

## HOSPITAL CLASSIFICATION TUG-OF-WAR: THE BATTLE BETWEEN PATIENTS AND MEDICARE OVER POST-HOSPITAL CARE

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### I. INTRODUCTION

Hospitals and physicians currently find themselves caught in the middle of what the American Hospital Association (“AHA”) refers to as a “tug-of-war.”<sup>1</sup> The “tugging” represents a conflict between patients, who need Medicare to cover post-hospital care, and the Department of Health and Human Services (“HHS”), WHO have put in place regulations controlling the ability of Medicare beneficiaries to receive post-hospital care.<sup>2</sup> The crux of the conflict, the “rope,” focuses on the classification of patients as either inpatient or as on observation status, an outpatient classification. These classifications enormously impact Medicare coverage for beneficiaries needing post-hospital services such as rehabilitation or skilled nursing care. Medicare beneficiaries will find that Medicare does not cover post-hospital services if the hospitals classify beneficiaries as on observation status instead of formally admitting them to the hospital. Because of the outpatient classification, beneficiaries may not meet a minimum three-day inpatient requirement and must pay out-of-pocket expenses for their post-hospital care, such as for care in a skilled nursing facility.

On one side of the rope are patients, like Sarah Mulcahy.<sup>3</sup> Ms. Mulcahy was taken to the emergency room where she was placed on observation status

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1. Brief of the Am. Hosp. Ass’n as Amicus Curiae in Support of Neither Party at 1, *Bagnall v. Sebelius*, No. 3:11CV1703 (MPS), 2012 WL 11875412 (D. Conn. Sept. 23, 2013) [hereinafter *Am. Hosp. Ass’n Brief*].

2. *Id.*

3. *Bagnall v. Sebelius*, No. 3:11CV1703 (MPS), 2013 WL 5346659, at \*4 (D. Conn. Sept. 23, 2013).

2014] *BLEVINS: HOSPITAL CLASSIFICATION TUG-OF-WAR* 157

for severe pain, urinary incontinence, and nausea.<sup>4</sup> She remained on observation status for her entire hospitalization, from June 24 to June 29, 2010.<sup>5</sup> During this time, the hospital administered intravenous (“IV”) medications, an incentive spirometry to assist lung function, venodynes to prevent deep vein thrombosis, X-rays, and a Computerized Tomography (“CT scan”) of her head.<sup>6</sup> Several weeks after her discharge, she received a Medicare Summary Notice informing her that she was responsible for approximately \$335 in Part B coinsurance payments for outpatient services and, because she was never formally admitted, that she did not satisfy a three-day requirement to receive Medicare coverage for a subsequent stay in a skilled nursing facility.<sup>7</sup> Her skilled nursing care ran from June 29 to October 7, for which she had to pay out-of-pocket expenses of about \$30,000.<sup>8</sup> In essence, Ms. Mulcahy found herself paying for her necessary post-hospital care because she was never classified as an inpatient. Most likely, another patient in her situation who had been admitted as an inpatient for three days would have been allowed Medicare benefits for post-hospital stay. Patients on this side of the rope call for new mechanisms to replace the three-day rule so that any necessary post-hospital care is covered under Medicare.

On the other side of the rope, the Centers for Medicare and Medicaid Services (“CMS”), under control of HHS, threaten hospitals with loss of Medicare reimbursement or monetary damages and penalties when they admit patients for short, medically necessary, inpatient stays.<sup>9</sup> These consequences result from mechanisms put in place by Medicare, including federal Recovery Audit Contractors and Department of Justice lawyers, whose purpose is to review claims and pursue Medicare fraud.<sup>10</sup> These contractors and prosecutors propose that hospitals and physicians use observation status as a substitute for inpatient admission, and, as a consequence, hospitals and physicians may feel pressured to more frequently order outpatient observation on a patient.<sup>11</sup> Traditionally, the treating physician in a hospital had the decision to admit a patient as an inpatient, with oversight from the hospital.<sup>12</sup> However, Medicare’s Recovery Auditor Contractors—charged with auditing Medicare claims and paid on a contingency fee basis—have started denying large numbers of claims for short, inpatient stays.<sup>13</sup> As a result, physicians and

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4. *Id.*

5. *Id.*

6. *Id.*

7. *Id.*

8. *Bagnall v. Sebelius*, No. 3:11CV1703 (MPS), 2013 WL 5346659, at \*4 (D. Conn. Sept. 23, 2013).

9. Am. Hosp. Ass’n Brief, *supra* note 1, at 3.

10. *Id.* at 2.

11. *Id.* at 3.

12. *Id.*

13. *Id.*

administrators increase their use of outpatient status, which in turn creates more out-of-pocket expenses for Medicare beneficiaries and their families.

The hospital system requires fluidity and flexibility in determining the need to formally admit a patient as well as which patients require post-hospital care. Current regulations created to solve the problem are inadequate to provide relief for Medicare beneficiaries who require subsequent stays in skilled nursing facilities.<sup>14</sup> Beneficiaries will still find themselves in a system where they will pay out-of-pocket costs for post-hospital care. Hospitals will remain continually worried about receiving Medicare reimbursement for patients or having that reimbursement taken away.

This comment analyzes the use of and problems associated with observation status. Part I provides an overview of Medicare and a breakdown of its parts, defines observation status, and introduces inpatient/outpatient classification. Part II scrutinizes the use of observation status and the pressures put on hospitals through audits and the Department of Justice's limits on formal inpatient admissions. Part III looks at two lawsuits filed against the Department of Health and Human Services over the use of observation status. Part IV analyzes legislation proposed by Senator Joe Courtney to eliminate the distinction between inpatient and outpatient statuses. Finally, Part V addresses other possible solutions to the problem of observation status and its effect on Medicare beneficiaries.

## II. BACKGROUND: MEDICARE AND OBSERVATION STATUS

### A. Medicare

Medicare, codified as Title XVIII of the Social Security Act, provides federally-funded and administered health insurance for those who are 65 years of age or older or are disabled.<sup>15</sup> Persons enrolled for Medicare coverage increased from 19.1 million in 1966 to a projected 52.3 million in 2013, a 174% increase.<sup>16</sup> 43.5 million of those enrolled are 65 years of age or older, representing about 82% of Medicare beneficiaries.<sup>17</sup> Over 1.8 million Medicare beneficiaries received care in skilled nursing facilities covered by Medicare during 2011.<sup>18</sup>

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14. Ctr. for Medicare Advoc., *New Study: CMS'S New 2-Midnight Rule Increases Hospital's Use of Observation Status*, <http://www.medicareadvocacy.org/new-study-cms-new-2-midnight-rule-increases-hospitals-use-of-observation-status/>.

15. Health Insurance for the Aged and Disabled, 42 U.S.C. §§ 1395–1395kkk-1 (2013).

16. CTRS. FOR MEDICARE & MEDICAID SERVS., 2013 CMS STATISTICS 1 (2013), available at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-andReports/CMS-Statistics-Reference-Booklet/Downloads/CMS\\_Stats\\_2013\\_final.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-andReports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2013_final.pdf) [hereinafter *2013 CMS Statistics*].

17. *Id.* at Table I.1.

18. *Id.* at 4.

2014] *BLEVINS: HOSPITAL CLASSIFICATION TUG-OF-WAR* 159

Medicare is composed of four parts, A through D.<sup>19</sup> If individuals are already getting benefits from Social Security, they are automatically enrolled in Part A and Part B starting the first day of the month they turn 65.<sup>20</sup> Those who are not automatically enrolled can sign up during a seven-month initial enrollment period that begins three months before the month they turn sixty-five and ends three months after they turn 65.<sup>21</sup> If individuals miss the initial enrollment period, they can sign up during a general enrollment period (between January 1 and March 31 each year) or a special enrollment period (if covered under a group health plan through an employer).<sup>22</sup> A person may have to pay a higher Part A and/or Part B premium for late enrollment.<sup>23</sup>

### 1. Part A

Part A of Medicare is entitled “Hospital Insurance Benefits for Aged and Disabled.”<sup>24</sup> It provides basic protection against the costs of hospital, related post-hospital, home health, and hospice care for individuals age 65 or over.<sup>25</sup> Usually, there is no monthly premium for Part A coverage if a person or their spouse paid Medicare taxes while working.<sup>26</sup> If a person is not eligible for premium-free Part A, they may buy Part A if they are 65 or older, are enrolled in Part B, and meet citizenship and residency requirements.<sup>27</sup> In 2013, people who had to buy Part A paid up to \$441 each month.<sup>28</sup> In general, Part A covers services considered medically necessary to treat a disease or condition.<sup>29</sup> Part A does not cover custodial or long term care.<sup>30</sup> Part A helps cover inpatient care in hospitals, as opposed to Part B which helps cover outpatient care.<sup>31</sup>

### 2. Part B

Part B is intended to “fill some of the gaps in medical insurance coverage left under Part A.”<sup>32</sup> It covers medically necessary doctor’s services, outpatient care, home health services, durable medical equipment, and other medical services as well as many preventative services.<sup>33</sup> CMS defines

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19. Health Insurance for the Aged and Disabled, 42 U.S.C. §§ 1395–1395kkk-1 (2013).

20. CTRS. FOR MEDICARE & MEDICAID SERVS., *MEDICARE & YOU* 2014,19, available at <http://www.medicare.gov/Pubs/pdf/10050.pdf> [hereinafter *MEDICARE & YOU* 2014].

21. *Id.* at 21.

22. *Id.*

23. *Id.*

24. 42 U.S.C. § 1395c (2013).

25. *Id.*

26. *MEDICARE & YOU* 2014, *supra* note 20, at 26.

27. *Id.*

28. *Id.*

29. *What does Medicare Part A Cover?*, MEDICARE.GOV, <http://www.medicare.gov/what-medicare-covers/part-a/what-part-a-covers.html> (last visited Oct. 15, 2013).

30. *MEDICARE & YOU* 2014, *supra* note 20, at 29.

31. *Id.* at 15.

32. *Part B*, CTR. FOR MEDICARE ADVOCACY, INC., <http://www.medicareadvocacy.org/medicare-info/medicare-part-b/> (last visited Nov. 24, 2013).

33. *MEDICARE & YOU* 2014, *supra* note 20, at 34.

“medically necessary” as “health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.”<sup>34</sup> Part B requires a Medicare beneficiary to make a copayment for any outpatient hospital services she receives, including observation status services.<sup>35</sup> A monthly premium is required for Part B, and most individuals pay a standard amount, which was \$104.90 in 2013.<sup>36</sup>

### 3. Parts C and D

Part C, or what is called the Medicare Advantage Program, operates like a Health Maintenance Organization or a Preferred Provider Organization where Medicare-approved private companies offer part C plans.<sup>37</sup> These plans may provide extra coverage, such as vision, hearing, and dental.<sup>38</sup> Part D provides prescription drug coverage.<sup>39</sup>

### 4. Billing and Appeals

When a hospital or other provider treats a Medicare beneficiary, the provider typically bills CMS for the appropriate payment. Medicare contractors, generally private insurance companies, perform most of the payment and review functions.<sup>40</sup> Providers submit their claims to these contractors, and the contractors determine whether the services are covered and how much the provider is entitled to be paid.<sup>41</sup> These contractors are subject to administrative review. The appeals process goes through a Qualified Independent Contractor (which includes an independent record review by a panel of health care professionals), a review by an Administrative Law Judge, the Department Appeals Board Medicare Appeals Council, and finally the decision may be appealed to a federal district court.<sup>42</sup>

### B. Observation Status – The Inpatient/Outpatient Issue

When a patient comes to a hospital for treatment, the attending physician must decide whether the patient should be formally admitted to the hospital.<sup>43</sup> If the patient is admitted, he or she is treated on an “inpatient” basis; if not, he

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34. *Id.* at 147.

35. *Bagnall v. Sebelius*, No. 3:11CV1703 (MPS), 2013 WL 5346659, at \*2 (D. Conn. Sept. 23, 2013).

36. *MEDICARE & YOU 2014*, *supra* note 20, at 27.

37. *Id.* at 72.

38. *Id.*

39. *Id.* at 75.

40. Memorandum in Support of Motion to Dismiss at 7, *Bagnall v. Sebelius*, No. 1:12-cv-01770-CKK (D. Conn. Jan. 9, 2012).

41. *Id.*

42. Second Amended Complaint at ¶ 50, *Am. Hosp. Ass’n v. Sebelius*, No. 1:12-cv-01770-CKK (D. Conn. Apr. 19, 2013).

43. *Id.* at ¶ 1.

2014] *BLEVINS: HOSPITAL CLASSIFICATION TUG-OF-WAR* 161

or she is treated on an “outpatient” basis.<sup>44</sup> There are differences between the two, but in some cases the same services can be provided in both statuses.<sup>45</sup> “Inpatient” is a term left undefined in the Medicare statutes.<sup>46</sup> However, according to a CMS manual, a patient is considered an inpatient if “formally admitted as an inpatient with the expectation that he or she will remain at least overnight and occupy a bed[.]”<sup>47</sup> The physician responsible for a patient’s care at the hospital is responsible for deciding whether the patient should be admitted as an inpatient.<sup>48</sup> The manual suggests that physicians should order admission for patients who are expected to need hospital care for 24 hours or more, but notes that admitting a patient is “a complex medical judgment” which looks at a number of factors.<sup>49</sup> These factors include medical history, current medical needs, types of facilities available to inpatients and outpatients, the hospital’s by-laws and admissions policies, and appropriateness of treatment in each setting.<sup>50</sup>

The alternative to admitting a patient is placing an individual on “observation status.” Observation care, as defined by the CMS Policy Manual, “is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment” before the hospital can determine whether to formally admit or discharge an individual.<sup>51</sup> These services are commonly ordered for patients who present to the emergency room and who then require monitoring in order to determine if they should be admitted or discharged.<sup>52</sup> The most common reasons for observation stays include chest pain, digestive disorders, fainting, nutritional disorders, dizziness, irregular heartbeat, circulatory disorders, respiratory signs and symptoms, and medical back problems.<sup>53</sup> Outpatient observation care is intended to help the attending physician determine the appropriate treatment

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44. *Id.*

45. *Id.*

46. *Bagnall v. Sebelius*, No. 3:11CV1703 (MPS), 2013 WL 5346659, at \*2 (D. Conn. Sept. 23, 2013).

47. *Id.* at \*3; *See also* MEDICARE BENEFIT POLICY MANUAL, CTRS. FOR MEDICARE AND MEDICAID SERVS. Ch. 1 § 10, *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf> [hereinafter POLICY MANUAL Ch. 1 § 10].

48. *Id.*

49. *Id.*

50. *Id.*

51. *Bagnall v. Sebelius*, No. 3:11CV1703 (MPS), 2013 WL 5346659, at \*3 (D. Conn. Sept. 23, 2013); *See also* POLICY MANUAL, CTRS. FOR MEDICARE AND MEDICAID SERVS. Ch. 6 § 20.6, *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf>.

52. *Id.*

53. OFFICE OF INSPECTOR GENERAL, MEMORANDUM REPORT: HOSPITALS’ USE OF OBSERVATION STAYS AND SHORT INPATIENT STAYS FOR MEDICARE BENEFICIARIES Table 1 (2013), *available at* <http://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf>.

setting for a patient.<sup>54</sup> When a physician orders that a patient receive observation care, the patient's status is that of an outpatient.<sup>55</sup> An outpatient "is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services from the hospital."<sup>56</sup> The main difference between the two statuses is a formal order written by a doctor to admit the patient into the hospital.<sup>57</sup> Patients may be admitted formally as inpatients and later have their status changed to observation.<sup>58</sup>

Medicare will only cover skilled nursing, rehabilitative services, and other medically necessary services and supplies after a three-day minimum medically necessary inpatient hospital stay for a related illness or injury.<sup>59</sup> The three-day minimum does not include the day a patient is discharged.<sup>60</sup> In addition, a doctor must certify that the patient needs daily skilled care, like intravenous injections or physical therapy.<sup>61</sup> Skilled nursing facilities ("SNF") provide services for residents who require medical or nursing care or rehabilitation services.<sup>62</sup> Part A provides payment for post-hospital care in SNFs for up to 100 days during each spell of illness.<sup>63</sup> A "spell of illness," with respect to any individual, means a period of consecutive days beginning when an individual is given inpatient hospital services, critical access hospital services or extended care services.<sup>64</sup> A "spell of illness" ends when the patient has spent 60 days outside the institution or remains at the institution but does not receive Medicare-coverable care for 60 consecutive days.<sup>65</sup>

Thousands of dollars may turn on whether a Medicare beneficiary received inpatient or outpatient hospital services.<sup>66</sup> If a patient is not considered an

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54. Brief of the Am. Hosp. Assoc. as Amicus Curiae in Support of Neither Party at 5, *Bagnall v. Sebelius*, No. 3:11CV1703 (MPS), 2013 WL 5346659 (D. Conn. Sept. 23, 2013).

55. MEDICARE BENEFIT POLICY MANUAL, CTRS. FOR MEDICARE AND MEDICAID SERVS. Ch. 6 § 20.6(B), available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf>.

56. *Id.* at Ch. 6 § 20.2.

57. *Find out if you're an inpatient or an outpatient—it affects what you pay*, MEDICARE.GOV, <http://www.medicare.gov/what-medicare-covers/part-a/inpatient-or-outpatient.html> (last visited Nov. 24, 2013).

58. *Bagnall v. Sebelius*, No. 3:11CV1703 (MPS), 2013 WL 5346659, at \*4 (D. Conn. Sept. 23, 2013).

59. MEDICARE & YOU 2014, *supra* note 20 at 33.

60. *Id.*

61. *Id.*

62. 42 U.S.C. § 1395i-3(a) (2013).

63. *Nursing Home / Skilled Nursing Facility Care*, CTR. FOR MEDICARE ADVOCACY, INC., <http://www.medicareadvocacy.org/medicare-info/skilled-nursing-facility-snf-services> (last visited Nov. 24, 2013) [hereinafter *Nursing Home*]; 42 U.S.C. § 1395e(a)(3).

64. 42 U.S.C. § 1395x(a).

65. *Nursing Home*, *supra* note 63; *See also* 42 U.S.C. § 1395x(a).

66. *Bagnall v. Sebelius*, No. 3:11CV1703 (MPS), 2013 WL 5346659, at \*2 (D. Conn. Sept. 23, 2013).

2014] *BLEVINS: HOSPITAL CLASSIFICATION TUG-OF-WAR* 163

inpatient, the medical services that the patient receives while in a hospital are covered under Medicare Part B, rather than Part A.<sup>67</sup> Under Part B, patients are required to make coinsurance payments, and, upon discharge from the hospital, Medicare will not cover subsequent stays in SNFs.<sup>68</sup> Therefore, an outpatient beneficiary must pay out-of-pocket for any care they may need after leaving the hospital.<sup>69</sup>

### III. THE PROBLEM, CAUSE, AND CURRENT RESPONSE

#### A. *The Problem: Increased Use of Observation Status*

The use of observation status is on the rise, and, at the same time, the average length of time a patient is on observation status has increased. According to a study cited by National Public Radio, in the past six years the use of observation status has roughly doubled.<sup>70</sup> An AARP study found that, in 2001, about 1 million beneficiaries used observation status, rising to 1.6 million in 2006, and rising to more than 2.1 million in 2009.<sup>71</sup> A study done by Brown University corroborates an increase in the use of observation status on a two-year scale, finding that observation stays rose to 1.01 million in 2009, up from 814,692 in 2007.<sup>72</sup> The same study found that the rate of observation status varies widely state by state and by hospital, but the nationwide ratio of Medicare patients held for observation to those admitted for inpatient stays increased by 34%.<sup>73</sup>

As observation stays have risen, inpatient admissions have fallen, and the average stays became “an average of 7 percent longer over the study period.”<sup>74</sup> In 2009, 44,843 patients were held for observation longer than 72 hours, compared to 23,841 in 2007.<sup>75</sup> In their amicus brief in *Bagnall v. Sebelius*, the American Hospital Association (“AHA”) reported that the “proportion of observation stays exceeding 48 hours doubled between 2006 and 2008.”<sup>76</sup>

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67. *See id.* at \*4.

68. *See id.* at \*4.

69. *See id.* at \*4.

70. Ina Jaffe, *For Hospital Patients, Observation Status Can Prove Costly*, NPR (Sept. 4, 2013), available at <http://www.npr.org/blogs/health/2013/09/04/218633011/for-hospital-patients-observation-status-can-prove-costly>.

71. LAN ZHAO, ET AL., *RAPID GROWTH IN MEDICARE HOSPITAL OBSERVATION SERVICES: WHAT'S GOING ON?*, AARP PUB. POLICY INST. 6 (2013), available at [http://www.aarp.org/content/dam/aarp/research/public\\_policy\\_institute/health/2013/rapid-growth-in-medicare-hospital-observation-services-AARP-ppi-health.pdf](http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2013/rapid-growth-in-medicare-hospital-observation-services-AARP-ppi-health.pdf).

72. Press Release, Brown University, *More Seniors Being Held for Observation* (June 4, 2012), <http://news.brown.edu/pressreleases/2012/06/observation>.

73. *Id.*

74. *Id.*

75. *Id.*

76. Brief of the Am. Hosp. Ass'n as Amicus Curiae in Support of Neither Party at 3, *Bagnall v. Sebelius*, No. 3:11CV1703 (MPS), 2013 WL 5346659 (D. Conn. Sept. 23, 2013).

**B. The Cause: Recovery Audit Contractors**

The AHA and Center for Medicare Advocacy both blame Recovery Audit Contractors (“RACs”) for the increased use of observation status. Hospitals have an incentive to place patients on observation status because it ensures that the hospital will receive some payment from Medicare for the patient’s stay in the hospital.<sup>77</sup> Medicare RACs are private entities contracted by CMS to identify underpayments and overpayments, as well as recoup overpayments.<sup>78</sup> According to CMS, the mission of the Recovery Audit Program is to “identify and correct Medicare improper payments through the efficient detection and collection of overpayments. . . and underpayments to providers.”<sup>79</sup> A permanent and national Recovery Audit Program was instituted by the Secretary of HHS in 2006.<sup>80</sup> While in the past providers complained about a lack of physician presence on the auditor staffs, CMS now requires each RAC to hire a minimum of one full-time physician Medical Director to oversee the medical record review process.<sup>81</sup> RACs audit Medicare claims going back up to three years and are paid on a contingency fee basis.<sup>82</sup> CMS pays Medicare RACs a contingency fee rate ranging between 9 and 12.50 percent of the money that the RACs recover from the hospitals.<sup>83</sup>

The auditing process typically consists of a nurse employed by the contractor deciding whether to approve or deny a claim based on a screening guide.<sup>84</sup> If the RAC determines that a claim resulted in an improper overpayment, it can recover the overpayment.<sup>85</sup> The provider can challenge this finding, but the multi-level appeal process is expensive and cumbersome.<sup>86</sup> Hospitals incur substantial costs appealing these decisions or they forgo payment for the claims in question.<sup>87</sup> The AHA has found that 74 percent of appealed RAC decisions are ultimately reversed.<sup>88</sup> Further, the AHA points to threats by the Department of Justice (“DOJ”) to pursue claims under the False

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77. *Bagnall v. Sebelius*, No. 3:11CV1703 MPS, 2013 WL 5346659, at \*5 (D. Conn. Sept. 23, 2013).

78. Medicaid Program; Recovery Audit Contractors, 76 Fed. Reg. 57808-01 (Sept. 16, 2011) (to be codified at 42 C.F.R. pt. 455).

79. *Recovery Audit Program*, CTRS FOR MEDICARE AND MEDICAID SERVS, [www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/index.html) (last visited Nov. 24, 2013).

80. *Id.*

81. Medicaid Program; Recovery Audit Contractors, *supra* note 78, at 57809.

82. Brief of the Am. Hosp. Ass’n as Amicus Curiae in Support of Neither Party at 3, *Bagnall v. Sebelius*, No. 3:11CV1703 (MPS), 2013 WL 5346659 (D. Conn. Sept. 23, 2013).

83. Medicaid Program; Recovery Audit Contractors, *supra* note 78, at 57809.

84. *Id.*

85. Brief of the Am. Hosp. Ass’n as Amicus Curiae in Support of Neither Party at 6, *Bagnall v. Sebelius*, No. 3:11CV1703 (MPS), 2013 WL 5346659 (D. Conn. Sept. 23, 2013).

86. *Id.*

87. *Id.* at 2.

88. *Id.* at 7.

2014] *BLEVINS: HOSPITAL CLASSIFICATION TUG-OF-WAR* 165

Claims Act for hospital submissions the lawyers deem not medically necessary because the patient could have received care in an observation bed.<sup>89</sup> The DOJ view is that a hospital submitting such a claim has committed fraud against the government.<sup>90</sup>

Missouri Baptist Sullivan Hospital's experience illustrates the effect of RACs on hospitals. Since January 30, 2010, the RAC has asked Missouri Baptist to turn over at least 517 patient records for review.<sup>91</sup> The RAC determined that 111 patients should not have been admitted as inpatients.<sup>92</sup> The denials required Missouri Baptist, a small rural hospital, to repay Medicare \$324,000, with \$30,748 of the payment going to the RAC based on its 9.49 percent contingency-fee rate.<sup>93</sup> According to the AHA, Missouri Baptist now has a negative cash flow for the care it provides to Medicare beneficiaries.<sup>94</sup>

This is the tug-of-war: the battle between CMS and patients. On one side, hospitals risk loss of reimbursement, monetary damages, and penalties from CMS, RACs, and prosecutors when they admit patients for short, medically necessary inpatient stays.<sup>95</sup> The threat of RACs clawing back money paid to hospitals influences the decisions they make with regard to admitting patients.<sup>96</sup> On the other side, patients criticize the use of observation status as a substitute for inpatient admission because of the unreasonable financial burden.<sup>97</sup> Hospitals find themselves in an unwinnable situation.<sup>98</sup>

### C. CMS Response

In response to the issue of increased use of observation status, CMS instituted new rules for inpatient hospital care, effective October 1, 2013.<sup>99</sup> This final rule, CMS-1599-F, updated Medicare payment policies and rates for the fiscal year 2014.<sup>100</sup> One pertinent part proposes a two-midnight benchmark

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89. *Id.* at 2–3.

90. Brief of the Am. Hosp. Ass'n. as Amicus Curiae in Support of Neither Party at 2, *Bagnall v. Sebelius*, No. 3:11CV1703 (MPS), 2013 WL 5346659 (D. Conn. Sept. 23, 2013).

91. Second Amended Complaint at ¶ 69, *Am. Hosp. Ass'n et al. v. Sebelius*, No. 1:12-cv-01770-CKK (D.D.C. Apr. 19, 2013).

92. *Id.* at ¶ 1.

93. *Id.*

94. *Id.*

95. Brief of the Am. Hosp. Ass'n as Amicus Curiae in Support of Neither Party at 3, *Bagnall v. Sebelius*, No. 3:11CV1703 (MPS), 2013 WL 5346659 (D. Conn. Sept. 23, 2013).

96. *Id.*

97. *Id.*

98. *See id.* at 3.

99. *Observation Status: New Final Rules from CMS Do Not Help Medicare Beneficiaries*, CTR. FOR MEDICARE ADVOCACY, INC. (Aug. 29, 2013), <http://www.medicareadvocacy.org/observation-status-new-final-rules-from-cms-do-not-help-medicare-beneficiaries/> (last visited Nov. 24, 2013).

100. *Inpatient Hospital Reviews*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/MedicalReview/>

for the purpose of medical review of hospital inpatient admissions.<sup>101</sup> Under the rule, treatments are generally appropriate for inpatient hospital admission and payment under Part A when: “(1) the physician expects the beneficiary to require a stay that crosses at least two midnights and (2) admits the beneficiary to the hospital based on that expectation.”<sup>102</sup> However, the rule does not amend the 3-day qualifying minimum inpatient stay rule for Part A coverage for post-hospital care.<sup>103</sup> The regulation is simply a “tool for physicians to apply in making inpatient admission decisions,” and documentation in the medical record must support the reasonable expectation of the need for the beneficiary to stay at least two midnights.<sup>104</sup> Further, the physician order is not retroactively effective, “[i]npatient status only applies prospectively, starting from the time the patient is formally admitted[.]”<sup>105</sup>

The other pertinent change allows for a hospital to resubmit a claim for a patient under Part B if they have been denied under Part A. If a patient’s claim is resubmitted and coverable under Part B, they will still be considered “inpatients” for the purpose of being covered for post-hospital stays in skilled nursing facilities (“SNFs”).<sup>106</sup> However, under Part B the patients will still be responsible for Part B copayments.<sup>107</sup> CMS proposed that:

[W]hen a Medicare Part A claim for inpatient hospital services is denied because the inpatient hospital admission was deemed not to be reasonable and necessary. . .the hospital may be paid for all the Part B services that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient. . .[.]<sup>108</sup>

In addition, claims for services to be rebilled under Part B must be filed within one year from the date of service.<sup>109</sup> However, RACs can select claims for audit up to three years after the date of services and it takes months to complete the review.<sup>110</sup> Thus, hospitals may be unable to meet the one year

InpatientHospitalReviews.html (last visited Nov. 24, 2013).

101. Payment Policies Related to Patient Status, 78 Fed. Reg. 50496, 50908 (August 19, 2013) (to be codified at 42 C.F.R. pt. 412–14, 419, 424, 482, 485, 489); *see also* 42 C.F.R. § 412.3(e)(1).

102. *Inpatient Hospital Reviews*, *supra* note 100.

103. *New CMS Rules Do NOT Change Requirement for 3-Day Qualifying Inpatient Hospital Stay*, CTR. FOR MEDICARE ADVOCACY, INC. (Oct. 31, 2013), <http://www.medicareadvocacy.org/new-cms-rules-do-not-change-requirement-for-3-day-qualifying-inpatient-hospital-stay/> [hereinafter *New CMS Rules*].

104. *Id.*

105. Payment Policies Related to Patient Status, *supra* note 101, at 50942.

106. *Id.* at 50921.

107. *New CMS Rules*, *supra* note 103.

108. Medicare Program; Part B Inpatient Billing in Hospitals, 78 Fed. Reg. 16632-01, 16633 (Mar. 18, 2013) (to be codified at 42 C.F.R. pt. 414, 419).

109. *Id.*

110. Plaintiff’s Supplemental Brief Regarding Effect of Final CMS Rule on Defendant’s Motion to Dismiss at 3, *Am. Hosp. Ass’n v. Sebelius*, No. 1:12-cv-01770-CKK (D.D.C. Oct. 28, 2013).

2014] *BLEVINS: HOSPITAL CLASSIFICATION TUG-OF-WAR* 167

statute of limitations. Further, the new Medicare rule does not solve the problem of costly RAC appeals, and hospitals will remain concerned about the cost of appealing RAC denials.

#### IV. THE LAWSUITS

Two separate lawsuits, one brought by the American Hospital Association (“AHA”), and the other brought by several Medicare beneficiaries, target the two main problems: the inability for hospitals to rebill RAC claw backs under Medicare Part B and the three-day minimum qualifying inpatient stay.

##### A. *American Hospital Association, et al. v. Sebelius*

In *American Hospital Association, et al. v. Sebelius*, the AHA promotes that if payment cannot be made for medically necessary hospital care under Part A, it must be made under Part B. In the past, when RACs determined that a provider was paid for inpatient hospital services, but that the patient should have been treated as an outpatient, CMS would take back the entire Part A payment and then refuse to let the hospital rebill under Part B for almost all the services provided.<sup>111</sup> This policy was called the “Payment Denial Policy.”<sup>112</sup> AHA claims that CMS has refused to provide Part B reimbursement, and that they have admitted their error by instituting regulations and rulings to correct the problem.

In their complaint, AHA states that CMS informed hospitals “over and over again that Part B payment was not available, under the Payment Denial Policy.”<sup>113</sup> The hospitals took CMS at its word and never sought payment by filing new Part B claims or appealing the Part A denials.<sup>114</sup> Now, AHA claims, CMS still refuses to pay the claims by reasoning the 1-year time limit for filing the Part B claims has expired.<sup>115</sup> Despite the ability to rebill Part B claims, there is a one-year time limit running from the date of treatment.<sup>116</sup> This makes rebilling after a RAC denial impossible because RACs may audit up to three-years back in time and denials are issued more than a year after the date of care.<sup>117</sup> Further, in a supplemental memorandum, the AHA maintains that CMS’s “multi-factor guidance on when to admit inpatients was (and remains) so woefully unclear that there was nothing hospitals could do to avoid at least

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111. Second Amended Complaint at ¶ 45, *Am. Hosp. Ass’n v. Sebelius*, No. 1:12-cv-01770-CKK (D.D.C. Apr. 19, 2013).

112. *Id.* at ¶ 5.

113. *Id.* at ¶ 8.

114. *Id.*

115. *Id.*

116. Plaintiff’s Supplemental Brief Regarding Effect of Final CMS Rule on Defendant’s Motion to Dismiss at 4, *Am. Hosp. Ass’n v. Sebelius*, No. 1:12-cv-01770-CKK (D.D.C. Oct. 28, 2013).

117. *Id.* at 3–4.

some RAC claw backs.”<sup>118</sup> They cite to malleable factors such as “‘severity of the patient’s signs and symptoms,’ ‘risk of an adverse event,’ and ‘relative appropriateness of treatment. . .,’” which will cause RACs to reach different conclusions than the admitting physician regarding patient status even with the new regulations.<sup>119</sup> So, despite a new two-midnight benchmark, admission is and should be based on “complex medical factors.”<sup>120</sup>

The case was dismissed due to a lack of subject matter jurisdiction on September 17, 2014.<sup>121</sup> The court dismissed because the Plaintiffs challenged “general policies” that do not apply to their claims.<sup>122</sup> Further, the Plaintiffs could not point to an “actual decision introducing the policy that they claim to be challenging.”<sup>123</sup> This created an insurmountable barrier for the Plaintiffs because judicial review under the Medicare Act is “limited to ‘any final decision . . . made after a hearing.’”<sup>124</sup>

## **B. Bagnall v. Sebelius**

### **1. Background**

On November 3, 2011, the Center for Medicare Advocacy and co-counsel National Senior Citizens Law Center filed a nationwide class action lawsuit to challenge what they call the “illegal policy and practice” of using observation status.<sup>125</sup> The plaintiffs consisted of seven Medicare beneficiaries, or their executors, who were placed on observation status and whose subsequent stay in a skilled nursing facility (“SNF”) was not covered by Medicare.<sup>126</sup> Two of the plaintiffs were initially admitted to the hospital but later had their status changed to observation during their hospital stay.<sup>127</sup> Each of the Plaintiffs suffered serious financial consequences because they were not admitted but instead placed on observation status.<sup>128</sup> The medical services they received as outpatients were covered under Part B, rather than Part A.<sup>129</sup> As a result, they

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118. *Id.* at 9–10.

119. *Id.*

120. *Id.* at 5.

121. Memorandum Opinion, *Am. Hosp. Ass’n v. Sebelius*, No. 1:12-cv-01770-CKK (D.D.C. Sept. 17, 2014).

122. *Id.*

123. *Id.*

124. *Id.*

125. *Observation Status & Bagnall v. Sebelius*, CTR. FOR MEDICARE ADVOCACY, INC., <http://www.medicareadvocacy.org/medicare-info/observation-status/> (last visited October 15, 2013).

126. Complaint at 3–5, *Bagnall v. Sebelius*, 3:11CV1703 (MPS), 2013 WL 5346659 (D. Conn. Sept. 23, 2013).

127. *Bagnall v. Sebelius*, No. 3:11CV1703 (MPS), 2013 WL 5346659, at \*4 (D. Conn. Sept. 23, 2013).

128. *Id.*

129. *Id.*

2014] *BLEVINS: HOSPITAL CLASSIFICATION TUG-OF-WAR* 169

were required to make coinsurance payments as well as pay for SNF care out-of-pocket.<sup>130</sup>

## 2. The *Landers* Decision

The court in *Bagnall* relied on *Estate of Landers v. Levitt*, a case with similarly situated plaintiffs.<sup>131</sup> The issue in *Landers* turned on whether the court should recognize the CMS interpretation of the Medicare statute regarding the three-day requirement.<sup>132</sup> The *Landers* court determined that “CMS’s interpretation is entitled to a great deal of persuasive weight.”<sup>133</sup> The *Bagnall* court found several *Landers* findings determinative: the CMS definition of “inpatient” is a “nonlegislative rule” rather than a legislative one, CMS received comments on the observation status issue, but ultimately declined to change the interpretation because it did not want to interfere with Congress’s intent, and an inpatient must be formally admitted because it accords with CMS’s interpretation, statutory text, and governing precedents.<sup>134</sup>

## 3. Dismissal

The court dismissed the Plaintiffs’ claims, relying on *Landers*. The grounds relevant to this discussion focused on CMS’s interpretation of “inpatient,” the inadequacy of Medicare Summary Notices, and the effect of RACs on the use of observation status as interfering with the practice of medicine. First, the court found that even if the Plaintiffs received services that were identical to those provided to inpatients, they were still not formally admitted or classified as inpatients.<sup>135</sup> The CMS interpretation still stands as persuasive.<sup>136</sup> Second, the court found that HHS’s failure to provide written notification to Medicare beneficiaries or require that they receive written notification of their observation status violates the Medicare statute and the Due Process Clause of the Fifth Amendment.<sup>137</sup> However, the court found no causal connection between the lack of notification and the Plaintiffs’ injuries.<sup>138</sup> The injuries, that their services were covered under Part B instead of Part A, were not caused by the inability to appeal their initial determination

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130. *Id.*

131. *Id.* at \*9 (describing how the court focused on whether the plaintiffs were “inpatients” after the plaintiffs spent three days in the hospital, were discharged less than three days after having been admitted as inpatients, and were not eligible for SNF care).

132. *Id.* at \*9.

133. *Estate of Landers v. Leavitt*, 545 F.3d 98, 107 (2d Cir. 2008).

134. *Bagnall v. Sebelius*, No. 3:11CV1703 (MPS), 2013 WL 5346659, at \*10 (D.Conn. Sept. 23, 2013).

135. *Id.* at \*11.

136. *Id.*

137. *Id.* at \*18.

138. *Id.*

of benefits.<sup>139</sup> Because the Plaintiffs did not appeal their initial determination of status they lacked standing.<sup>140</sup>

Finally, one of the Plaintiffs' causes of action focused on the use of observation status as interfering with the practice of medicine because potential claw backs influence the physician's medical judgment about whether beneficiaries should be admitted as inpatients or placed on observation status.<sup>141</sup> The court found that retroactive reversal of admission decisions by RACs does not "actually direct or prohibit any kind of treatment or diagnosis."<sup>142</sup> The court found that although RAC reversals may influence some medical decisions, the effect is tangential and RAC denials only refuse subsequent Medicare reimbursement for certain kinds of services.<sup>143</sup>

### C. Significance

The AHA case is illustrative of the multi-layer problem associated with observation status as a classification. Despite new regulations instituted by CMS, audits will continue to be a problem because CMS guidance on when to formally admit a patient as an inpatient does not provide much guidance at all. Because of unclear guidance and because medical judgments are inherently subjective, RACs will continue to claw back Medicare payments for up to three years from the date of service and hospitals will continue to pay for appeals which may still be denied because there is a one-year time limit to rebill Part B claims running from the date of treatment. The *Bagnall* decision highlights the importance the courts put on regulations instituted by CMS and how powerful those regulations can be in determining the reimbursement of a beneficiary or provider. Most importantly, the *AHA* and *Bagnall* cases show a lack of judicial willingness or authority to fix the problem. Therefore, amending the root of the problem—the Medicare statute—is necessary.<sup>144</sup>

## V. THE PROPOSED LEGISLATION

### A. H.R. 1179: Improving Access to Medicare Coverage Act of 2013

In response to the increased use of observation status in hospitals, Representative Joe Courtney (R-CT2) introduced a bill in the 113<sup>th</sup> Congress amending the Social Security Act.<sup>145</sup> H.R. 1179 would amend 42 U.S.C.

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139. *Id.*

140. *Bagnall v. Sebelius*, No. 3:11CV1703 (MPS), 2013 WL 5346659, at \*18 (D.Conn. Sept. 23, 2013).

141. *Id.* at \*24.

142. *Id.* at \*25 (quoting *Goodman v. Sullivan*, 891 F.2d 449, 451 (2d Cir. 1989).

143. *Id.* (quoting *Goodman v. Sullivan*, 891 F.2d 449, 451 (2d Cir. 1989).

144. OFFICE OF INSPECTOR GENERAL, MEMORANDUM REPORT: HOSPITALS' USE OF OBSERVATION STAYS AND SHORT INPATIENT STAYS FOR MEDICARE BENEFICIARIES 15 (2013), available at <http://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf>.

145. H.R. 1179, 113th Cong. (2013).

2014] *BLEVINS: HOSPITAL CLASSIFICATION TUG-OF-WAR* 171

1395x(i), which defines “post-hospital extended care services.”<sup>146</sup> Currently, the section limits the definition of post-hospital extended care service to services furnished to a patient after transfer from a hospital in which they were an “inpatient for not less than 3 consecutive days.”<sup>147</sup> The bill would add:

For the purposes of this subsection, an individual receiving outpatient observation services shall be deemed to be an inpatient during such period, and the date such individual ceases receiving such services shall be deemed the hospital discharge date (unless such individual is admitted as a hospital inpatient at the end of such period.)<sup>148</sup>

The bill would eliminate the distinction between an inpatient and a patient on observation status. Instead, all time in the hospital would be counted toward the three-day required stay. At the time of publication of this article, the bill had 159 cosponsors, including 126 democrats and 33 republicans, indicating bipartisan support.<sup>149</sup> Senator Sherrod Brown (D-OH) has proposed a companion bill in the Senate, S. 569, with 27 cosponsors – 24 democrats, 2 independents, and 1 republican.<sup>150</sup> While the amount of cosponsors indicates broad support, it is unclear whether either bill will make it out of committee.

Eliminating the distinction between inpatient and outpatient status may solve the problem for Medicare beneficiaries. However, observation status and outpatient care have a legitimate purpose in helping physicians determine the best care. Additionally, inpatient and outpatient classifications aid in helping Medicare determine which patients actually need Medicare reimbursement for post-hospital care. Patients on observation status for over three days in a hospital may not need post-hospital care but they would be eligible to receive it under this new statutory definition. Even with the amendment, individuals on inpatient status for just one or two days may actually need post-hospital care, but will still not be eligible to receive it because they have not met the three-day requirement. A true solution should target the increased use of observation status as well as inpatient classification requirements.

***B. H.R. 3531: Creating Access to Rehabilitation for Every Senior (CARES) Act of 2013***

Representative James Renacci (R-OH) presented a bill on November 19, 2013 amending 42 U.S.C. 1395(d) and eliminating the three-day minimum stay requirement for Medicare beneficiaries to receive post-hospital care.<sup>151</sup>

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146. 42 U.S.C. § 1395x(i).

147. *Id.*

148. H.R. 1179, 113th Cong. (2013).

149. *H.R. 1179: Improving Access to Medicare Coverage Act of 2013*, GOVTRACK.US, <http://www.govtrack.us/congress/bills/113/hr1179> (last visited Oct. 16, 2014).

150. S. 569, 113th Cong. (2013).

151. *Creating Access to Rehabilitation for Every Senior (CARES) Act of 2013*, H.R. 3531, 113<sup>th</sup> Cong. (2013).

However, the SNF facility that the Medicare beneficiary attends must meet a particular quality rating.<sup>152</sup> The Center for Medicare Advocacy (“CMA”) maintains that nursing facilities are not reliable self-reports for quality measures.<sup>153</sup> CMA does not recommend the proposed amendment until “[q]uality measures are fixed.”<sup>154</sup>

### C. H.R. 3114: *Fairness for Beneficiaries Act of 2013*

Finally, on September 19, 2013, Representative Jim McDermott (D-WA) introduced a bill in an attempt to solve the problem.<sup>155</sup> Representative McDermott’s bill closely parallels the proposed solution of this article by eliminating the three-day minimum stay requirement completely for Medicare beneficiaries to qualify for post-hospital care.<sup>156</sup> The bill amends 42 U.S.C. 1395(d) and allows health care practitioners to make a determination that extending coverage to an individual is medically necessary.<sup>157</sup> This solves the deficiency of Representative Courtney’s Bill in regards to one-day stay patients. The Center for Medicare Advocacy agrees that this major change is an appropriate long-term goal.<sup>158</sup> However, they also believe it requires “additional analysis and evaluation” and could be costly to the Medicare program.<sup>159</sup>

## VI. THE SOLUTION

The current proposed solutions are insufficient to solve the heavy financial burden placed on Medicare beneficiaries requiring post-hospital care who do not meet the three-day inpatient admission requirement. Observation status is on the rise, due to the threat of RAC claw backs, as are the number of Medicare beneficiaries paying out of pocket expenses for post-hospital care. In the end, the ability of physicians to provide medical care and patients receiving that care should be the priority. Setting a bureaucratic time limit on an otherwise unpredictable and organic situation between physician and patient is tenuous. CMS should consider how to ensure that Medicare beneficiaries with similar post-hospital care needs have the same access and cost-sharing for SNF services.<sup>160</sup> Any “benchmark” set for qualifying inpatient stays—3 days,

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152. *Three Observation Status Bills Have Been Introduced; Only Congressman Courtney’s Has Immediate Promise*, CTR. FOR MEDICARE ADVOCACY, INC. (Nov. 27, 2013), <http://www.medicareadvocacy.org/three-observation-status-bills-have-been-introduced-only-congressman-courtneys-has-immediate-promise/>.

153. *Id.*

154. *Id.*

155. *Fairness for Beneficiaries Act of 2013*, H.R. 3144, 113<sup>th</sup> Cong. (2013).

156. *Id.*

157. *Id.*

158. *Three Observation Status Bills Have Been Introduced*, *supra* note 152.

159. *Id.*

160. OFFICE OF INSPECTOR GENERAL, *supra* note 144.

2014] *BLEVINS: HOSPITAL CLASSIFICATION TUG-OF-WAR* 173

2 days, 1 day—will always leave some patients, with medically specific situations, out in the proverbial cold. Providing a bright-line rule that observation status should never extend beyond forty-eight hours does not recognize the individuality of patients. However, due to the size and scope of Medicare, some mechanisms must be present to ensure fairness and to safeguard against abuse.

Eliminating the distinction between inpatient and outpatient on observation status when it comes to Medicare billing may not be the answer, especially considering that observation status serves a legitimate purpose for physicians in determining the care of their patients. Even so, greater oversight and enforcement of the forty-eight hour time limit for physicians to admit patients is insufficient to solve the problems facing Medicare beneficiaries.<sup>161</sup> Greater oversight does not solve the problem that patients who spend two days on observation status and one day on inpatient status will still not be eligible for Medicare coverage of their post-hospital care, nor does it solve the problems that hospitals face when appealing RAC denials.

More guidance from CMS is necessary to prevent RAC denials. As the AHA lawsuit emphasizes, the guidelines that CMS has provided for determining inpatient status do not adequately help physicians and hospitals avoid RAC denials. Despite inpatient admission being “a complex medical judgment which can be made only after the physician has considered a number of factors,” RACs are left to judge physician admissions without adequate guidelines.<sup>162</sup> The two-midnight benchmark that helps physicians determine inpatient status, as promulgated by the Medicare guidelines,<sup>163</sup> still does not provide much guidance to physicians. The benchmark is only a tool, as opposed to a hard and fast rule requiring them to formally admit a patient after two-midnights. If the two-midnight benchmark was a requirement, imagine a patient placed on observation status at 11:59 PM. That patient’s physician has only one more midnight to start and finish necessary tests to determine if the patient should be formally admitted. This places enormous pressure on physicians to treat patients because of their status, not because of their condition. Because medical decisions are individualized and sometimes difficult to predict, the two-midnight benchmark is not always feasible.

The problem with creating a hard and fast rule for inpatient admissions, such as the current three-day minimum qualifying stay requirement, is illustrated in the three following examples of patients Alex, Blair, and Chris.

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161. *But see* Onyinyechi Jeremiah, Note, *A Thin Line Between Patient and Outpatient: Observation Status and Its Impact on the Elderly*, 20 *GEO. J. ON POVERTY L. AND POL’Y* 141, 157 (2013).

162. *POLICY MANUAL* Ch. 1 § 10, *supra* note 47.

163. *Payment Policies Related to Patient Status*, 78 *Fed. Reg.* 50496-01 (Aug. 19, 2013) (to be codified at 42 C.F.R. pts. 412–14, 419, 424, 482, 485, and 489).

Alex is brought into a hospital on observation status and kept on observation status for two days. On day three, Alex is formally admitted as an inpatient. On day four, Alex is discharged from the hospital. However, Alex is in need of post-hospital care that her family cannot provide. In this situation, a retroactive classification of those outpatient days to inpatient would be helpful.

Blair was brought into the hospital and instantly admitted since his physician believed he would need care that surpassed two-midnights. In the end, Blair stays as an inpatient for two days and the hospital discharges him on day three. Here, Blair would also not qualify for subsequent post-hospital care, but retroactive classification does not help him. Blair requires a mechanism to allow him to qualify for post-hospital care with just one or two days of inpatient care.

Chris was admitted as an outpatient and stayed an outpatient for the duration of her stay. However, her family could also not provide the necessary post-hospital care, like inserting IV antibiotics or providing certain medications, and so she needs to be transferred to a SNF. Unfortunately, because she was never an inpatient, Medicare does not cover her post-hospital care. Here, Chris also needs a way for the doctors to bypass the three-day minimum and simply rely on physician certification. It is in the best interest of the patient to find care outside of the hospital if she can. It is cost effective for the hospital, CMS, and Chris, who do not want Chris remaining in an expensive hospital bed for three days plus the day of discharge simply to reach the qualifying minimum.

Despite new regulations, CMS has failed to solve the problem the three-day inpatient stay requirement has put on the nation's elderly who cannot pay for post-hospital care without Medicare's help. The new regulations set up a two-midnight benchmark, but this does not change the statutory requirement for a three-day inpatient stay.<sup>164</sup> With a simple two-midnight benchmark requiring a physician to admit a patient after two midnights of outpatient care, a patient still may not qualify to be covered for post-hospital care even if they are put on inpatient status. With current statutes creating the three-day qualified inpatient stay requirement, a judicial solution is unlikely. Thus, a change in legislation will be necessary.

A melding of the two ideas – eliminating the distinction of inpatient and outpatient classification in determining post-hospital Medicare coverage and keeping a hard two-midnight benchmark for inpatient admission – may be the best solution. Instead of completely eliminating the distinction like in Congressman Courtney's bill, Congress could institute a policy that *retroactively* counts outpatient days toward a three-day minimum once a Medicare beneficiary is formally admitted as an inpatient OR provides a way

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164. See *New CMS Rules*, *supra* note 103.

2014] *BLEVINS: HOSPITAL CLASSIFICATION TUG-OF-WAR* 175

for physicians to certify that a patient who does not meet the three-day requirement still needs post-hospital care. For example, if Patient Alex is placed on observation status for two days, is then admitted as an inpatient for two days, and the physician signs off on the medical necessity of subsequent SNF care, the admission would trigger a retroactive admission for the previous two days the patient had been classified as an outpatient. In this scenario, the patient would, with retroactive admission, be classified as an inpatient for four days and then be qualified to receive Medicare coverage for any post-hospital stay in an SNF.

In order to satisfy Patients Blair and Chris's needs for post-hospital care, an overriding mechanism is needed to bypass the three-day inpatient rule. Such a mechanism should allow for formally admitted patients only admitted for two days or less to receive post-hospital care, which is cost-effective for both Medicare and the patient. Leaving this decision up to the medical provider allows for decisions to be made medically. This solution balances the need for physician control over patient admissions and the Medicare mechanisms in place to insure against fraud. Allowing the patient's attending physician to decide whether to admit a patient allows a physician to use medical reasoning to determine their care, rather than financial influences.

## VII. CONCLUSION

The tug-of-war continues and, as of now, the parties are locked in a stalemate, with hospitals stuck in the middle of a fight between the nation's struggling Medicare beneficiaries and HHS. Unless a solution is found, more and more Medicare beneficiaries will find themselves placed on observation status and bearing the brunt of the costs for post-hospital care. Although compelled to act, the CMS has yet to find a solution to the problem. In fact, the problem can only be remedied by a combination of actions: clarifying the factors and guidelines RACs utilize in determining how an inpatient or outpatient should be classified and a legislative change of the Medicare statute creating flexibility in the 3-day qualifying inpatient stay for post-hospital care in a skilled nursing facility.