CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-01 Medicare General Information, Eligibility, and Entitlement	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11764	**Date: December 22, 2022**
	Change Request 12804

Transmittal 11646 issued October 19, 2022, is being rescinded and replaced by Transmittal 11764, dated, December 22, 2022 to add provider education business requirements to the instructions. All other information remains the same.

NOTE: This Transmittal is no longer sensitive and is being re-communicated October 31, 2022. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: New Medicare Part B Immunosuppressant Drug Benefit (PBID) - Implementation

I. SUMMARY OF CHANGES: The purpose of this change request is to update certain sections in Pub. 100-01 with policy information regarding the new Part B-ID benefit.

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2023

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	2/ 20/ 20.2.1/ Premiums Paid by Other Than Enrollee
N	2/ 20/ 20.2.1.1/ Part A Buy-in States
N	2/ 20/ 20.2.1.2/ Part A Group Payer States
R	2/ 40.4/ Nature and Purpose of State Buy-in
R	2/ 40/ 40.7.7/ Premiums Under Buy-In
N	2/ 40.9/ Extended Coverage for Part B Immunosuppressive Drugs (PB-ID)
N	2/ 40.9.1/ Part B-ID Eligibility Requirements
N	2/ 40.9.2/ Other Health Coverage Making an Individual Ineligible for Part B-ID
N	2/ 40.9.3/ Effective Date of Entitlement to Part B-ID
N	2/ 40.9.4/ Initial Enrollment & Reenrollment in Part B-ID
N	2/ 40.9.5/ Procedure for Enrolling in Part B-ID
N	2/ 40.9.6/ Termination of Part B-ID
N	2/ 40.9.7/ Part B-ID Premiums
N	2/ 40.9.8/ Procedure for Termination of Part B-ID
N	2/ 40.9.9/ Medicare Savings Programs for Part B-ID Premiums

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-01	Transmittal: 11764	Date: December 22, 2022	Change Request: 12804

Transmittal 11646 issued October 19, 2022, is being rescinded and replaced by Transmittal XXXX, dated, Month Day, Year to add provider education business requirements to the instructions. All other information remains the same.

NOTE: This Transmittal is no longer sensitive and is being re-communicated October 31, 2022. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: New Medicare Part B Immunosuppressant Drug Benefit (PBID) - Implementation

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2023

I. GENERAL INFORMATION

A. Background: The majority of individuals with End-Stage Renal Disease (ESRD) are eligible for Medicare, regardless of age. A kidney transplant is ultimately considered the best treatment for ESRD. When an individual receives a kidney transplant, Medicare coverage extends for 36 months after the month in which the individual receives a transplant. Currently, Medicare Part B beneficiaries have coverage for immunosuppressive drug therapy for as long as they remain eligible and enrolled in Medicare Part B. After the 36th month, Medicare coverage will end unless the individual is otherwise entitled to Medicare (i.e., if they would now be eligible based on age or disability). Once ESRD-only beneficiaries exhaust their 36 months of Medicare eligibility, they lose Part B coverage for immunosuppressive drugs and must pay for the medications out of pocket, through other insurance, or with third-party assistance. The cost of paying for immunosuppressive drug therapy could be prohibitive for individuals who lose Medicare coverage at the 36th month and who do not have another source of healthcare coverage. If an individual does not take these immunosuppressive drugs, however, it is possible that the transplant will be rejected and the individual will be at risk of developing ESRD again, which would lead to further Medicare entitlement, dialysis, and potentially another transplant.

In 2020, section 402 of the Consolidated Appropriations Act (CAA) amended sections 226(a), 1836, 1837, 1838, 1839, 1844, 1860-D-1, 1902, and 1905 of the Act to make an exception for eligibility for enrollment under Medicare Part B solely for the purposes of coverage of immunosuppressive drugs described in section 1861(s)(2)(J) of the Act. Effective January 1, 2023, this provision allows individuals whose Medicare entitlement based on ESRD ends 36 months after the month in which they received a successful kidney transplant to continue enrollment under Medicare Part B only for the coverage of immunosuppressive drugs described in section 1861(s)(2)(J) of the Act without a time limit. This benefit will be referred to as the Part B immunosuppressive drug benefit or "Part B-ID" or "PBID". The PBID benefit, is unique in that it is classified as a Part B benefit, but it provides coverage limited to immunosuppressive drugs for which only a select subset of Medicare beneficiaries would be eligible. Because it is considered a part of the Part B benefit, most rules and requirements applicable to Part B also apply to the PBID benefit. Individuals entitled to Part B for coverage of immunosuppressive drugs, would not receive Medicare coverage for any other items or services, and would only be eligible for the immunosuppressive drug coverage if they are not enrolled in certain other types of coverage (e.g., group health plan, TRICARE, or a Medicaid state plan that covers immunosuppressive drugs). Section 402 of the CAA does not make changes to payment limits for applicable billing and payment codes associated with immunosuppressive drugs, supplying fees to pharmacies (as described in section 1842(o)(6) of the Act), or applicable beneficiary deductible and coinsurance amounts.

Section 402 of the CAA also amends the Medicare Savings Programs (MSP) under sections 1905(a)(1)(A) and 1902(a)(10)(E) of the Act to pay some of the Part B premiums, and in some cases, all the cost sharing for certain low-income individuals under the MSP eligibility groups. The Office of the Actuary (OACT) estimates that a small number of individuals (250) will enroll in the Part B-ID benefit each year, and it is anticipated that most will also qualify for the Qualified Medicare Beneficiary group (QMB), the MSP group that covers Part B-ID premiums, deductibles, coinsurance and copayments. Under MSP Part B-ID coverage, states will pay Part B-ID premiums and cost sharing for QMBs, and Part B-ID premiums for Specified Low-Income Beneficiaries (SLMBs) and Qualifying Individuals (QIs). The Centers for Medicare & Medicaid Services (CMS) anticipates enrollment in MSP Part B-ID mainly occurring in the 12 states that, as of December 2021, have elected to not expand Medicaid eligibility to adults with income up to 133 percent Federal Poverty Level (FPL) ("non-expansion states") because individuals in the expansion states will likely be eligible for the adult group under 42 CFR § 435.119. Those 12 states are Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin and Wyoming.

The CAA established criteria which make an individual eligible for the PBID benefit. In new § 410.184(a) an individual is eligible to enroll in, be deemed enrolled, or re-enroll in, the PBID benefit if their Part A entitlement ends under § 406.13(f)(2). Section 402 of the CAA also requires that an individual attest that they do not have other health coverage. This requirement is established at new § 410.188 (Attestation). Individuals whose 36-month post-transplant period ends before January 2023 can enroll starting in October 2022 and their coverage will start the later of January 2023 or the month after the month in which they enroll. Individuals whose Part A entitlement ends on or after January 1, 2023, and is not deemed enrolled, can enroll at any time, and their coverage will start in accordance with the articulated time frames. Beneficiaries are not required to have the PBID benefit and can terminate their benefit by filing notice that they no longer wish to participate in the PBID benefit program.

For any individual enrolled in the PBID program, there will be a new enrollment code that will be provided by the Social Security Administration (SSA) to identify them as separate Medicare enrollees. The effort conducted by SSA is an EPIC in Jira, project MEPS-1419. This effort is currently scheduled for implementation in October 2022. PBID enrollees will also receive a new Medicare card that will identify them as only eligible for immunosuppressant drugs under the PBID benefit.

Section 1861(s)(2)(J) of the Act provides for coverage of only prescription drugs used in immunosuppressive therapy furnished to an individual who receives an organ transplant for which payment is made by Medicare. Therefore, coverage is limited to those drugs that are medically necessary and appropriate for the specific purpose of preventing or treating the rejection of a transplanted organ or tissue by suppressing a patient's natural immune responses. Accordingly, drugs that are used for the treatment of conditions that may result from an immunosuppressive drug regimen (for example, antibiotics, antihypertensives, analgesics, vitamins, and other drugs that are not directly related to organ rejection) are not covered under this benefit. A drug must be approved by the Food and Drug Administration (FDA), be available only through a prescription, and belong to one of the following three categories:

- It is a drug approved for marketing by the FDA and is labeled as an immunosuppressive drug.
- It is a drug, such as a corticosteroid, that is approved by the FDA and is labeled for use in conjunction with immunosuppressive drugs to treat or prevent the rejection of a patient's transplanted organ or tissue.
- It is a drug that a Part B carrier, in processing a Medicare claim, determined to be reasonable and necessary for the specific purpose of preventing or treating the rejection of a patient's transplanted organ or tissue, or for use in conjunction with those immunosuppressive drugs for the purpose of preventing or treating the rejection of a patient's transplanted organ or tissue.

Per the Medicare Benefit Policy Manual, Chapter 15, Section 50.5.1, covered drugs include those immunosuppressive drugs that have been specifically labeled as such and approved for marketing by the FDA. (This is an exception to the standing drug policy which permits coverage of FDA approved drugs for

nonlabelled uses, where such uses are found to be reasonable and necessary in an individual case.)

The FDA has identified and approved for marketing the following specifically labeled immunosuppressive drugs. They are: Sandimmune (cyclosporine), Sandoz Pharmaceutical; Imuran (azathioprine), Burroughs Wellcome; Atgam (antithymocyte globulin), Upjohn; Orthoclone OKT3 (Muromonab-CD3), Ortho Pharmaceutical; Prograf (tacrolimus), Fujisawa USA, Inc; Celicept (mycophenolate mefetil, Roche Laboratories; Daclizumab (Zenapax); Cyclophosphamide (Cytoxan); Prednisone; and Prednisolone. The CMS expects contractors to keep informed of FDA additions to the list of the immunosuppressive drugs. So, the above list is not all inclusive.

This new implementation change request instructs downstream systems to make the necessary system changes, activities, and efforts to ensure that processes are implemented accordingly. These changes include directives that contractors shall be able to properly identify PBID eligible beneficiaries in their systems, be able to accept and store effective and termination dates for PBID eligible beneficiaries, and accept updated screens with a new PBID indicator. A more extensive list of necessary system changes for proper implementation are outlined in the Business Requirements sections below.

Finally, this change request provides updates to Publication (Pub.) 100-01, Chapter 2. The specific modifications are outlined below:

- Added new subsections to section 20 'Hospital Insurance Obtained by Premium Payment'
    - 20.2.1 – Premiums Paid by Other Than Enrollee
    - 20.2.1.1 – Part A Buy-in States
    - 20.2.1.2 – Part A Group Payer States
- Revised subsection 40.4 'Nature and Purpose of State Buy-in'
- Revised subsection 40.7.7 'Premiums Under Buy-in'
- Added new section 40.9 ‘Extended Coverage for Part B Immunosuppressive Drugs – PB-ID'

B. Policy: This Change Request (CR) instructs contractors to conduct implementation activities, necessary system changes, and levels of effort required to implement the new Part B-ID benefit. This CR also instructs contractors to refer to designated Internet Only Manual (IOM) Publications for detailed information related to the new Part B-ID benefit.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12804 - 01.1	The contractor shall refer to Publication 100-01 Medicare General Information, Eligibility, and Entitlement, Chapter 2, new subsections 20.2.1, 20.2.1.1, and 20.2.1.2 for premium, Part A buy-in, and group payer information, respectively.	X	X		X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12804 - 01.2	The contractor shall refer to Publication 100-01 Medicare General Information, Chapter 2, Section 40.4 and 40.7.7 for updated general state buy-in information	X	X		X					
12804 - 01.3	The contractor shall refer to Publication 100-01 Medicare General Information, Eligibility, and Entitlement, Chapter 2, new Section 40.9 for specific policy, entitlement, eligibility, and termination information regarding the new Part B-ID benefit.	X	X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12804 - 01.4	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X	X		X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Kelechi Anyatonwu, kelechi.anyatonwu@cms.hhs.gov (For questions related to Part B-ID in the Medicare General Information, Eligibility and Entitlement Manual 100-01)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare General Information, Eligibility, and Entitlement

Chapter 2 - Hospital Insurance and Supplementary Medical Insurance

Table of Contents
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Transmittals for Chapter 2

20.2.1 - Premiums Paid by Other Than the Enrollee
(Rev.11764; Issued 12-22-22; Implementation: 01-01-2023; Effective 01-03-23)

The following subsections describe Medicare Part A premiums paid by other than the enrollee.

20.2.1.1 - Part A Buy-in States
(Rev.11764; Issued 12-22-22; Implementation: 01-01-2023; Effective 01-03-23)

States that include the payment of Medicare Part A premiums for Qualifying Medicare Beneficiaries (QMBs) in their state buy-in agreements are known as Part A buy-in states. Individuals in Part A buy-in states can file for Premium Part A at any time, without regard to enrollment periods. Late enrollment penalties do not apply. Please see the Manual for State Payment of Medicare Premiums, chapter 1, sections 1.7 and 1.11 for additional information about Part A buy-in states.

20.2.1.2 - Part A Group Payer States
(Rev.11764; Issued 12-22-22; Implementation: 01-01-2023; Effective 01-03-23)

States that do not include the payment of Medicare Part A premiums for QMBs in their state buy-in agreements are known as group payer states. To become entitled to Part A, individuals in group payer states can file for premium Part A during their Initial Enrollment Period (IEP) or the General Enrollment Period (GEP). Part A premiums and any applicable late enrollment penalties are paid under a group payer arrangement. Please see the Manual for State Payment of Medicare Premiums, chapter 1, section 1.7 and 1.11 for additional information about Part A group payer states.

40.4 - Nature and Purpose of State Buy-in
(Rev.11764; Issued 12-22-22; Implementation: 01-01-2023; Effective 01-03-23)

Under the State Buy-in program, states, the District of Columbia, and the U.S. territories may enter into buy-in agreements with CMS to enroll certain individuals who are dually eligible for Medicare and Medicaid into Medicare Part B and pay the premiums on their behalf.

Most states have expanded their buy-in agreements to also include payments of Part A premiums for individuals who must pay a premium to enroll in Medicare Part A and who are eligible for the Qualified Medicare Beneficiary (QMB) eligibility group. State buy-in agreements maximize the number of full-benefit Medicaid recipients enrolled in Medicare, which ensures that Medicare pays primary to Medicaid. State buy-in agreements also facilitate enrollment in Medicare for low income individuals who are not eligible for full-benefit Medicaid coverage by paying Medicare premiums and cost sharing. Please see the Manual for State Payment of Medicare Premiums, chapter 1, section 1.2 for additional state buy-in information.

40.7.7 - Premiums Under Buy-In
(Rev.11764; Issued 12-22-22; Implementation: 01-01-2023; Effective 01-03-23)

States pay the Part B premiums for any eligible individual specified in the state's buy-in agreement. Under buy-in agreements, states can enroll individuals in Part B at any time without regard to Medicare enrollment periods or late enrollment penalties. Please see the Manual for State Payment of Medicare Premiums, chapter 1, section 1.4 for additional information about state payment of premiums under a buy-in agreement.

40.9 - Extended Coverage for Part B Immunosuppressive Drugs (PB-ID)
(Rev.11764; Issued 12-22-22; Implementation: 01-01-2023; Effective 01-03-23)

The Consolidated Appropriations Act of 2021 amended section 1836(b) of the Social Security Act to add a new form of coverage that provides solely for coverage of immunosuppressive drugs beginning January 1,

2023, for eligible individuals whose entitlement to Medicare based on End-Stage Renal Disease (ESRD) ends the 36th month after the month in which the individuals receive a successful kidney transplant.

This new benefit is referred to as the Part B immunosuppressive drug benefit or "Part B-ID."

Beneficiaries enrolled in Part B-ID will not be covered for any other Medicare benefit or for any items or services other than Part B Immunosuppressive Drugs.

40.9.1 - Part B-ID Eligibility Requirements
(Rev.11764; Issued 12-22-22; Implementation: 01-01-2023; Effective 01-03-23)

An individual is eligible for Part B-ID if he or she:

1. *Is or was entitled to Medicare Part A based on ESRD that ends 36 months after a successful kidney transplant; and*

2. *Attests that he or she is not enrolled in other health coverage that would make them ineligible for Part B-ID, as outlined in section 40.9.2. Every individual enrolling in Part B-ID must:*
    i. *Attest that they are not enrolled in other health coverage and do not expect to enroll in other coverage which would make them ineligible for Part B-ID; and*
    ii. *Agree to notify SSA within 60 days of enrolling in other health coverage.*

    NOTE: An individual can inform SSA of other health coverage up to 6 months in advance

40.9.2 - Other Health Coverage Making an Individual Ineligible for Part B-ID
(Rev.11764; Issued 12-22-22; Implementation: 01-01-2023; Effective 01-03-23)

An individual who has other certain health coverage is not eligible for Part B-ID. Other health coverage includes:

- *Group Health Plans or Individual Health Plans;*
- *Enrolled in the patient enrollment system of the Department of Veterans Affairs (VA) or otherwise eligible to receive immunosuppressive drugs from the VA;*
- *TRICARE for Life;*
- *Health Insurance Marketplace qualified health plans; and*
- *Medicaid or State Children's Health Insurance Program (CHIP) coverage that includes immunosuppressive drugs.*

40.9.3 - Effective Date of Entitlement to Part B-ID
(Rev.11764; Issued 12-22-22; Implementation: 01-01-2023; Effective 01-03-23)

The effective date of an individual's eligibility for the Part B-ID benefit depends on when their entitlement to Medicare Part A based on ESRD ends and when they submit the attestation described in section 40.9.1 of this chapter.

When an individual's Medicare Part A entitlement based on ESRD ends on or after January 1, 2023:

- *If they submit the attestation before the end of the 36th month after the month of the kidney transplant (i.e. before their Medicare Part A entitlement based on ESRD ends), Part B-ID begins effective at the start of the month after their Medicare Part A on the basis of ESRD ends.*

- *If they submit the attestation after their Medicare Part A entitlement ends, Part B-ID begins at the start of the month following the month in which the attestation is submitted.*

When an individual's Medicare Part A entitlement based on ESRD ends prior to January 1, 2023:

- *If they submit the attestation to enroll from October 1, 2022 through December 31, 2022, Part B-ID begins effective January 1, 2023.*
- *If they submit the attestation to enroll after December 31, 2022, Part B-ID begins the following month.*

40.9.4 - Initial Enrollment & Reenrollment in Part B-ID

(Rev.11764; Issued 12-22-22; Implementation: 01-01-2023; Effective 01-03-23)

There are no enrollment periods associated with Part B-ID. Therefore, eligible individuals can enroll at any time without regard to Medicare enrollment periods. The earliest date on which they may initially enroll depends on when their Medicare Part A entitlement based on ESRD ends, under the following two scenarios:

1. *When an individual's Medicare Part A entitlement based on ESRD ends on or after January 1, 2023, they may enroll in Part B-ID any time after their Medicare Part A on the basis of ESRD entitlement ends.*

2. *When an individual's Medicare Part A entitlement based on ESRD ends prior to January 1, 2023, they may enroll in Part B-ID beginning October 1, 2022 and their coverage will start the later of January 2023 or the month after they enroll.*

Individuals who had previously enrolled in Part B-ID can reenroll at any time if they meet the eligibility requirements in section 40.9.1.

NOTE: Late enrollment penalties are ***not*** *applicable to Part B-ID enrollment. Additional information is outlined under subsection 40.9.7 (Part B-ID Premiums).*

40.9.5 - Procedure for Enrolling in Part B-ID

(Rev.11764; Issued 12-22-22; Implementation: 01-01-2023; Effective 01-03-23)

Eligible individuals may enroll by:

1. *calling SSA at 1-877-465-0355 and providing an oral attestation, or*
2. *completing and filing the Application for Enrollment in Part B-ID. Immunosuppressive Drug Coverage Form CMS-10798 and mailing it to the following address:*

SOCIAL SECURITY ADMINISTRATION
OFFICE OF CENTRAL OPERATIONS
PO Box 32914
BALTIMORE, MARYLAND 21298

Note: The Office of Central Operations Office of Disability Operations teleservice center (ODO TSC) will only be handling the telephonic enrollments and PC 7 will process the enrollment for Part B-ID.

40.9.6 - Termination of Part B-ID

(Rev.11764; Issued 12-22-22; Implementation: 01-01-2023; Effective 01-03-23)

1. ***Individuals enrolled in other health coverage are required to notify SSA and terminate Part B-ID***
    a. *When a Part B-ID covered individual notifies SSA that they have enrolled in other coverage, and if not otherwise specified, Part B-ID terminates effective with the first day of the month following the month SSA receives the notification.*

    b. *If the individual states that their other health insurance begins in the future, the individual may request a termination date up to 6 months in the future.*

Example: If an individual enrolls in employer health coverage during an employer's open enrollment period in October, for a January 1st effective date, the individual can submit their request for termination of the Part B-ID benefit in October or November, and not lose their Part B-ID benefit prior to the January 1st effective date.

c. *When a state ends buy-in for Part B-ID because an individual gained full Medicaid eligibility that includes immunosuppressive drug coverage, the individual must report this new eligibility to SSA and terminate Part B-ID coverage.*

If a Part B-ID covered individual fails to notify SSA of their enrollment in other health coverage, including employer and Medicaid, Part B-ID will terminate effective the first day of the month after the month in which SSA discovers the individual has other health coverage.

2. ***Voluntary termination request –*** *In general, Part B-ID terminates effective with the first day of the month following the month in which we receive the request.*

   There is an exception to this general rule for individuals who had state payment of their Part B-ID premium under a Medicare Savings Program (as described in section 40.9.9) and who are notified by SSA that their state will no longer pay their Medicare Part B-ID premiums. For these individuals the following entitlement end dates apply:

   a. *If the individual files a voluntary termination request within 30 days after the date of the notice that state payment of premiums will end or has ended, the individual's Part B-ID entitlement ends on the last day of the last month for which the state paid the premium.*

   b. *If the individual files the voluntary termination request more than 30 days but not more than 6 months after state payment of Medicare Part B-ID premiums ends, Part B-ID entitlement ends on the last day of the month in which the request is filed.*

   c. *If the individual files the voluntary termination request later than the 6th month after state payment of Medicare Part B-ID premiums ends, entitlement ends at the end of the month after the month in which request is filed.*

We note that individuals who lose eligibility for state payment of Medicare Part B-ID premiums through a Medicare Savings Program will continue to be eligible for the Part B-ID benefit without interruption with the individual assuming responsibility for paying the Part B-ID premiums, unless they voluntarily terminate. The options for financial relief from Part B billing in SSA's Program Operations Manual System (POMS), section HI.00815.042, also apply for the Part B-ID coverage here.

3. ***Death*** *- Entitlement to Part B-ID continues into the month of death,* ***up to and including the date of death.***

4. ***Non-payment of premiums*** *– Part B-ID coverage will terminate for non-payment of premiums following the same rules, including grace periods, used for Medicare Part B for monthly billing in sections 40.5 and 40.7.4 of this manual. Note that section 40.5 provides end of coverage information, and section 40.7.4 provides grace period payment information.*

5. ***Individual becomes entitled to Medicare on another basis*** *– In cases where a Part B-ID enrollee becomes eligible for Medicare based on age, disability, or ESRD, Part B-ID will terminate effective with the last day of the month prior to the month in which they become entitled on the other basis. Equitable relief for retroactivity may apply.*

40.9.7 - Part B-ID Premiums
(Rev.11764; Issued 12-22-22; Implementation: 01-01-2023; Effective 01-03-23)

Part B-ID premiums may be adjusted based on rounding, the income-related monthly adjusted amounts (IRMAA), and the hold harmless provision, but will not be increased based on late enrollment.

If the individual is directly billed for premiums, billing will be on a monthly basis.

40.9.8 - Procedure for Termination of Part B-ID
(Rev.11764; Issued 12-22-22; Implementation: 01-01-2023; Effective 01-03-23)

Individuals enrolled in the Part B-ID benefit can report other coverage and request to terminate their enrollment by either:

1. *calling SSA at 1-877-465-0355 to disenroll over the phone to verbally request termination, or*
2. *completing and submitting Form CMS-1763, Request for Termination of Premium Hospital and/or Supplementary Medical Insurance, and mailing it to:*

SOCIAL SECURITY ADMINISTRATION
OFFICE OF CENTRAL OPERATIONS
PO Box 32914
BALTIMORE, MARYLAND 21298

3. any other request to SSA that shows the unequivocal desire to end coverage.

Note: The Office of Central Operations Office of Disability Operations teleservice center (ODO TSC) only will handle the telephonic disenrollment and PC 7 will process the disenrollment for Part B-ID.

When the individual is reporting other coverage and choosing a future termination date, a termination effective date that is more than 6 months in the future ***cannot*** *be processed.*

40.9.9 - Medicare Savings Programs for Part B-ID Premiums
(Rev.11764; Issued 12-22-22; Implementation: 01-01-2023; Effective 01-03-23)

Individuals enrolled in Part B-ID with limited income and resources may be eligible for assistance through the Medicare Savings Programs (MSPs). The MSPs include three eligibility groups that cover Part B-ID premiums and sometimes cost sharing, including:

- *Qualified Medicare Beneficiary (QMB)*
- *Specified Low-Income Medicare Beneficiary (SLMB)*
- *Qualifying Individuals (QI)*

There are two ways to enroll in the MSPs for the payment of the Part B-ID premiums. First, once enrolled in Part B-ID, individuals may apply for the MSPs and be determined eligible by their state for an MSP eligibility group based on Part B-ID.

Second, individuals who are enrolled in an MSP group and lose Medicare entitlement based on ESRD 36 months after the month in which they receive a kidney transplant can transition to an MSP based on Part B-ID enrollment without a break in coverage if: (1)they attest that they do not have other health coverage as described in 40.9.1 by the end of the 36th month after the month in which they receive a kidney transplant; and (2) the state redetermines the individual's Medicaid eligibility on all bases and does not otherwise find the individual ineligible for the MSP group.