Department of Health and Human Services
OFFICE OF MEDICARE HEARINGS AND APPEALS
Phoenix, Arizona

Appeal of: [redacted]	OMHA Appeal No.: **1-9329667990**
Enrollee: [redacted]	Medicare: **Part C**
Medicare No.: ****[redacted]	Before: **Salena Bowman-Davis** Administrative Law Judge

DECISION

After considering the evidence and arguments presented in the record, I enter a **FULLY FAVORABLE** decision. The Enrollee appeals from the Medicare Advantage organization's determination denying coverage for extended care services provided after April 7, 2020, the date the Medicare Advantage organization determined was the 100th day of coverage during the Enrollee's benefit period. The central issue before me in this appeal is whether the Enrollee was entitled to coverage for extended care services beyond April 7, 2020. For the reasons stated below, I find the Enrollee was entitled to coverage beyond April 7, 2020 because the Enrollee had not exhausted 100 days of coverage by the end of April 7, 2020. I also find the Enrollee was entitled to coverage beyond April 7, 2020 because the Enrollee falls under a temporary policy issued by the Centers for Medicare & Medicaid Services, a policy that provides up to 100 additional days of coverage for certain beneficiaries affected by the COVID-19 emergency.

PROCEDURAL HISTORY

On April 1, 2020, the Medicare Advantage ("MA") organization issued written notice that it was denying coverage for extended care services provided to the Enrollee after April 7, 2020. Exh. 3, pp. 45-46. On April 3, 2020, the Enrollee requested expedited reconsideration. Exh. 3, p. 59. On April 4, 2020, the MA organization made an unfavorable expedited reconsideration, affirming its determination in whole. Exh. 3, p. 39. Later, on April 6, 2020, Maximus Federal Services, the Independent Review Entity ("IRE") made an unfavorable reconsidered determination. Exh. 3, pp. 9-10.

On April 13, 2020, the Office of Medicare Hearings and Appeals ("OMHA") received the Enrollee's timely request for an Administrative Law Judge ("ALJ") hearing. On June 25, 2020, a hearing was held before ALJ Bowman-Davis. [redacted] Enrollee's son and Power of Attorney, was present and testified at the hearing. There were no other participants present. Exhibits 1-4 were admitted into evidence without objection. On July 2, 2020 and July 6, 2020, OMHA received additional records from the Evergreen Health Care Center, the skilled nursing

facility where the Enrollee was admitted as an inpatient. This new evidence is admissible under 42 C.F.R. § 422.562(d)(2)(vi) and has been admitted into evidence as Exhibit 5.

ISSUE

Whether the Enrollee was entitled to coverage for extended care services beyond April 7, 2020, as part of the MA organization's obligation to provide coverage for benefits under Medicare Part A.

APPLICABLE LAW AND POLICY

Under the Medicare Advantage Program, also known as Medicare Part C, each Medicare Advantage ("MA") organization must provide coverage for all items and services that are covered by Medicare Part A (except hospice services) and Medicare Part B that are available to beneficiaries residing in the plan's service area. 42 C.F.R. §§ 422.100(c)(1), 422.101(a). Section 1812 of the Social Security Act defines the scope of benefits under Medicare Part A. Two provisions of section 1812 address Medicare Part A coverage of extended care services (certain services provided to an inpatient of a skilled nursing facility). First, section 1812(a)(2)(A) states Medicare Part A covers "post-hospital extended care services" for up to 100 days during any "spell of illness." The term "post-hospital extended care services" means "extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer." Act § 1861(i). A "spell of illness" (also known as a "benefit period") is a period of consecutive days beginning with the first day on which a Medicare Part A beneficiary is furnished with inpatient hospital services, inpatient critical access hospital services, or extended care services. Act § 1861(a); 42 C.F.R. § 409.60(a). A "spell of illness" ends when the beneficiary has not been an inpatient in a hospital, a critical access hospital, or a skilled nursing facility for at least 60 consecutive days. Act §§ 1819(a)(1), 1861(a), (y)(1); 42 C.F.R. § 409.60(b).

The second provision of section 1812 that addresses Medicare Part A coverage of extended care services is 1812(a)(2)(B). Section 1812(a)(2)(B) states Medicare Part A covers extended care services that are not post hospital extended care services to the extent provided in section 1812(f). Section 1812(f), in turn, states the Secretary of the Department of Health and Human Services ("the Secretary") shall provide for coverage of extended care services which are not post-hospital extended care services at such time and for so long as the Secretary determines, and under such terms and conditions as the Secretary finds appropriate, that the inclusion of such services will not result in any increase in the total payments made under Medicare and will not alter the acute care nature of the extended care services benefit.

If payment cannot be made for extended care services provided in a SNF under Medicare Part A, the services may be reimbursable under Medicare Part B if they constitute "medical and other health services" and the beneficiary is entitled to Medicare Part B benefits. *Medicare Benefit Policy Manual (MBPM)*, pub. 100-02, ch. 8, § 70 (Oct. 2016). This coverage under Medicare Part B includes situations where the beneficiary has exhausted the 100 covered days during the benefit period. *Id.*

Under section 319 of the Public Health Service Act, the Secretary may determine that: (1) a disease or disorder presents a public health emergency; or (2) a public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. When the

Secretary determines a public health emergency exists under section 319 of the Public Health Services Act and the President of the United States declares an emergency or disaster under the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act, section 1135 of the Social Security Act allows the Secretary to temporarily waive or modify certain requirements the of the Medicare program. Act § 1135(a)-(b), (g).

On January 31, 2020, the Secretary determined a public health emergency existed under section 319 of the Public Health Service Act due to confirmed cases of the 2019 Novel Coronavirus ("COVID-19"). 85 Fed. Reg. 27550, 27552 (May 8, 2020). On March 13, 2020, the President declared a national emergency under the National Emergencies Act. 85 Fed. Reg. 15335, 15337-15338 (Mar. 18, 2020). Later on March 13, 2020, the Secretary exercised his authority under section 1135 of the Social Security Act to waive or modify certain requirements of the Medicare program. United States Department of Health & Human Services, Public Health Emergency: Waiver or Modification of Requirements Under Section 1135 of the Social Security Act, https://www.phe.gov/emergency/news/healthactions/section1135/Pages/covid19-13March20.aspx.

On March 13, 2020, the Administrator of the Centers for Medicare & Medicaid Services ("CMS"), the federal agency within the Department of Health and Human Services that administers the Medicare program on behalf of the Secretary, announced temporary emergency policies that invoked the Secretary's authority to provide coverage for extended care services under sections 1812(a)(2(B) and 1812(f) of the Act. Exh. 3, pp. 30-31 (Administrator, Centers for Medicare & Medicaid Services: Findings Concerning Section 1812(f) of the Social Security Act in Response to the Effects of the 2019-Novel Coronavirus (COVID-19) Outbreak (March 13, 2020)). The emergency policies affect Medicare Part A coverage of extended care services in two ways. First, the emergency policies allow Medicare Part A coverage for extended care services provided in a SNF without a prior 3-day inpatient hospital stay for those beneficiaries who experience dislocation or are otherwise affected by the emergency. *Id.* Second, the policies allow for renewed coverage of extended care services provided in a SNF for up to an additional 100 days without requiring the start of a new spell of illness. *Id.* Regarding renewed coverage of extended care services, the Administrator has stated the following:

> In addition, we will recognize special circumstances for certain beneficiaries who, prior to the current emergency, had either begun or were ready to begin the process of ending their spell of illness after utilizing all of their available SNF benefit days. Existing Medicare regulations state that these beneficiaries cannot receive additional SNF benefits until they establish a new benefit period (i.e., by breaking the spell of illness by being discharged to a custodial care or non-institutional setting for at least 60 days). However, the dislocations resulting from the emergency (including emergency-related measures that could result in discharge delays) may delay or prevent such beneficiaries from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances. Accordingly, I find that covering additional SNF care without requiring a break in the spell of illness for those beneficiaries in connection with the above-captioned emergency would not increase total payments made under the Medicare program and would not change the essential acute-care nature of the Medicare SNF benefit. Therefore, we are also utilizing the authority under section 1812(f) of the Act to provide renewed coverage

> for extended care services which will not first require starting a new spell of illness for such beneficiaries, who can then receive up to an additional 100 days of SNF Part A coverage for care needed as a result of the above-captioned emergency. This policy will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances.

Id.

FINDINGS OF FACT AND ANALYSIS

The Enrollee in this case, a 79-year-old patient with a history of prostate cancer and dementia, was enrolled in the UnitedHealthcare Medicare Advantage Plan 2. Exh. 2, pp. 1, 4. On December 10, 2019, the Enrollee was admitted to the Johnson Memorial Hospital as an inpatient due to a left femoral neck fracture. Exh. 2, p. 7. On December 12, 2019, the Enrollee was discharged and transferred to the Evergreen Health Care Center, a skilled nursing facility ("SNF"), where he received daily skilled services until his discharge on January 28, 2020. Exh. 2, p. 7.

On February 8, 2020, the Enrollee was admitted to the St. Francis Medical Center as an inpatient due to metabolic encephalopathy caused by acute renal failure. Exh. 2, pp. 1, 7. On February 15, 2020, the Enrollee was discharged and admitted to the Evergreen Health Care Center, where he received daily skilled physical, occupational, and speech therapy. Exh. 2, p. 7; Exh. 5, pp. 283-293. The ultimate goal in therapy was to return the Enrollee to his prior level of function of being independent with mobility and with his daily activities. Exh. 2, p. 5.

The Enrollee made progress through his therapy. When he arrived at the Evergreen Health Care Center, the Enrollee was unable to ambulate, and he required maximum assistance from 2 people to perform toilet and commode transfers. Exh. 5, pp. 284, 292. By March 16, 2020, the Enrollee required only moderate assistance with toilet and commode transfers, and by March 17, 2020 the Enrollee was able to walk 10 to 15 feet with contact guard/minimal assistance using a rolling walker. Exh. 5, pp. 284, 292. A note dated March 12, 2020 indicates the Enrollee was expected to be discharged from the SNF on March 30, 2020. Exh. 2, p. 5.

As the Enrollee was making progress in therapy, COVID-19 was making its own sort of progress around the world. On January 31, 2020, the Secretary determined a public health emergency existed due to the number of confirmed cases of COVID-19. U.S. Department of Health and Human Services, Determination that a Public Health Emergency Exists, https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx. On March 11, 2020, the World Health Organization publicly declared COVID-19 a pandemic. 85 Fed. Reg. at 27552. On March 13, 2020, the President declared COVID-19 a national emergency. 85 Fed. Reg. at 27552.

Eventually, COVID-19 found its way inside the Evergreen Health Care Center. Exh. 2, p. 4; Exh. 5, p. 293. On March 18, 2020, the Evergreen Health Care Center began quarantine because a resident had tested positive for COVID-19. Exh. 2, p. 4. The quarantine meant that no resident of the facility was allowed to discharge. Exh. 2, p. 4. On March 25, 2020, the Enrollee's physical,

occupational, and speech therapy services were put on hold due to a COVID-19 outbreak at the facility. Exh. 5, pp. 95, 293.

The quarantine at the Evergreen Health Care Center continued into April. Exh. 2, p. 4. Records from the MA Organization indicate that on April 1, 2020, the MA organization mailed a notice of denial of medical non-coverage to the Enrollee and the Evergreen Health Care Center. Exh. 2, p. 2. The notice of denial of medical non-coverage stated the Enrollee was about to reach his 100-day benefit limit and that his last day of coverage for the extended care services at the SNF would be April 7, 2020. Exh. 3, p. 45. On April 3, 2020, the Enrollee, through his authorized representative, requested expedited reconsideration from the MA organization. Exh. 3, p. 59. On April 4, 2020, the MA organization made an unfavorable expedited reconsideration. Exh. 3, p. 39. On April 6, 2020, the IRE made an unfavorable reconsidered determination. Exh. 3, pp. 9-10.

Although continued coverage had been denied, the Enrollee remained at the Evergreen Health Care Center after April 7, 2020. On April 14, 2020, it was determined medically appropriate for the Enrollee to resume physical, occupational, and speech therapy. Exh. 5, pp. 66, 236. Also on April 14, 2020, the Enrollee was found to have an elevated blood urea nitrogen (BUN) level. Exh. 5, pp. 77, 235. For his elevated BUN level, the Enrollee was administered intravenous fluids, and he was encouraged to drink additional fluids. Exh. 5, pp. 83, 85, 233, 236. The Enrollee's condition improved with the additional fluids. Exh. 5, pp. 66, 236. In early May, however, the Enrollee began having increased lethargy and confusion, and blood work showed the Enrollee had profoundly elevated creatinine and BUN levels. Exh. 5, pp. 180-181. On May 5, 2020, the Enrollee was taken to the emergency department of the Saint Francis Hospital and Medical Center, where he was admitted as an inpatient with a diagnosis of right-sided hydrophrenosis. Exh. 5, pp. 180-182. The Enrollee was also found to be positive for COVID-19. Exh. 5, p. 182.

At the hospital, the Enrollee underwent a percutaneous nephrostomy tube placement. Exh. 5, p. 182. On May 21, 2020, the Enrollee was discharged to the Evergreen Health Care Center after he tested negative for COVID-19. Exh. 5, p. 182. The Enrollee was scheduled to be discharged home from the Evergreen Health Care Center on June 22, 2020. Exh. 5, p. 209. That discharge was postponed, however, because the Enrollee had once again tested positive for COVID-19. Exh. 5, p. 208.

The record contains the Evidence of Coverage ("EOC"). Exh. 1, pp. 75-354. The EOC states the Plan does not require a 3-day prior hospital stay before the Plan will cover extended care services. Exh. 1, p. 174. Other than the prior 3-day hospitalization requirement, the language of the EOC regarding coverage of extended care services in a SNF follows the coverage requirements under Medicare Part A. The EOC states the Plan will cover up to 100 days of extended care services in a SNF during each benefit period and that a benefit period begins on the first day the Enrollee goes to a Medicare-covered inpatient hospital or skilled nursing facility. Exh. 1, p. 174.

At issue in this appeal is whether the Enrollee was entitled to additional coverage for extended care services beyond April 7, 2020 as part of the MA organization's obligation to provide coverage for all items and services that are covered by Medicare Part A. In its expedited reconsideration, the MA organization found the Enrollee had exhausted 100 days of covered extended care services during the benefit period. Exh. 3, p. 39. More specifically, the MA organization found the Enrollee had used 47 days of covered services between December 12, 2019 and January 28, 2020 and 53 days of covered services between February 15, 2020 and April 7, 2020. Exh. 3, p. 39. In

its reconsidered determination, IRE found the Enrollee had used 100 days of covered extended care services during the benefit period from December 12, 2019 to April 7, 2020. Exh. 3, pp. 9-10.

Contrary to what the IRE and MA organization determined, the Enrollee had not used 100 days of coverage for extended care services by the end of April 7, 2020. A benefit period begins the first day a Medicare beneficiary is furnished with inpatient hospital services, inpatient critical access hospital services, or extended care services. Act § 1861(a); 42 C.F.R. § 409.60(a). Here, the Enrollee's benefit period began on December 10, 2019 (the day the Enrollee was admitted to the Johnson Memorial Hospital with a fractured femoral neck) because that was the first day the Beneficiary received such services. Exh. 2, p. 7. The record does show the Enrollee was an inpatient at the Evergreen Health Care Center for 100 days between December 10, 2019 (the day the benefit period began) and April 7, 2020 (the day the MA organization determined was the Enrollee's final day of covered services during the benefit period). The Enrollee spent 47 days as an inpatient from December 12, 2019 to January 28, 2020 and 53 days as an inpatient from February 15, 2020 to April 7, 2020. *See* Exh. 2, p. 8 (record from MA organization listing dates Enrollee was admitted and discharged from the Evergreen Health Care Center) and *MBPM,* ch. 3, § 20.1 (stating the day of admission counts as a full day but the day of discharge generally does not count towards the 100 days of coverage). Not all of these 100 days, however, were covered days.

For Medicare to cover extended care services in a SNF, the beneficiary must both require and receive daily skilled nursing services or daily skilled rehabilitation services. 42 C.F.R. 409.34(a); *MBPM,* ch. 8, §§ 30, 30.6. In this case, the Enrollee did not receive daily skilled care from March 25, 2020 to April 7, 2020. After he was admitted to the Evergreen Health Care Center on February 15, 2020, the Enrollee received daily skilled rehabilitation services in the form of daily physical, occupational, and speech therapy. Beginning on March 25, 2020, however, the Enrollee stopped receiving daily skilled rehabilitation because all therapy was put on hold due to the outbreak of COVID-19 at the facility. The therapy did not resume until at least April 14, 2020, the day it was determined to be medically appropriate for the Enrollee to resume therapy. Exh. 5, p. 66.

The record also shows the Enrollee did not receive daily skilled nursing services between March 25, 2020 and April 7, 2020. Nursing services are considered skilled services "when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse." *MBPM,* ch. 8, § 30.3. Here, the record shows the Enrollee was provided with services provided between March 25, 2020 and April 7, 2020 that included administration of the medication Tramadol orally every 6 hours for pain management, the administration of Tylenol Extra Strength orally for pain management, the administration of Robitussin DM for cough suppression, and the administration of the medication Trazadone HCI orally every 6 hours as needed for anxiety. Exh. 5, pp. 109, 243-244. The record also shows the Enrollee was administered a protective ointment as an incontinent care barrier every shift between March 25, 2020 to March 27, 2020. Exh. 5, p. 343. As the MBPM explains, however, routine care of the incontinent patient and the administration of ointments and routine oral medication do not amount to skilled services unless the beneficiary has a special medical complication that required the services to be performed by or under the supervision of skilled nursing personnel. 42 C.F.R. §§ 409.32(b), 409.33(d). Here, the records do not demonstrate the Enrollee had a special medical complication that required skilled nursing personnel to administer his ointment or oral medications.

The record also shows the Enrollee underwent medical observation between March 25, 2020 and April 7, 2020. This observation included monitoring the Enrollee's intake and out take every shift, conducting a weekly basic metabolic panel, and checking the Enrollee's vital signs every shift. Exh. 5, pp. 87, 90, 92, 94. Medicare regulations and policy state observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation to identify and evaluate the patient's need for modification of treatment or initiation of additional medical procedures until his or her condition is stabilized. 42 C.F.R. § 409.33(a)(2); *MBPM*, ch. 8, § 30.2.3.2. In this case, the basic metabolic panels (even if they were conducted by nurses) could not have amounted to daily skilled nursing services because the services were performed once per week. Regarding the taking of the Enrollee's vitals and monitoring of his intake and outtake, the records show these services were performed on a daily basis. Nevertheless, the records do not demonstrate these services were so inherently complex that they could only have been safely and effectively performed by, or under the supervision of, a registered nurse or a licensed practical nurse. The vitals, for instance, consisted of temperature, heart rate, blood pressure, blood sugar level, and oxygen saturation. Exh. 5, pp. 10-57. There is nothing in the records that indicates the Enrollee's condition made the collection of this information so complex that other personnel, such as a medical assistant or a nurse aid, could not have safely and effectively performed the services.

Since the Enrollee did not receive daily skilled services between March 25, 2020 and April 7, 2020, Medicare did not cover the extended care services provided on those days. And because Medicare did not cover the extended care services between March 25, 2020 and April 7, 2020, those days do not count towards the 100 days of covered services in the Enrollee's benefit period. Thus, the Enrollee still had 14 days of covered services remaining on April 7, 2020, the day that MA organization determined was the last day of covered services during the Enrollee's benefit period.

Medicare regulations state that written notice of discontinuation of provider services must be delivered to the beneficiary no later than 2 days before the proposed end of services. 42 C.F.R. § 422.624(b). The written notice must be a standardized notice required by the Secretary, and, among other things, the written notice must include the date that coverage of the services ends and a description to the enrollee's right to a fast-track appeal. 42 C.F.R. § 422.624(b)(2). Delivery of the termination notice is not valid unless the enrollee or the enrollee's representative has signed and dated the notice to indicate receipt and understanding, the notice contains all the required elements, and the notice was delivered no later than 2 days before the proposed end of services. 42 C.F.R. § 422.624(c). An MA organization is financially liable for continued services until 2 days after the enrollee receives valid notice. 42 C.F.R. § 422.624(d). The EOC contains similar language regarding the Plan's obligation to inform the Enrollee when it determines the Enrollee no longer needs SNF care. Exh. 1, pp. 311-313. The EOC states the Plan must inform the Enrollee in writing in advance when it decides it is time to stop covering extended care services in a SNF and the written notice must be signed by the Enrollee or someone acting on the Enrollee's behalf. Exh. 1, pp. 312-313.

In this case, there is no indication the Enrollee received written notice that the extended care services provided between March 25, 2020 and April 7, 2020 would not be covered. The only written notice of non-coverage in the record is the notice of denial dated April 1, 2020. Exh. 3, pp. 45-46. The notice states the last day of covered services at the SNF would April 7, 2020 and

makes no mention of non-coverage for the services provided between March 25, 2020 and April 7, 2020. Exh. 3, pp. 45-46. Furthermore, because the Enrollee had not actually exhausted the 100 days of coverage during the benefit period, the April 1st notice was not valid written notice under 42 C.F.R. § 422.624. The written notice was a Form CMS-10003-NDMCP, not a FORM CMS-10123-NOMNC, which is the CMS approved form for advance written notice to enrollees of termination of services in a SNF. *See* Notices and Forms, CMS.gov, https://www.cms.gov/Medicare Appeals-and-Grievances/MMCAG/Notices-and-Forms (describing the various forms for notices). Additionally, the written notice dated April 1, 2020 was not signed by the Enrollee or the Enrollee's representative, and the notice did not inform the Enrollee of the right to a fast-track appeal under 42 C.F.R. § 422.626. Because the Enrollee had not exhausted his 100 days of coverage by March 25, 2020 and because the MA organization did not provide valid written notice that the extended care services provided from March 25, 2020 to April 7, 2020 were not covered, the MA organization is financially liable for the non-covered services provided on those dates.

The Enrollee was also entitled to coverage for extended care services beyond April 7, 2020 because the Enrollee was entitled to up to 100 days of SNF Part A coverage under the temporary emergency policy issued by CMS in response to the COVID-19 outbreak. Under the emergency policy, CMS has invoked the Secretary's authority under section 1812(f) of the Act to provide renewed coverage for extended care services for up to an additional 100 days without requiring a new spell of illness. According to the Administrator of CMS, the policy applies only to beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances. Exh. 3, pp. 30-31 (Administrator, Centers for Medicare & Medicaid Services: Findings Concerning Section 1812(f) of the Social Security Act in Response to the Effects of the 2019-Novel Coronavirus (COVID-19) Outbreak (March 13, 2020)).

In this case, the COVID-19 outbreak delayed the Enrollee from beginning the process of ending his benefit period because his therapy was put on hold due to an outbreak of COVID-19 at his SNF. The record shows the Enrollee was making progress in therapy and that he was expected to complete therapy by March 30, 2020. Exh. 2, p. 5. Thus, had COVID-19 not led to a stoppage of therapy, the Enrollee would have begun the process of ending his benefit period by being discharged from the SNF on March 30, 2020. Because the COVID-19 outbreak prevented the Enrollee from beginning the process of ending his benefit period, the Enrollee fell under the emergency policy of CMS and was entitled to up to an additional 100 days of SNF Part A coverage.

CONCLUSIONS OF LAW

The Enrollee was entitled to additional coverage of extended care services beyond April 7, 2020 because the Enrollee had not exhausted his 100 days of covered services during the benefit period. The Enrollee had not exhausted his 100 days of covered services by the end of April 7, 2020 because he was not provided with daily skilled care from March 25, 2020 and April 7, 2020. The Enrollee was also entitled to additional coverage of extended care services beyond April 7, 2020 because the Enrollee fell under the temporary emergency policy issued by CMS, the policy that provides up to 100 days of additional coverage for those beneficiaries who have been delayed or prevented by the COVID-19 emergency from commencing or completing the process of ending their current benefit period. In accordance with 42 C.F.R. § 422.624(d), the MA organization is financially liable for the non-covered services provided between March 25, 2020 and April 7, 2020

because the MA organization did not provide valid written notice under 42 C.F.R. § 422.624(b). The MA organization is also liable for the extended care services provided after April 7, 2020 because the Enrollee had not yet exhausted his 100 days of covered services during the benefit period and the Enrollee was entitled to up to an additional 100 days of coverage under the temporary policy issued by CMS.

ORDER

For the reasons discussed above, this decision is **FULLY FAVORABLE**. I direct the Medicare Advantage organization to process the determination in accordance with this decision.

SO ORDERED

Dated: **July 10, 2020**

Salena Bowman-Davis
Administrative Law Judge