Issue Brief

FEDERAL ISSUE BRIEF

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January 3, 2024

CMS Proposing Appeal Rights for Certain Changes in Patient Status

The Centers for Medicare & Medicaid Services (CMS) are proposing a rule would implement an order from the Federal district court for the District of Connecticut in Alexander v. Azar that requires HHS to establish appeals processes for certain Medicare beneficiaries who are initially admitted as hospital inpatients but are subsequently reclassified as outpatients receiving observation services during their hospital stay and meet other eligibility criteria.

The proposal is scheduled to be published in the ***Federal Register*** on December 27. A copy of the 105-page document is currently available at: https://public-inspection.federalregister.gov/2023-28152.pdf. A 60-day comment period staring from publication is provided.

Comments

Over 40% of the rule consists of the actual regulatory text.

CMS says that it expects relatively few appeals and as a result, the regulatory analysis section is extremely brief.

The proposal has a well-versed introductory section describing the rule.

Executive Summary

The proposed processes would consist of the following:

- Expedited appeals: "We are proposing an expedited appeals process for certain beneficiaries who disagree with the hospital's decision to reclassify their status from inpatient to outpatient receiving observation services (resulting in a denial of coverage for the hospital stay under Part A). Eligible beneficiaries would be entitled to request an expedited appeal regarding that decision prior to discharge from the hospital. Appeals would be conducted by a Beneficiary & Family Centered Care - Quality Improvement Organization (BFCC-QIO)."

- Standard appeals: "We are proposing that beneficiaries who do not file an expedited appeal would have the opportunity to file a standard appeal (that is, an appeal requested by a beneficiary eligible for an expedited appeal, but filed outside of the expedited timeframes) regarding the hospital's decision to reclassify their status from inpatient to outpatient receiving observation services (resulting in a denial of coverage for the hospital stay under Part A). Under our proposal, these standard appeals will follow similar procedures to the expedited appeals process but without the expedited timeframes to file and for the QIO to make decisions."
- Retrospective appeals: "We are proposing a retrospective review process for certain beneficiaries to appeal denials of Part A coverage of hospital services (and certain SNF services, as applicable), for specified inpatient admissions involving status changes that occurred prior to the implementation of the prospective appeals process, dating back to January 1, 2009. Consistent

with existing claims appeals processes, we are proposing that Medicare Administrative Contractors (MACs) will perform the first level of appeal, followed by Qualified Independent Contractor (QIC) reconsiderations, Administrative Law Judge (ALJ) hearings, review by the Medicare Appeals Council, and judicial review."

The court's order requires new appeal procedures be afforded to the following class:

Medicare beneficiaries who, on or after January 1, 2009—

- Have been or will have been formally admitted as a hospital inpatient;
- Have been or will have been subsequently reclassified by the hospital as an outpatient receiving "observation services";
- Have received or will have received an initial determination or Medicare Outpatient Observation Notice (MOON) indicating that the observation services are not covered under Medicare Part A; and
- Either -- (1) were not enrolled in Part B coverage at the time of their hospitalization; or (2) stayed at the hospital for 3 or more consecutive days but were designated as inpatients for fewer than 3 days, unless more than 30 days has passed after the hospital stay without the beneficiary's having been admitted to a skilled nursing facility. Medicare beneficiaries who meet the requirements of the foregoing sentence but who pursued an administrative appeal and received a final decision of the Secretary before September 4, 2011, are excluded from the class.

The court determined that beneficiaries who are members of the class described previously have been deprived of due process and ordered the following:

- Class members shall have an opportunity to appeal the denial of their Part A coverage.
- Class members who have stayed, or will have stayed, at a hospital for 3 or more consecutive days, but who were designated as inpatients for fewer than 3 days, shall have the right to an appeal through an expedited appeals process substantially similar to the existing expedited process for challenging hospital discharges.
- Class members shall be permitted to argue that their inpatient admission satisfied the relevant criteria for Part A coverage—for example, that the medical record supported a reasonable expectation of a medically necessary two-midnight stay at the time of the physician's initial inpatient order, in the case of a post–Two Midnight Rule hospital stay—and that the hospital utilization review committee's (URC) determination to the contrary was therefore erroneous. If a class member prevails, then for the purposes of determining Part A benefits, including both Part A hospital coverage and Part A SNF coverage, the beneficiary's reclassification as an outpatient that resulted from the URC's erroneous determination shall be disregarded.
- For class members whose due process rights were violated, or will have been violated, prior to the availability of the procedural protections as previously set forth, such beneficiaries shall be afforded a meaningful opportunity to appeal the denial of their Part A coverage, as well as effective notice of this right.

In addition, on December 9, 2022, the district court issued an "Order Clarifying Judgment" with respect to the claims for outpatient hospital services received by beneficiaries who were enrolled in Part B of the program at the time such services were furnished. In this clarifying order, the judge stated that while he

intended to provide a meaningful opportunity for class members whose due process rights were violated to appeal the denial of Part A coverage, he also stressed the need to provide a remedy for class members who endured undercompensated stays at skilled nursing facilities. He further stated that, since class members with Part B coverage had much of their past hospital stays paid for by such coverage, he did not intend to require the unwinding of previously approved Part B outpatient hospital claims so they could be reprocessed as Part A claims. The clarification states that if a class member enrolled in Part B coverage at the time of their hospitalization prevails in an appeal of a claim, then an adjustment of payment for the underlying hospital services (including any applicable deductible and coinsurance amounts) is not required, and Part A payment for covered SNF services may be made without any adjustment to the payment for the underlying hospital services.

Section III.A. of this proposed rule, describes the proposed procedures that would be available to members of the class described previously (hereinafter, eligible beneficiaries) to appeal denials of Part A coverage of hospital services (and certain SNF services, as applicable), for specified inpatient admissions involving status changes that occurred prior to the implementation of the prospective appeals process, dating back to January 1, 2009.

Section III.B. describes the expedited and standard appeals procedures that would be available prospectively (meaning to beneficiaries whose status is changed after the effective date of this rule and after the implementation and availability of the procedures established by the rule) to eligible beneficiaries who, among other things, are admitted as hospital inpatients and are reclassified by hospitals as outpatients receiving observation services.