



February 20, 2024

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4201-P
P.O. Box 8013
Baltimore, MD 21244

Re: Medicare Appeal Rights for Certain Changes in Patient Status

Submitted electronically via www.regulations.gov

Dear Administrator Brooks-LaSure,

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this proposed rule regarding its effect on those living with serious illness.

C-TAC is a national non-partisan, not-for-profit coalition dedicated to ensuring that all those living with serious illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC comprises more than 200 national and regional organizations including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving care for serious illness in the U.S.

C-TAC [defines serious illness](#) as a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life, or excessively strains their family caregivers. This definition has been widely adopted, including by the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF).

Serious illness is also a health equity issue. A history of disenfranchisement has led to healthcare gaps across the country. Per a [2021 Commonwealth report](#) on racial and ethnic health equity, communities of color live fewer years, on average, than white people do, are more likely to die from treatable conditions, and are also at higher risk for many chronic health conditions. For serious illness, the lack of access to health insurance and [primary care](#) mean many are [diagnosed only at a late or end stage](#) of illness, when disease-modifying treatment is typically no longer effective. Those from historically under-resourced communities who also

have serious illness experience poorer care and access, making improving their care a health equity opportunity.

Overall, we support the three appeals options in this proposed rule. We appreciate that there are clinical situations whereby an admitted patient in the hospital may be more appropriately changed to observation status. The proposed appeals processes hopefully will allow some to appeal that status as or just after they receive hospital and potentially skilled nursing facility (SNF) bills or when they are denied home health care.

Our key concern is ensuring patients will be notified of both the change in admission status and the appeals options in a clear and understandable way. Per the proposed rule, the new process is to “require hospitals to deliver, as soon as possible after certain conditions are met and prior to release from the hospital, a new standardized beneficiary notice, informing eligible beneficiaries of the change in their status, the resulting effect on Medicare coverage of their stay, and their appeal rights if they wish to challenge that change. This new notice will be called the Medicare Change of Status Notice (MCSN). This new notice follows the format and structure of the Important Message from Medicare (IM), which is the notice hospitals are required, by § 405.1205, to provide to beneficiaries to inform them of their right to appeal an inpatient hospital discharge.”.

While this sounds straightforward, we would urge CMS to make sure that this form is clear and written in plain language so that it is easy for a beneficiary in this situation to understand both that their admission status has been changed *and* that there is an available appeals process.

Beyond this, we also hope that the addition of a Beneficiary & Family Centered Care - Quality Improvement Organization (BFCC-QIO) as the place beneficiaries file these appeals will not be too confusing to beneficiaries and that the BFCC-QIO’s will provide prompt and respectful responses and support to beneficiaries filing such appeals.

Finally, we recommend that the final rule use provider-neutral language throughout. (It currently refers to “physicians” only in several places when “advanced practice providers” or the phrase “physician or other qualified practitioner” would be more appropriate.) The first example is the beginning of the Background section on page 1: “This proposed rule sets forth new appeals procedures to implement the court order in *Alexander v. Azar*, 613 F. Supp. 3d 559 (D. Conn. 2020), *aff’d sub nom., Barrows v. Becerra*, 24 F.4th 116 (2d Cir. 2022). In this order, the court directed the Department of Health and Human Services (HHS) to “permit all members of the . . . class to appeal the denial of their Part A coverage” and to establish appeal procedures for certain beneficiaries in Medicare Part A and B (“Original Medicare”) who are initially admitted to a hospital as an inpatient by a **physician** but whose status during their stay is changed to outpatient by the hospital, thereby effectively denying Part A coverage for their hospital stay.” Changing that and other physician-only phrases to “physician or other qualified practitioner” is more appropriate.

Thank you for the opportunity to comment on this proposed rule. If you have any questions, please contact Marian Grant, Senior Regulatory Advisor, C-TAC, at mgrant@thectac.org.

Sincerely,

Marian Grant

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