UnityPoint Health

Government & External Affairs
1776 West Lakes Parkway, Suite 400
West Des Moines, IA 50266
unitypoint.org

February 26, 2024

Secretary Xavier Becerra
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–4204–P
P.O. Box 8013
Baltimore, MD 21244–8013

RE: Medicare Program: Appeal Rights for Certain Changes in Patient Status published in 88(247) Fed. Reg. 89506-89538 on December 27, 2023.

Submitted electronically via http://www.regulations.gov

Dear Secretary Becerra,

UnityPoint Health appreciates this opportunity to provide input on the proposed rule, "Appeal Rights for Certain Changes in Patient Status." UnityPoint Health is one of the nation's most integrated health care systems. Through more than 29,000 employees and our relationships with 375+ physician clinics, 36 hospitals in urban and rural communities, and 13 home health agencies across our 8 regions, UnityPoint Health provides care throughout Iowa, central Illinois, and southern Wisconsin.

The Centers for Medicare and Medicaid Services (CMS) has proposed this rule in response to *Alexander v. Azar*, 613 F. Supp. 3d 559 (D. Conn. 2020), aff'd sub nom., *Barrows v. Becerra*, 24 F.4th 116 (2d Cir. 2022). The proposed notice and appeals processes would 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. UnityPoint Health respectfully offers the following input.

PROSPECTIVE APPEALS

CMS proposes both an expedited and standard appeals process. An expedited appeals process applies to 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).

A standard appeals process applies to beneficiaries 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). Proposed standard appeals would follow similar procedures to the expedited appeals process but without the expedited timeframes to file and for the QIO to make decisions.

Comment: **UnityPoint Health supports the right of beneficiaries to appeal**. As CMS has proposed prospective appeals, there are two distinct classes of eligible beneficiaries – those not enrolled in Part B coverage at the time of hospitalization, and those with a hospital stay of 3 or more consecutive days whose inpatient status comprised less than 3 days[1]. The latter is important to access coverage under the Medicare skilled nursing facility (SNF) benefit. When a beneficiary's inpatient status is reclassified to observation status (i.e. outpatient Part B status), this proposed rule establishes a process to review determination of Part A coverage, including a new beneficiary notice and accompanying appeal process.

Timing of Notice – CMS proposes a new notice for this subset of beneficiaries. The Medicare Change of Status Notice (MCSN) is distinct and separate from the Important Message from Medicare (IMM), written Condition Code 44 notification, and the Medicare Outpatient Observation Notice (MOON). The hospital must deliver the MCSN:

> *not later than 4 hours before release from the hospital and as soon as possible after the earliest of either of the following:*
> *(i) The hospital reclassifies the beneficiary from an inpatient to an outpatient receiving observation services and the beneficiary is not enrolled in Part B.*
> *(ii) The hospital reclassifies the beneficiary from an inpatient to an outpatient receiving observation services and the beneficiary has stayed in the hospital for 3 or more consecutive days but was an inpatient for fewer than 3 days.*[2]

In many instances, beneficiaries receiving a MCSN will also receive at least two of the other notices previously referenced and perhaps all three. Hospital team members must already juggle delivering and explaining current notices in a timely manner. First and foremost, this rule is intended to afford patient due process. By putting an arbitrary backstop of 4 hours for delivery prior to hospital discharge, this prioritizes process over care delivery. This 4-hour timeframe may have unintended consequences of further delaying discharge and in some cases alternative placement for this beneficiary as well as impacting overall throughput for other patients. **We encourage CMS to consider flexibility related to notice timeframe prior to discharge.**

QIO Information Request – For expedited determinations, the hospital must furnish "all information that the QIO needs" to make its determination "as soon as possible, but no later than noon of the calendar day after the QIO notifies the hospital" of the expedited determination request.[3] In addition, hospitals must furnish this information to beneficiaries upon request "no later than close of business of the first calendar day after the material is requested."[4] In order to timely respond to these records requests, which are typically beyond the purview of our clinical team members, **we seek clarification related to the intent**

[1] Pursuant to 42 USC 1935x(i), beneficiaries must have a prior inpatient hospital stay of no fewer than three consecutive days to be eligible for Medicare coverage of inpatient SNF care.
[2] Proposed 42 USC 405.1210(b)(1)
[3] Proposed 42 USC 405.1211(d)(1)
[4] Proposed 42 USC 405.1211(d)(2)

of QIOs to staff weekend requests as well as CMS' expectations for hospitals to respond to beneficiary documentation requests over weekends.

SNF 3-Day Rule – **This proposed rule exposes an antiquated trigger[5] for beneficiaries to receive Medicare coverage for SNF services**. The 3-Day SNF rule was waived during the COVID-19 public health emergency, and the 3-Day rule is now relegated mainly to fee-for-service beneficiaries outside a robust value-based environment offered by Accountable Care Organizations or Medicare Advantage plans. In addition, while a medically necessary inpatient stay has been defined in general terms and clarified with the "2-Midnight rule,"[6] the specifics related to the 3-day qualifying stay for SNF Part A benefits continues to cause confusion and concern for bedside clinicians and, most importantly, patients whose status may have changed more than once during their stay based on utilization review or changing clinical condition but who ultimately require SNF services at discharge. Although the proposed rule responds to a court case, **we would suggest that CMS support efforts to pivot the conversation from medical necessity for an inpatient day(s) to whether there is medical necessity for a SNF benefit**. In a time of widespread workforce challenges in health care, this clarity would greatly assist with hospital throughput and help alleviate the nationwide crisis of patients being boarded in emergency departments.

RETROSPECTIVE APPEALS

CMS proposes 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, CMS proposes that Medicare Administrative Contractors (MACs) 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.

Comment: Again, UnityPoint Health generally supports the provision of beneficiary appeal rights. For retrospective appeals, **we are concerned with the 15-year lookback period and its misalignment with medical record retention requirements**. "[W]here significant time may have passed since a beneficiary was hospitalized," CMS acknowledges there will be challenges for beneficiaries and their representatives to obtain and produce medical records.[7] For medical records exceeding mandated retention periods, these challenges also exist for providers. While we appreciate that CMS has identified its contractors as a central point of contact to seek medical records from providers for these appeals, **we encourage CMS to**

[5] Mor V. A Brief History of the 3-Day Hospital Stay Rule. JAMA Intern Med. 2023;183(7):645–646. doi:10.1001/jamainternmed.2023.0744

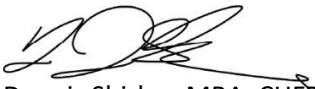
[6] 42 CFR 412.3 – "an inpatient admission is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights."

[7] Pages 89512-3 – "Medical records would also assist in determining whether the beneficiary received observation services following the reclassification from inpatient to outpatient receiving observation services. However, we understand the challenges beneficiaries and their representatives may face in obtaining and producing such information in situations where significant time may have passed since a beneficiary was hospitalized. Therefore, we are proposing in § 405.932(c)(2), that the eligibility contractor would work with MACs, eligible parties, and providers, whenever necessary, to attempt to obtain the information needed to make such determinations."

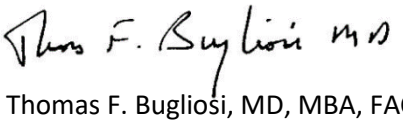
issue guidance to contractors to use a streamlined and uniform response process to minimize provider administrative burden.

We are pleased to offer feedback on this proposed rule and its impact on our hospitals, patients and communities. To discuss our comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Government & External Affairs at Cathy.Simmons@unitypoint.org or 319-361-2336.

Sincerely,

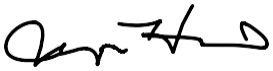


Dennis Shirley, MBA, CHFP
Executive Director, Patient Finincial Services

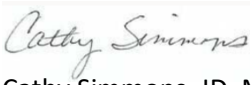


Thomas F. Bugliosi, MD, MBA, FACP, FACEP, FHM,CHCQM, CPE
Medical Director Utilization Management

Angela M. Wilson Reis BSN, RN, IQCI, IQCER
Director, Utilization Management



Jayne Hildebrand, MBA, CHFP
Excutive Director, Patient Financial Services



Cathy Simmons, JD, MPP
Executive Director, Government & External Affairs