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Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

Submitted electronically via regulations.gov

Re: Medicare Program: Appeal Rights for Certain Changes in Patient Status (CMS-4204-P)

The undersigned 75 organizations representing Medicare beneficiaries appreciate the opportunity to comment on this notice of proposed rulemaking (NPRM) implementing the court order to establish Appeal Rights for Certain Changes in Patient Status. We support the general approach to the appeal processes that the Centers for Medicare and Medicaid Services (CMS) has outlined for Medicare beneficiaries who were admitted to hospitals as inpatients and subsequently reclassified as outpatients receiving observation services. **We strongly urge CMS to finalize and implement this rule as quickly as possible.** Some members of the class and their families who have suffered significant financial and health costs have waited 15 years for a remedy. CMS must not make them wait any longer and must make this rule a top priority.

This NPRM stems from the nationwide class action, *Alexander v. Azar,* 613 F. Supp. 3d 339 (D. Conn. 2020), *aff'd sub nom. Barrows v. Becerra*, 24 F.4th 116 (2d Cir. 2022). In their lawsuit, Medicare beneficiaries established the right to challenge changes in their patient status determinations from inpatient to outpatient receiving observation services. Such reclassifications constitute denials of Part A coverage.

Although the actual hospital services received are typically indistinguishable to beneficiaries under either classification, the distinction between designation as an inpatient (Part A coverage) versus outpatient (Part B coverage) can result in devastating financial consequences for Medicare beneficiaries. Namely, Medicare only covers subsequent care in a skilled nursing facility (SNF) for those who were hospitalized as inpatients under Part A for three or more consecutive days. Any time in the hospital categorized as outpatient and covered under Part B does not count toward the three-day requirement. This has forced many Medicare beneficiaries to either pay thousands of dollars out of pocket for required SNF care or to forgo it altogether, even when they have spent more than three days in the hospital. In addition, individuals who are not enrolled in Part B when they are hospitalized and designated as outpatients can face enormous out-of-pocket costs because Part A does not cover observation services. These beneficiaries are responsible for the *full cost* of their hospitalization.

In March 2020, the U.S. District Court in Hartford, Connecticut issued a decision concluding that Medicare beneficiaries whose classification is changed from inpatient to outpatient receiving observation services have the right to appeal that decision to Medicare and a chance to receive certain types of coverage, or to receive reimbursement for certain noncovered services resulting from that change. The U.S. Court of Appeals for the Second Circuit subsequently upheld the district court's decision. This NPRM implements the district court's order.

Retrospective Appeals

We support the general approach CMS is proposing for retrospective appeals by eligible Medicare beneficiaries who experienced changes from hospital inpatient to outpatient status receiving observation services dating back to January 1, 2009. Several aspects of the proposed process will make it relatively easy for beneficiaries to navigate. For example, the proposed process will be familiar to Medicare beneficiaries and their advocates because it is largely similar to existing Medicare claims appeals processes. Also, CMS's proposals to create a model appeal form and establish a single point of contact to initiate retrospective appeals will minimize burden on beneficiaries and simplify the messaging around starting the process.

CMS is proposing to limit the time to file a request for a retrospective appeal to 365 calendar days following the implementation date of the final rule. **We recommend CMS extend this filing period to two years, in addition to allowing extensions for a showing of good cause.**

One year is too short. Certainly, some eligible beneficiaries who were aware of the court order and awaiting this rulemaking will be equipped to file their appeal requests quickly. However, not everyone who benefits from this rulemaking will be so well informed. Given that some of the changes in status underlying the appeals occurred a decade or more ago, impacted individuals or their caregivers may no longer be alive or otherwise able to follow through with the new process. Their medical and other records from that time may be hard, if not impossible, to locate. It can take time to find and establish a relationship with an advocate who can help. Moreover, the particular individuals eligible for this relief are likely to experience the health and other complications that serve as the basis for good cause extensions. We believe that extending the deadline for filing retrospective appeals requests to two years would minimize both the burden on beneficiaries to show good cause and the burden on CMS to review requests for extensions.

Relatedly, **we also strongly urge CMS to conduct additional education and outreach to ensure impacted beneficiaries and their representatives are aware of the new retrospective appeal process.** We support CMS's plans to continue posting information on Medicare.gov and CMS.gov. However, impacted class members may not visit these websites. We recommend including information about the new retrospective appeal process on a separate page with the annual *Medicare & You* Handbook and with Medicare Summary Notices during the request filing period. CMS should also consider adding information about the new appeals processes to 1-800-MEDICARE hold messages and creating materials that social workers, enrollment counselors, and advocates can provide to individuals and families. The informational materials and model appeal request forms should be translated into other languages and accessible formats, and otherwise comply with regulations implementing Section 1557 of the Affordable Care Act and Section 504 of the Rehabilitation Act of 1973.

We recommend that CMS provide more clarity and guidance to beneficiaries about submitting their medical records as part of the appeal request. The model appeal form and instructions should encourage beneficiaries to submit their medical records if possible, specify which records they should provide, and explain how to obtain assistance from the eligibility contractor in getting their records (and that such assistance is free of charge). The instructions should also make clear that Medicare beneficiaries can still submit appeal requests even if their medical records are unavailable and specify that in the absence of medical records, acceptable evidence would include things like written

statements from beneficiaries, their family members, and their providers who are familiar with the facts giving rise to their appeal.

Prospective Appeal Rights

We agree with the general approach to establishing the expedited and standard appeals processes for individuals whose hospital status is changed from inpatient to outpatient going forward. **We strongly support CMS's proposal to extend eligibility for expedited appeals to individuals who lacked Medicare Part B coverage and did not stay in the hospital for three or more consecutive days.** We believe that this is not only fair, but will minimize confusion and make the process easier to implement in that anyone who is eligible to appeal their change in status can access the expedited process.

We support CMS's proposal to require hospitals to deliver a timely Medicare Change of Status Notice (MCSN) to individuals who are eligible to appeal their change from inpatient to outpatient. We recommend CMS revise the current draft MCSN to ensure its purpose is clear and that it accurately describes the benefits as well as the risks of appeal. We are concerned that the current draft may discourage appeals by warning of potentially higher hospital costs if the appeal is won without explaining that the ultimate cost varies depending on a beneficiary's particular situation. We appreciate that the notice includes instructions on how to get the MCSN in alternate formats. This language should be updated and translated to comply with the Notice of Availability requirements in the forthcoming 1557 rule. Requiring a Notice of Availability in at least the top 15 languages in the state would align with CMS's approach in the Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program proposed rule.

Conclusion

We urge CMS to finalize this rule as soon as possible and implement it immediately. People with Medicare who are switched from inpatient to outpatient receiving observation services while hospitalized have been without recourse for too long. They deserve their appeal rights, and in many cases reimbursement for out-of-pocket costs that Medicare should have covered, right away.

If you have any questions concerning this submission please contact Natalie Kean (nkean@justiceinaging.org) and Alice Bers (abers@medicareadvocacy.org).

Sincerely,

30 National Organizations
AARP
ALS Association
ALS Problem Solvers
AMDA The Society for Post-Acute and Long-Term Care Medicine
American Association on Health and Disability
American Federation of Teachers
American Physical Therapy Association
American Speech-Language-Hearing Association
Angmar Medical Holdings, Inc.
Center for Medicare Advocacy
Compassionate Care ALS
Diverse Elders Coalition

Elder Options
FairNow.org
Justice in Aging
K&K Health Care Solutions
Lakeshore Foundation
Long Term Care Community Coalition
Medicare Rights Center
National Association of Local LTC Ombudsman (NALLTCO)
National Association of State Long Term Care Ombudsman Programs (NASOP)
National Committee to Preserve Social Security and Medicare
National Consumer Voice for Quality Long-Term Care
National Disability Rights Network (NDRN)
National Health Law Program
The AIDS Institute
The ALS Association
The American Occupational Therapy Association
United Spinal Association
Well Spouse Association

45 State & Local Organizations

Agency on Aging of South Central Connecticut
AgeOptions
Alliance on Aging - SHIP Program
Ashford Senior Center
Bristol Hospital, Inc.
California Advocates for Nursing Home Reform
California Health Advocates
Care Partner to Caregiver, LLC
Carolyn Butler Norton, Esq. LLC
CCH Seniors
Center for Advocacy for the Rights and Interests of Elders (CARIE)
Center for Elder Law & Justice
Community Legal Aid
CT Alliance for Retired Americans
CT Long Term Care Ombudsman Program
Delaware Elder Care Advocacy Coalition
Dignity Alliance Massachusetts
GENERATION HOME HEALTH, LLC
Greater Wisconsin Agency on Aging Resources, Inc.
HICAP
Holistic Elder Services LLC
Hunt Insurance Solutions, LLC
KOLAH BIOETHICS & NEUROETHICS INSTITUTE
Lakeview Village Senior Living
Little Tokyo Service Center

Michigan Elder Justice Initiative
Mount Kisco Foot Specialists, PLLC
NECALG/Area Agency on Aging
New Fairfield Senior Services
New York State Wide Senior Action Council, Inc.
Northwest Health Law Advocates
Our Mother's Voice
PDA, NJ Chapter
Public Justice Center
R. Thomas Murphy and Associates
Rosewood
Senior Citizens' Law Office
SHINE
South Coastal Counties Legal Services
Steward & Sheridan. PLC
Tamara Maher Law Firm
Ulster Activists
Vermont Legal Aid, Inc.
Western Ohio Oral Head & Neck Cancer Support
Wilco Justice Alliance (Williamson County, TX)