AHCA Summary of CMS Final Rule on Medicare Program: Appeal Rights for Certain Changes in Patient Status

On Friday, October 11, the Centers for Medicare and Medicaid Services (CMS) finalized the *Medicare Program: Appeal Rights for Certain Changes in Patient Status* rule, which established court-ordered appeals processes for Medicare beneficiaries admitted as hospital inpatients but later reclassified as outpatients receiving observation services during their hospital stay. The final rule stayed largely as proposed but offers expanded timelines and additional beneficiary protections, which AHCA/NCAL advocated for and supports as part of its coalition efforts.

Medicare beneficiaries should have the right to appeal and ensure they are not denied their needed skilled nursing benefits. While this final rule will be helpful, AHCA/NCAL continues to urge Congress to resolve this issue permanently by eliminating the three-day-stay requirement or recognizing observation days in the determination of SNF benefit eligibility. AHCA/NCAL has long advocated for counting observation stays towards the three-day stay requirement or waiving the three-day stay requirement all together, as was done during the COVID-19 Public Health Emergency.

Additionally, AHCA/NCAL continues to be a strong supporter of the bipartisan and bicameral *Improving Access to Medicare Coverage Act* (S. 4137/H.R. 5138). This bill would help Medicare beneficiaries who are hospitalized in observation by requiring that time spent in observation be counted towards meeting the three-day prior inpatient stay. AHCA/NCAL, along with the Center for Medicare Advocacy, spearheads a coalition effort consisting of 35 national organizations advocating for this bill.

Final Rule Summary

The final rule is the result of a court order issued in the case *Alexander v. Azar*. The processes will apply to 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 processes include the outlined below.

Expedited Appeals

An expedited 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 will be entitled to request an expedited appeal regarding that decision prior to release from the hospital.
- Appeals will be conducted by a Beneficiary & Family Centered Care – Quality Improvement Organization (BFCC-QIO).

Standard Appeals

Those who do not file an expedited appeal will still have the opportunity to file a standard appeal outside of the expedited timeframes.

- These 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

The retrospective process will apply to status changes that occurred prior to the implementation of the prospective appeals process, dating back to January 1, 2009. The process is consistent with existing claims appeals processes. Eligible beneficiaries will have 365 calendar days from the implementation date of this rule to file a request for a retrospective appeal.

Prospective Appeals

New procedures will be available to beneficiaries who, on or after January 1, 2009:

- Have or will have been admitted as a hospital inpatient and have been or will have been subsequently reclassified to an outpatient receiving "observation services."
- Have or will have received an initial determination/Medicare Outpatient Observation Notice (MOON) indicating observation services are not covered under Part A:
    - And either (1) were not enrolled in Part B coverage when hospitalized; or (2) stayed at the hospital for three or more consecutive days but were designated as inpatients for fewer than three days, unless more than 30 days has passed after the hospital stay without the beneficiary's having been admitted to a SNF.
    - Medicare beneficiaries who meet the requirements but who pursued an administrative appeal and received a final decision of the Secretary before September 4, 2011, are excluded.

Appeals Processes

Appeals processes will be consistent with existing appeals processes:

- Medicare Administrative Contractors (MACs) will perform the first level of appeal.
- A Qualified Independent Contractor (QIC) will handle reconsiderations, and, if needed, Administrative Law Judge (ALJ) hearings will occur followed by review by the Medicare Appeals Council, and judicial review.
- Eligible beneficiaries will have 365 calendar days from the implementation date of this rule to file a request for a retrospective appeal.

Key Revisions in the Final Rule

In the final rule, CMS:

- Extended the timeframe for providers to submit a claim following a favorable decision from 180 calendar days to 365 calendar days.
- Extended the timeframe for providers to submit records as requested by a contractor from 60 calendar days to 120 calendar days.
- Clarified the effect of a favorable appeal decision to explain that if a hospital chooses to submit a Part A inpatient claim, the hospital must refund any payments received for the Part B outpatient claim before submitting the Part A inpatient claim to Medicare. If a Part

A claim is submitted, the previous Part B outpatient claim will be reopened and canceled, and any Medicare payments will be recouped to prevent duplicate payment.

- Clarified the effect of a favorable decision for a beneficiary who was not enrolled in Medicare Part B at the time of hospitalization to explain that the hospital must refund any payments collected for the outpatient services even if the hospital chooses not to submit a Part A claim for payment to the program.
- Clarified the effect of favorable appeals involving beneficiaries who were enrolled in Medicare Part B at the time of hospitalization to explain that hospitals must refund any payments collected for the outpatient hospital services only if the hospital chooses to submit a Part A inpatient claim for such services.
- Clarified that out-of-pocket payments made by a family member on behalf of a beneficiary for SNF services may include out-of-pocket payments made by individuals who are not biologically related to the beneficiary.

This rule is effective on the publication date of October 11, 2024.