it.[5] Individuals who become eligible for Medicare based on receipt of Social Security benefits based on age or Social Security Disability Insurance (SSDI) must forgo and if received repay their Social Security cash benefits if they wish to decline Medicare Part A benefits.[6] Additionally, individuals who are steered into an individual market plan for renal dialysis services and then have a kidney transplant while enrolled in the individual market plan will not be eligible for Medicare Part B coverage of their immunosuppressant drugs if they enroll in Medicare at a later date.[7]

Federal regulations at 45 CFR 156.1250 require that issuers offering Qualified Health Plans (QHPs), including stand-alone dental plans, and their downstream entities, accept premium and cost-sharing payments on behalf of QHP enrollees from the following third-party entities (in the case of a downstream entity, to the extent the entity routinely collects premiums or cost sharing): (a) A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act; (b) an Indian tribe, tribal organization, or urban Indian organization; and (c) a local, state, or Federal government program, including a grantee directed by a government program to make payments on its behalf.[8] Issuers are not required to accept such payments from other entities. These regulations were finalized in the 2017 HHS Notice of Benefit and Payment Parameters Final Rule, which made several amendments to the regulations previously codified through a March 19, 2014, HHS Interim final rule (IFR) with comment period titled, Patient Protection and Affordable Care Act; Third Party Payment of Qualified Health Plan Premiums (79 FR 15240).

Prior to publishing the IFR, HHS issued two ''Frequently Asked Questions'' (FAQ) documents regarding premium and cost-sharing payments made by third parties on behalf of individual market plan enrollees. In an FAQ issued on November 4, 2013 (the November FAQ), HHS discouraged QHP issuers from accepting third-party payments made on behalf of enrollees by hospitals, other health care providers, and other commercial entities due to concerns that such practices could skew the insurance risk pool and create an unlevel field in the Exchanges. The FAQ also noted that HHS intended to monitor this practice and to take appropriate action, if necessary.

On February 7, 2014, HHS issued another FAQ (the February FAQ) clarifying that the November FAQ did not apply to third party premium and cost-sharing payments made on behalf of enrollees by Indian tribes, tribal organizations, and urban Indian organizations; state and Federal government programs (such as the Ryan White HIV/AIDS Program); or private, not-for-profit foundations that base eligibility on financial status, do not consider enrollees' health status, and provide assistance for an entire year. In the February FAQ, HHS affirmatively encouraged QHP issuers to accept payments from Indian tribes, tribal organizations, and urban Indian organizations; and state and Federal government programs (such as the Ryan White HIV/AIDS Program) given that Federal or state law or policy specifically envisions third party payment of premium and cost-sharing amounts by these entities.

CMS seeks to clarify that offering premium and cost-sharing assistance in order to steer people eligible for or receiving Medicare and/or Medicaid benefits to individual market plans for a provider's financial gain is an inappropriate action that may have negative impacts on patients. CMS is strongly encouraging any provider or provider-affiliated organization that may be currently engaged in such a practice to end the practice. As noted above, enrollment decisions should be made based on an individual's particular financial and health needs.

As we assess the extent of potential steering activities, its impact on beneficiaries and enrollees and the individual market single risk pool, CMS reminds healthcare providers and other entities that may be engaged in such behavior that we have several regulatory and operational tools that we may use to discourage premium payments and routine waiver of cost-sharing for individual market plans by health care providers, including, but not limited to, revisions to Medicare and Medicaid provider conditions of participation and enrollment rules, and imposition of civil monetary penalties for individuals who failed to provide correct information to the Exchange when enrolling consumers into QHPs.[9] CMS is also working closely with federal, state and local law enforcement to investigate instances of potential fraud and abuse, as well as collaborating with private and public health plans on provider fraud in the Healthcare Fraud Prevention Partnership.[10] We are exploring ways to use our existing authorities to impose civil monetary penalties on health care providers when their actions result in late enrollment penalties for Medicare eligible individuals who were steered to an individual market plan and delayed Medicare enrollment.

II. Solicitation of Comments

We are seeking information from the public about circumstances in which steering into individual market plans may be taking place and the extent of such practices. We are particularly interested in transparency around the current practices providers may be using to enroll consumers in coverage. Our goal is to protect consumers from inappropriate health care provider behavior. People eligible for or receiving Medicare and/or Medicaid benefits should not be unduly influenced in their decisions about their health coverage options. We also seek to maintain continuity of care for these beneficiaries and ensure patient choice is the primary reason for any change in health coverage. We also want to ensure healthcare is being provided efficiently

[5] *https://www.medicare.gov/your-medicare-costs/part-b-costs/penalty/part-b-late-enrollment-penalty.html.*

[6] *https://www.cms.gov/Outreach-and-Education/Find-Your-Provider-Type/Employers-and-Unions/Top-5-things-you-need-to-know-about-Medicare-Enrollment.html.*

[7] *https://www.medicare.gov/coverage/prescription-drugs-outpatient.html.*

[8] 2017 HHS Payment Notice Final Rule.

[9] 45 CFR 155.285 Bases and process for imposing civil penalties for provision of false or fraudulent information to an Exchange or improper use or disclosure of information.

[10] See *https://hfpp.cms.gov/* for more information.

and affordably. Accordingly, to more fully understand the types of situations in which steering may occur as we develop regulatory or operational changes to address these problems, we request comments on the following:

- In what types of circumstances are healthcare providers or provider-affiliated organizations in a position to steer people to individual market plans? How, and to what extent, are health care providers actively engaged in such steering?
- What impact is there to the single risk pool and to rates when people enter the single risk pool who might not otherwise have been in the pool because they would normally be covered under another government program? Are issuers accounting for this uncertainty when they are setting rates?
- Are there examples of steering practices that specifically target people eligible for or receiving Medicare and/or Medicaid benefits to enroll in individual market plans? In what ways are people eligible for or receiving Medicare and/or Medicaid benefits particularly vulnerable to steering? To what extent, if any, are providers steering people eligible for or receiving Medicare and/or Medicaid to individual market plans because they are prohibited from billing the Medicare and Medicaid programs, through exclusion by the HHS Office of Inspector General, termination from State Medicaid plans or the revocation of Medicare billing privileges?
- Is the payment of premiums and cost-sharing commonly used to steer individuals to individual market plans, or are other methods leading to Medicare and Medicaid eligible individuals being enrolled in individual market plans? Specifically, how often are issuers receiving payments directly from health care providers and/or provider affiliated organizations? Are issuers capable of determining when third party payments are made directly to a beneficiary and then transferred to the issuer? What actions could CMS consider to add transparency to third party payments?
- How are enrollees impacted by the practice of a health care provider or provider-affiliated organizations enrolling an individual into an individual market plan and paying premiums for that individual market plan, when the individual was previously or concurrently receiving Medicare and/or Medicaid benefits? We are concerned about instances where individuals eligible for Medicare and/or Medicaid benefits may have been disadvantaged by unscrupulous practices aimed at increasing provider payments, including impacts to the enrollee's continuity of care. We would be interested in knowing more about these practices and the extent to which they may be more widespread or varied than we have identified.
- How are enrollees impacted by the practice of a health care provider enrolling an individual into an individual market plan and paying premiums for individual market plans, when the individual was eligible for Medicare and/or Medicaid, but not enrolled? We are particularly interested in information about how to measure negative impacts on beneficiaries and enrollees, and what data sources and measurement methodologies are available to assess the impact of this behavior described in this request for information on beneficiaries and enrollees. We are seeking information on any financial impacts that are in addition to Medicare late enrollment penalties. For example, differentials in copayments and deductibles paid by enrollees in individual market plans, Medicare or Medicaid, and the impact of individual market plan network limitations on the financial obligations of enrollees, such as increased copayments and deductibles where the enrollee's chosen provider is out-of-network to the individual market plan.
- What remedies could effectively deter health care providers or provider-affiliated organizations from steering people eligible for or enrolled in Medicare and/or Medicaid to individual market plans and paying premiums for the provider's financial gain? CMS is considering modifying regulations regarding civil monetary penalties and authority related to individual market plans.
- What steps do third party payers take to effectively screen for Medicare and/or Medicaid eligibility before offering premium assistance? What steps do these entities take to make sure that any such individuals understand the impact of signing up for an individual market plan if they are already eligible for or receiving Medicare and/or Medicaid benefits?
- For providers that offer premium assistance, who is interacting with beneficiaries to determine proper enrollment? What questions are asked of the consumer to determine eligibility pathways? How are consumers connected to foundations or others who are in the position to provide premium assistance? How are premiums paid by providers or foundations for consumers?
- We seek comment on policies prohibiting providers from making offers of premium assistance and routine cost-sharing waivers for individual market plans when a beneficiary is currently enrolled or could become enrolled in Medicare Part A and other adjustments to federal policy on premium assistance programs in the individual market to prevent negative impact to beneficiaries and the single risk pool.
- We seek comments on changes to Medicare and Medicaid provider enrollment requirements and conditions of participation that would potentially restrict the ability of health care providers to manipulate patient enrollment in various health plans for their own benefit. We are also interested in information on the extent steering is associated with other inappropriate behavior, such as billing for services not provided, or quality of care concerns. We seek comment on the advisability of such restrictions, as well as considerations of how such restrictions would affect health care providers and beneficiaries.
- We seek comment on policies to require Medicare and Medicaid-enrolled providers to report premium assistance and cost-sharing waivers for individual market enrollees to CMS or issuers.
- We seek comments on whether individual market plans considered limiting their payment to health care providers to Medicare-based amounts for particular services and items of care and on potential approaches that would allow individual market plans to limit their payment to health care providers to Medicare-based amounts for particular services and items of care.
- We seek comment on policies that would allow individual market plans to make retroactive payment adjustments to providers, when health care providers are found to have steered Medicare or Medicaid beneficiaries and enrollees to enroll in an individual market plan for the provider's financial gain.

III. Collection of Information Requirements

This request for information constitutes a general solicitation of public comments as stated in the implementing regulations of the Paperwork Reduction Act at 5 CFR 1320.3(h)(4). Therefore, this request for information does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Dated: August 16, 2016.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. 2016–20034 Filed 8–18–16; 4:15 pm]

BILLING CODE 4120–01–P