

Observing Observational Status -- Auditors and Inequities

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OBSERVING OBSERVATIONAL STATUS – AUDITORS AND INEQUITIES

Lori J. Parker*

As a cost-saving measure, the Center for Medicare and Medicaid services created the Recovery Audit Program (RAC). Non-physician auditors from the RAC examine whether physicians (in the opinion of the auditor) improperly admitted patients to the hospital rather than placing them on observational status. Classification as observational rather than “admitted” can result in significant financial liability to patients, in that Medicare significantly limits the benefits available to observational patients. To date, court decisions and proposed legislation have done little to address the legitimacy of the RAC program itself. Rather, efforts to date have been limited to decision making at the hospital and care provider level—a focus that tends to divide the interests of physicians and patients rather than uniting them. Genuinely meaningful reform must come from the grassroots level, and must build alliances between patients and their care providers.

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TABLE OF CONTENTS

INTRODUCTION.....	85
I. MEDICARE AND THE RAC.....	87
A. MEDICARE	
BASICS.....	87
B. LEGISLATIVE AND REGULATORY HISTORY OF THE RAC PROGRAM.....	88
1. GENERAL OPERATION OF THE RAC.....	89
2. INPATIENT VERSUS OBSERVATIONAL STATUS	
3. REAL-WORLD IMPACT.....	93
II. CHALLENGES TO OBSERVATIONAL STATUS.....	95
C. CASES.....	95
D. THE COURTS' VIEWS.....	97
4. INPATIENT ARE INPATIENTS BECAUSE THEY ARE INPATIENTS.....	97
5. FORM TRUMPS SUBSTANCE IN DETERMINING WHETHER A PATIENT'S STATUS IS INPATIENT OR OBSERVATIONAL.....	98
6. NOTICE, COMMENT, AND CONTORTIONS.....	99
7. PUBLICATION AND OBFUSCATION.....	100
8. DUE PROCESS—PERMISSIVE IS THE NEW MANDATORY.....	101
i. NO PROPERTY INTEREST.....	101
ii. NO NEED FOR NOTICE.....	101
9. AUDITORS IN COMMAND.....	102

**E. GHOSTS OF OBSERVATION PAST, PRESENT, AND
FUTURE.....103**

**III. LEGISLATIVE, REGULATORY, AND GRASSROOTS
REFORM.....103**

CONCLUSION.....109

INTRODUCTION

Conspiracy theorists sometimes claim that unusual, mediagenic events are “staged” by the government to “distract” the population from particularly nefarious doings at higher echelons. There may be dubious merit to the claims that 9/11 was an inside job,¹ or that the 1969 moon landing occurred on a Hollywood sound stage.²

Nonetheless, there is often a morsel of truth at the bottom of the far-fetched cracker box. For example, social scientists have documented the powerful influence of a request to focus on a given task.³ When attention is so focused on one phenomenon, any others that would be attention getting under other circumstances, go unnoticed.⁴

And so goes the story of the Medicare Fee-For-Service Recovery Audit Contractor program (RAC), which has its genesis in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).⁵ The MMA brought with it the novelty of Medicare Part D prescription drug coverage.⁶ The availability of prescription drug coverage to Medicare recipients represented a sea change; policy analysts, scholars, and the

1. Chris McGreal, *9/11 Conspiracy Theories Debunked*, THE GUARDIAN (Sep. 5, 2011), available at <http://www.theguardian.com/world/2011/sep/05/9-11-conspiracy-theories-debunked>.

2. See Ker Than, *Photos: 8 Moon-Landing Hoax Myths — Busted*, NAT'L GEOGRAPHIC (Jul. 16, 2009), available at <http://news.nationalgeographic.com/news/2009/07/photogalleries/apollo-moon-landing-hoax-pictures/>.

3. See, e.g., Daniel J. Simons & Christopher F. Chabris, *Gorillas in Our Midst: Sustained Inattention Blindness for Dynamic Events*, 28 PERCEPTION 1059, 1059-60 (1999).

4. *Id.*

5. CTRS. FOR MEDICARE & MEDICAID SERVS., IMPLEMENTATION OF RECOVERY AUDITING AT THE CENTERS FOR MEDICARE & MEDICAID SERVICES: FY 2010 REPORT TO CONGRESS iii, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/downloads/FY2010ReportCongress.pdf>.

6. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub.L. No. 108-173, Title I, §§ 101, 117 Stat. 2066, 2071 (codified at 42 U.S.C. §§ 1395w-101).

general public sat up and took notice of this new, “hot” issue.⁷ Beneficiaries’ eyes were focused on their prescriptions, but there was more to the MMA than subsidized Viagra. Due to the high level of interest in Part D, other provisions of the law were virtually overlooked.⁸

The RAC is one example of an unnoticed provision. Over its eleven-year existence, the RAC has engaged in vigorous efforts to recover funds paid from Medicare Part A for hospital inpatient services.⁹ The stringency of these efforts resulted in what Medicare beneficiaries could easily view as a conspiracy to undercut their benefits or at least a catch-22 with Orwellian overtones. RAC auditors use a carrot-and-stick approach¹⁰ to

7. The purpose of the Act is “to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes.” *Id.* See HEALTH POLICY ALTERNATIVES, INC., KAISER FOUND., PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES: AN OVERVIEW OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003 (PUBLIC LAW 108-173) 1 (2004), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/prescription-drug-coverage-for-medicare-beneficiaries-an-overview-of-the-medicare-prescription-drug-improvement-act-2003.pdf>; Dawn E. Havrda et al., *Impact of the Medicare Modernization Act on Low-Income Persons*, 143 ANNALS OF INTERNAL MED., 600, 600-04 (2005); Brian M. Meyer & Kathleen M. Cantwell, *The Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Implications for Health-System Pharmacy*, 61 AM. J. HEALTH-SYS. PHARM. 1042, 1042-43 (2004); Kenneth Gilpin, *Market Insight: Gauging the Winners in the Medicare Bill*, N.Y. TIMES (Dec. 14, 2003), <http://www.nytimes.com/2003/12/14/business/market-insight-gauging-the-winners-in-the-medicare-bill.html>.

8. E.g., Susan Bartlett Foote, *The Impact of the Medicare Modernization Act’s Contractor Reform on Fee-For-Service Medicare*, 1 ST. LOUIS U. J. OF HEALTH L. AND POL’Y 67, 67-77 (2007) (explaining that other MMA programs that failed to garner significant attention included changes to Part C, including restrictions to care from in-network providers (other than emergency care) and use of formularies to restrict prescription drug choices, and contractor reforms in fee-for-service Medicare).

9. See, e.g., Emily Egan, *Primer: Recovery Audit Contractor Program and the “Two Midnight” Rule*, AM. ACTION FORUM, 1, 3 (Dec. 11, 2013), <http://americanactionforum.org/research/primer-recovery-audit-contractor-program-and-the-two-midnights-rule>.

10. Colin Elliot & Ken Miller, *Alphabet Soup: Medical Necessity Review & Medicare Recovery Audits*, 46 THE QUARTERLY REPORT, AM. PHYSICAL THERAPY ASS’N., 1, 3 (2010), available at http://c.ymcdn.com/sites/www.homehealthsection.org/resource/resmgr/imported/V46_N1_Partner.pdf.

influence hospital and physician decisions about patient care.¹¹ When a healthcare provider admits a Medicare recipient to the hospital as an inpatient, the provider faces the punitive stick of payment denial. By using “observational” status for the same patient, however, both the physician and the hospital are in an advantageous position to receive the RAC’s reimbursement carrot.

This note explores the inequities associated with the growing use of observational status and critiques some of the court decisions that addressed this issue.

I. MEDICARE AND THE RAC

A. MEDICARE BASICS

Medicare provides health insurance to the nation’s elderly.¹² There are four “parts” to Medicare;¹³ the use of “observational status” creates issues under Parts A and B. Part A covers inpatient hospital services and various forms of institutional care.¹⁴ Part A also covers post-hospitalization care in a skilled nursing facility for up to one hundred days,¹⁵ provided that the beneficiary has been a hospital inpatient for at least three consecutive calendar days prior to discharge from the hospital.¹⁶ In contrast, Part B of Medicare pays for nonhospital medical services such as: physician services, nurse practitioner services, home healthcare, and hospital outpatient services.¹⁷ Under Part

11. *Egan, supra* note 9, at 3.

12. Medicare is codified under Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395kkk-1 (2012).

13. Medicare Parts A and B are sometimes referred to as “traditional” Medicare. Medicare recipients may opt out of traditional Medicare and instead, enter Part C; this is often referred to as “Medicare Advantage.” Medicare Advantage allows the beneficiary to enroll in an HMO as an alternative to coverage under Parts A and B. There are no reported decisions addressing use of observational status for Part C beneficiaries. The fourth component of Medicare, Part D, deals with coverage for prescription medications.

14. 42 U.S.C. § 1395d(a)(1)-(4) (2012).

15. 42 U.S.C. § 1395d(a)(2)(A), 1395x(i)(2012).

16. 42 U.S.C. § 1395x(i)(2012); 42 C.F.R. § 409.30(a)(1) (2011).

17. 42 U.S.C. §§ 1395k(a); 42 U.S.C. 1395m(a)(1)(E)(ii); 42 U.S.C. § 1395x(b)-(s)

B, the beneficiary must pay coinsurance or a copayment for these services.¹⁸ Part B does not pay for skilled nursing care, but can cover some outpatient services, such as physicians' visits, that a patient might receive during a hospital stay.¹⁹

B. LEGISLATIVE AND REGULATORY HISTORY OF THE RAC PROGRAM

Authorized by Section 306 of the MMA, the Recovery Audit Contract program ("RAC") began in 2005 as a demonstration project.²⁰ The RAC program initially focused on the states with the highest Medicare expenditures: California, Florida, and New York and later expanded to include Arizona, Massachusetts, and South Carolina.²¹ As Section 306 shows, the RAC was intended as a cost-saving measure. In that regard, it was a blistering success, with the blisters primarily inflicted on the backs of Medicare beneficiaries. During the three-year span of the demonstration program, the recovery auditors collected nearly \$1 billion. Only 12.7% of RAC overpayment determinations were appealed during that time.²² Based on these results, Congress made the program permanent via Section 302 of the Tax Relief and Health Care Act of 2006.²³ The RAC program is

(2012).

18. 42 U.S.C. § 1395cc(a)(2)(A) (2012).

19. See *What's Not Covered by Part A & Part B?*, MEDICARE.GOV, <http://www.medicare.gov/what-medicare-covers/not-covered/item-and-services-not-covered-by-part-a-and-b.html> (last visited Oct. 26, 2014).

20. See MLN MATTERS: CTRS. FOR MEDICARE & MEDICAID SERVS. (CMS) RECOVERY AUDIT CONTRACT (RAC) INITIATIVE, <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0469.pdf> (last updated Mar. 29, 2013).

21. *Id.* The MMA mandated the CMS to establish the RAC program; this was to be a three-year demonstration. Due to its success, the *Tax Relief and Healthcare Act of 2006, Section 302* was passed. This required CMS to establish a National RAC Program by 2010. *Id.*

22. See CTRS. FOR MEDICARE AND MEDICAID SERVS., THE MEDICARE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM: UPDATE TO THE EVALUATION OF THE 3-YEAR DEMONSTRATION (Jun. 2010), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/downloads/DemoAppealsUpdate61410.pdf>.

23. *Medicare Recovery Audit Contractors (RACs): Permanent Program Basics*, AM. HOSP. ASS'N., (Apr. 20, 2009), available at

presently operational in all fifty states and is expanding to Medicaid and Medicare Parts C and D.²⁴

1. GENERAL OPERATION OF THE RAC

Four companies, hired as independent contractors to the Center for Medicare and Medicaid Services (CMS), have the job of identifying and correcting improper payments under Parts A and B.²⁵ The contractors work purely on a contingency-fee basis, with fees ranging from 9-12.5% of the amount recovered.²⁶ The larger the overpayment, the greater the fee.²⁷ Given the substantial costs associated with skilled nursing care, recovery auditors have been eager to pursue the recovery of funds paid under Part A for post-hospitalization skilled care. Observational status has been the first tool out of their recovery toolbox. For

<http://www.ashrm.org/ashrm/advocacy/advisories/files/2009rac.pdf>.

Medicare and Medicaid providers and suppliers already are subject to significant claims scrutiny (e.g., Medicare Administrative Contractor ("MAC") medical reviews, Zone Program Integrity Contractor ("ZPIC") audits, routine state program integrity audits, Medicaid Integrity Contractor ("MIC") audits, and audits conducted by other state and federal agencies). The expanded RAC program creates an additional layer of auditing activity, creating increased administrative burdens for providers and suppliers in tracking and responding to records requests and appealing claim denials.

Abby Pendleton & Jessica Gustafson, *The Future of the Recovery Audit Contractor Program*, ABA HEALTH ESOURCE (Aug. 2011), available at http://www.americanbar.org/newsletter/publications/aba_health_esource_home/aba_health_law_esource_1108_pendleton.html.

24. *Medicare Recovery Audit Contractors (RACs): Permanent Program Basics*, AM. HOSP. ASS'N., (Apr. 20, 2009), available at <http://www.ashrm.org/ashrm/advocacy/advisories/files/2009rac.pdf>.

25. *Recovery Audit Program*, CTRS. FOR MEDICARE AND MEDICAID SERVS., <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/> (last updated Sep. 26, 2014).

26. *Recovery Auditing in Medicare and Medicaid for Fiscal Year 2012*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Report-To-Congress-Recovery-Auditing-in-Medicare-and-Medicaid-for-Fiscal-Year-2012_013114.pdf (last visited Jan. 10, 2015).

27. See Egan, *supra* note 9, at 2. Table 1 shows the dramatic differences in the amounts of overpayments recovered versus underpayments corrected. *Id.* See also, Evan Albright, *Medicare Reports Fraud and Waste Grew in 2013 After Years of Decline*, FORBES (Dec. 20, 2013), <http://www.forbes.com/sites/insidepatientfinance/2013/12/20/medicare-reports-fraud-and-waste-grew-in-2013-after-years-of-decline>.

example, observational status was a favorite subject for audits during the demonstration period representing 55% of all recoveries.²⁸

2. INPATIENT VERSUS OBSERVATIONAL STATUS

Part A does not define either inpatient or observational status.²⁹ The only definition is found in the CMS's Medicare Benefit Policy Manual³⁰ ("the Manual"). According to the Manual, an "inpatient" is someone who is (1) admitted to a hospital; (2) expected to occupy a bed minimally overnight; (3) in order to receive inpatient hospital services.³¹ If admitted as an inpatient, that status should remain in effect, even if the patient is discharged earlier than initially anticipated.³² Patients on observational status, on the other hand, are monitored to determine whether they should be formally admitted as inpatients.³³ Beyond that, observational status becomes more amorphous. There are no criteria detailing what observational services include. Likewise, there are no guidelines to distinguish how observational services differ substantively from inpatient services.

28. Rudy Braccili Jr, *Medicare's Recovery Audit Contractor Program*, HFMA Northern California Spring Conference, CONIFER HEALTH SOLUTIONS, INC. (Apr. 30, 2009), available at http://www.hfmanca.org/documents/2009%20Spring%20Conference%20Handouts/April_30/Revenue%20Cycle/Preparing%20for%20the%20RAC%20Attack_Rudy%20Braccili.pdf.

29. See 42 U.S.C. §§ 1395d(a), x(b), x(i) (2012).

30. See CTRS. FOR MEDICARE AND MEDICAID SERVS., *Internet Only Manuals: Medicare Benefit Policy Manual*, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>. [hereinafter POLICY MANUAL]. The Policy Manual is issued by the CMS, an agency within Department of Health and Human Services, and under the Secretary's powers to administer the Medicare program. *Id.*

31. CTRS. FOR MEDICARE AND MEDICAID SERVS., MEDICARE BENEFIT POLICY MANUAL CHAPTER 1, (Jun. 27, 2014), <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c01.pdf>. [hereinafter POLICY MANUAL CHAPTER 1].

32. CTRS. FOR MEDICARE AND MEDICAID SERVS., MEDICARE BENEFIT POLICY MANUAL CHAPTER 6, (Mar. 21, 2014), <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf>. [hereinafter POLICY MANUAL CHAPTER 6].

33. *Id.* at § 20.6.

The “two-midnights rule,”³⁴ enacted in August 2013, has done little to differentiate between circumstances where observational status is appropriate from those demanding inpatient admissions.³⁵ The rule modifies and clarifies CMS’s longstanding policy on how Medicare contractors review inpatient hospital admissions for payment purposes. It creates, in effect, a set of circumstances in which inpatient admission (and thus payment by Medicare Part A) is presumptively appropriate: (1) The physician must expect the beneficiary to require a stay that crosses at least two midnights; and (2) the physician admits the beneficiary to the hospital based upon that expectation.³⁶

A second dimension of the two-midnights rule relates to when time begins to “count” toward the two midnights. The clock begins to run when the beneficiary starts receiving services in the hospital. This includes outpatient observation services or services in an emergency department, operating room or other treatment area. In other words, the physician may consider outpatient time in determining whether the patient is likely to need treatment crossing two midnights.³⁷

34. Dep’t of Health and Human Svcs.: Ctrs. for Medicare & Medicaid Svcs., 78.160 Fed. Reg. 50, 496, 50, 506 (Aug. 19, 2013) (to be codified at 42 C.F.R. pts. 412, 413, 414, 419, 424, 482, 485, and 489).

35. The two-midnights rule does not change the overall requirement that a Medicare beneficiary must be hospitalized for three days as an inpatient for Medicare to cover the cost of subsequent nursing home care. Rather, the CMS made the two-midnights rule as a guide for physicians when determining, from the outset, whether a patient should be treated as “inpatient” or “outpatient”. *See id.*

36. *Id.*

37. *See CMS Addresses Observation Status Again... And Again, No Help for Beneficiaries*, CTR. FOR MEDICARE ADVOCACY, <http://www.medicareadvocacy.org/cms-addresses-observation-status-again-and-again-no-help-for-beneficiaries/> (last visited Oct. 19, 2014), explaining that “[U]nder the proposed rules, Medicare would presume that an individual is an inpatient if the physician documents that the patient requires *more* than two midnights in the hospital *following an inpatient admission*. The “starting point for this time-based instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which the additional hospital services will be provided.” . . . For patients whose inpatient stay was fewer than two midnights, CMS would pay for inpatient care only if the services were identified on Medicare’s inpatient-only list or “in exceptional cases such as beneficiary death or transfer.” *Id.* (emphasis in original).

At first blush, the two-midnights rule looks like a welcome change. Physicians—not auditors—make the determination of whether patients are likely to need care covering at least two midnights.³⁸ The rule offers physicians and patients a clear, easily understood benchmark—at least in theory. Implementation of the rule, however, has obscured that clear standard.

Critics of the two-midnights guideline have voiced numerous concerns. First, the treating physician's determination that the patient's care will likely encompass at least two midnights is not a binding one.³⁹ Supervisory physicians or hospital review committees can override the treating doctor's decision to make an inpatient admission.⁴⁰ Further, as of March 31, 2015, physicians' determinations under the rule will be subject to audit under the RAC program.⁴¹

An additional concern with the two-midnights rule is that the length of a patient's stay is not always reflective of the seriousness of their ailment.⁴² Some physicians have also expressed concern regarding how admission and discharge

38. *See Id.*

39. *Id.*

40. *See* 42 C.F.R. § 412.3(d)(1) (2015) (providing, in relevant part, that “[t]he expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event” in determining whether to classify a patient as inpatient or observational).

41. *See FY2015 Final Hospital Inpatient Rule Summary*, BOSTON SCIENTIFIC, 1, 1-2, http://www.bostonscientific.com/content/dam/bostonscientific/Reimbursement/PI/CRV_FY2015%20FR_IPPS_AUG%202014%20_FINAL.pdf (last visited Jan. 10, 2015). Although the utilization of RAC audits enforcing is delayed until spring, 2015, RACs are still able to “probe and educate” to guide compliance and thus hospitals are feeling the impact. *Id.* Even the American Hospital Association filed a lawsuit, arguing that the arbitrary standards documentation requirements of the two-midnights rule is a burden to hospitals. Nevertheless, CMS has not withdrawn the rule. *Id.*

42. *See News and Events: New Medicare Guidelines do not Solve Problems of ‘Observation’ Patients*, UNIV. OF WIS. SCH. OF MED. AND PUB. HEALTH (Feb. 20, 2014), <http://www.med.wisc.edu/news-events/new-medicare-guidelines-do-not-solve-problems-of-observation-patients/42874>. *See also*, Chris Edwards, *Medicare Needs to End Observation Status for Patients*, MODERN HEALTHCARE (Sep. 6, 2014), <http://www.modernhealthcare.com/article/20140906/MAGAZINE/309069975/medicare-needs-to-end-observation-status-for-patients#src=serp>.

times can easily be manipulated to prevent a patient from crossing the requisite two midnights.⁴³

If there is a general rule, it is that generality pervades all of the Manual's pronouncements on observational care, including the factors it provides for physicians' use in determining whether to classify a patient as either observational or inpatient.⁴⁴ Thus, the generality leaves ample room for auditors to second-guess physicians' decisions. Since recovery contractors and Medicare view observational care as an outpatient service, thus ineligible for payment under Part A, the two-midnights rule is nothing more than a new package on an unchanged product.

3. REAL-WORLD IMPACT

When a recovery auditor believes Medicare has overpaid for inpatient care, or has paid for inpatient care for a patient who, in the contractor's opinion, should have been treated as an outpatient, the auditor may deny the hospital's claim.⁴⁵ In turn, the hospital goes unpaid, despite having provided services to the patient.⁴⁶ Adding complexity, the contractors can audit medical records for the three previous years.⁴⁷ If a hospital has

43. See Ann M. Sheehy, et al., *Hospitalized but not Admitted: Characteristics of Patients with "Observation Status" at an Academic Medical Center*, 173 JAMA INTERNAL MED. 1991, 1997 (Nov. 25, 2013).

44. See POLICY MANUAL CHAPTER 1, *supra* note 31, stating, "the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting." *Id.*

45. See Medicare Learning Network, *The Medicare Fee-For-Service Recovery Audit Program Process*, CTRS. FOR MEDICARE AND MEDICAID SERVS. (Jan. 2013), <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Fee-For-Service-Recovery-Audit-Program-Process-Educational-Tool-ICN908524.pdf>.

46. See Patricia Barry, *Medicare: Inpatient or Outpatient? Staying in the Hospital Without Being Formally Admitted Can Cost You Thousands of Dollars*, AARP (Oct. 2012), <http://www.aarp.org/health/medicare-insurance/info-08-2012/medicare-inpatient-vs-outpatient-under-observation.html>.

47. See *The Recovery Audit Program and Medicare: The Who, What, When, Where, How, and Why?*, CTRS. FOR MEDICARE AND MEDICAID SERVS. (May 13, 2013),

billed Part A and an auditor later determines that the patient should have been on observational status, the hospital must repay what it received under Part A.⁴⁸ This is problematic for the now-unpaid hospital, but even worse for the patient whose status has been altered from inpatient to observational status. Long after the patient has returned home, she may confront an unexpected bill for their observational stay.

Under the new rules, the hospital may submit the patient's bill for payment under Part B; however, Part B does not pay for hospital services.⁴⁹ Hospital services include, but are not limited to, the costs associated with the room and services provided by the hospital.⁵⁰ Thus, if the hospital receives any reimbursement under Part B, that reimbursement will be, at best, limited to items such as physician services provided during the patient's time in the hospital.⁵¹ The gap between Parts A and B leaves the patient with financial responsibility to the hospital plus any co-insurance owed under Part B.⁵²

Patients who enter skilled nursing facilities following observation face an additional financial burden. Part A pays for skilled nursing care only if the patient spends three consecutive days in the hospital as an inpatient prior to entering the skilled nursing facility.⁵³ Since observational patients are not considered inpatients, the time they spend at the hospital does not count toward the three-day requirement.⁵⁴ As a result,

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/The-Recovery-Audit-Program-and-Medicare-Slides-051313.pdf>.

48. *Id.*

49. See CMS' Proposed Rules on Observation Status Would Not Help Beneficiaries, CTR. FOR MEDICARE ADVOCACY, <http://www.medicareadvocacy.org/cms-proposed-rules-on-observation-status-would-not-help-beneficiaries/> (last visited Oct. 19, 2014).

50. See Barry, *supra* note 46.

51. See *Your Medicare Coverage: Is My Test, Item, or Service Covered?*, MEDICARE.GOV, <http://www.medicare.gov/coverage/outpatient-hospital-services.html>.

52. See Barry, *supra* note 46.

53. *Id.*

54. *Id.*

patients must bear the personal financial responsibility for the significant costs associated with skilled nursing care. This observational status “double whammy” (no hospital coverage and no skilled nursing care coverage either) has given rise to two court challenges.⁵⁵ These cases, in turn, have yielded two deplorable opinions for the rights of Medicare patients.

II. CHALLENGES TO OBSERVATIONAL STATUS

A. CASES

*Estate of Landers v. Leavitt*⁵⁶ and *Bagnall v. Sebelius*,⁵⁷ both considered the CMS’s definitions relevant to observational status, as well as the manner in which observational status is applied.⁵⁸ The plaintiffs in both cases were Medicare beneficiaries or representatives of the estates of deceased beneficiaries⁵⁹ who challenged the administrative determinations upholding the denial of their Part A claims for post-hospital care at skilled nursing facilities.⁶⁰

In *Landers*, three beneficiaries, Marion Landers, Marion Dixon, and Muriel Grigley, received hospital care for at least three days, followed by care at a skilled nursing facility.⁶¹ However, because each beneficiary spent at least part of their

55. *Id.*

56. *Estate of Landers v. Leavitt*, 545 F.3d 98, 102-104 (2d Cir. 2008); 42 U.S.C. § 1395d(a)(2) (2000) (states that Medicare will cover “[Post-hospital extended care services for up to 100 days during any spell of illness” but only if services are provided “after transfer from a hospital in which [the Medicare beneficiary] was an inpatient for not less than 3 consecutive days before his discharge.”).

57. *Bagnall v. Sebelius*, 2013 WL 5346659 (D. Conn. Sept. 23, 2013), *appeal docketed*, No.13-4179 (2d Cir. Feb. 20, 2014). *Bagnall* is currently on appeal to the Second Circuit on the limited issue of whether the plaintiffs were provided with effective notice and access to review procedures when placed on observation status.

58. *Landers*, 545 F.3d at 103; *Bagnall*, 2013 WL 5346659 at *4.

59. *Id.*

60. Lee Barrows, one of the *Bagnall* plaintiffs, commented publicly about the harm that she and her family suffered due to the unfair application of observational status. *Observation Status Bagnall & Sebelius*, CTR. FOR MEDICARE ADVOCACY, <http://www.medicareadvocacy.org/medicare-info/observation-status/#video> (last visited Oct. 27, 2014).

61. *Landers*, 545 F.3d at 103.

stay on observational status, each was denied reimbursement under Part A for their nursing home care.⁶² In a class action law suit, the plaintiffs challenged the CMS's interpretation of "inpatient" and "qualifying stay,"⁶³ arguing that the misinterpretation of these terms resulted in the denial of coverage under Medicare Part A.⁶⁴ Nevertheless, the U.S. District Court for Connecticut as well as the Second Circuit Court of Appeals found for the CMS and upheld the policy manual's interpretation.⁶⁵

In *Bagnall*, fourteen Medicare beneficiaries, or representatives of their estates, stayed for periods ranging from three to seven days — seven of whom moved to intervene in the this action. Although the length of each plaintiff's stay in the hospital was for at least three consecutive days, each plaintiff was placed on observational status for the entire duration.⁶⁶ Those admitted as inpatients had their status changed retroactively from inpatient to observational.⁶⁷ As a result, each plaintiff's claim for skilled nursing care under Part A was likewise denied.⁶⁸

The plaintiffs in *Bagnall* argued that dramatic increases in the use of observational status resulted from misapplication of 42 C.F.R. § 414.5.⁶⁹ In addition, some of the *Bagnall* plaintiffs

62. *Id.* at 104. A Medicare beneficiary was not an inpatient within the meaning of 42 U.S.C.S. § 1395x(i) unless he or she had been formally admitted to a hospital. *Id.*

63. 42 U.S.C. § 1395x(i) (2014); 42 CFR § 409.30(a)(1) (2007).

64. *Landers*, 545 F.3d at 104.

65. *Id.* at 102. On appeal, the Second Circuit resolved the issue of what level of deference should be given to the CMS's interpretation, holding *Chevron* deference inappropriate. *Id.* at 107. The CMS rule was not a violation of equal protection rights because the interpretation did not concern a suspect class and was "rationally related to a legitimate government interest." *Id.* at 112 (quoting *Kraham v. Lippman*, 478 F.3d 502, 506 (2d Cir. 2007)) (internal quotation marks omitted). In addition, the court found that the district judge did not err in declining to consider evidence outside the administrative record. *Id.* at 113–14.

66. *Bagnall*, 2013 WL 5346659 at *4.

67. *Id.*

68. *See Id.*

69. *See Zhanlian Feng, et al., Sharp Rise in Medicare Enrollees Being Held in Hospitals for Observation Raises Concerns about Causes and Consequences*, 31 HEALTH AFFAIRS, 1251, 1254 (2012) (noting that "the ratio of observation stays to inpatient

claimed unfairness because they were unaware, until months following their hospital visit, that their status was observational.⁷⁰ Ultimately, and unfortunately, the *Bagnall* decision relied heavily on *Landers*.⁷¹

Together, these cases affirm the CMS's self-serving view of observational status. In that bleak view, saving money reigns supreme to the detriment of logic, efficiency, and compassion.

B. THE COURTS' VIEWS

1. INPATIENTS ARE INPATIENTS BECAUSE THEY ARE INPATIENTS

In *Landers*, the Second Circuit used circuitous reasoning to uphold the Manual's definition of inpatient. According to the Manual, an inpatient is defined as a person who has been formally admitted to a hospital.⁷² The court found the Manual's definition was entitled to significant judicial deference because the definition represented the CMS's use of its expertise to interpret statutory meaning.⁷³ Thus, according to the circuitous reasoning of both the *Landers* and *Bagnall* courts, an inpatient is an inpatient because she is an inpatient—and that explanation is true because the Manual says so.

Neither decision explored what constitutes an admission, let alone a formal admission. Similarly, neither decision considered how, in practical terms, being in a hospital under

admissions increased 34 percent, from an average of 86.9 observation stay events per 1,000 inpatient admissions per month in 2007 to 116.6 in 2009. Medicare beneficiaries were increasingly subjected to hospital observation care and treated as outpatients instead of inpatients, which can expose them to greater out-of-pocket expenses if they are eventually admitted to skilled nursing facilities.”)

70. See 42 C.F.R. § 414.5 (2013), (codifying the “double whammy” that a hospital must refund monies that it received under Part A if they “improperly” classify a patient as inpatient rather than observational status. The plaintiffs challenged only how § 414.5 was applied, and not the terms of the section.).

71. *Bagnall*, 2013 WL 5346659 at *4.

72. See POLICY MANUAL CHAPTER 1, *supra* note 31, at §§ 1, 10.

73. *Landers*, 545 F.3d at 111. The court discusses how, “The *Skidmore* factors lead [the Court] to regard the statutory interpretation set forth in CMS's policy manual as persuasive.”) (citing *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944)).

observational status differs from being an inpatient.⁷⁴ Perhaps the judges' reticence is derived from a concern that even the slightest interpretative turbulence could destroy the flimsy "inpatient is an inpatient is an inpatient" reasoning.

2. FORM TRUMPS SUBSTANCE IN DETERMINING WHETHER A PATIENT'S STATUS IS INPATIENT OR OBSERVATIONAL

Inpatients and observational patients alike receive services such as a bed, food, nursing care, and other diagnostic services.⁷⁵ However, according to the Manual, these services fall under the auspices of inpatient services.⁷⁶ The *Landers* and *Bagnall* plaintiffs argued that a patient who receives inpatient services should be classified as an inpatient.⁷⁷ This logical trail takes a detour to the land of RAC doublespeak. Based on "an inpatient is an inpatient is an inpatient," both the *Landers* and the *Bagnall* courts held that inpatient services are not inpatient services unless they are furnished to an inpatient.⁷⁸ Thus, two patients might share a room, be attended by the same nurse, and receive their meals from the same service cart. If the first patient is labeled an inpatient, then the services she receives are inpatient services. On the other hand, if the second patient is on observational status, then the services she receives—even though identical to inpatient services—fall in some other category. In this victory of form over substance, administrative labels and medical billing codes take preeminence over patient care.

By endorsing this prioritization of form over substance, *Landers* and *Bagnall* open the door to abuses of recovery

74. *Id.*

75. See POLICY MANUAL CHAPTER 1, *supra* note 31, at §§ 10, 20, 50.

76. *Id.* at § 1.

77. *Landers*, 545 F.3d at 109 (stating that CMS did not consider admission to an emergency room prior to inpatient care to be "observation time" because admission alone would not "identify the degree of severity of a particular patient's condition during that time"); *Bagnall*, 2013 WL 5346659 at *3 (defining "inpatient" and "observational status," but not clarifying the distinction between two terms).

78. *Id.*

contractors' power. If observational status can be applied to some patients, then why can it not to others? Given CMS's focus on protecting the Medicare Trust Fund and the recovery auditors' unchecked financial incentive to find overpayments (perhaps even where none legitimately exist), it is not difficult to envision further erosion of "admitted" in favor of "on observation." Some beneficiaries have reported observational hospital stays of up to fourteen days. Will this save money for Part A? Perhaps, but the expense has to be absorbed elsewhere (such as by Medicaid). Shifting financial responsibility between two related governmental programs, at the expense of hospitals, patients, and taxpayers, does not offer meaningful reform, cost savings, or accountability.

3. NOTICE, COMMENT, AND CONTORTIONS

The *Landers* and *Bagnall* courts performed contortions worthy of Cirque de Soleil to avoid the plaintiffs' claims that the growing use of observational status should have been subject to notice and comment provisions. Both judicial decisions found the interpretative nature of the definitions exempted those definitions from notice and comment requirements.⁷⁹ The *Bagnall* court went on to reject the plaintiffs' argument that the increasing use of observational care was, in effect, an agency rule change that required a public notice and comment period.⁸⁰

79. See *Bagnall*, 2013 WL 5346659, at *15 (citing *St. Mary's Hosp. of Troy v. Blue Cross & Blue Shield Ass'n*, 788 F.2d 888, 891 (2d Cir. 1986) ('[m]annual rules have consistently been held to be interpretive rules,' and thus exempt from the notice and comment requirements'). The Secretary published the statements regarding observation status in the Policy Manual, rather than the Code of Federal Regulations, and as a result, several courts have found Policy Manual provisions to be interpretive rather than legislative rules. *Id.* The Secretary published the statements regarding observation status in the Policy Manual, rather than the Code of Federal Regulations, and as a result, several courts have found Policy Manual provisions to be interpretive rather than legislative rules. *Bagnall*, 2013 WL 5346659, at *15. (citing *St. Mary's Hosp. of Troy v. Blue Cross & Blue Shield Ass'n/Blue Cross & Blue Shield of Greater N.Y.*, 788 F.2d 888, 891 (2d Cir. 1986) ('[m]annual rules have consistently been held to be interpretive rules,' and thus exempt from the notice and comment requirements').

80. *Bagnall*, 2013 WL 5346659, at *15.

The Secretary of Health and Human Services (“the Secretary”), the *Bagnall* court found, was not responsible for the growing use of observational status.⁸¹ Since the Secretary had not instituted any changes, notice and comment was not required.⁸² Further, had notice and comment been necessary, such requirements would have been satisfied by the CMS’s 2005 unilateral reconsideration of whether to include the time patients spent in observational status toward the three-day hospital stay requirement.⁸³

4. PUBLICATION AND OBFUSCATION

Another claim in *Bagnall* was that the changes regarding observational status should have been published in the Federal Register.⁸⁴ The court held that the publication requirement was not needed for several reasons. First, the publication requirement only applied to matters which, if not published, would adversely affect a member of the public.⁸⁵ The court found nothing in the complaint to suggest that the physicians’ choice to admit the plaintiffs or place them on observational status would have been impacted by publication.⁸⁶ Further, the publication in CMS’s 2005 discussion in the Federal Register — that considered using observational status time toward the

81. The Court pointed to hospitals as the responsible parties for using observational status—averting its eyes from the truth that recovery auditors—functionaries of CMS, an agency under the Secretary’s power, quite effectively use the threat of declined Part A reimbursements to hold hospitals financially hostage. Even though the recovery auditors may have several degrees of separation from the Secretary, they are nonetheless her agents, and it is they who have established the circumstances under which observational status is the logical choice for hospitals that want to remain financially viable.

82. *Bagnall*, 2013 WL 5346659, at *15.

83. *Id.* at *17. The CMS ultimately declined to change its interpretation. *Id.* at *10. Congress, it reasoned, established the “qualifying stay” requirement to limit Medicare’s costs associated with the skilled nursing benefit. *Id.* Changing its interpretation of observational status as impacting on a qualifying stay would frustrate Congressional intent. *Id.*

84. *Id.*

85. *Id.* (citing *State of N.Y. v. Lyng*, 829 F.2d 346, 354 (2d Cir.1987)).

86. *Id.* at *17.

three-day requirement⁸⁷ — would have been enough to satisfy notice and comment requirements.⁸⁸ For similar reasons, the *Bagnall* court rejected the plaintiffs' claim that as agency interpretations of general applicability, the rules regarding observational status should have been published in the Federal Register.⁸⁹

5. DUE PROCESS—PERMISSIVE IS THE NEW MANDATORY

a. NO PROPERTY INTEREST

The *Bagnall* court found no protected property interest under the Due Process Clause of the Fifth Amendment.⁹⁰ The court reasoned that the Manual made clear formal admission is not mandatory under any circumstances;⁹¹ there are no fixed, objective eligibility criteria, and the twenty-four hour "benchmark" is phrased in permissive terms.⁹² Thus, the court concluded, the decision to admit remains within the physician's discretion, as provided by the Manual.⁹³ As discretionary, the plaintiffs had no actionable interest.

87. Although published in the Federal Register, the re-visitation of observational status does not appear to have been done in the context of public notice and an opportunity to comment. The Court refers to CMS' 2005 "discussion" in the Federal Register as addressing the concept of observation services and the decision to classify such services as outpatient services..

88. *Bagnall*, 2013 WL 5346659, at *10, *13, *17.

89. The *Bagnall* court, relying on the *Landers*' summary of the CMS's 2005 discussion, makes clear that both the decision to classify certain services as outpatient services as well as the concept of observation services have been published in the Federal Register. See, e.g., 71 Fed. Reg. 67960, 68151 (Nov. 24, 2006) ("[A]ll hospital observation services, regardless of the duration of the observation care, that are medically reasonable and necessary are covered by Medicare, and hospitals receive either packaged or separate OPPTS [outpatient prospective payment system] payment for these covered observation services."); see also, 70 Fed. Reg. 29070, 29098–100 (May 19, 2005) (discussing "observation status," defining it, citing relevant Policy Manual provisions, and stating that it is covered "under the outpatient prospective payment system," i.e., Part B rather than Part A). *Bagnall*, 2013 WL 5346659, at *7.

90. *Bagnall*, 2013 WL 5346659, at 82-83.

91. *Id.*

92. *Id.* at *22.

93. *Id.* at *23.

b. NO NEED FOR NOTICE

On procedural grounds, the *Bagnall* court rejected the plaintiffs' claim that the Medicare statute and Fifth Amendment Due Process Clause demanded they receive written notification of (1) placement on observational status, (2) the implications of observational status for their Medicare coverage, and (3) the right to expedited review to challenge the observational classification.⁹⁴ The plaintiffs received only a Medicare Summary Notice, which did not contain the words "observational status" or "observation services" and did not explain why the plaintiffs' hospital claims were being submitted under Part B rather than Part A.⁹⁵ From the court's perspective, the alleged inadequacy of the notices did not cause the plaintiffs to suffer an "injury in fact" that was "fairly traceable to the challenged action of the defendant."⁹⁶ The absence of such a causal link left the plaintiffs without standing to challenge the content of the notices.⁹⁷ Likewise, the court found that the government was not required to provide expedited notice to beneficiaries placed on observational status.⁹⁸ As before, the court shielded the Secretary, the CMS, and the recovery auditors from any responsibility to notify patients.⁹⁹ Additionally, as before, the court foisted responsibility onto the care providers: the physicians and the hospitals.¹⁰⁰ Because there was no allegation of any alleged failures in notice attributable to the Secretary, the court dismissed the due process claim.¹⁰¹

6. AUDITORS IN COMMAND

The *Bagnall* court also rejected the claim that observational

94. *Id.* at *18.

95. *Id.*

96. *Id.* at *18 (citing *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560, (1992)).

97. *Id.*

98. *Id.* at *19.

99. *Id.*

100. See 42 C.F.R. § 405.1205(b)(1) (2007).

101. *Bagnall*, 2013 WL 5346659, at *19.

status interferes with the practice of medicine, in violation of 42 U.S.C. § 1395,¹⁰² even though the court admitted that medical decisions could well be influenced by physicians' awareness that Part A payment might be denied, while at least some services would be reimbursed under Part B.¹⁰³ In this instance, the court took refuge behind the robes of the Second Circuit, which previously held such influence as tangential, and thus, not in violation of Section 1395.¹⁰⁴ Similarly tangential, in the view of the court, were the policies of hospital utilization review committees to reverse physician decisions to formally admit Medicare beneficiaries and retroactively place beneficiaries on observational status.¹⁰⁵

C. GHOSTS OF OBSERVATION PAST, PRESENT, AND FUTURE

Landers and *Bagnall*, both decided by the Second Circuit, have stayed in the safety of shallow water regarding the issues of observational status. However, these opinions do not likely reflect a universal judicial view on observational status and its proper scope. As members of the public become more informed, other circuits will have the opportunity to consider the issues in greater depth. Moreover, other courts will also have the opportunity to address new dimensions of the observational status issue (such as the two-midnights rule), and the reasons underlying the disproportionate number of observational stays in comparison to inpatient admissions. Further, courts outside the Second Circuit will have a better ability to recognize that observational status does not generate spontaneously, but rather it is a product of the RAC. Other courts might likewise see the nexus between the Secretary, the CMS, and the recovery auditors in order to prevent the Secretary from diverting attention away from these linkages. Beneficiaries, hospitals, and Medicare administrators will all benefit from judicial opinions

102. *Id.*

103. *Id.* at 38-45.

104. *Id.*

105. *Id.* at *24.

that bring clarity to the rather confused situation that is currently presented.

III. LEGISLATIVE, REGULATORY, AND GRASSROOTS REFORM

Legislative and regulatory reforms may offer the opportunity to bring greater transparency to determinations of whether Medicare patients should be classified as observational versus inpatient. Critical assessment of the role of the RAC program and its auditors should be a focal point of future enactments. Presently, however, there are few immediately available remedies for the inappropriate use of observational status on either the legislative or regulatory fronts.¹⁰⁶ Moreover, there has been virtually no legislative consideration of whether the RAC program has gone beyond the scope of its powers.

The most viable legislative proposal on topic has been H.R. 1179: Improving Access to Medicare Coverage Act of 2013.¹⁰⁷ This bill, introduced March 14, 2013, by Representative Joe Courtney (D-Conn.), would have counted all the time that a Medicare patient spends in the hospital towards the three-day inpatient requirement.¹⁰⁸ Even though Representative Courtney had bipartisan support and some 158 co-sponsors, the bill went to committee with a dismal 0% chance of being enacted.¹⁰⁹ This prediction became truth. The bill died after referral to the House Subcommittee on Health.¹¹⁰ A similar fate met the companion bill in the Senate, S.569 - Improving Access to Medicare

106. With the exceptions of the state statutes discussed in Part B of this section.

107. See Improving Access to Medicare Coverage Act of 2013, H.R. 1179 – *Improving Access to Medicare Coverage Act of 2013*, CONGRESS.GOV, <http://www.congress.gov/bill/113th-congress-house-bill/1179/text>.

108. H.R. 1179, 113th Cong. (2013) (To amend title XVIII of the Social Security Act to count a period of receipt of outpatient observation services in a hospital toward satisfying the 3-day inpatient hospital requirement for coverage of skilled nursing facility services under Medicare.). See *Three Observation Status Bills Have Been Introduced; Only Congressman Courtney's Has Immediate Promise*, CTR. FOR MEDICARE ADVOCACY, <http://www.medicareadvocacy.org/three-observation-status-bills-have-been-introduced-only-congressman-courtneys-has-immediate-promise/> (last visited Oct. 15, 2014).

109. *Id.*

110. *Id.*

Coverage Act of 2013, which was sponsored by Senator Sherrod Brown and twenty-seven co-sponsors.¹¹¹ The bill died after two readings before the Senate Committee on Finance.¹¹²

By quickly dispatching both the Senate and House bills to committee, where they were quickly set aside, Congress has demonstrated that it is not yet sufficiently mobilized to protect the interests of Medicare recipients.¹¹³ More fundamentally, none of the proposed laws mentioned the need for checks on the power of the RAC program. This suggests that members of Congress have not fully traced the problem with observational status back to its source: the CMS and its RAC program.

Even though the Affordable Care Act (ACA) does not directly address the issue of observational status, the ACA and observational status are philosophical comrades. The ACA pretextually speaks about improving the quality of patient care, but many of its provisions, including those impacting Medicare patients, simultaneously (and more vigorously) focus on cost savings. While it is possible for high-quality care to coincide with cost efficiency, the more likely scenario is for quality care and cost efficiency to pull in opposite directions. Within this dynamic, patients and physicians have competing interests. While patients want good care, physicians want the financial rewards that the ACA promises for cost-effective performance. Likewise, physicians are loathing to feel the financial bite that the ACA inflicts on providers deemed inefficient. Thus, even though patients' and physicians' interests should be allied on the observational status issue, the ACA drives a divisive wedge between these two groups.

Alienation of physicians from patients allows the RAC program to operate virtually unchecked. An alliance of physicians and patients, in which both groups demand greater accountability from CMS and its RAC contractors, offers one

111. *Id.*

112. *Id.*

113. *See generally* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended at 42 U.S.C. § 18001 (Supp. 2010)).

option for meaningful reform. However, widespread physician support for changes in the use of observational care is unlikely without revision of the ACA. That law's system of rewards to physicians who prioritize the "bottom line" and punishments for those who prioritize patients' needs is in derogation of physicians' professional responsibilities. Yet for most, practicing within the strictures of the ACA and CMS requirements is the route to payment. Advocacy for patients leads in the opposite direction of payday.

Medicare beneficiaries and public interest organizations are therefore on the front lines of advocacy for change in the application of observational status.¹¹⁴ Their efforts have yielded some positive results, but much more remains to be done.

While state legislatures cannot control the operation of the RAC program, they can approach reform of observational care from a different perspective. Regulation of hospitals is typically a matter of state law; accordingly, state legislatures can control the use of observational status via laws and regulations that govern the operation of hospitals. To date, Connecticut, Maryland, New York, and Pennsylvania have enacted laws requiring hospitals to notify patients placed on observational status.¹¹⁵ In Massachusetts, an observational status statute is

114. *Observation Status & Bagnall v. Sebelius*, CTR. FOR MEDICARE ADVOCACY, (Nov. 7, 2014) <http://www.medicareadvocacy.org/medicare-info/observation-status/> (The Center for Medicare Advocacy is the preeminent non-profit.). CTR FOR MEDICARE ADVOCACY, <http://www.medicareadvocacy.org> (The Medicare Rights Center is another organizational, national in scope.). MEDICARE RIGHTS CTR. <http://www.medicarerights.org>. In addition, the American Association of Retired Persons (AARP), has an advocacy section. AARP, <http://action.aarp.org>. There are also state-based organizations such as the Wisconsin Senior Medicare Patrol, a division of the Coalition of Wisconsin Aging Groups. COAL. OF WIS. AGING GRP., <http://cwagwisconsin.org/elder-law-center/wisconsin-senior-medicare-patrol-smp/>.

115. See Susan Jaffe, *Medicare covers less when a hospital stay is an observation, not an admission*, THE WASH. POST, Sep. 2014, http://www.washingtonpost.com/national/health-science/medicare-covers-less-when-a-hospital-stay-is-an-observation-not-an-admission/2014/09/08/9c609544-2d5c-11e4-9b98-848790384093_story.html. Maryland and New York have passed laws compelling hospitals to tell all patients when they are under observation care and; the Maryland notice warns, "that may increase the patients' out-of-pocket costs for their stay." *Observation Status- Notice and Appeal*, CTR. FOR MEDICARE

currently under consideration.¹¹⁶

There is a vast gulf between notifying a patient that they are on observational status and preventing denial of Part A claims for post-hospital care. The notification statutes enacted represent an initial and tentative step toward protecting patients' interests. These statutes, however, leave much to be desired. For example, both statutes require hospitals to provide patients notice that they have been placed on observational status within twenty-four hours of the decision to observe rather than admit.¹¹⁷ Whether this provision will effectively protect patients remains to be seen. A patient who is sufficiently ill to warrant a hospital bed may not understand the significance of the notification. Further, a patient may be concerned that pursuing their rights while in the hospital may compromise the quality of care that they receive.

The corruption of observational status into a cost-saving device is a tale deeply rooted in federal regulations. Since the source of the problem is regulatory power run amok, the most

ADVOCACY, <http://www.medicareadvocacy.org/observation-status-notice-and-appeal/>. In June 2014, Connecticut Governor Dannel P. Malloy signed into law a requirement that hospitals must give both oral and written notice to patients placed on observation status for twenty-four hours or more; this is similar to laws in New York and Maryland. *Id.* See also, Patient Notice of Observational Services, N.Y. Pub. Health L. § 2805-W (effective January 19, 2014). (Notification provisions substantially similar to those of Connecticut statute which provides that notice must also explain the implications of observational status for the patient's Medicare, Medicaid or private insurance coverage for hospital services, including medications and pharmaceutical supplies, or home or community-based care, or care at a skilled nursing facility upon the patient's discharge, and that the patient should contact their insurer and or the state Office of the Healthcare Advocate for more information). Pennsylvania's governor signed Act 169 of 2014 into law in December 2104. That enactment requires hospitals to provide both verbal and written notice to patients who have not been formally admitted to the hospital if they have been at the hospital for more than 23 consecutive hours. HB 1907 (Pa. 2013).

116. S. 542, 188th Cong. (Mass. 2014). The proposed bill provides that, after due consideration of the patient's initial presenting symptoms and based on the medical judgment of the physician, the patient shall be classified as receiving observation services. If the physician anticipates greater than 24 hours for a diagnostic assessment, the patient must be deemed as an inpatient; however, that the physician may authorize observation status for services provided beyond 24 hours. See <https://malegislature.gov/Bills/188/Senate/S542>.

117. N.Y. Public Health Law § 2805-w (McKinney 2014); H.R. 5535, 198th G.A., Reg Sess. (Pa 2014).

meaningful solution will be one that both reins in the power of RAC contractors and redirects it toward patient care. It is unlikely that the CMS will voluntarily curtail auditors' broad powers under the RAC program. Similar to proposed congressional and state legislative reforms, the CMS's limited effort at regulatory change has focused on the hospital, rather than on the RAC.¹¹⁸ For example, the two-midnights rule¹¹⁹ has generated a great deal of controversy and only served to increase confusion about the line between inpatient and outpatient status. This begs the fundamental question: Why should non-physician auditors call the shots about which patients are admitted and how long patients spend in the hospital?

If meaningful reform is to occur, members of Congress may need a refresher in a foundational principle of administrative law: The Department of Health and Human Services, its sub-agency, the CMS, and its contractors through the RAC, derive power from one source alone—legislation enacted by Congress.¹²⁰ If Congress tiptoes around the observational status issue, ignores the RAC, and continues to burden hospitals with policing the two-midnights rule, then Medicare beneficiaries will continue to suffer the burden of unpaid expenses resulting from observational hospital stays.

118. Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction; Part II, 79 Fed. Reg. 27106, 27106, 27108-27157 (May 12, 2014) (codified in 42 CFR Parts 413, 416, 440 et al.).

119. For further discussion of the two midnights rule, see *supra* Part II.B.2.

120. *Avenal Power Center LLC v. U.S. E.P.A.*, 787 F.Supp.2d 1, 4 (D.D.C. 2010). The power of administrators of regulatory agencies is derived from Congress' statutory enactments and not from the discretionary regulatory pronouncements drafted for their assistance and convenience. See *North Carolina v. EPA*, 531 F.3d 896, 922 (D.C.Cir.2008) (citing *Michigan v. EPA*, 268 F.3d 1075, 1081 (D.C. Cir. 2001)); See *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43, 104 S.Ct. 2778 (1984) ("If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress."); *Ernst & Ernst v. Hochfelder*, 425 U.S. 185, 213-14, 96 S.Ct. 1375 (1976) ("The rulemaking power granted to an administrative agency charged with the administration of a federal statute is not the power to make law. Rather it is the power to adopt regulations to carry into effect the will of Congress as expressed by the statute." (internal quotations omitted)).

It is wrong for non-physician auditors to manipulate physicians like marionettes. Additionally, it is wrong to leave vulnerable Medicare patients in the financial lurch. These two impacted groups—providers and patients—could join forces to obtain meaningful reform. Such an alliance would make sense, in that both physicians and providers suffer from the arbitrarily exercised power of RAC program audits. But because the ACA pits physicians against patients in the interest of cost savings, an alliance of physicians and patients is unlikely to arise.¹²¹

Congress could take action to modulate and refine the powers of RAC contractors. That, of course, is not likely to happen until a critical mass of individual representatives are sufficiently educated about and mobilized to reform the RAC program. Congress is unlikely to act, however, unless and until it hears an outcry from their constituents. The onus, then, must rest on individual activism. This might include:

- Peer and community support for Medicare recipients who have suffered financial harm due to the misuse of observational status, focusing not only on whether the provider should have admitted the patient, but also going behind the decision rendered and considering whether the RAC auditor or ACA cost-savings measures contributed to the decision;
- Involvement in political campaigns on behalf of candidates who support the rights of Medicare patients and the accountability of RAC contractors;
- Lobbying of legislators, seeking both patient protections and regulation/accountability of the RAC program;
- Building of alliances, where possible, between patients and physicians, against the mutually-felt threat of RAC auditors; or

121. Jason Fodeman, *The New Health Law: Bad for Doctors, Awful for Patients*, THE GALEN INSTITUTE 1 (Apr. 2011), http://www.galen.org/assets/NewHealthLaw_BadForDoctors_AwfulForPatients.pdf.

- Financial and volunteer support for nonprofit Medicare interest and advocacy groups, such as the Center for Medicare Advocacy and the American Association for Retired Persons (AARP).

CONCLUSION

Although unnoticed at the time of its creation, the strictures of the RAC program and the resulting misuse of observational status have now come into view, at least for Medicare beneficiaries and their medical care providers. In response to public concern, members of Congress, interest groups, and members of the public have raised concerns about hospitals' misuse of observation stays. It is encouraging that the issue of observational status has finally garnered attention and it is simultaneously disconcerting that legislators appear distracted from an important point: Hospitals are not the prime movers behind the use of observational status. Instead, hospitals' complicity in the misuse of observational stays represents a defensive reaction to the financial pressures exerted by recovery contractors.

A more incisive, thoughtful, and meaningful method of reform is one that targets the source of the problem: the individual employees of recovery contractors who are medically untrained yet in a position to second-guess qualified medical decisions. These employees—to the patient, the physician, and the health care facility—are anonymous and invisible. Likewise, the patients are reduced to their medical histories, without the humanizing element of personal contact. The decisions by these individuals are from office buildings—geographically distant from the health care facility and potentially three years removed from the time of the patient's treatment.

If the relationship described above was a description of how physicians make diagnoses, the general public would be shocked and appalled. We expect, and prevailing standards of care require, physicians to make medical decisions based not only on their medical knowledge, skill and experience, but also

in the best interest of the individual patient; physicians should not be distracted nor motivated by competing interests. Not surprisingly, there is no simple "one size fits all" diagnostic protocol.

Just as physicians must take a holistic approach to a patient's needs, recovery auditors too should be required to look beyond medical records in assessing whether admission as an inpatient was justified. Further, contractors making determinations should have the same credentials as the professionals whose decisions are being questioned. In short, they should be physicians.

Imposition of strict requirements about auditors' personnel and methods would increase the time and cost associated with audits. If audits were costly and time-intensive, RACs would soon learn that audits should be limited to situations where abuse or errors are egregious. Removing the generalized threat of audits would allow physicians and hospitals to return to the business of caring for sick people, rather than practicing with an eye on the bottom line.

A slightly different approach to reform would focus on how contractors are compensated. The current system, under which contractors earn more based on collection of long-paid Part A benefits, demands examination and reform. If contractors are rewarded based on amounts collected, they have a very obvious incentive to reject every inpatient admission and recast it as a stay that should have been observational in nature.

The perverse financial incentives, coupled with the lack of accountability and expertise discussed above, would be rich ground for congressional exploration. To date, however, legislative efforts have focused on the hospitals, rather than the RAC auditors. Until the seemingly overarching powers, or the auditors, are curtailed, the misuse of observational status will continue, simply adapting to subvert any hospital-based measures. On the other hand, if individual Medicare beneficiaries, their families, and health care providers, join together, this could generate a bolus of support for change; a

unified voice that Congress would be unable to ignore. Before this can happen, however, physicians and hospitals need to reassess their missions and priorities. If indeed the goal is to serve the needs of patients, they will join with Medicare beneficiaries in supporting reform rather than serving as conduits for the unjust practices of recovery contractors.