Center for
Medicare Advocacy
Advancing Access to Medicare and Health Care

September 9, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Office of the Secretary
Attention: CMS-1809-P, P.O. Box 8010
Baltimore, Maryland 21244-8010

Submitted electronically to: https://www.regulations.gov

Honorable Chiquita Brooks-LaSure:

The Center for Medicare Advocacy provides these comments regarding CMS-1809-P and the impact of the proposed rule revising the Medicare hospital Outpatient Prospective Payment System (OPPS) and the Medicare Ambulatory Surgical Center (ASC) payment system for calendar year 2025.

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

The Center for Medicare Advocacy's response to the 2025 Proposed Rule will focus on the following:

I. Narrowing the definition of "custody" in 42 C.F.R. § 411.4(b).
II. Amending the SEP at §§ 406.27(d)(1) and 407.23(d)(1) to align the SEP triggering event more closely with the basis on which an individual's OASDI benefit is reinstated or initiated rather than on the scope of the Medicare payment exclusion in § 411.4(b).

I. Strong Support of narrowing the definition of "custody" in 42 C.F.R. § 411.4(b).

Currently, 42 C.F.R. § 411.4(b) provides that Medicare does not pay for services for individuals who are "in custody" of "penal authorities," which includes, but is not limited to, individuals who are "under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, on medical furlough, required to reside in mental health facilities, required to reside in halfway

houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule."

The Center strongly supports CMS' proposed rule to amend the description of "custody" to remove individuals who are on supervised release and home detention. Further, the Center strongly supports using specific language in regulatory text that individuals on bail, parole, probation, or home confinement are not considered to be in "custody."

The Center agrees that those individuals on bail, parole, probation, or home confinement typically *do* have a legal obligation to pay for health services, and typically *do not* have the status of public charges. As such, Federal, State, local government or law enforcement or "penal authorities" are not typically responsible for providing health care for such individuals.

When applying the current definition of "custody," there is a presumption (which can be rebutted, albeit by the individuals themselves) that Medicare will not pay for health care items or services furnished to individuals who are outside the physical confines of a jail or prison and instead released on parole, probation, or home detention. The Center agrees that the confusion about whether Medicare *may* pay for health services has led to the following:

- Individuals released from incarceration may not apply for Medicare even if they are eligible;
- Individuals released from incarceration may apply for Medicaid, only;
- Providers/suppliers may be hesitant or refuse to treat individuals released from incarceration because they believe Medicare will not pay; and
- Individuals released from incarceration may delay or forgo necessary treatment upon release.

The Center agrees that the proposed changes to "custody" would clarify that Medicare may pay for health care items and services without the need for the individual to prove that the special conditions in § 411.4(b)(1) have been satisfied. By narrowing the definition of "custody" to no longer include individuals who are on parole, probation, and home detention, this facilitates access to Medicare coverage for individuals who are reentering society and living in the community following incarceration.

For these same reasons, we strongly support adding a definition of "penal authority" to section § 411.4(b) that is broad enough to include all agencies or institutions that might place or hold an individual in custody, as the term is described at proposed § 411.4(b)(3), regardless of whether the individual has actually been convicted of a crime. Already, formerly incarcerated individuals report criminal record discrimination by healthcare workers, which often impacts individuals' healthcare utilization.[1] By not focusing on conviction status, the proposed changes can help alleviate what could be another hurdle for recently incarcerated individuals accessing health care.

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[1] Joseph W. Frank, et al., *Discrimination Based on Criminal Record and Healthcare Utilization Among Men Recently Released From Prison: A Descriptive Study*, Health Justice, (March 25, 2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4308970/.

Further, CMS has asked for specific comments regarding how individuals residing in halfway houses should be treated as it pertains to the definition of "custody." Broadly speaking, "halfway house" is an umbrella term, which can refer to a number of different types of facilities and arrangements.[2] While carceral in nature, a function of most, if not all, halfway houses is to facilitate successful reentry into society. Therefore, rather than focusing on the details of how each individual halfway house is funded or what specific services or parameters of control are provided, the Center suggests the definition of "custody" § 411.4(b), as it pertains to individuals residing in halfway houses, should focus on whether the type of release to this arrangement is intended to facilitate an individual's successful reintegration into society.

Support of this interpretation is evidenced by the U.S. Department of Health and Human Services' shift in policy to allow released prisoners residing in halfway houses to take advantage of the services made available through the Affordable Care Act's Medicaid Expansion.[3] Here, a "freedom of movement" test is applied. As part of this test, individuals are eligible for Medicaid "if residents [of halfway houses] can seek health care treatment in the broader community to the same or similar extent as other Medicaid enrollees in the state."

To support this, the Center suggests explicitly stating in regulatory text that individuals on bail, parole, probation, home confinement, *and residing in halfway houses where individuals are free to seek health care treatment in the broader community* are not considered to be in "custody" under § 411.4(b). With this language, individuals residing in halfway houses and seeking health care treatment can be confident that Medicare may pay if enrolled, and health care providers can be confident that Medicare may pay if the individual is residing in a halfway house.

II. Strong support of amending the SEP at §§ 406.27(d)(1) and 407.23(d)(1) to align the SEP triggering event more closely with the basis on which an individual's OASDI benefit is reinstated or initiated rather than on the scope of the Medicare payment exclusion in § 411.4(b).

Currently, the SEP for formerly incarcerated individuals at 42 C.F.R. § 406.27(d)(1) (Medicare Premium Part A) and 42 C.F.R. § 407.23(d)(1) (Medicare Part B) provide that an individual is eligible for the SEP "if they … failed to enroll or reenroll … due to being in custody of penal authorities." These sections instruct seeing Section 411.4(b) for a definition of "in custody of penal authorities."

Rather than referring to § 411.4(b), CMS proposes that eligibility for this SEP should use language more consistent with section 202(x)(1)(A)(i) of the Social Security Act ("the Act"), which directs suspension of Old-Age, Survivors, and Disability Insurance (OASDI) benefits when the individual

[2] Roxanne Daniel and Wendy Sawyer, *What You Should Know About Halfway Houses,* Prison Policy Initiative, (September 3, 2020), https://www.prisonpolicy.org/blog/2020/09/03/halfway/.
[3] CMS, SHO # 16-007 Re: To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities, Q3 (April 28, 2016), https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf.

is "confined in a jail, prison, or other penal institution or correctional facility pursuant to his conviction of a criminal offense."

CMS states three main reasons for no longer referencing § 411.4(b) in the SEP provisions. First, SSA is the entity that processes the SEP enrollments, and collects data that show whether a person is "released form confinement in a jail, prison, or other penal institution or correctional facility." Second, § 411.4(b) creates a rebuttable presumption within its definition, making the determination confusing to both SSA workers and individuals seeking Medicare enrollment. Third, aligning the SEP with OASDI benefit payment has the potential to streamline the administration of both benefits, which includes deducting Medicare premiums from benefit checks.

As an example, the Center learned of an individual in Wisconsin who was released from prison in July, 2023.[4] The day after he was released, he contacted SSA to reinstate his Social Security Retirement benefits and re-enroll in Medicare Part B. He was told (erroneously) that he needed to wait until the General Enrollment Period (GEP) in January, 2024, with coverage beginning the following July, 2024. After meeting with a State Health Insurance Assistant Program (SHIP) counselor, he learned he could apply for Medicare Part B using the new SEP for formerly incarcerated individuals. It took many months for SSA to process his SEP and Medicare enrollment, even though his Social Security Retirement benefits were reinstated with no issues. The confusion and delay in enrollment into health coverage had a chilling effect on this individual accessing health care. Even after he received his Medicare cards in the mail, he did not seek medical treatment out of fear of nonpayment. It took him until February of 2024 to ultimately seek medical services, at which point he learned he had cancer. Even after receiving this diagnosis, he would not agree to any cancer treatments until meeting with a SHIP counselor again and confirming Medicare coverage.

The Center strongly agrees that amending the SEP for formerly incarcerated individuals to align more closely with the basis on which an individual's OASDI benefit is initiated or reinstated has the potential to streamline the administrative process. Using SSA language to determine SEP eligibility should increase the chances it is applied correctly, and SSA can more easily verify eligibility status with the data it already collects.

In this case, the Wisconsin individual's SEP eligibility could have been confirmed more easily by SSA, and his Part B could have coincided with his Social Security Retirement benefits. Had the reenrollment process been more streamlined, he may have felt more confident seeking medical services. With the changes CMS is proposing, this individual may have caught his cancer diagnosis earlier and felt comfortable undergoing further treatment.

Conclusion

For the reasons set forth in this comment, the Center for Medicare Advocacy strongly supports CMS' proposed changes, as they address real and perceived barriers to accessing medical care

[4] This individual sought legal services through the Greater Wisconsin Agency on Aging Resources, Inc. (GWAAR) in 2023, where I was employed at the time.

following incarceration. The Center has experienced real-world examples of recently incarcerated individuals delaying or forgoing medical care due to enrollment confusion and fear of nonpayment by Medicare. Receiving health coverage that an individual is legally entitled to should not be an added obstacle for a successful reentry into society, and the Center supports CMS in its efforts to remove these hurdles.

Sincerely,

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