American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

June 27, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Subject: Medicare Program; Implementing Certain Provisions of the Consolidated Appropriations Act, 2021 and other Revisions to Medicare Enrollment and Eligibility Rules (CMS-4199-P)

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the proposed changes to Medicare enrollment and eligibility rules. **The AHA supports the Centers for Medicare & Medicaid Services' (CMS) continued focus on strengthening health insurance coverage and ensuring ease of enrollment and limited gaps in coverage, including through these proposed updates to Medicare enrollment and eligibility rules.**

Specifically, through this proposal, CMS plans to simplify the Medicare enrollment process and reduce gaps in health care coverage by streamlining the effective date for Medicare entitlement. In addition, the proposed rule looks to implement policies to mitigate coverage losses for those transitioning from Medicaid to Medicare coverage and address needed improvements to the Medicare Savings Programs (MSPs). These administrative changes could have a significant, positive impact on individuals' access to coverage and care.

Our comments on the proposed rule follow.

ENTITLEMENT EFFECTIVE DATE

In response to changes enacted through the Consolidated Appropriations Act (CAA) of 2021, CMS is proposing to change when an enrollee's Medicare entitlement begins. Under longstanding policy, Medicare-eligible individuals can enroll in Part B during their initial enrollment period (lasting from three months before to three months after their first month of eligibility) or during the annual general enrollment period (Jan. 1 through March 31). Currently, for individuals that enroll during their initial month of eligibility or in the three months following, their entitlements begin one to three months after the month of enrollment. For individuals that enroll during the general enrollment period, their entitlements begin on July 1 following their enrollment. The CAA modifies the entitlement effective date as of Jan. 1, 2023, such that individuals enrolling during or after their first month of eligibility (either through the initial or general enrollment period) would have their entitlement begin the first day of the month following the month of enrollment. **The AHA supports this change to the Medicare entitlement effective date, which would simplify the enrollment process and help minimize gaps in coverage.**

SPECIAL ENROLLMENT PERIODS

The CAA also provided the Department of Health and Human Services with enhanced discretion to establish additional special enrollment periods (SEP). Under this new authority, CMS is proposing to create several additional SEPs that would give individuals a chance to enroll in Medicare outside of the initial and general enrollment periods and exempt such enrollees from being subject to a late enrollment penalty. The proposed SEPs would be available in the following circumstances: (1) to individuals impacted by an emergency or disaster; (2) in instances when a health plan or employer misrepresents or provides incorrect information about Medicare enrollment; (3) for formerly incarcerated individuals; (4) to coordinate with termination of Medicaid coverage; and (5) in other exceptional conditions. **The AHA supports this proposal**.

These special enrollment periods provide Medicare-eligible individuals an opportunity to enroll in coverage and avoid a late enrollment penalty in situations where they miss an initial or general enrollment period for reasons that are out of their control. For example, as CMS notes in the proposed rule, residing in an area during a declared disaster or emergency can cause significant disruptions to daily life for both the enrollee and the field offices processing the Medicare enrollment. Such situations should not result in enrollees having to delay enrolling in Medicare coverage until a general enrollment period.

For those on Medicaid, ensuring a seamless transition to Medicare is important for preventing gaps in coverage and access to services. The COVID-19 public health emergency (PHE) presents some unique challenges in promoting a seamless process. While we have supported the continuous coverage requirement during the emergency, states largely suspended the redetermination process, and thus Medicaid beneficiaries

may not have been aware they needed to enroll in Medicare once eligible. Particularly, those in Medicaid's adult group that became eligible for Medicare during the PHE could face the loss of their Medicaid eligibility and higher penalties for delayed enrollment in Medicare. The proposed SEPs would help ensure that these lower-income individuals have coverage opportunities when the PHE ends.

STATE PAYMENT OF MEDICARE PREMIUMS ENHANCEMENTS

The proposed rule also clarifies and streamlines regulations related to individuals dually eligible for Medicare and Medicaid. There are several provisions that promote access to affordable coverage, particularly for the low-income beneficiaries that benefit from the Medicare Savings Programs (MSPs) where state Medicaid programs help pay for Medicare premiums (buy-in) and some Medicare cost sharing for low-income adults over age 65 and adults with disabilities. Specifically, the proposal would extend MSPs to cover premiums and cost sharing for individuals enrolling in the new Medicare Part B immunosuppressive drug benefit. It also would specify that state premium buy-in agreements reside entirely within the Medicaid state plan to enhance accountability for state payment of Medicare premiums on behalf of lower-income individuals. Lastly, it would codify the requirement that the state buy-in Medicare premium is for all eligible individuals. **The AHA supports this combination of proposals to both expand access to and improve the functionality of the MSPs intended to help lower-income and structurally marginalized beneficiaries.**

We look forward to continuing to work closely with you to strengthen health insurance coverage, including through improvements to Medicare enrollment and eligibility rules. Please contact me if you have any questions or feel free to have a member of your staff contact Ariel Levin, AHA's director of coverage policy, at 202-626-2335 or alevin@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President