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CENTER FOR MEDICARE

Medicare Appeal Rights for Certain Changes in Patient Status Proposed Rule (CMS-4204-P) Fact Sheet

On December 21, 2023, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would establish appeals processes for certain people with Medicare in Original Medicare who are initially admitted to a hospital as an inpatient but subsequently reclassified by the hospital as an outpatient receiving observation services during their hospital stay and meet other eligibility criteria.

The proposed rule can be downloaded from the Federal Register at: https://www.federalregister.gov/public-inspection/current.

Background

Alexander v. Azar was a nationwide class action case filed in 2011 that sought to require the Secretary of Health and Human Services to afford Medicare beneficiaries rights to a hearing to challenge their placement as outpatients receiving observation services. In March 2020, the United States District Court for District of Connecticut issued a decision explaining that beneficiaries were not entitled to appeal rights for their placement as outpatients receiving observation services. However, the court directed the Secretary of the Department of Health and Human Services to create additional appeals processes for a specified class of people with Medicare who were initially admitted as hospital inpatients but were subsequently reclassified by the hospital as outpatients receiving observation services and meet other conditions specified in the order. The government appealed and the United States Court of Appeals for the Second Circuit affirmed the district court's decision in January 2022.

Beneficiaries included in the class are those who either had, or will have, Part A benefits denied for hospital inpatient services and Skilled Nursing Facility (SNF) care as a result of the hospital's reclassification. The class also includes beneficiaries who did not have Part B coverage at the time of hospitalization.

The court ordered the Secretary to create additional appeals processes for such beneficiaries, including an expedited appeals process that is substantially similar to the existing hospital discharge appeals for class members who appeal while they are in the hospital, and a retrospective review process for beneficiaries who met the conditions for the class prior to the implementation of the prospective appeals process.

Proposed Rule Highlights

Expedited Appeals:
CMS is proposing in this rule an expedited appeals process for eligible beneficiaries who disagree with the hospital's decision to reclassify their status while they are still in the hospital from inpatient to outpatient receiving observation services (resulting in a denial of coverage for the hospital stay under Part A). These beneficiaries would be able to file an appeal with a Beneficiary & Family Centered Care - Quality Improvement Organization (BFCC-QIO). The BFCC-QIO would independently review the beneficiary's patient record to determine whether the inpatient admission satisfied the relevant criteria for Part A coverage. After receiving patient records from the hospital, the BFCC-QIO would render a determination within one day for timely requests.

Standard Appeals:
CMS is also proposing a standard appeals process for eligible beneficiaries who do not file an expedited appeal that would allow them to pursue an appeal 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). In some cases, this may happen after processing of the hospital's Part B outpatient claim and any denial of SNF coverage. This proposed process would follow similar procedures to the expedited appeals process but with longer timeframes to file and for the BFCC-QIO to make decisions.

Retrospective Appeals:
CMS is also proposing to establish a retrospective process that applies to beneficiaries with hospital admissions on or after January 1, 2009, involving status changes before the implementation of the prospective appeals processes discussed above. Consistent with the Court's order, the beneficiary must demonstrate eligibility for an appeal as a class member and show that the initial inpatient admission satisfied the relevant criteria for Part A coverage. Under this proposed process, CMS would use an "eligibility contractor," which would be an existing appeals contractor to serve as a single point of contact for incoming beneficiary retrospective appeal requests and as a gatekeeper in determining eligibility for an appeal. Beneficiaries would have a full year from the implementation date of the final rule to gather any related documentation and file an appeal request. Appeals following the eligibility determination would generally mirror the existing five level claim appeals procedures.

To conform with the appeals processes proposed above, CMS also proposed the following conforming changes:

- The delivery of a related appeals notice would be required as part of the Medicare provider agreement.
- The QIO regulations would be modified to specify that the QIO performs review functions for certain beneficiary appeals in a manner that is consistent with other QIO review functions while ensuring alignment with the proposed beneficiary eligibility and process requirements for such appeals.

If finalized, these appeals processes would be available to beneficiaries after an operational implementation period.