June 27, 2022

The 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

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

Dear Administrator Brooks-LaSure:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule: Medicare Program; Implementing Certain Provisions of the Consolidated Appropriations Act, 2021 and Other Revisions to Medicare Enrollment and Eligibility Rules, 87 Fed. Reg. 25090 (April 27, 2022).

Over the past several years, the Commission has engaged in many conversations related to coverage for individuals who are dually eligible for Medicaid and Medicare. Our focus has been on policies to support states and promote integration of Medicaid and Medicare because of its potential to improve outcomes for beneficiaries and reduce spending. While this notice of proposed rulemaking is primarily focused on the implementation of certain provisions of the Consolidated Appropriations Act, 2021 (CAA, P.L. 116-260), it makes several changes that would affect state Medicaid programs and dually eligible beneficiaries (CMS 2022a).

The Commission commends CMS for its efforts to update and clarify policies intended to promote access and improve health equity for individuals enrolled in both Medicaid and Medicare.

# Selected Provisions Affecting Dually Eligible Beneficiaries

Many of the policy changes in this proposed rule align with MACPAC's interest in improving the beneficiary experience and reducing the burdens dually eligible beneficiaries face in navigating coverage under two programs.

## Medicare Savings Program coverage for individuals enrolled in the Medicare Part B immunosuppressive drug benefit

Medicare Savings Programs (MSPs) provide eligible low-income Medicare beneficiaries with Medicaid assistance in paying their Medicare premiums and, in some cases, cost sharing.[1] Individuals enrolled in the MSPs are dually eligible beneficiaries, for whom Medicare is the primary payer of services such as physician visits, hospital stays, post-acute skilled care, and prescription drugs.[2] Medicaid covers services that Medicare does not cover, such as long-term services and supports.

The proposed rule would extend MSP coverage to eligible individuals who are entitled to Medicare based on a diagnosis of end-stage renal disease (ESRD), had a successful kidney transplant, and do not have other health insurance coverage but are eligible to enroll in Medicare Part B for purposes of immunosuppressive drug coverage. Prior to enactment of the CAA, such individuals could extend their Medicare coverage for 36 months following the transplant. However, Medicare coverage would end after 36 months unless the individual was eligible for Medicare on a basis other than ESRD, such as age. Section 402 of the CAA extends Medicare coverage beyond 36 months for purposes of obtaining coverage of immunosuppressive drugs and also provides for coverage under the MSPs. This benefit is referred to in the proposed rule as the immunosuppressive drug benefit, or the Part B-ID benefit. Individuals enrolled in this benefit would not be eligible for other Part B benefits. Under the proposed rule, these provisions would be effective on January 1, 2023. These provisions are consistent with previous MACPAC statements about the role of Medicaid payment of Medicare premiums and cost sharing in ensuring access to care for dually eligible beneficiaries.

## Updating regulations affecting state payment of Medicare premiums

In the proposed rule, CMS describes ongoing efforts to modernize the processes for state payment of Medicare premiums and proposes updates to federal regulations affecting state payments for Medicaid beneficiaries who are enrolled in the MSPs and for other Medicaid eligibility groups. Since the Medicare program was implemented in 1966, states have had the option to enter into a "state buy-in" agreement with the federal government where the state agrees to enroll certain Medicaid beneficiaries who are eligible for Medicare into the program and pay the Medicare premiums for those individuals (CMS 2022b). All states and the District of Columbia have buy-in agreements for Part B while 37 states have buy-in agreements for Part A (CMS 2022b). The use of state buy-in agreements helps individuals enroll in both parts of Medicare, which provides access to the services available through the Medicare program, and, for people already enrolled in Medicare, can lead to increases in Social Security benefits because the state takes over payment of the Medicare Part B premiums (CMS 2022a).

### Clarify that state buy-in agreements with CMS are part of the Medicaid state plan

In the proposed rule, CMS would codify a long-standing practice of making changes to a state's buy-in policy through the Medicaid state plan rather than through freestanding written agreements originally used. According to CMS, none of the original freestanding agreements have been updated since 1992 even though changes have been made to state buy-in policies. CMS expects no negative impacts or substantive changes as a result of this proposed change. MACPAC supports this change as it codifies existing policy and will help clarify state buy-in policies going forward.

### Limiting retroactive state liability for Medicare Part B premiums to 36 months

Under section 1843 of the Social Security Act, states are responsible for paying Medicare Part B premiums starting in the first month that an individual is both eligible for Medicare Part B and a member of a Medicaid state buy-in coverage group. The state identifies these coverage groups and the groups are made up of multiple Medicaid eligibility categories (CMS 2022b). The Social Security Administration (SSA) determines eligibility for Medicare and in some cases, SSA determines that a Medicaid beneficiary is retroactively eligible for Medicare. CMS explains that this generally occurs when someone under age 65 files a claim for disability benefits with SSA and receives a favorable award multiple years after their application. A favorable determination can be retroactive for more than 24 months, which means that their eligibility for Medicare Part A and B benefits is also retroactive. This affects state Medicaid programs because the state buy-in coverage period begins the first month that an individual is enrolled in Medicaid and qualifies for Medicare, with no limit on retroactivity, meaning states could be retroactively liable for Medicare premiums years into the past. The proposed rule provides helpful examples of scenarios in which the state is liable to pay Medicare premiums going back as far as 48 months.

In cases of retroactive Medicare eligibility, states must determine if any Medicaid claims were paid for an individual when they would have been eligible for Medicare given Medicare is the primary payer for dually eligible beneficiaries when a service is covered by both programs. The state would need to recoup Medicaid payments from providers for any Medicare-covered services that it paid for in the retroactive eligibility period. The provider would then need to bill Medicare for those amounts.

To address the burdens that retroactively processing claims places on states and providers, CMS proposes to limit state liability for retroactive Medicare Part B premium payments for full-benefit dually eligible beneficiaries to no more than 36 months before the date of Medicare eligibility determination. The 36-month limit is intended to strike a reasonable balance between payment accuracy and reducing administrative burden. This provision is in line with previous MACPAC recommendations for Medicaid program integrity efforts to make efficient use of federal resources and to minimize undue burden on states or providers.

## Medicare Special Enrollment Period to coordinate with termination of Medicaid coverage

The proposed rule would establish a new Medicare special enrollment period (SEP) for individuals who lose Medicaid eligibility after the public health emergency (PHE) ends or on or after January 1, 2023,

whichever is earlier, and have missed a Medicare enrollment period so have not yet enrolled in Medicare. According to CMS, this SEP may be particularly useful for individuals who became eligible for Medicaid as part of the new adult group and aged into Medicare upon turning 65 years old but did not enroll in Medicare and instead stayed on Medicaid under the PHE rules (CMS 2022a). MACPAC supports CMS' efforts to establish streamlined, seamless eligibility and enrollment processes across the continuum of programs for which individuals may qualify.

We appreciate the opportunity to provide comments on this proposed regulation.

Sincerely,

Melanie Bella, MBA
Chair

cc: The Honorable Ron Wyden, Chair, Senate Finance Committee
The Honorable Mike Crapo, Ranking Member, Senate Finance Committee
The Honorable Frank Pallone, Jr., Chair, House Energy and Commerce Committee
The Honorable Cathy McMorris Rodgers, Ranking Member, House Energy and Commerce Committee

**Endnotes**

[1] There are four MSPs with varying eligibility requirements: the Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Medicare Beneficiary (SLMB) program, the Qualifying Individual (QI) program, and the Qualified Disabled and Working Individuals (QDWI) program.