American Hospital Association™
Advancing Health in America

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February 26, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: CMS–4204–P: Medicare Program. Appeal Rights for Certain Changes in Patient Status Proposed Rule (Vol. 88, No. 247), December 27, 2023.

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule to establish new appeal rights for Medicare beneficiaries who had or will have certain changes in patient status.[1]

The AHA supports the general approach that CMS has proposed for appeals by Medicare beneficiaries who were admitted for an inpatient hospital stay and subsequently reclassified to an outpatient stay with observation services. We appreciate that CMS' proposals have attempted to mirror existing appeals processes, which would help reduce confusion for beneficiaries. However, we have a number of recommendations that would help make these policies even more clear, ensure that

[1] The new appeal procedures apply to two court-identified classes of Medicare beneficiaries who, on or after Jan. 1, 2009, (1) have been or will have been formally admitted as a hospital inpatient; (2) have been or will have been subsequently reclassified by the hospital as an outpatient receiving observation services; (3) have received or will have received an initial determination or Medicare Outpatient Observation Notice indicating that the observation services are not covered under Medicare Part A; and (4) either were not enrolled in Part B coverage at the time of their hospitalization or 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 skilled-nursing facility.

beneficiaries better understand CMS guidelines regarding covered inpatient care, and reduce burden on all parties involved.

RETROSPECTIVE APPEALS

As required by the court order issued in *Alexander v. Azar*, CMS proposes a retrospective review process that would allow certain beneficiaries to appeal denials of Part A coverage of hospital services and certain skilled-nursing facility (SNF) services, as applicable. Specifically, this process would apply to specified inpatient admissions involving status changes (inpatient hospital stays that were subsequently reclassified as outpatient stays with observation services) that occurred prior to the implementation of the proposed prospective appeals process, dating back to Jan. 1, 2009. Consistent with existing appeals processes, CMS proposes that Medicare Administrative Contractors (MACs) would perform the first level of appeal, followed by Qualified Independent Contractor reconsiderations, Administrative Law Judge hearings, Medicare Appeals Council reviews, and, finally, judicial review.

Look-back Period

The AHA recognizes that CMS has little discretion regarding the retrospective appeals timeline. That said, a look-back period of over 15 years poses several problems for hospitals. Indeed, similar retrospective appeals have a much narrower window. For example, Recovery Audit Contractor (RAC) audits can have a look-back period of only three years from the date a claim was submitted. Further, most hospitals have a medical record retention policy that is far shorter than 15 years, with many organizations retaining records for 7 years from the date of service in accordance with CMS' own medical record maintenance and access regulations.[2] Therefore, if a beneficiary files an appeal for services that took place prior to the hospital's record retention date, the hospital could not provide any medical records or other information about the stay. Moreover, hospitals and health systems have evolved and changed substantially since 2009, including because of transitioning to electronic health records, which has resulted in multiple system integrations and changes and the use of many different operating platforms. Therefore, even beyond the limitations resulting from record retention policies, providers may not have the ability to re-bill or send a corrected claim for beneficiary accounts that predate any of these changes. **As such, the AHA urges CMS to ensure to that the contractors processing these appeals are aware of this limitation and that hospitals are not penalized regarding their ability to provide requested medical records in these instances.**

In addition, the retrospective appeals process would go further back than several critical CMS policy modifications. For example, the two-midnight rule was implemented in October 2013, and it is unclear on which criteria the MACs will base their determinations from 2009 through September 2013. In addition, during the COVID-19 public health

[2] 42 CFR 424.516(f).

emergency (PHE), CMS waived the SNF three-day stay rule; as such, we would expect that no retrospective appeals for SNF services would be filed from March 1, 2020, through May 11, 2023. **We recommend that in the final rule, CMS clearly explain on which policy basis the MACs and the other contractors processing these appeals will make their determinations during which periods. In addition, the AHA recommends that CMS clarify with its contractors that there should be no appealable SNF stays during the COVID-19 PHE.**

SNF Stays

With respect to retrospective appeals for SNF stays, if a favorable appeal decision includes coverage of SNF services, CMS proposes that, following a refund of amounts collected from the beneficiary, the SNF may submit a claim for services to determine Medicare payment. The agency states that providers may submit such claims within 180 days of receiving notice of a favorable appeal decision. However, CMS does not outline how providers could submit such new or corrected claims. Specifically, as CMS knows, Medicare's SNF payment methodology has changed. CMS formerly used the Resource Utilization Group (RUG) payment model. However, beginning in fiscal year (FY) 2020, CMS implemented the Patient-driven Payment Methodology (PDPM), which substantially modified how SNF services are reimbursed. As such, it is unclear how providers would submit and how Medicare's contractors would process and pay claims for services that took place before FY 2020. CMS notes briefly that it plans to issue operating instructions related to the submission of new claims after this rulemaking is finalized and effective. **However, the AHA recommends that CMS acknowledge the complexity involved here and clearly address how it will be resolved in the final rule itself.**

Finally, SNFs can bill Medicare Part B for certain services that would typically be covered under the SNF Part A benefit when the SNF inpatient stay is not covered.[3] It is therefore likely that SNFs billed Part B for ancillary services (such as physical or occupational therapy) for beneficiaries covered under these appeals**. As such, we also urge CMS to explain whether and how a favorable appeal and request for SNF Part A payment would trigger a recoupment of any previously paid Part B payments that would not have been allowable had the patient been in a covered SNF Part A stay.**

PROSPECTIVE APPEALS

Modifications to the Expedited Appeals Process and Medicare Change of Status Notice

[3] Medicare Claims Processing Manual, Chapter 7 – SNF Part B Billing; 10.1 – Billing for Inpatient SNF Services Paid Under Part B (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c07.pdf).

As required by the court, CMS also proposes an expedited appeal process, beginning on the final rule's effective date, for certain beneficiaries who, *prior to their discharge from the hospital,* disagree with the hospital's decision to reclassify their status from inpatient to outpatient receiving observation. These appeals would be reviewed by the Beneficiary & Family Centered Care-Quality Improvement Organizations (BFCC-QIOs). Hospitals would be required to deliver a proposed Medicare Change of Status Notice (MCSN) to beneficiaries as soon as possible after a beneficiary is eligible for this expedited appeal process, but no later than four hours prior to discharge. The MCSN would inform 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. Eligible beneficiaries wishing to file an expedited appeal would be required to make the request by telephone or in writing to the BFCC-QIO prior to their release from the hospital. The BFCC-QIO would be required to render a decision and notify all relevant persons and entities within one calendar day of receiving all requested pertinent information. The rule also provides beneficiaries with the right to request a reconsideration by a BFCC-QIO when they are dissatisfied with the initial determination.

We strongly support Medicare beneficiaries having access to expedited appeal pathways where appropriate and urge CMS to ensure that beneficiaries have the information necessary to exercise these rights in the most appropriate circumstances. Hospitals do not initiate and make patient status changes in an arbitrary manner; indeed, they use robust utilization management systems to review these cases. They are committed to CMS guideline compliance and only make a change if they are certain that it is correct. Medicare guidelines regarding what qualifies as a Part A inpatient admission versus an outpatient stay with observation service, and all associated financial liability rules, are complicated. In addition, these expedited appeals would require time and resources from the beneficiary, the hospital and the BFCC-QIO. **Thus, to help ensure that expedited appeals are requested in the most appropriate situations, the AHA urges CMS to inform Medicare beneficiaries about its Part A inpatient admission and medical review criteria as it relates to their proposed appeal rights.** Specifically, we recommend that CMS amend its draft MCSN to include a summary of these criteria. We also urge the agency to provide additional education and outreach about these criteria to beneficiaries and their representatives when they are first eligible for Medicare Parts A and B. Finally, CMS should offer such information on its Medicare.gov and CMS.gov websites, as well as on a separate page with the annual Medicare & You Handbook and with the Medicare Summary Notices.

In addition, the proposed rule leaves open the question of whether beneficiaries who request an expedited appeal would remain in the hospital while the appeal process plays out. If the expectation is that they would, then we are concerned that this would exacerbate the existing, substantial challenges that hospitals are already facing regarding occupancy and capacity. Specifically, both inpatient and outpatient bed availability is very limited, with many hospitals at over 90% bed capacity. If beneficiaries requesting an expedited appeal remain in a hospital bed until the process is concluded, even if they could be appropriately and safely discharged, this could result in delays for

other patients waiting for inpatient and outpatient services. Such delays would add to the incredible strain on hospitals and health systems as they must bear the costs of caring for other patients during those excess days without appropriate reimbursement, and they also add burden on an already thin workforce.

Moreover, the current draft MCSN, under the section "How to Appeal Your Status Change," is not specific regarding this issue. In the absence of such clarity, we are concerned that some patients may refuse to be discharged until they hear from the BFCC-QIO and their appeal is resolved. **Therefore, the AHA requests that CMS clarify that an appeals-eligible patient who has been provided with the MCSN and has requested an expedited appeal may be discharged from the hospital and sent to another facility or home, as appropriate, before the expedited determination process and reconsideration process is complete. We also recommend that CMS modify the draft MCSN to include language that informs eligible beneficiaries that the hospital may discharge them, as appropriate, while the expedited appeal is pending.**

The proposed rule also specifies that unlike hospital discharge appeals, beneficiaries would not have financial liability protection. **As such, we recommend that the MCSN be updated to include language that the patient is financially liable during the appeals process.**

In addition, CMS-required notices, like the draft MCSN, are usually only provided by the agency in English and Spanish. As hospitals and health system care for patients who speak a multitude of languages and in the interest of ensuring that beneficiaries are able to read and understand the MCSN, **the AHA urges CMS to provide translations of the final notice in at least the top 15 languages spoken by individuals with limited English proficiency in each of the states.**[4] For each hospital and health system to independently do so not only poses a financial burden to the hospital, but also raises the possibility that the translations may be inconsistent.

Additional Considerations

Correctly identifying beneficiaries eligible for the prospective appeals process will be challenging to implement within a hospital or health system as it would likely only apply to a relatively small subset of their patients. The AHA is concerned that creating a robust new process to quickly identify these eligible patients and deliver the MCSN will be logistically challenging and put hospitals and health system at risk of noncompliance. This is particularly the case as patients are often reclassified from inpatient to outpatient observation status after they are discharged or just as they are leaving the hospital. **Because hospitals will need to establish an entirely new and complex system to identify the subset of patients eligible for appeal rights, we request that CMS use its enforcement discretion to monitor the new requirements, including the timely**

[4] https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/appendix-a-top-15.pdf.

delivery of the MCSN, for at least 12 months after the final rule's effective date to determine whether changes or additional requirements are warranted.

In addition, CMS proposes that a hospital may not bill a beneficiary who has appealed timely for any services at issue in the appeal until the expedited determination process and reconsideration process is complete. However, hospitals can bill a beneficiary if the appeal is not timely. We are concerned that hospitals may not be aware of either whether the patient has appealed timely or when the process has been completed. It appears from the proposed rule that the hospital would be reliant on the BFCC-QIO to provide them with this information, but it is unclear whether there would be any other tools available if such communication is not forthcoming to the appropriate hospital personnel. **The AHA recommends that CMS provide more detailed information in the final rule to clarify precisely how and when the BFCC-QIO would provide hospitals with this information and that the agency establish an electronic means for the BFCC-QIO to provide these updates to hospitals.**

We appreciate your consideration of these issues. Please contact me if you have questions or feel free to have a member of your team contact Roslyne Schulman, AHA's director for policy, at rschulman@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President