CMS Response to Public Comments for CMS-10544, OMB 0938-1271

The Centers for Medicare and Medicaid Services (CMS) received comments on the Good Cause Processes information collection (CMS-10544, OMB 0938-1271), as outlined by the *Federal Register* notice dated March 18, 2026 from Medicare Advantage (MA) and Prescription Drug Plan (PDP) Organizations and other interested parties. This is the reconciliation of the comments.

Comment: A commenter requested that CMS reconsider its time burden estimate for plans to process good cause reinstatements. Specifically, the commenter asserts that the current estimate of 10 minutes per reinstatement does not adequately reflect the full scope of work required under existing CMS guidance, which mandates that reinstatement requests received after the disenrollment effective date be submitted through the Retroactive Processing Center (RPC). The commenter further recommended that CMS reduce this administrative burden by permitting plans to submit Category 1 Good Cause Reinstatements directly via the daily enrollment file, limiting RPC submission requirements to Category 2 requests only.

The commenter stated that members reinstated under the CMS-approved good cause reinstatement process must be treated as continuously enrolled and must not be processed as new enrollments. The commenter added that if members reinstated for good cause are treated as new enrollments, primary care provider (PCP) assignment logic may inappropriately reassign primary care providers, resulting in member disruption and misalignment with CMS-defined continuous coverage.

Response: Thank you for your comment. CMS acknowledges the commenter's concern that the current burden estimate of 10 minutes per reinstatement may not fully capture the administrative effort required to process good cause reinstatement requests, particularly those that must be routed through the RPC for manual review. However, CMS notes that not all reinstatement requests require the full scope of this administrative workflow. Many cases are resolved at earlier steps in the process. For example, where an individual does not provide a credible statement of unforeseen circumstances, the guidance is clear that the plan should promptly communicate that the request does not meet the criteria for reinstatement and close the matter without further review. Similarly, cases involving no past-due premium amounts require only a verbal or written notification of the favorable determination, without the additional steps of payment verification, bank processing, and RPC submission. As a result, the 10-minute estimate may reasonably reflect the average burden across the full population of reinstatement requests, including those resolved quickly at early stages of review, even if more complex cases may require greater effort. CMS will nonetheless take this feedback under consideration as part of its ongoing review of burden estimates associated with this information collection. CMS appreciates the recommendation to have plans submit good cause reinstatements as category 1 requests via the daily enrollment file and we will continue considering ways to reduce the administrative burden associated with good cause reinstatement processes on plans and enrollees.

CMS appreciates the comment about continuous enrollment and offers the following clarification. Plans process good cause determinations for failure to pay plan premiums, and CMS caseworkers review and issue favorable or unfavorable good cause determinations related to disenrollment for failure to pay Part D Income-Related Monthly Adjustment Amounts (IRMAA). Members reinstated under the good cause reinstatement process are not treated as new enrollments. Rather, members resume enrollment in their original plan without a break in coverage.

Comment: A commenter argued that the current collection instrument does not adequately protect beneficiaries who are incapacitated, such as those experiencing unexpected hospitalizations, when automated disenrollment is triggered due to non-payment, and recommended that the information collection incorporate cross-agency verification fields capable of matching hospital admission and emergency medical records against plan termination timestamps to prevent erroneous coverage loss. Second, the commenter noted that the reported volume of 54,789 annual respondents indicates a broader systemic issue, and recommended that CMS apply statistical analysis to identify plan sponsors or regions exhibiting anomalous rates of involuntary disenrollment that may warrant further oversight. Third, the commenter raised concerns about information latency during data transfers between plan sponsors and federal systems, recommending that CMS mandate real-time electronic acknowledgments upon receipt of a good cause reinstatement request, with an automatic administrative stay applied across all relevant federal health databases to halt further disenrollment processing until a formal determination is made. The commenter recommended that CMS update the information collection prior to final OMB renewal to incorporate cross-agency verification fields, including emergency room admission logs, verified medical necessity data, and state-level disability status, to reduce household burden and improve the accuracy and utility of the information collected.

Response: CMS acknowledges the commenter's concern regarding beneficiaries who may be unable to respond to premium payment obligations due to incapacitation, such as an unexpected hospitalization. The MA and Part D enrollment and disenrollment guidance addresses the non-payment disenrollment framework in detail. Specifically, § 60.3.1 of the MA and Part D Enrollment and Disenrollment Guidance establishes that disenrollment for failure to pay plan premiums is optional for each plan, and that plans must apply disenrollment policies consistently across all enrollees, including a grace period of no less than two whole calendar months. This grace period is intended to provide additional time to avoid termination of enrollment due to temporary financial or personal hardship. Regarding the commenter's concerns about data transfers between plan sponsors and CMS systems, we appreciate the recommendation but believe it is outside the scope of this information collection.

We appreciate the commenter's suggestions to incorporate cross-agency verification fields to prevent erroneous coverage loss and conduct statistical analysis to identify plans or regions demonstrating outlier patterns of involuntary disenrollment. Adopting the recommendation to incorporate cross-agency verifications fields to prevent erroneous coverage loss is outside the scope of this information collection. We appreciate the suggestion to conduct statistical analysis to identify outlier patterns of involuntary disenrollment and may consider doing so to maintain program integrity and ensure appropriate application of enrollment and disenrollment policies.

Comment: A commenter stated that when a beneficiary is reinstated after involuntary disenrollment, the claims spanning that coverage gap become the evidentiary record. If those claims carry ambiguous, physician-selected procedure codes, CMS cannot reliably determine what services actually occurred or whether a non-payment was genuinely unforeseen. The commenter added that a deterministic procedure coding system would be able to detect fraud and reduce burden on beneficiaries.

Response: CMS appreciates the commenter's recommendation that a deterministic procedure coding system could enhance fraud detection and reduce beneficiary burden. However, the design and implementation of a revised procedure coding framework falls outside the scope of this Paperwork Reduction Act (PRA) package, which is focused solely on the information collection requirements associated with good cause reinstatement processes. CMS also notes that claims data do not factor into favorable or unfavorable good cause determinations.

Comment: A commenter expressed general support for the good cause reinstatement framework, affirming that the framework appropriately protects beneficiaries who experience unforeseen circumstances that impair their ability to make timely premium payments, and noting that the Medicare population's demographic characteristics make continuity of coverage particularly critical. The commenter recommended that the collection remain narrowly tailored to information reasonably necessary to evaluate reinstatement eligibility, consistent with PRA principles of practical utility and proportionality; that documentation requirements not become barriers for vulnerable beneficiaries who are often seeking reinstatement during periods of personal, medical, or financial instability; that CMS promote standardized documentation expectations and review timelines across plan sponsors to reduce confusion and administrative burden; that CMS permit electronic, telephonic, and other efficient submission pathways for supporting documentation; that information requests directed to providers and caregivers be limited to materials directly relevant to evaluating good cause; and that CMS periodically reassess whether burden estimates accurately reflect real-world administrative experience. The commenter concluded by urging CMS to ensure that reinstatement protections remain transparent, proportionate, and realistically accessible to the beneficiaries they are intended to protect.

Response: CMS appreciates the commenter's support for the good cause reinstatement framework and agrees that continuity of coverage is particularly critical for the Medicare population, which frequently includes individuals managing chronic illness, disability, and complex medical needs. As established in the MA and Part D Enrollment and Disenrollment Guidance, the reinstatement framework is designed to restore coverage as if a disenrollment had not occurred, and CMS is committed to ensuring that this process remains accessible and workable for enrollees experiencing unforeseen circumstances.

CMS notes that the existing framework already reflects many of the principles the commenter endorses, including individualized case-by-case review, timely notification requirements, and a focus on practical utility. CMS agrees that documentation expectations should remain proportional to the information reasonably necessary to evaluate good cause eligibility, consistent with the PRA's requirements of practical utility and burden minimization. With respect to the commenter's recommendations regarding standardized documentation expectations, flexible submission pathways, proportional requests directed to providers and caregivers, and periodic reassessment of burden estimates, CMS will take these recommendations under consideration as part of its ongoing oversight of plan sponsor implementation and its continued review of the accuracy of burden estimates associated with this information collection.