MEDICARE RIGHTS CENTER
Getting Medicare right

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September 9, 2024

VIA ELECTRONIC SUBMISSION

Hon. Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Attention: CMS-1809-P
Baltimore, MD 21244-8010

Re: RIN 0938-AV35 Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities [CMS–1809–P]

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the **Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems** proposed rule for 2025. 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.

Our comments focus on the important proposals in support of formerly incarcerated individuals. We appreciate the Centers for Medicare & Medicaid Services (CMS) working to ensure Medicare payment and enrollment rules align with the lived experiences of this population and their responsibility for their own health care costs.

Individuals Currently or Formerly in the Custody of Penal Authorities (XXIII.A)

Both the health care and carceral systems are dizzyingly complex. Though carceral institutions have a range of health care contracts in place, there will be times when a Medicare enrollee in custody receives health care from a health care provider outside of that contracting structure. For example:

- A person in a halfway house that restricts their freedom of movement sets up a mental health appointment with a therapist in the community as part of their re-entry plan.

- A person under arrest receives emergency care at a community hospital before being detained in jail.

- A person on furlough to attend a family funeral requires emergency care at a hospital.

The current and proposed language at 42 C.F.R. 411.4(b) assumes that a person wishing to show their legal obligation to pay for care while in custody has received such care from the penal authority. This makes the rebuttal process difficult for individuals who have received care from a health care provider not contracted with the penal authority.

Thank you for considering alternative pathways to coverage for this population, including raising the possibility that the presumption of coverage may not apply in these cases. We request a pathway for coverage in the instances where services are provided by a third party not contracted with the carceral institution and the individual is in custody, by not applying the presumption that such person has no legal obligation to pay. Alternatively, if such a presumption does continue to apply in these circumstances, information about how to rebut such a presumption should be amended to include circumstances where a non-contracted third party has provided health care.

We urge CMS to consider: (1) Providing clear guidance and instruction provided to agency staff (e.g. through the Social Security Administration Program Operations Manual System (SSA POMS); (2) Updating provider materials to make clear that coverage for people in the carceral system is not prohibited in all cases; (3) Establishing billing codes and procedures that allow the provider and patient to attest to facts about non-contracted third party health care sufficient to obtain Medicare coverage; and (4) Establishing a process for showing that non-contracted third party health care was provided during an initial appeal process.

We ask that CMS reiterate in the preamble to the final rule and any subsequent guidance that, for services provided by the carceral entity or a contractor to the carceral entity the burden of rebutting the presumption is on the state/local government, not on the individual. As CMS explains in discussing the regulatory history of this provision, the burden is not on the hospital or provider to determine whether an individual is in custody or has a legal obligation to pay.

Description of "custody" (XXIII.A.2.b)

CMS proposes to narrow the description of "custody" so that individuals who have been lawfully released from confinement or released following arrest would not be presumed to be in custody for purposes of Medicare's no legal obligation to pay payment exclusion.

We strongly support this proposal to explicitly narrow the definition of custody in the context of Medicare coverage of items and services. As we flagged in our comments on the proposed rule that

established the Special Enrollment Period for Formerly Incarcerated Individuals (CMS-4199-P),[1] the current definition can impede Medicare coverage for individuals who remain embroiled in the penal system but who are financially responsible for their own care, including those who are out on bail, parole or other supervised release, or in home detention.

The regulatory text should explicitly state that individuals on bail, parole, probation, or home confinement are not considered to be in custody for purposes of exclusion from Medicare coverage. We support an explicit statement to ensure that the availability of Medicare coverage for this population is understood by all stakeholders, including individuals, providers, suppliers, advocates, and public employees.

We suggest CMS remove "under arrest" from proposed language in 42 C.F.R. 411.4(b)(3). None of Medicare Part C, Medicare Part D, Medicaid, or the Marketplace exclude people solely because they are under arrest. Individuals may be under arrest for a brief time, even a few minutes or hours. They may not always know they are under arrest; the standards distinguishing arrest from detainment or an investigatory stop overlap, and often require a court case to determine. In addition, an individual does not get documentation that they have been released from arrest. We urge CMS to limit the description of pretrial custody to situations where a person is incarcerated in a jail or prison.

We recommend removing "under arrest" from the proposed description of custody as individuals who would generally have no legal obligation to pay would be confined and therefore captured by the incarcerated in jail provision. We are also concerned that "under arrest" could cause confusion for individuals on bail or home detention (which can be referred to as house arrest). This term is too broad and imprecise and could encompass people who are not confined and are responsible for their health care.

At minimum, we recommend that any mention of "arrest" makes clear that individuals who have been arrested but released from confinement, e.g., are out on bail, are not considered to be in custody.

Halfway houses (XXIII.A.2.c)

For individuals in halfway houses, CMS proposes to draw from Medicaid's payment exclusion rule for use in Medicare. We appreciate that CMS aims to ensure people required to reside in halfway houses who must pay for their own health care can access Medicare, and we urge CMS to finalize its proposal or a similar proposal for halfway houses in the final rule. From our research and conversations with advocates helping formerly incarcerated individuals connect to services, people residing in halfway houses are typically responsible for their own health care costs.

CMS is seeking feedback on whether the factors described in its proposal are appropriate for presuming that an individual required to reside in a halfway house is in custody. We strongly support CMS's

[1] Medicare Rights Center, "Re: CMS-4199-P—Medicare Program; Implementing Certain Provisions of the Consolidated Appropriations Act, 2021 and Other Revisions to Medicare Enrollment and Eligibility Rules " (June 27, 2022), https://www.medicarerights.org/pdf/062722-benes-act-proposed-rule-comments.pdf.

proposal to align the Medicare payment exclusion and description of custody for people required to reside in halfway houses with the Medicaid guidance. If individuals have "freedom of movement," they should be entitled to have Medicare pay for their care. Aligning the two programs will have the added benefit of facilitating access to care and coverage for people who are dually eligible. And would also make implementation easier as many stakeholders are already familiar with the Medicaid payment policies.

Definition of penal authority (XXIII.A.2.d)

Rather than "penal authority," CMS might consider using the term "correctional institution." We also recommend that CMS seek alternatives to the term "penitentiary."

Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals (XXIII.B.2)

We strongly support CMS's proposal to amend the Medicare SEP and agree that the proposed changes will streamline SEP eligibility determinations and align with an individual's obligation to pay for their healthcare.

Specifically, we support the proposed changes to no longer tie the SEP eligibility criteria to the payment exclusion rule. We agree with CMS's analysis that the rebuttable presumption in the payment exclusion context does not work in an enrollment context.

A plain reading of the current Reentry SEP regulatory text, the SEP application, and the SSA POMS indicate that people released from incarceration but on bail, parole, probation, home confinement or other forms of community supervision are not eligible for the SEP. The logical conclusion that many people make that this population is not eligible for Medicare at all because Medicare considers them to be "in custody."

CMS's proposal to align the SEP eligibility criteria with SSA's criteria for determining incarceration will help ease confusion and streamline the enrollment process for individuals leaving incarceration.

A. Explicit description of confinement

As discussed more thoroughly below (in C. SEP Access for People in Halfway Houses), we are concerned that the current description of the triggering event for the SEP, combined with the limitations on SSA data and differences in who has access to Old Age, Survivors, and Disability Insurance (OASDI) benefits, does not clearly indicate that halfway house residents can access the SEP. We recommend explicitly stating in the regulation the following categories of individuals are considered "released from confinement in a jail, prison, or other penal institution or correctional facility": on parole, on probation, under home confinement, released to the community pending trial (including those under pre-trial supervision and those released pursuant to cash bail), and residing in a halfway house (whether or not the individual meets the requirements of 411.4(b)(4)(v)).

B. Documentation for SEP

We appreciate that the proposed rule allows for "discharge documents" or SSA data to be used for the record of release to trigger SEP eligibility. We have encountered cases where SSA data was not accurate or took time to update, preventing Medicare access. Therefore, it is important that individuals can provide other proof of release. As CMS's question about documentation for people who were confined and released without conviction suggests, this documentation may be difficult to obtain because it is not necessarily formalized. Therefore, we recommend changing the wording of (d)(2) from "discharge documents" to "documentation of discharge." This will allow CMS to use its discretion to accept documentation – for example, an attestation from a defense attorney or social worker. We believe this would avoid an unnecessary and unintended limitation on what is considered documentation—which may not be discharge papers or formal records.

C. SEP Access for People in Halfway Houses

Halfway houses are short-term models designed to support a person's successful re-entry. This is a time (typically a few weeks) when a person is setting up the support that will follow them after the halfway house – including finding housing, obtaining identification documents, gaining employment, and securing health care coverage.

Making the Reentry SEP available to halfway house participants will allow for individuals getting appropriate health care coverage support – for example, assistance with coordinating enrollment in Medicare Savings Programs alongside Medicare as soon as possible following release from jail or prison. It does not make sense for Medicare to only be available after a time when health coverage navigation support is no longer available, especially considering that halfway house duration is typically relatively short.

As discussed above, most halfway house residents are responsible for their health care, even when their freedom of movement is restricted. It makes sense for CMS to allow for the SEP to happen early, so individuals establish consistent and accessible health care relationships. The ability to enroll in Medicare should be considered separately from whether Medicare can pay for items or services provided, as CMS recognizes by proposing to decouple the payment rule from the SEP.

D. Equitable relief for a subset of individuals

A small group of people will experience a smaller or no SEP due to this rule change. For example, let us say "Mark" is released from a state prison in February 2024 and is on parole until June 2025. Under the regulation in place in 2024, Mark may be considered to have stayed "in custody" as a parolee and not had access to the Incarceration SEP in 2024. Under the new rule in effect in January 2025, Mark would be considered released from custody in February 2024 and would only have a month of SEP available. If Mark's date of release from state prison was December 2023, he would not have access to the Incarceration SEP at all.

We request that CMS ensure that individuals who were or are released from incarceration under conditions that prevent or hinder their access the current SEP between the initial implementation of the

SEP (January 1, 2023), and the effective date of this proposed rule have an opportunity to enroll in Medicare coverage as well with equitable relief, either by expressly including overlapping effective dates or by establishing an instruction for local Social Security Administration offices.

Technical Corrections (XXIII.B.3)

The current language in § 407.23(d)(3)(ii) states that the individual has the option to request entitlement retroactive to the *date of release* from incarceration and this implies that coverage could start in the middle of the month. CMS proposes to revise the language above to state that coverage could begin retroactive to the beginning of the month of release from incarceration, rather than suggesting the coverage could begin mid-month. The payment exclusion would continue to apply to any items and services furnished during the period between the first of that month and the actual date of release, provided that the individual or other person has no legal obligation to pay for such services. We support this correction.

CMS also proposes to adjust the retroactive enrollment for individuals who file in the last 6 months of their SEP to have a coverage effective date retroactive to the 6th month before the month of enrollment rather than 6 months after the date of release from incarceration. We support this change which better reduces gaps in coverage.

We strongly support the proposed technical corrections clarifying that coverage can be retroactive to the beginning of the month of release and to ensure the retroactive period is tied to the date of Medicare application. These changes help clarify the availability of retroactive coverage and will also help reduce health coverage gaps for older adults leaving incarceration.

To further clarify the individual's ability to make decisions about the length of retroactive coverage that best suits their needs, we recommend adding the phrase "no earlier than" before the description of when coverage begins in § 407.23(d)(3)(ii):

> …If retroactive enrollment is requested and the application is filed within the first 6 months of the SEP, the effective date is retroactive to no earlier than the beginning of the month of their release from incarceration. If retroactive enrollment is requested and the application is filed in the last 6 months of the SEP, the coverage effective date is retroactive to no earlier than the 6th month before the month of enrollment.

Conclusion

Thank you again for the opportunity to provide comment to help coverage access for this underserved population. 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
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