Center for Medicare Advocacy

Advancing Access to Medicare and Health Care

June 27, 2022

Submitted electronically to www.regulations.gov

Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Brooks-LaSure:

Re: Medicare Program; Implementing Certain Provisions of the Consolidated Appropriations Act, 2021 and Other Revisions to Medicare Enrollment and Eligibility Rules - File Code CMS-4199-P, 87 Federal Register 25090 (April 27, 2022)

The Center for Medicare Advocacy (the Center) is a national, non-profit law organization that works to ensure access to Medicare, health equity, and quality healthcare. The organization provides education, legal assistance, research and analysis on behalf of older people and people with disabilities, particularly those with long-term conditions. The Center's policy positions are based on its experience assisting thousands of individuals and their families with Medicare coverage and appeal issues. Additionally, the Center provides individual legal representation and, when necessary, challenges patterns and practices that inappropriately deny access to Medicare and necessary care. We appreciate the opportunity to submit these comments to the above-referenced rule.

These comments are also submitted on behalf of California Health Advocates (CHA). Founded in 1997, California Health Advocates is the leading Medicare advocacy and education non-profit in California. CHA is dedicated to providing quality Medicare, Medicare Supplement, and long-term care insurance information, training, and education. CHA supports the local Health Insurance Counseling and Advocacy Programs (HICAP) with training, materials and technical assistance. HICAP is California's State Health Insurance Assistance Program (SHIP).

I. General Comments

The Center for Medicare Advocacy was a strong supporter of the key provisions of the Beneficiary Enrollment Notification and Eligibility Simplification (BENES) Act (S. 1280/H.R. 2477) that were included in section 120 of the Consolidated Appropriations Act (CAA) signed

into law in December 2020. As CMS notes, these changes "will result in coverage under Part B that becomes effective sooner after an individual enrolls during the IEP, deemed IEP, or GEP." We agree that "these changes will simplify the enrollment process and reduce gaps in health care coverage, and make it easier for affected beneficiaries to understand the effective date of their Medicare coverage" (p. 25091).

We applaud CMS for using its new discretion under section 1837(m) of the Act to propose new Special Enrollment Periods (SEPs) for Part A and B enrollments and corresponding effective dates. As noted in the CMS fact sheet discussing this proposed rule, "[t]hese proposals would expand Medicare enrollment opportunities and reduce multi-month coverage gaps in Medicare." We could not agree more, and applaud CMS for proposing SEPs that would address many of the barriers to timely Medicare enrollment, including reliance on erroneous information from an employer or plan sponsor. In addition, the proposed SEP that would apply when someone loses Medicaid coverage would assist individuals who lose Medicaid eligibility following the end of the COVID-19 Public Health Emergency (PHE) and who did not enroll in Medicare in a timely manner.

II. Comments to Provisions of the Proposed Rule

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A. Proposals for Beneficiary Enrollment Simplification

1. Effective Dates of Entitlement

We support the proposed conforming amendments implementing section 120 of the CAA that revises the entitlement periods for individuals who enroll in Part B (or premium Part A) in the last 3 months of their IEP, deemed IEP, or during the GEP, beginning January 1, 2023. We agree with CMS that "these changes … 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" (p. 25093).

We also support CMS' plan to "update all public facing materials to reflect date changes from any final rule. This would include updated information in CMS publications, on Medicare.gov, and in training materials" (p. 25094). We urge CMS to ensure that such revisions are made for materials used by or otherwise relied upon by other Medicare stakeholders, including the Social Security Administration (SSA), State Health Insurance Assistance Programs (SHIPs), Senior Medicare Patrol (SMP) programs, broker/agent training materials and others. In addition, we urge CMS to ensure that such materials are translated into threshold languages.

2. Special Enrollment Periods for Exceptional Conditions

While CMS has used its authority in the past to develop a number of SEPS relating to Medicare Advantage and Part D enrollment, as the agency notes, prior to the CAA its authority to establish SEPs based on exceptional conditions for enrollees in Parts A and B was limited.

We strongly support and applaud CMS for proposing to exercise its new authority to establish new exceptional conditions SEPs for Parts A and B. We also strongly support the proposal "that should an individual who missed an enrollment period due to an exceptional condition, enroll in premium Part A or Part B using one of the following SEPs, they would not be subject to a LEP [late enrollment penalty]." (p. 25095)

In determining what new SEPs would be beneficial to the Medicare program and beneficiaries, CMS states that it considered 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 individuals to not educate themselves about the importance of enrolling in Medicare timely and make informed decisions during other available enrollment periods;
- 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.

We appreciate CMS' careful consideration of the criteria for evaluating proposed SEPs, which we agree are, for the most part, reasonable and useful. In particular, drawing from experience with SEPs applicable to Parts C and D, as well as the Marketplace, promotes consistency and administrative ease, and can serve to reduce confusion among beneficiaries. We urge CMS to reconsider, however, whether "incentive for individuals to not educate themselves about the importance of enrolling in Medicare timely and make informed decisions during other available enrollment periods" is an appropriate factor to consider with respect to establishing new SEPs. In our experience assisting Medicare beneficiaries, the vast majority of people who encounter Part A and B enrollment pitfalls and need corresponding relief made genuine mistakes based on the information (or lack thereof) available to them, rather than calculated ignorance or a desire to manipulate the rules or otherwise "game the system." It is difficult 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. As noted below in the discussion concerning the proposed SEP for employer or health plan misrepresentation, organizations and entities tasked with knowing the rules surrounding insurance coverage and eligibility – employers and their agents, including HR firms, agents/brokers – too often do not understand the rules themselves, giving rise to the need for an SEP to correct the negative impacts of their mistakes and misunderstanding.

SEP for Individuals Impacted by an Emergency or Disaster (p. 25096)

We support this proposed SEP that would apply to situations in which disasters or emergencies may interfere with individuals' ability to enroll in Medicare without any error or inaction by the

Federal government, when individuals are prevented from submitting a timely Medicare enrollment request by an emergency or disaster declared by either a Federal, state, or local government.

CMS is soliciting comments regarding whether the agency should limit the time frame 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. Given how disruptive emergencies and disasters can be to the lives of those impacted, including loss of life, health, property, along with corresponding impacts on family, friends and supportive community, we urge CMS to employ maximum flexibility in establishing any time frames for this SEP, and assert that such restriction is warranted. While not every disaster or emergency will impact people in the same way, it is very likely that some will face more significant barriers to resuming normal activity than others. Two months might not be enough time to recover from a disaster or emergency, particularly if temporary or permanent relocation is required as a result. In addition, we encourage CMS to broaden the application of this proposed SEP in accord with SEPs that have been established for Parts C and D during certain emergencies (such as for Hurricane Irena) to allow for an individual to show that a person(s) on whom they rely for assistance in managing their financial or health care needs resides in a location that is affected by an emergency or disaster.

SEP for Health Plan or Employer Misrepresentation or Providing Incorrect Information (p. 25096)

CMS proposes to establish 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" (p. 25097).

We applaud CMS for proposing this SEP, and strongly support it being finalized. In our experience counseling Medicare beneficiaries and those who assist them, this is the most widespread and common enrollment pitfall facing Medicare beneficiaries, trapping many people with gaps in coverage, late enrollment penalties and unpaid or recouped medical claims. We concur with CMS' observation of "multiple instances in which individuals received erroneous information from their employer that resulted in the individual not enrolling in Part B timely and consequently they were assessed an LEP."

However, in order to ensure that individuals who are impacted by such "unintentional, inadvertent, or erroneous" non-enrollment that "results from material misrepresentation or reliance on incorrect information" from these entities, CMS must revise its proposed evidentiary standards, as discussed below, otherwise the availability of this SEP will be so limited as to be unavailable to the vast majority of those who are targeted for relief.

<u>Need to Revise Proposed Evidentiary Standards</u>

Under CMS' proposal, an individual would have to demonstrate material misrepresentation. "Individuals would be required to provide SSA or CMS evidence that shows what misinformation was initially provided by the employer, GHP or representative" and CMS solicits comments on

whether the agency should require additional evidence (p. 25097). The preamble states: (at p. 25097):

> To demonstrate material misrepresentation, an individual would be required to provide documentation of the relevant misrepresentation to SSA. The documentation must show that the information was provided on or after January 1, 2023, was directly from an employer, GHP or their representative prior to an enrollment period, and that the inaccuracy caused the individual not to enroll timely. Examples of such evidence could be a letter from the employer or GHP that materially misrepresents the Medicare enrollment process or a letter from the employer or GHP acknowledging that they provided misinformation in a previous communication. 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. (p. 25097)

While we strongly support the proposal to establish this SEP, we strongly object to the proposed evidentiary standards one must demonstrate in order to obtain an SEP. CMS proposes a standard that is too onerous and would screen out a significant number of affected individuals who would not be able to meet the standards. As discussed further below, we urge CMS to: 1) expand the sources of misinformation that give rise to the SEP to include non-employer sources; 2) revise the proposed evidentiary standard concerning written proof of misinformation from an employer; and 3) reconsider including omissions of information from employers/GHPs from the evidence required to establish an SEP.

First, CMS should expand the sources of misinformation that give rise to the SEP to include non-employer insurance sources, including 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, we urge CMS to revise the proposed evidentiary standards for this proposed SEP to include information other than written proof from an employer. In our experience, the type of misinformation being targeted by this SEP is almost always oral – over the phone or in person – and rarely in writing. More broadly, we urge CMS and SSA to take this opportunity while expanding available SEPs to revise the evidentiary standards outlined in the Social Security's Program Operations Manual System (POMS) to allow more flexibility when documentary or other evidence is not available see, e.g., POMS HI 00830.010).

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 of these parties – plus group health plan benefits administrators – can and do provide misinformation to those they are seeking to assist. Most often this happens 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 oral, communicated through spoken word; letters or other documentary evidence

reflecting misinformation is rare or non-existent. Further, it is very unlikely that any of these parties would readily admit error, particularly in writing, with respect to counseling or advising about coverage options, in order to assist a former employee of their employer client with whom they owe allegiance and a desire to maintain a business relationship. For example, an individual we assisted last year faced over $100,000 in medical liability through claims erroneously paid by his COBRA insurer due to misinformation about COBRA's interaction with Medicare provided by an employer's workforce management company upon which he relied – information about COBRA's relationship or coordination with Medicare that was always asserted with authority, but nonetheless oral and never in writing.

While we urge CMS and SSA to generally revise their current rules with respect to evidentiary standards concerning equitable relief, we note here that even existing standards in the Social Security's Program Operations Manual System (POMS) allow for more flexibility than CMS' current proposal for this SEP. When processing Part B SEP requests, including premium surcharge rollbacks, SSA generally requires Form CMS-L564 to obtain information about employment and employer-based health insurance coverage. See HI 00805.295 Evidence of GHP or LGHP Coverage Based on Current Employment Status. This POMS provision allows for an applicant to submit documents when the employer or group health plan cannot provide such evidence. Other documentation that reflects employment and group health plan coverage submitted by the applicant is permissible. Although not articulated in the POMS provision, this includes when the employer/former employer cannot be found, is no longer in business, or is unresponsive to inquiries from the applicant and/or SSA. Such documentation in the place of employer provided information is much more readily available in this scenario than the one contemplated in the proposed rule. For example, one need only provide a health insurer's routinely issued explanation of benefits (EOB) or similar statements reflecting claims processing and payment to demonstrate that a group health plan was primary payer of benefits for some period of time. In other words, in the absence of an employer-completed form, a claimant can substitute other documentation to confirm the facts being sought.

When it comes to misinformation provided by an employer or affiliate (as opposed to documentation generated in the normal course of business, such as EOBs) such information is unlikely to appear anywhere in writing. In order to grant relief under the proposed SEP, then, CMS and SSA must allow for a beneficiary to provide or otherwise use a broader scope of evidence to demonstrate that relief is warranted. In situations where documentary evidence of misrepresentation is not available, enrollees should be permitted to show, instead, situation-specific information, that 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.

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 requirement would serve the aims listed above. CMS might 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.

Third, CMS should revisit its proposal that "[a]n 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." While employers and GHPs do not necessarily have a fiduciary duty to employees regarding Medicare education, this proposed standard fails to account for situations in which an employer advises someone whom they know to be Medicare eligible (e.g. based on age) to enroll in COBRA or retiree coverage, without reference to how such coverage does (or does not) coordinate with Medicare. When an employee is leaving active employment, that individual will almost certainly interface with the employer or one acting on behalf of the employer about COBRA coverage and possibly retiree insurance coverage. Advice or direction to elect COBRA or retain retiree coverage as primary insurance should constitute "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".

Thus, we therefore strongly encourage CMS to establish a more reasonable evidentiary standard, one that does not disregard the beneficiaries' testimony about their own experience. CMS should loosen its proposed evidentiary standards and allow election of COBRA coverage on the one hand, or retention of employer coverage as primary insurance that is no longer based on current, active employment on the other hand, to be included in the evidence necessary to demonstrate that an employer or related entity failed to adequately advise an individual. Such action on the part of the individual should be considered as among evidence that there was "reliance on incorrect information."

Finally, we note that making the evidentiary standards more flexible, including the allowance of omissions on the part of employers or their agents, would still meet the articulated goals of establishing new SEPs for exceptional circumstances. People who would seek this SEP would not, by and large, be trying to "game the system" and avoid responsibility of paying timely Part B premiums. Rather, they will almost always have relied on those providing and governing their employer-based insurance to guide them appropriately with respect to their ability to retain such employer-based coverage, or elect COBRA based on the end of employment. When applying CMS' own factors in determining whether to establish an SEP (see p. 25095), allowing a more permissible evidentiary standard would "not create an incentive for individuals to delay timely enrollment in Medicare" – in fact, monthly COBRA premiums almost always far surpass any Medicare premiums an individual is likely to pay (e.g., including combined premiums for Part B, a Medigap and a stand-alone Part D plan). Further, with respect to "not creat[ing] an incentive for individuals to not educate themselves about the importance of enrolling in Medicare timely and make informed decisions during other available enrollment periods," we assert – based on decades of experience counseling Medicare beneficiaries – that the complexity of Medicare enrollment rules is such that even the most educated, diligent and responsible individuals can have problems parsing the rules and therefore make erroneous enrollment decisions to their own detriment. In fact, the entire premise of this proposed SEP – with which we strongly agree and support – is that organizations and entities tasked with knowing the rules surrounding insurance coverage and eligibility – employers and their agents, including HR firms, agents/brokers – too often do not understand the rules themselves.

SEP for Formerly Incarcerated Individuals

We applaud CMS for both recognizing and responding to the currently untenable situation that incarcerated individuals face concerning their interaction with Medicare, including ineligibility for coverage of medical services, while there are ongoing expectations of timely enrollment and premium payments. We strongly support CMS' proposed SEP for formerly incarcerated individuals and agree that it will have a positive impact on this population.

In order to protect against potential gaps in coverage, we urge CMS to allow for pre-release enrollment with a record of a planned discharge date, so that an enrollment can be processed, and the individual would have access to effective coverage upon release. This change would allow for the state, federal government or other incarcerating entity to provide assistance in the enrollment process, decrease the risk of disruptions in ongoing care or treatment, and reduce the number of immediate post-release obligations. Further, a more flexible SEP could account for individuals on supervised release, medical custody or other situations that might not reflect a formal release from custody date that is uniform across the corrections system. Individuals utilizing the SEP pre-release should be allowed to elect their effective date – either the date of release or upon resumption of OASDI payment. Second, CMS should extend the SEP through a year post release, for the reasons stated in the proposed rule in support of a six-month SEP. Further, CMS and SSA should revisit the rules surrounding collection and recoupment of Part B premiums for individuals who are incarcerated when Part B is terminated for non-payment of premiums. Finally, CMS should revise its coordination of benefits (COB) rules concerning incarceration to reflect actual shifts in responsibility of coverage based on incarceration status.

SEP To Coordinate With Termination of Medicaid Coverage

We appreciate that CMS acknowledges the difficulties faced by individuals who lose Medicaid coverage after newly qualifying for Medicare, including "multiple scenarios that prevent a seamless transition to Medicare coverage." We also appreciate the particular problems related to the eventual expiration of the current Public Health Emergency (PHE) the end of the continuous enrollment requirement. We strongly support this proposed SEP.

SEP for Other Exceptional Conditions

We support CMS' proposal "to retain the ability to provide SEPs on a case-by-case basis for other unanticipated situations that involve exceptional conditions and warrant an SEP," which would allow the agency to "grant SEPs on a case-by-case basis for circumstances we do not have enough experience to consider or anticipate that could create a barrier to enrollment" (p. 25100).

CMS proposes to grant SEPs on this basis "if two conditions are met. First, an individual must demonstrate that conditions outside of their control caused them to miss an enrollment period. Second, the condition must be determined exceptional in nature." We urge CMS to be flexible with respect to determining whether conditions are outside of one's control.

We appreciate that CMS notes that "[s]etting forth a specific duration for this SEP could disadvantage enrollees whose condition may require additional time" and is thereby leaving the duration of the SEP to a case-by-case determination.

Alternatives Considered

We appreciate that CMS explored potential SEPs in addition to what is proposed in the rule. We urge CMS to reconsider an SEP for individuals who are experiencing a health event, particularly if CMS does not revise the proposed evidentiary standards for the proposed SEP based on employer or GHP misinformation, as discussed in our comments above. In our work assisting beneficiaries, we have encountered instances in which someone did not enroll timely in Part B not due to apparent attempts to game the system, but, rather misunderstanding or misdirection about the enrollment rules, who later developed serious health conditions (such as terminal cancer) with no recourse.

In addition, we ask CMS to consider other SEPs for exceptional conditions in future rulemaking, including:

- Immigrants who thought they had to wait until citizenship to enroll in Medicare; immigrants who have passed the 5-year bar, but are under the impression that they need to wait until citizenship- Eligibility rules for public benefits, including Medicare and Social Security, are more complicated for immigrants and involves 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 about many older adults who immigrated to the U.S. and 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(s) are cost-prohibitive and they are unaware that the Medicare Savings Programs 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. As the underlying issue here is a misunderstanding of eligibility for Medicare for immigrants and a lack of notice, we believe an SEP, rather than individual equitable relief, is necessary to provide clarity to this population. A specific SEP would serve as a signal both for people who did in fact miss their IEP due to a misunderstanding of their eligibility that they can enroll, and for immigrants and advocates more generally so that they are better informed and less likely to miss their IEP in the first place. In addition, an SEP would provide much needed financial relief from late enrollment penalties for immigrants who do not qualify for Medicare Savings Programs.

- Veterans (e.g. with Veterans Administration (VA) coverage) - As CMS notes, there is 12-month SEP for certain individuals who are enrolled in TRICARE and become eligible to enroll in Part A on the basis of disability or ESRD status but who elect not to enroll during their IEP. CMS should consider an additional SEP for individuals who have relied on VA coverage but find that such coverage no longer meets all of their needs, and they wish to enroll in Part B'
- Those returning from living abroad - As CMS notes, there is currently an SEP for individuals serving as volunteers outside the U.S. at the time they first become eligible for Medicare (and who are participating in a program sponsored by a 501(c)(3) covering at least a year, and who demonstrate health insurance coverage while serving in the program); we urge CMS to expand this existing SEP to include those living abroad and

who have been covered by private/national insurance, and wish to return to the U.S. and enroll in Medicare.

Proposals for Extended Coverage of Immunosuppressive Drugs for Certain Kidney Transplant Patients

Effective January 1, 2023, certain individuals whose Medicare entitlement based on ESRD would otherwise end after a successful kidney transplant will be able to continue enrollment under Medicare Part B only for the coverage of immunosuppressive drugs described in section 1861(s)(2)(J) of the Act.

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 for such medication. We also appreciate the thought that went into the designation and description of the benefit – we share CMS' 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 highlight the fact that the coverage is distinct from Part B by putting the modifying word or words before Part B in the name.

Part B-ID Eligibility, Enrollment, Entitlement and Termination

We support the proposal to allow beneficiaries to primarily use an oral (telephonic) attestation as part of enrolling in the Part B-ID benefit. Generally, for this attestation, an individual would contact SSA, and an SSA representative, using a standard script, conveys the requirements to the individual that are in the CMS-10798 attestation form, 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.

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 QMB, SLMB, or 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" and strongly encourage CMS to pursue outreach and education for 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

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 work with state Medicaid agencies and state legislatures 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.

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."

Technical Changes to Regulations on State Payment of Medicare Premiums

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.

Alternatives Proposals Considered on Modernizing State Payment of Medicare Programs

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. It is particularly problematic for those very low-income individuals for whom the QMB program is also paying the Part A premium, but 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.

State Payment of Medicare Premiums When Medicare Benefits Are Not Available

We strongly encourage CMS to move forward with 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.

III. Conclusion

Thank you for the opportunity to submit these comments. For additional information, please contact David Lipschutz, Associate Director at DLipschutz@medicareadvocacy.org, or Kata Kertesz, Senior Policy Attorney at KKertesz@medicareadvocacy.org, both at (202)293-5760.

Sincerely,

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