AMERICAN ACADEMY OF FAMILY PHYSICIANS

June 24, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

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

Dear Administrator Brooks-LaSure:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 127,600 family physicians and medical students across the country, I write in response to the notice of proposed rulemaking titled "Implementing Certain Provisions of the Consolidated Appropriations Act, 2021 and Other Revisions to Medicare Enrollment and Eligibility Rules" published in the Federal Register on May 27, 2022.

Effective Dates of Entitlement

Medicare Part B is an optional supplementary medical insurance that covers many preventive services, outpatient care, and medical supplies. New Medicare beneficiaries have the opportunity to enroll in Part B during their initial enrollment period (IEP) which occurs 3 months before the individual turns 65 and ends 3 months after the month in which they turned 65. Following the IEP, beneficiaries can enroll in Part B during the general enrollment period (GEP) from January 1 to March 31 of each year. However, under current requirements, certain beneficiaries may face up to a 3-month lag between enrollment and access to benefits depending on when their IEP eligibility begins and when they complete enrollment, or up to a six-month lag depending on their enrollment during the GEP.

The proposed changes in this rule would allow coverage to begin for newly eligible individuals on the first day of the month following the month in which they enroll if they enrolled in Part B during the last 3 months of their IEP or during the GEP. This will limit the amount of time beneficiaries must go without comprehensive coverage and simplify the enrollment process. **The AAFP supports this proposal as it would facilitate continuous access to care and make enrollment simpler.** Health coverage disruptions often result in care disruptions, because individuals may delay care due to higher out-of-pocket costs or are forced to seek care from a new physician with whom they do not have an existing relationship or who may not understand the patient's full medical history. By eliminating unnecessary delays between when a beneficiary enrolls and their coverage becomes effective, this proposal will reduce care delays and ultimately improve beneficiaries' health. We urge CMS to finalize this proposal.

1133 CONNECTICUT AVE., N.W., STE. 1100 | WASHINGTON, DC 20036-4305 | (800) 794-7481 | (202) 232-9033

Special Enrollment Periods for Exceptional Conditions

This proposed rule establishes special enrollment periods (SEPs) for exceptional conditions, which would apply to individuals who miss an IEP, GEP, or other SEPs. It also amends language so that beneficiaries who enroll in Medicare Part A or B during an SEP for exceptional conditions would not be subject to the lifetime 10 percent increase in premiums due to late enrollment. The exceptional conditions that qualify under this proposed rule are:

- **Individuals effected by an emergency or disaster, as declared by the Federal, state, or local government.** CMS proposes to require individuals demonstrate that they reside in the area of a disaster and would establish an SEP that ends 2 months after the end of the declared emergency or disaster.

- **Health plan or employer misrepresentation or incorrect information.** CMS proposes to require individuals provide the Social Security Administration (SSA) with documentation of misrepresentation of information by employer or health plans. The SEP would begin on the day the individual contacts SSA and last for 2 months. CMS specifically states that omission of information by an employer or health plan does not qualify as misrepresentation.

- **Formerly incarcerated individuals.** CMS proposes to require individuals provide documentation that they were incarcerated during their IEP, GEP, or other SEP and provide documentation of release through discharge documents or data available to SSA. This SEP would begin the day of release and end after 6 full months.

- **Coordination of termination of Medicaid coverage.** This includes any individual who loses Medicaid eligibility at the sooner of either the end of the COVID-19 public health emergency (PHE) or January 1, 2023. After January 1, 2023, the SEP will begin when an individual receives notice of termination of Medicaid eligibility and ends 6 months after termination of eligibility.

- **Other exceptional conditions.** This allows CMS and SSA to grant a SEP on a case-by-case basis when an individual can demonstrate that they did not enroll due to circumstances out of their control and for reasons that are “exceptional” in nature.

The AAFP supports the addition of these SEPs and the accompanying language to exempt SEP enrollees from late enrollment penalties. The AAFP also specifically appreciates and supports the extended 6-month enrollment timeframe for many of these SEPs. The AAFP has long advocated for eligibility and enrollment policies that facilitate continuous, comprehensive coverage. For example, we’ve previously supported continuous coverage policies for formerly incarcerated individuals and are pleased CMS has proposed an SEP for this population. The AAFP has urged CMS to take steps to minimize Medicaid coverage disruptions after the end of the COVID-19 public health emergency (PHE), including by efficiently connecting Medicaid beneficiaries who lose their coverage to other forms of comprehensive coverage. Creating an SEP for Medicaid beneficiaries who experience terminations will help advance this goal when the PHE ends, as well as in the future. We urge CMS to finalize these proposals.

Where possible, the AAFP strongly encourages CMS and SSA to use existing data resources to automatically apply these SEPs for individuals who are able to provide basic documentation with their enrollment materials. This is particularly relevant for individuals effected by emergency or disaster declarations, formerly incarcerated and recently released individuals, and

those who lose Medicaid coverage at the end of the current PHE or otherwise. For example, CMS should work with the Federal Emergency Management Agency, Department of Justice, state Medicaid agencies, and other relevant stakeholders to obtain contact information for those who are losing health coverage due to justice involvement, Medicaid terminations, or a disaster. Additionally, for many of these populations, contact via mail may not be appropriate or effective. **The AAFP strongly encourages CMS to implement alternative methods for contacting individuals about the SEP, including how events like disaster declarations or release from incarceration will be streamlined with notification of the SEP. We believe alternative communication methods will help ensure individuals are aware of the SEP and given the appropriate opportunity to enroll in a timely manner.**

CMS opted to not include a SEP for individuals who lose Medicare coverage for failure to pay premiums. The AAFP acknowledges CMS' rationale that this could create a cyclical re-enrollment process for individuals who are unable to pay their premiums or fail to use other existing mechanisms for payment support. However, if CMS can monitor and track SEP use per beneficiary, the AAFP recommends CMS consider implementing this SEP for individuals who lose Medicare coverage for failure to pay premiums such that it can only be used twice per beneficiary. We believe this would avoid the cyclical problems CMS is anticipating while still allowing re-enrollment opportunities for Medicare beneficiaries who may struggle to pay their premiums due to cost, life changes, or other barriers.

Limiting State Liability for Retroactive Changes and Related Updates

States pay for the cost of Medicare Part B premiums for millions of low-income individuals who are eligible for both Medicare and Medicaid. Sometimes SSA determines that an individual is entitled to retroactive Medicare Part A coverage once they make a disability determination. States then become liable for the cost of retroactive Medicare Part B premiums for several years. When this occurs, states will often move to recoup Medicaid payments from physicians, other clinicians, and facilities because Medicare is the primary payer for dual eligible beneficiaries. This process results in administrative burden for physicians, who have to undergo a special filing process in order to submit Medicare claims for services that occurred more than one year prior to filing the claim. This process is also burdensome for state Medicaid agencies and CMS.

To help address these challenges, CMS is proposing to limit retroactive Medicare Part B premium liability for states to 36 months for full-benefit dually eligible beneficiaries. This would cap the amount of time for which a state is liable for premiums and can try to recoup funds. There would be no negative impact on the beneficiaries involved. The AAFP supports this proposal and thanks CMS for taking action to reduce administrative burdens while also ensuring continuous, affordable access to care for beneficiaries.

The AAFP appreciates the opportunity to submit comments on the proposed rule. We look forward to working with CMS to facilitate continuous coverage and equitable access to high-quality primary care. To further discuss the AAFP's comments or to schedule a meeting, please contact Meredith Yinger, Manager of Regulatory Affairs, at myinger@aafp.org.

Sincerely,

Ada D. Stewart, MD, FAAFP
Board Chair, American Academy of Family Physicians