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VIA ELECTRONIC SUBMISSION

June 27, 2022

Re: CMS-4199-P—Medicare Program; Implementing Certain Provisions of the Consolidated Appropriations Act, 2021 and Other Revisions to Medicare Enrollment and Eligibility Rules

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4199-P, P.O. Box 8013
Baltimore, MD 21244-4199

Dear Administrator Brooks-LaSure:

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the **Medicare Program; Implementing Certain Provisions of the Consolidated Appropriations Act, 2021 and Other Revisions to Medicare Enrollment and Eligibility Rules** proposed rule. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable and equitable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over three million people with Medicare, family caregivers, and professionals. We address below the proposed changes to both the Part A and Part B programs.

We appreciate the complex administrative work behind the outlined changes to state buy-in programs and the thoughtful implementation of significant statutory changes. Overall, we support the proposed rules and the agency's stated aims in promulgating them.

Beneficiary Enrollment Simplification in Medicare Parts A and B

The basic rules underpinning the Part B enrollment system were developed more than 50 years ago, when Medicare was first established. These outdated and overly complex rules have had serious consequences for millions of people. In 2021 alone, about 779,400 people with Medicare were paying a Part B Late Enrollment Penalty (LEP), with the average penalty

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amounting to nearly a 30% increase in their monthly premium.[1] In addition to this considerable financial burden, many older adults and people with disabilities have faced large out-of-pocket health care costs, gaps in coverage, and barriers to care continuity because of honest enrollment mistakes.

The Beneficiary Enrollment Notification and Eligibility Simplification (BENES) Act—passed as section 120 of Title I, subpart B of the Consolidated Appropriations Act, 2021 (CAA)—provides long-overdue solutions to modernize and simplify Part B enrollment. It also allows the Secretary to establish important flexibilities—Special Enrollment Periods (SEPs)—for individuals facing exceptional circumstances. We are grateful for the Administration's timely choice to implement the requirements of the BENES Act and appreciate the scope of the proposed rule.

By updating enrollment timelines and establishing SEPs, the provisions of the Proposed Rule, if finalized, would allow many Americans who have previously or would have otherwise missed a Medicare enrollment period the chance to enroll in health insurance with less or no delay. In addition to providing essential financial security and peace of mind for those without pressing or immediately known health needs, this increased access will also reduce disparities in care and promote health equity among those who would delay or go without needed care in the absence of insurance coverage.[2]

Increasing access to needed health care through reduced barriers to Medicare enrollment and improved financial security for enrollees are, of course, the primary benefits and appropriate focus of the rulemaking. But we urge the Centers for Medicare & Medicaid Services (CMS) not to ignore other benefits of this simplification and flexibility. Logical effective dates and Special Enrollment Periods that are consistent with other insurance programs—including Medicaid, employer and other group health insurance, Marketplace coverage, Medicare Advantage, and Part D—will ease educational and administrative burdens for beneficiaries and those who work with them. Even the seemingly straightforward shift in coverage effective dates from the existing Initial Enrollment Period (IEP) timelines to the simpler rule of the first day of the following month will help counsellors, Social Security Administration (SSA) employees, and others who aid beneficiaries in navigating Medicare enrollment to devote more time to other complex aspects of that decision-making process.

A. Proposals for Beneficiary Enrollment Simplification

[1] Congressional Research Service, "Medicare Part B: Enrollment and Premiums," May 19, 2022, https://www.everycrsreport.com/files/2022-05-19_R40082_143a23f28239eec6ef87bac952856d5a14d0a22e.pdf.

[2] Kaiser Family Foundation, "The Uninsured and the ACA: A Primer – Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act," January 2019, https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-care/.

1. Effective Dates of Entitlement

The proposed rule states that CMS "expect[s] that these changes to the entitlement for individuals who enroll during their IEP or [General Enrollment Period] are likely to increase access to continuous coverage under Medicare Part B, both by expediting these individuals' entitlement dates and decreasing enrollees' confusion about when their coverage becomes effective. Therefore, we anticipate this change having a positive impact on Medicare beneficiaries, including those in communities who may be disproportionately impacted by lack of continuous health coverage."[3] We agree and thank CMS for this proposal, which we urge the agency to finalize. We support this update and appreciate the publication of the updated table at page 25093.

The proposed rule correctly references Section 1818(c) of the Act, which, in part, requires that the provisions of Section 1838 apply to individuals enrolling in premium Part A. Because the updates to the enrollment periods effectuated in these rules modify section 1838, a conforming and parallel change to the rules regarding premium Part A enrollees is required. We support this change.

The proposed rule includes the "note that CMS would update all public facing materials to reflect the date changes from any final rule. This would include updated information in CMS publications, on *Medicare.gov*, and in training materials."[4] We agree that updates to public facing materials will be required, and we encourage CMS to go further and ensure that the Social Security Administration also updates its public facing and internal documents and engages in affirmative outreach to community-based organizations and individuals, including insurance agents; social workers; human resources offices within large companies; the Aging and Disability network; as well as customer service representatives and case workers at state Medicaid agencies and Marketplaces, to effectively communicate these and other changes in the final rule. When making such updates and engaging in such trainings, we encourage CMS to be particularly attentive to language access and to communications and educational initiatives aimed at historically underserved communities.

In particular, updates to trainings, scripts, and manuals for Social Security Administration workers and 1-800-Medicare call center staff will be critical for both these changes and for those in the rest of the rule given their responsibilities in processing Medicare applications and enrollments, as well as advising callers about their Medicare rights and obligations. We urge CMS to utilize various stakeholder engagement processes to ensure that all sub-regulatory materials are understandable, accurate, actionable, and reflective of the policy aims and positions of the statute and these regulations.

[3] 87 FR 25090, 25093.
[4] *Id.* at 25094.

2. Special Enrollment Periods for Exceptional Circumstances

The proposed rule briefly describes the very limited existing SEPs for Part B and premium Part A. These SEPs are narrow, technical, and inconsistent with the enrollment rules of other types of insurance. For example, they cover only people who are enrolled in a group health plan (GHP) or large GHP (LGHP) at the time they first become eligible for Medicare and who elect not to enroll or be deemed enrolled in Medicare during their IEP, a very limited number of people who are eligible for disability benefits and are covered under a GHP, international volunteers working for certain 501(c)(3) tax exempt organizations and who have health insurance while living overseas, and people enrolled in TRICARE in the first 12 months of their eligibility for Medicare based on disability or ESRD status.

Under the statutory authority now granted by Section 120(a)(2)(A), the Secretary can establish SEPs for individuals who satisfy the requirements for enrollment in Medicare and "meet such exceptional conditions as the secretary may provide, beginning January 1, 2023."[5] In determining what new SEPs would be beneficial to Medicare and its enrollees, CMS reports considering numerous factors:

- Whether the conditions are "exceptional" as required by the act,
- That the SEP not incentivize individuals to delay enrollment into Medicare,
- That the SEP should not create incentive for people to avoid educating themselves about Medicare timely,
- Whether an SEP would be the most appropriate resolution to the conditions in question or whether other remedies would more appropriately apply, and
- That the SEP should apply to a significant number or broad category of individuals.

The proposed rule states that CMS "leveraged our previous program experiences with Medicare enrollment in determining which SEPs to propose… consider[ing] the SEPs for exceptional conditions established under Medicare Parts C and D, the Health Insurance Marketplace, and commercial health plans… [and] whether the proposed new SEPs and the associated entitlement would protect access to continuous coverage for individuals eligible for Medicare Part A and Part B…" We appreciate this careful consideration and the explication of the criteria for evaluating proposed SEPs. The criteria and sources of comparison are, for the most part, reasonable and useful. In particular, we commend the Agency's consideration of the SEPs that have been important in the Medicare Part C and D and Marketplace settings, both to transfer those learnings to the Part B program as well as to promote consistency and administrative ease, where appropriate. Doing so can reduce confusion and frustration among beneficiaries and may increase enrollment. We urge CMS to consider, however, whether "incentive for people to avoid educating themselves about Medicare timely" is realistic given that for such incentive to have effect, the person would need to be aware of the rule that could create the

[5] *Id.*

incentive. If a soon-to-be beneficiary is aware enough of the complicated Medicare enrollment rules to know that there exists an opportunity for relief, it is hard to envision how that same individual would not also be sufficiently aware of the underlying rule itself. In our experience, the vast majority of people who need enrollment relief made genuine mistakes based on the information (or lack thereof) available to them, not out of calculated ignorance or a desire to manipulate the rules. It is hard to imagine an SEP that could incentivize a person to "avoid educating themselves," but easy to imagine how such a standard might undermine relief for people who made honest mistakes because of a lack of timely, directed, helpful information or the existence of hard to understand or incomplete materials. We urge CMS to reconsider its position and the use of the incentive in crafting the SEPs.

A. SEP for Individuals Impacted by an Emergency or Disaster

We appreciate that CMS has utilized its authority under 1837(h) of the Act to provide relief to individuals whose enrollment or non-enrollment was "unintentional or erroneous and resulted from an error, misrepresentation or inaction by the federal government" where disrupted mail delivery and office closures due to disaster have justified such relief. The use of this authority is extremely limited, as the proposed rule notes, and disasters or emergencies may interfere with individuals' ability to enroll in Medicare without any error or inaction by the Federal government. It is not hard to imagine such conditions. We strongly support the proposed establishment of an SEP for people who are not able to enroll in premium Part A or Part B or both if they reside in an area for which a Federal, state, or local government entity newly declared a disaster or other emergency.

The proposed rule notes that "not every emergency declaration would impact an individual's ability to enroll in a timely manner" and solicits comments specifically on whether CMS should limit the timeframe of the SEP based on the type of emergency or specify that the type of emergency must explicitly restrict an individual's ability to enroll. We do not believe such a restriction is appropriate or necessary. While it is true that not every emergency will impact every individual in the affected geographic region's ability to timely enroll, it is hard to imagine an emergency that would not have that impact on at least some people, and it is not clear what benefit is served by limiting relief in this way. It is highly unlikely that a beneficiary would strategically delay enrollment in expectation of an emergency or disaster and requiring beneficiaries to prove a nexus between the emergency and their missed enrollment creates a burden for both the individual and the Social Security workforce. Further, we encourage CMS to revisit the geographic limitation—in line with SEPs that have been established for Medicare Parts C and D during other emergencies[6]—to allow for an individual to show that a person on whom they rely for assistance in managing their financial or health care affairs resides in a location affected by an emergency or disaster.

[6] Hurricane Irene SEP for Part C and D / extension of FOE.

B. SEP for Health Plan or Employer Misrepresentation or Providing Incorrect Information

We support the establishment of an SEP for individuals whose "non-enrollment in premium Part A or Part B is unintentional, inadvertent, or erroneous and results from material misrepresentation or reliance on incorrect information provided by the individual's employer or GHP, or any person authorized to act on behalf of the employer or GHP."[7] Many individuals who call the Medicare Rights Center helpline have relied on such employer advice to their detriment, and face significant gaps in coverage, recoupment of erroneous primary payments made by a secondary insurer, high out of pocket costs, and care disruptions as a result. We strongly encourage CMS to revisit three aspects of this SEP, however, to ensure that it serves the purposes and meets the standards outlined above.

First, we urge CMS in the Final Rule to expand the sources of misinformation that give rise to the SEP to include non-employer insurance sources, such as insurance agents and individual policy sellers, as well as non-federal government entities and agents, including Medicaid, the Marketplace, and State Departments of Insurance or similar. Because the SEP does not arise out of a particular duty (as discussed below), but instead reflects that misinformation from these trusted and presumed reliable sources is reflective of a genuine mistake, rather than manipulation, it is not necessary to artificially circumscribe the sources of misinformation or incorrect information.

Second, CMS should revisit the evidentiary standard proposed, to more accurately and realistically represent the types of misinformation and the availability of documentary evidence to support the statement. In our experience, the type of misinformation for which this SEP would most frequently be needed is almost always verbal, over the phone or in person, and rarely in writing.

Employers often contract with workforce management or human resource (HR) companies, or agent/brokerage firms that handle employee benefit issues. Again, based on our experience assisting Medicare beneficiaries, it is not uncommon that all these parties—along with group health plan benefits administrators—can and do provide misinformation to those they are seeking to assist. Most often we see this happen when an individual is retiring or has otherwise lost his/her job and is transitioning to retiree or COBRA coverage. As noted above, almost all of this type of misinformation is verbal; letters or other documentary evidence reflecting misinformation are rare or non-existent. Further, it is very unlikely that any of these parties would readily admit error, particularly in writing, even if the beneficiary were to continue to have access to them when applying for the SEP. This raises another issue: Employers could be out of business, the person who provided the misinformation may no longer work there or may be deceased, and the entities most likely to provide misinformation regarding Medicare

[7] 87 FR 25090, 25097.

enrollment obligations may be the least likely to voluntarily utilize formal, written processes that would create documentary evidence of their error. We therefore strongly encourage CMS to establish a more reasonable evidentiary standard—one that does not disregard the beneficiary's testimony about their own experience—by accepting their attestation as sufficient evidence. Even if CMS is disinclined to do so, which we strongly caution against, due process demands that the form of proof should not be narrower than would be accepted in any other adjudicatory setting.

In situations where documentary evidence of misrepresentation is not available, enrollees should be permitted to instead show situation-specific information that a misrepresentation was provided and caused their delayed enrollment. For example, they could submit their own records or notes of conversations, proof of payment of premiums for alternative coverage, or other evidence that demonstrates good faith. To the extent that the examples listed in the proposed rule are meant to be illustrative, and that this comment reflects a narrower reading of the documentation requirement than intended, we suggest that CMS clarify this requirement.

Third, CMS should revisit the position that "an omission by the employer or GHP or the representative of such organization would not be considered a misrepresentation for purposes of this proposed SEP, as employers and GHPs do not have an affirmative responsibility to educate employees about Medicare."[8] It is true that no such affirmative responsibility exists. However, providing relief for individuals harmed by such omission does not actually create that responsibility on behalf of the employer or GHP, because the relief is neither harmful nor costly to the informing entity. Even if such a limitation is deemed necessary, CMS should clarify that while broad omissions, such as providing no information about Medicare transitions, may not be considered misrepresentation, more narrow ones may. For example, an employer could provide information to retirees turning 65 that affirmatively states: "your coverage is not changing; you still have your retiree insurance from us." That information omits crucial information about Part B enrollment periods, the Late Enrollment Penalty, and coordination of benefits policies that may result in phantom coordination and a lack of effective coverage if the person relies on the retiree coverage and does not enroll into Medicare Part B. It is essential that such omissions—incomplete information in the context of information that would be reasonably relied upon—be considered misinformation. Beneficiaries cannot know when incomplete information is misleading.

The proposed rule also solicits comment "on whether we should require additional evidence, for example, evidence of what new information was received that caused discovery of the misinformation and evidence of when the discovery was made." We do not support such additions. The burden of proof contemplated for this SEP is already significant, as is the administrative burden to review such proof, and it is not clear that such additional

[8] *Id.*

requirements would serve the aims listed above. Instead, we urge CMS to consider that such proof could be useful, not in addition to the enumerated requirements, but in its place. In cases where the documentary evidence described above is unavailable, proof of later-received information and subsequent action could serve as persuasive evidence of prior-received misinformation.

C. SEP for Formerly Incarcerated Individuals

We strongly support this SEP, which would allow formerly incarcerated individuals to avoid potential gaps in coverage and Late Enrollment Penalties. We suggest the following changes to more accurately reflect the circumstances facing individuals who are exiting incarceration.

Specifically, we urge CMS to revise the proposed SEP timeline. We support a SEP start date that begins before release to better achieve the SEP's aim of reducing gaps in coverage and interruptions in care, and to better reflect the reality of the complex intersection of Medicare rules, state, local, and federal penal law, and the relevant provisions of the Social Security Act for the termination and resumption of OASDI payments. Similarly, we support an SEP end date that is 12 months post-release, rather than six.

These changes are needed to best support enrollment decisions and ensure access to care. For example, as proposed, because Medicare would not begin until the first of the month following enrollment, individuals using this SEP would face a gap in coverage. The timeline CMS contemplates would also reduce the ability of the institution to engage in meaningful pre-release planning and add to the often overwhelming number of high-stakes decisions an individual must make upon release.

In addition, utilizing the "release from incarceration" as described in Section 411.4 gives rise to particular problems. First, as a technical correction, Section 411.4 provides rules for when an individual is in "custody of penal authorities," and does not use or define "incarceration." Second, that section's definition of those "in custody" includes a broad range of individuals – including those who are under arrest (pre-conviction), on medical furlough, required to live under home detention, or are under supervised release (also known as parole). It is important to note that this section does not preclude Medicare payment for these individuals. Rather, it establishes the presumption that another payer is responsible, and provides that "payment may be made for services furnished to individuals or groups of individuals who are in the custody of police or other penal authorities... only if the following conditions are met: (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody and (2) The state or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."[9] Many penal authorities

[9] 42 CFR. § 411.4.

do impose such requirements on individuals "in custody," particularly on people who are under house arrest, medical furlough, or supervised release, as reflected by the fact that both the Medicaid and Marketplace definitions of incarceration and eligibility rules allow for enrollment and payment for care in those situations.[10]

Because Medicare non-payment during incarceration is not a consequence of conviction, or punishment, but is, instead, a reflection of the fact that another entity has financial responsibility for the cost of the person's care, we urge CMS to align this SEP to the SEP for people who have coverage as a result of enrollment in a GHP or LGHP. That is, the SEP should run from the start of their eligibility for Medicare or incarceration, whichever is later though a period after the incarceration ends.

This would allow for pre-release enrollment into Medicare including conditional Part A, where applicable, and coordination with Medicaid so the person would have access to effective coverage upon release. It would also allow the state or other incarcerating entity to assist in the enrollment process, decrease the risk of disruptions in ongoing care or treatment post-release, and reduce the number of the individual's immediate post-release obligations.

Those utilizing the SEP pre-release should be allowed to elect their effective date, either the date of release or upon resumption of OASDI payment. This would better allow for differences in the treatment of payment obligations by different states or localities—permitting a person to enroll when the conditions listed in Section 411.4 are met.

Second, CMS should extend the SEP through a year post-release. As the Agency states in the proposed rule, it takes approximately three months post release for OASDI payments to be reinstated and data demonstrate that individuals with arrest or conviction records face barriers in obtaining employment and other social risk factors that increase both potential obstacles to enrollment and need for healthcare services. [11]

Relatedly, to fully realize the equity and access aims CMS has described in the proposed rule, we urge CMS to work with SSA to establish better procedures for those who lose Medicare due to non-payment of premiums when OASDI is stopped after a conviction. The operation of the automatic grace period – essential for those in the community – in these cases places an unnecessary and unforeseen financial burden on people who are incarcerated and creates an additional barrier to reenrollment. Our helpline has worked with many people who cannot afford to pay three months of premiums in a lump sum. Because Medicare will not generally pay during periods of incarceration, and, with the introduction of this SEP, it will be unusual for a beneficiary to wish to continue to pay Part B premiums while incarcerated. CMS and SSA should explore a change to the default two-month grace period for those whose OASDI payments are terminated post-conviction and instead immediately terminate Part B coverage,

[10] https://www.healthcare.gov/incarcerated-people/
[11] 87 FR 25090, 25097.

allowing for an individual to affirmatively request re-enrollment under either a grace period or by utilizing this SEP.

D. SEP to Coordinate with Termination of Medicaid Coverage

We strongly support this SEP to provide for relief in situations where the transition from Medicaid to Medicare is mismanaged, delayed, or confusing. Especially considering the circumstances described in the proposed rule related to the end of the COVID-19 Public Health Emergency (PHE), but also in other circumstances, failure to enroll timely in Medicare in reliance on or upon the loss of Medicaid coverage can be extremely disruptive and costly.

We also support the proposal at § 406.27(e)(4) and § 407.23(e)(4) that individuals who otherwise would be eligible for this SEP but enrolled in Medicare during the COVID-19 PHE prior to January 1, 2023, if applicable, are eligible to have any LEPs collected under §§ 406.32(d) or 408.22 reimbursed, and ongoing penalties removed.

E. SEP for Other Exceptional Conditions

We support the Secretary retaining flexibility to allow CMS to grant SEPs on a case-by-case basis for unanticipated circumstances that could create a barrier to enrollment. The proposed rule rightly acknowledges that "there is no way to predict the full range of circumstances that would warrant an SEP—they are 'exceptional'—so we need this SEP for exceptional conditions to be timely in our response to beneficiaries with unique cases, given the time it takes to establish a more targeted SEP via rulemaking. There is a similar SEP under Medicare Part C and Part D, and we are leveraging our experience from those programs to afford beneficiaries who have unique exceptional conditions beyond their control that prevent them from enrolling in Medicare, an SEP. In addition, some of the SEPs that are now codified under Part C and Part D started out as case-by-case SEPs. We were able to use the information and experience gained as a basis for establishing a new SEP, through rulemaking, for a broad category of people corresponding to a more specific set of circumstances." CMS should adopt this further flexibility in the Final Rule.

We also suggest that CMS and, to the extent relevant, the Social Security Administration track and report any trends or patterns in the use (and limitations) of these new SEPs. We applaud CMS's desire to use the information and experience gained from this flexibility to establish new SEPs through rulemaking and encourage the agency to do so in a transparent, data-driven, and public way.

A. Additional Suggested SEPs

We appreciate that CMS will consider establishing additional SEPs in the future, looking to the experience of people utilizing these new flexibilities. In particular, we urge CMS to consider SEPs for people with complicated immigration and/ or residency situations. We have worked with people who need such relief in various specific circumstances including immigrants who are unaware of their Medicare eligibility prior to citizenship, people who are told that they are not eligible prior to five years of residency but believe they are permanently barred from

Medicare coverage, and fully insured individuals (citizens or not) who return to the United States after a period of time outside the country and have missed their IEP or dropped Part B.

Eligibility rules for public benefits, including Medicare and Social Security, are more complicated for immigrants and others with changing residency and involve complex calculations that vary based on immigration status, residency, work history, and waiting periods. Further obscuring the situation is that immigrants do not receive any notice when they become eligible for Medicare. We have heard from advocates that many older adults who immigrated to the U.S. may miss their IEP because they, and sometimes the advocates themselves, do not realize that Medicare eligibility can start prior to citizenship. Some low-income individuals may understand that they are eligible to enroll, but the premium is cost-prohibitive, and they are unaware that the Medicare Savings Programs (MSPs) exist or are concerned about implications of enrolling in Medicaid on their path to citizenship, especially in light of the chilling effect of the prior administration's public charge rulemaking.

Extended Coverage of Immunosuppressive Drugs for Certain Kidney Transplant Patients

1. History and Scope of Benefit

We appreciate the statutory creation of this narrow benefit to provide for continued coverage of immunosuppressive drugs for individuals whose Medicare eligibility has terminated after a kidney transplant and who do not have other access to coverage of such medication. We also appreciate the thought that went into the designation and description of the benefit; we share CMS's concern that individuals might misapprehend this coverage as equal or similar to comprehensive coverage under other parts of Medicare. We urge CMS to conduct consumer and community testing to evaluate whether such confusion is increased or decreased with different naming conventions and descriptive strategies. In particular, we suggest testing naming designations that use more plain language and highlighting the fact that the coverage is distinct from Part B by putting the modifying word or words before Part B in the name.

2. Part B-ID Eligibility, Enrollment, Entitlement, and Termination

We support the proposal to allow beneficiaries to primarily use a verbal (telephonic) attestation as part of enrolling in the Part B-ID benefit. For verbal attestation, in general, an individual would contact SSA, and an SSA representative, using a standard script, would convey the requirements to the individual that are in the CMS-10798 attestation form, as described in § 407.59 of this proposed rule. The individual would then attest that the individual does not have coverage under any of the specified health programs or insurance.

3. Ensuring Coverage under the Medicare Savings Programs

As a result of changes made under section 402(f) of the CAA, low-income individuals who are entitled to Medicare based on enrollment in the Part B-ID benefit may also be eligible for enrollment in the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare

Beneficiary (SLMB), or Qualifying Individual (QI) MSPs for payment of some or all of their Part B-ID benefit premiums and cost sharing.

We agree that the simplest way to maintain continuity of coverage for individuals enrolled in an MSP who are losing Medicare entitlement based on ESRD status is through the Medicaid redetermination process. However, even though § 435.916(d)(1) requires state Medicaid agencies to promptly redetermine an individual's eligibility for Medicaid whenever it receives information about a change in a beneficiary's circumstances that may affect their eligibility, we are concerned that this does not always happen timely, or accurately.

We support the proposed agency statement that would "encourage states to reach out to individuals who are likely eligible for the MSP Part B-ID benefit to explain the Part B-ID benefit and if necessary, coordinate with SSA, SHIPs and beneficiary advocates to help them submit the attestation to enroll in the Part B-ID benefit, which will assist the state in enrolling them in the appropriate MSP." We strongly encourage CMS to conduct outreach and education to beneficiaries and multiple external partners, including those who regularly assist beneficiaries with health insurance counseling, regarding the most appropriate coverage options for MSP beneficiaries transitioning off Medicare entitlement based on ESRD.

Modernizing State Payment of Medicare Premiums

1. State Plan Amendment as Agreement between State and CMS

If this proposal is finalized, the free-standing buy-in agreements would be superseded by provisions related to buy-in practices within a state Medicaid plan. We encourage CMS to actively work with states to identify any needed updates to their state plans and to ensure that any necessary conforming changes are made timely so that there is no interruption to programming.

CMS "welcomes comments on whether there are benefits to maintaining the free-standing buy-in agreements or other unintended effects of our proposal." We encourage the agency to proactively coordinate with all states that utilize a stand-alone agreement to ensure that the change does not cause disruption.

2. Limiting State Liability for Retroactive Changes and Related Updates

We support this proposal in light of the paired proposal of a "good cause" exception to allow for retroactive periods of more or less than 36 months "if a currently unforeseen situation arises in which application of the proposed paragraph (f)(1) would result in harm to a beneficiary. Proposed paragraph (f)(2) would also allow CMS to provide relief to states for periods of less than 36 months if we determine the state cannot benefit from Medicare and limiting state liability would not result in harm to the beneficiary."

3. State Payment of Medicare Premiums When Medicare Benefits are Not Available

We strongly encourage CMS to move forward with the consideration of removing state Medicaid program Medicare premium payment responsibility for individuals whose Medicare coverage is in suspension. The arguments for taking this step for incarcerated individuals are particularly compelling.

CMS both permits and encourages states to suspend Medicaid coverage for periods from one month to the entire length of incarceration. Suspending benefits rather than disenrolling incarcerated individuals facilitates timely start-up of Medicaid benefits upon release and eases both administrative burden and burden on those reentering the community.

For non-Medicare eligible individuals, suspending Medicaid imposes no financial liability on states. With incarcerated individuals who are enrolled in Medicare, however, states bear the cost of Part B premiums without receiving any benefit. This financial burden disincentivizes states from adopting a policy of extended Medicaid suspension and thus interferes with the broader aims of putting policies in place to make reintegration into the community as seamless as possible.

The policy that CMS is considering would resolve this policy conflict and be consistent with the agency's other initiatives—including the proposed SEP for incarcerated individuals—to ensure that individuals returning to the community do not experience gaps in health care coverage.

Technical Changes to Regulations on State Payment of Medicare Premiums

1. Revision to enrollment under state buy-in

We support this important clarification, codifying the policy that under a buy-in agreement people with QI, like those with QMB and SLMB, may enroll outside of usual coverage periods.

Alternative Proposals Considered on Modernizing State Payment of Medicare Programs

1. Months of Premiums for Which SSA May Bill Beneficiaries When Buy-in Ends

As noted in the proposed rule, when federal systems "eventually process a buy-in termination, SSA begins charging the beneficiary for Part B premiums, and CMS refunds the state for those same premiums. Since 1972, federal regulations have specified that, after buy-in ends, SSA can retroactively recoup up to 2 months of premiums from the individual's Social Security benefits. In practice, SSA deducts 3 months of premiums at a time to account for 2 months retroactive premiums plus the current processing month. This can jeopardize the individual's ability to pay for food and rent in the first month, increasing the risks of hunger or eviction." We have seen the outsize impact of this policy frequently. It is particularly problematic for those very low-income individuals for whom the QMB program is also paying the Part A premium, but it can be disastrous to all. People who previously qualified for the buy-in have definitionally low incomes and, in most states, resources. In our experience, the reason for buy-in termination is very seldom dramatically changed financial circumstances. Frequently, we hear from beneficiaries who did not have a change in finances or eligibility, but who only realize that they have failed to

complete an administrative obligation such as recertification or lost eligibility due to an administrative error such as lack of awareness of the buy-in from local agencies when they see the significant reduction in their benefit checks. To minimize this impact, especially for those who remain eligible for benefits, we suggest that only the normal premium be deducted in the first month. The two additional months then can be repaid through deductions spread over the next 6 months, or 1 year in cases where the Part A premium is also being paid.

Conclusion

Thank you again for this opportunity to provide comment. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Casey Schwarz, Senior Counsel, Education & Federal Policy at CSchwarz@medicarerights.org or 212-204-6271.

Sincerely,

Fred Riccardi
President
Medicare Rights Center