

# COALITION FOR WHOLE HEALTH

June 27, 2022

Chiquita Brooks-LaSure, Administrator  
Dr. Meena Seshamani, Deputy Administrator, and Director, Center for Medicare  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Baltimore, MD 21244-8016

RE: CMS-4199-P

Dear Administrator Brooks-LaSure and Director Seshamani:

The Coalition for Whole Health is a broad coalition of local, State, and national organizations in the mental health and substance use disorder prevention, treatment, and recovery communities. Thank you for the opportunity to provide comments on the proposed amendments to the Medicare program to implement certain provisions of the Consolidated Appropriations Act of 2021 and other revisions to Medicare enrollment and eligibility rules.

The undersigned organizations strongly support the Medicare rule's proposal to establish a special enrollment period (SEP) for formerly incarcerated individuals and to exempt those who enroll under the SEP from a Late Enrollment Penalty (LEP). Currently, individuals who turn 65 while they are incarcerated are not automatically enrolled in Medicare Part A and do not have the ability to enroll in Medicare Part B. As a result, when they are released from incarceration, they may be forced to go months without health coverage and incur a Late Enrollment Penalty (LEP) that would make their Medicare premiums more expensive for the rest of their lives, even though their failure to enroll in Medicare was beyond their control. Unfortunately, coverage disruptions as people return home to the community from incarceration, such as those perpetuated by current Medicare policy, are common and extremely harmful. People with mental health and substance use disorders who are reentering the community from incarceration are particularly vulnerable; in the first two weeks of reentry, people are 129 percent more likely to die from a drug overdose and are at significantly higher risk to die by suicide.

Given the numerous barriers formerly incarcerated individuals face upon their release, we strongly support the proposed rule's recommendation to make the SEP last for six months, so that these individuals have a sufficient opportunity to learn about their enrollment options and get the assistance they need to make enrollment decisions. We further strongly support the proposal to exempt those who enroll under this SEP from the LEP.

Creating a SEP for formerly incarcerated individuals is aligned with the pillars of the Administration's vision for the Medicare program: advancing health equity, expanding access to affordable health coverage and care, and promoting affordability and sustainability.

**Advancing Health Equity:** Due to systemic racism, Black and Brown people face significant inequities in health care coverage and access.<sup>1</sup> As a result, they experience poorer health outcomes. Untreated mental health and

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<sup>1</sup> See generally St. Catherine University, *Racial Discrimination in Healthcare: How Structural Racism Affects Healthcare* (June 15, 2021), available at <https://www.stkate.edu/academics/healthcare-degrees/racism-in-healthcare>.

substance use disorders, coupled with racism in the criminal legal system, is a major driver of the overrepresentation of Black and brown people in jails and prisons.

People in the criminal legal system have complex health needs that are often largely unaddressed. The COVID-19 public health emergency has underscored the close relationship between the health of people in prisons and jails, and the health of families and communities. People with criminal legal system involvement often have an extremely high need for health care. For example, incarcerated individuals' rates of HIV infection are four to six times higher than the general population, and one in three incarcerated individuals are estimated to have hepatitis C. The rates of mental illness also are extremely high: in 2005, according to U.S. Department of Justice data, more than half of all people incarcerated in prisons and jails had a mental illness. Left untreated, these conditions worsen health outcomes and reduce the likelihood of successful reentry.

Removing barriers to Medicare enrollment as people return home from jail and prison will promote greater health equity and better health outcomes for formerly incarcerated people.

**Expanding Access to Affordable Health Coverage and Care:** As advocates for mental health and substance use disorder care, we note the high need for coverage and accessibility of these services for formerly incarcerated people. Overdose is the leading cause of death among people recently released from prisons. Approximately 65% of the United States prison population has an active SUD and another 20% were under the influence of alcohol or drugs at the time of their crime. Over 3% of those living in state or federal correctional facilities are 65 years or older and 3.6% are individuals between 60 and 64 years of age. When these individuals are released from custody, it is critical that they have insurance to pay for care so that they can continue treatment they received while incarcerated or initiate treatment, at a time when they need it the most.

**Promoting Affordability and Sustainability:** As CMS notes, this incarceration status at the time of initial eligibility for Medicare is “exceptional” and a one-time event, for which creating an SEP would not create an incentive for individuals to delay timely enrollment or to not educate themselves about the importance of enrolling in Medicare or making informed decisions during other available enrollment periods. This SEP is the most appropriate resolution to the exceptional circumstance in question and protects the financial health of the Medicare program.

As this Administration continues to advance these goals, we additionally urge CMS to revise its current definition of “in custody” for the Medicare population to be consistent with the definition it uses for Medicaid. Medicare does not pay for services for individuals who are in custody of a penal authority, which currently includes “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.” 42 C.F.R. § 411.4(b). Medicare has adopted this broad definition based on federal court case law, developed outside the Medicare context, that has found that “custody” is not limited to those who are physically confined. Thus, individuals on parole, probation, bail, or supervised release may be ‘in custody’ for purposes of the Medicare exclusion, even if they live outside of a correctional facility and, therefore, receive no correctional health services. CMS addressed similar reimbursement restrictions in the Medicaid program in 2016, clarifying that individuals who are on parole or probation or have been released to the community pending trial are eligible for Medicaid-reimbursed services. We urge CMS to extend this definition to Medicare, and issue guidance to its effect, to achieve the Medicare vision of advancing health equity,

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expanding access to affordable health coverage and care, driving high quality person-centered care, and promoting affordability and sustainability.

Thank you again for the opportunity to provide comments on this proposed rule. We appreciate your careful consideration of our comments and look forward to working with you. Please contact Gabrielle de la Guéronnière ([gdelagueronniere@lac-dc.org](mailto:gdelagueronniere@lac-dc.org)) or Deborah Steinberg ([dsteinberg@lac.org](mailto:dsteinberg@lac.org)) if you have any questions or if we can be of further assistance.

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American Society of Addiction Medicine  
Association for Behavioral Health and Wellness  
Church World Service  
COCHS  
Community Catalyst  
Faces & Voices of Recovery  
Families USA  
The Kennedy Forum  
Legal Action Center  
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NAMI  
National Association of Addiction Treatment Providers  
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