In this Session We Will Provide:

- Information about flexibility that Medicare Advantage Plans have to waive the Medicare 3-day patient admission rule for Medicare coverage of post acute rehabilitation in a Skilled Nursing Facility.
- We will explain observation status, how it impacts the Medicare 3-day requirement, what they are allowed to do regarding coverage of rehab in an SNF.
- This presentation is targeted for consumers and their caregivers.
- This presentation is not intended to provide guidance to providers, insurers, or health care professionals.

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What is Observation Status?

- It is a category used in Medicare for care for certain patients while they are in a hospital and is considered by Medicare as outpatient care (even though the patient may be staying overnight in the hospital for their care.
- It is paid under Part B (outpatient services).
- It was invented over a decade ago in the US to save Medicare money by paying for less intensive patient care while a hospital is determining if an emergency room patient needs to be admitted as an "inpatient" (inpatient is paid under Part A).
- Recent studies have shown it does not reduce hospital or nursing home days and does not save the system costs.
- It has increased costs for many patients needing post acute rehab.

For Example:

1. A patient presents to the hospital with chest pains and nausea.
2. The hospital will run tests before deciding if they should admit them or send them.
3. While they are waiting to determine the diagnosis, they place the patient into "observation status".

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What do Observation Services Include?

- Hospital care provided intended as “outpatient services” for monitoring purposes or to determine whether a person should be admitted as an inpatient.
- They include ongoing short-term treatment, assessment, and reassessment and other services needed before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.
- Often these services are ordered for patients in an emergency room, or observation unit, or general hospital who need a significant period of monitoring to make a decision concerning admission or discharge.

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Observation Services Are Classified Outpatient Services

- Only in rare and exceptional cases are outpatient services supposed to span more then 48 hours.
- Hospitals in USA were eventually required to inform patients with a Medicare Outpatient Observation Notice (MOON) within 36 hours if the patients are receiving observation services as an outpatient for 24 hours.
- It is important to always ask the hospital staff before, during and after being treated in the hospital if you are in observation status or being admitted.

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What Is The Difference Between Observation Status And Inpatient Status? Why Is This A Problem For Patients Needing Rehab In A Skilled Nursing Facility (SNF)?

- Essentially there is no difference in terms of the type, scope, intensity, or quality of care. It is the same care provided to those with "inpatient status".
- Observation care is classified as an outpatient service and not Inpatient hospital care and is not considered counting toward the 3-day inpatient status requirement for coverage of post acute rehabilitation an SNF care.
- Many beneficiaries entering a hospital are placed into observation status unless there is documentation provided by an admitting doctor that the beneficiary merits inpatient care.
- There are many instances where inpatient care is needed, but the lines are becoming blurred.

EXAMPLE:

An **amputation or an organ transplant** would be good examples of persons that should clearly be placed into inpatient status.

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During Covid 19 the 3-midnight requirement was waived

- Beneficiaries needing post acute rehab in an SNF were able to have part A cover the costs of allowable days.
- This meant that all new SNF stays beginning on or after May 12, 2023 once again were required to have a 3-midnight qualifying hospital stay before Medicare Part A coverage for facility-based rehab care.

> These waivers ended May 11, 2023, with the expiration of the COVID-19 Public Health Emergency

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CMS Has Provided Some Special Waivers for the 3-Midnight Requirement

- Medicare allows Accountable Care Organizations who successfully apply for waivers to provide Part A coverage of the transition to SNF for rehab without 3 inpatient days. (Few of the ACOs publicize it and you must ask them. Don't assume they cover it automatically).
- **Medicare Advantage Plans were also allowed to waive the requirement.**
- CMS also allows hospitals participating in the Transforming Episode Accountability Model (TEAM) to waive the 3-day requirement. We are not going to discuss the use of the Waiver under the TEAM model.
- **The flexibility provided by CMS is intended to allow Medicare Advantage plans that seek to use it to increase quality and decrease cost (for example by assuring a patient needing rehab receives it in a timely manner, can inpatient obtain therapy to recover and return home and hopefully not have to return to the hospital).**

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The CMS Advantage Plan Compare Website Does Not Indicate if Plans Waive the Rule

- The site lists some services that are covered but comparative information about coverage of SNF Rehab.
- Under definitions it includes the following statement regarding Skilled Nursing Facility Care: "… ask your doctor or hospital staff if Medicare will cover your SNF stay. Medicare Advantage Plans may also waive the 3-day minimum. Contact your plan for more information." under the website definition of SNF care.

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Medicare Advantage Plans Provide Beneficiaries With Evidence of Coverage (EOC) Each Year

- Provided in September (before open enrollment period)
- EOC Includes:
  - ✓ List of services covered and non-covered services
  - ✓ Definitions of Services
  - ✓ How much the beneficiary must pay (coinsurance, deductibles, and copayments)
  - ✓ Costs of in-network providers and out-of-network providers
  - ✓ Indication of if Prior Authorization is required
  - ✓ How to appeal decisions

Medicare Advantage Plans Provide Beneficiaries With an Annual Notice of Change (ANOC) Each Year

- Provided in September (before open enrollment period)
- ANOC Includes:

✓ cost changes to deductibles, copays, and premiums. Unlike Original Medicare, which sets standard costs nationally, costs for private plans can vary from year to year.

✓ additions or exclusions of certain services from coverage from the previous year or changes in provider networks from prior year.

Check Your Evidence of Coverage

- Check to see what it says regarding coverage of Skilled Nursing Care Coverage.
- Notes will pay for Services that are Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Covers all medically necessary services as listed in a Medical Benefits Chart.
- If you get services that aren't covered by our plan, or you get services out-of-network without authorization, you're responsible for paying the full cost of services.
- If they are making a referral for rehab in an SNF they will most likely use and in-network nursing home.

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Finding Out if Your Advantage Plan Will Provide Post Acute Rehabilitation at a Skilled Nursing Facility

- Many (most?) Medicare Advantage Plans Provide such coverage if they deem the care medically necessary however some many not.
- Remember there is no listing of Medicare Advantage Plans that provide such coverage.
- It is best to ask your plan representative (if you are thinking or enrolling) or doctor if the plan will cover such rehab.
- If you are considering any surgery or procedures in the hospital, ask the physician(s) if it may require post acute rehabilitation in an SNF and if your plan will cover it.

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Appeals

- You have the right to appeal the denial of coverage or if you feel that you think your coverage is ending too soon.
- An Advantage Plan should give you a notice of non-coverage in writing at least 2 days before the plan is going to stop covering care.
- The notice will explain your appeal rights and who to contact for an appeal (the Quality Improvement Organization (QIO) contracted by Medicare to handle appeals).
- You can ask for a "fast track appeal" to keep covering your care for a longer period of time.
- You must contact the QIO for an appeal by noon of the effective date of the Notice of Non-Coverage
- The EOC includes information suggesting that if you have questions or need assistance with an appeal you can call their member services office or through the State Health Insurance Program (HIICAP)

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Upcoming Teach Ins

- **April 28:** Learn About the New Medical Aid in Dying Act in NYS.

  Speaker: Francesca Triest, Campaign Manager, Compassion & Choices
- **May 26:** Updates from CMS: New Developments to Help Improve Medicare

  Speaker: Thomas Bane, Regional Director of CMS
- **June 23:** Commence Health (Formerly known as Livanta): Information on how Medicare beneficiaries, patients, and families can file discharge appeals or quality of care complaints for Medicare health care services.

  Speaker: James Mellot, Director of Communications, Quality Improvement Organization (QIO)

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Questions about:

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- ✓ Medical Debt
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- ✓ Becoming an SMP Volunteer

- **Email: patientsrights@nysenior.org** **Call:** Patients Rights Helpline **1-800-333-4374**
- **Stay informed:** listen to our monthly Teach Ins (visit **www.nysenior.org** for more information).

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