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Stephanie Masaba

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DIAGNOSED WITH TIME IS MONEY: ARBITRARY MEDICARE PROVISIONS DIFFERENTIATING OBSERVATION SERVICES FROM INPATIENT ADMISSIONS VIOLATE BENEFICIARIES' DUE PROCESS RIGHTS

Stephanie Masaba*

INTRODUCTION

In recent years, an upward trend in the denials of Medicare reimbursement has triggered heightened scrutiny of provisions governing coverage.¹ A hospital service known as “observation care” is one reason behind these increases. Observation care is when a patient goes to the hospital, the doctor must determine the patient’s admission status by evaluating the patient’s medical need.² The doctor decides whether a patient shall be admitted as an inpatient or discharged as an outpatient.³ For billing purposes, the hospital may categorize a patient’s use of service as only observation care; a short-term treatment and assessment service used to evaluate incoming patients.⁴ This type of outpatient service that is “commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.”⁵

While this triaging method serves as a legitimate tool to avoid unnecessary hospital admissions, Medicare coverage for outpatient services comes at a cost for beneficiaries;⁶ outpatient coverage does not extend to any follow-up care, including skilled nursing care and prescription costs.⁷ Medicare beneficiaries complain that the distinction

* J.D. Candidate 2015, William & Mary Law School; B.Hsc. 2011, University of Western Ontario. I would like to thank my family and friends for celebrating this accomplishment with me. I would also like to thank the staff members of the *Bill of Rights Journal* for their hard work.

¹ Kristen Schorsch, *Hospitals Play with Medicare Patients’ Status*, MODERN HEALTHCARE (Oct. 13, 2013, 8:45 AM), <http://www.modernhealthcare.com/article/20131013/INFO/310139984/hospitals-play-with-medicare-patients-status> (“A growing number of senior citizens are ensnared in a Medicare crackdown on hospitals over costly inpatient admissions. Hospitals nationwide are responding by classifying more overnight visitors as outpatients held for observation.”).

² MEDICARE BENEFIT POLICY MANUAL (CMS Pub. 100-02), Ch. 6, §§ 20.6(A)–(B), *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf> [hereinafter MEDICARE BENEFIT POLICY MANUAL].

³ *Id.*

⁴ *Id.* § 20.6(A); *see infra* Part I.B.

⁵ MEDICARE BENEFIT POLICY MANUAL, *supra* note 2, at §§ 20.6(A)–(B).

⁶ *With ICD-10, Expect Claim Denials to Rise*, HEALTH CARE COLLECTOR, Aug. 2013, at 3–4 (“Patients in observation care are not admitted to the hospital, so they face higher co-payments, sometimes much higher out-of-pocket drug costs than admitted patients, and do not qualify for nursing-home coverage.”).

⁷ *Id.*

between inpatient status and observation status is not clear enough to result in the fair categorization of patients in all cases.⁸ At times, this results in beneficiaries unfairly being deemed ineligible for coverage despite their medical need. Unfortunately, most beneficiaries, if not all, are left in complete darkness without any initial disclosure about their admission status before being billed for a hospital visit.

The classification confusion stems from the arbitrary provisions that differentiate outpatient and inpatient care. Doctors refuse to bear the blame because they believe that current regulations and provisions lack the clarity needed to avoid misclassifying patients.⁹ Hospitals blame their mistakes on the government's auditing pressures, which include heavy fines for failure to correctly classify patients on claim submissions.¹⁰ In May 2013, the Centers for Medicare and Medicaid Services (CMS) responded to accumulating frustrations by proposing changes to the federal regulations of Medicare Part A.¹¹ The proposed changes will aim to solve ambiguous eligibility criteria to make it easier to correctly classify inpatient admissions.¹² In August 2013, the CMS finalized changes, but the implementation of the new rules has been delayed until March 31, 2015.¹³

This Note will argue that the proposed new changes to Medicare's provisions of inpatient admission lack the sufficiency necessary to protect beneficiaries from a Fifth Amendment procedural Due Process rights violation. The background section will first discuss Medicare and the outpatient service-observation care, then the Medicare appeals process and current problems with the provisions governing inpatient and outpatient admissions. The next part examines the Due Process Clause and established case law.

The discussion section will first show that all Medicare beneficiaries have an existing property interest because of governing provisions' intent to reimburse beneficiaries' use of medical services, enrollees' expectations, and the inability to easily distinguish outpatients and inpatients. Next, federal oversight of the distribution of Medicare benefits is strong enough to create federal action. Last, the appeals claim system is an inadequate procedural safeguard due to its inability to review claims in a timely manner. The last section will present several recommendations to make

⁸ See Schorsch, *supra* note 1.

⁹ See Bob Wachter, *Medicare's Observation Status—And Why Attempts to Make Things Better May Make Them Worse*, THE HEALTH CARE BLOG (July 30, 2013), <http://www.thehealthcareblog.com/blog/2013/07/30/medicares-observation-status-and-why-attempts-to-make-things-better-may-make-them-worse>.

¹⁰ See *infra* Part I.D.

¹¹ Medicare Program, 78 Fed. Reg. 27,486, 27,644 (proposed May 10, 2013) (to be codified at 42 C.F.R. pts. 412, 462, 485, 489).

¹² *Id.*

¹³ See *id.*; see also Kelly April Tyrrell, *Delays, Controversy Muddle CMS' Two-Midnight Rule for Hospital Patient Admissions*, THE HOSPITALIST (Apr. 1, 2014), <http://www.the-hospitalist.org/article/delays-controversy-muddle-cms-two-midnight-rule-for-hospital-patient-admissions/>; Letter from Allyson Y. Schwartz et al. to Marilyn Tavenner (Sept. 24, 2013), *available at* http://www.forbes.house.gov/uploadedfiles/two_midnights_letter_to_cms_9_25.pdf.

the new provisions more effective, including improving clarity of language and notice to beneficiaries.

I. BACKGROUND

A. Medicare: A Principal Government Program for Healthcare

In 1965, Congress added amendments to the Social Security Act (SSA)¹⁴ to establish Medicare, a form of federal health insurance that aids with medical costs for the elderly and disabled.¹⁵ Eligible citizens fall into three categories: (1) over 65 years old; (2) under 65 years old with certain disabilities; and (3) anyone with End Stage Renal Disease.¹⁶

Federal statutes, rules and regulations promulgated by the Secretary of Health and Human Services, and numerous court decisions govern the administration of this complex program.¹⁷ Various factors affect the distribution of the program's benefits. The extent of Medicare's health care benefits (Coverage) provided for health and drug services is based on three main factors: (1) federal and state laws; (2) national coverage decisions that determine the exact services covered; and (3) local state coverage decisions, made by claims processing companies, which decide the medical necessity of a service and whether to provide coverage for that service in their area.¹⁸

To enroll in the Medicare program, one must go to a Social Security Office or apply online.¹⁹ The Social Security Administration determines eligibility of applicants and processes premium payments.²⁰ The Department of Health and Human Services oversees most agencies that aid with the facilitation and functioning of the program.²¹ In the provisions of the SSA, the Secretary of Health and Human Services has the authority to delegate most of her functional administration duties to medical administrative entities.²² The entity that has the responsibility of assuming that role

¹⁴ See Social Security Act, 42 U.S.C. § 1395c (2006); see also *id.* § 1395b-7 (2006).

¹⁵ MEDICARE EXPLAINED 15 (Nicole T. Stone ed., 2013).

¹⁶ *Medicare Program—General Information*, CTRS. MEDICARE & MEDICAID SERVS. (July 25, 2014), <http://www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/index.html> (“End stage renal disease is a permanent kidney failure requiring dialysis or a kidney transplant.”).

¹⁷ See, e.g., *Medicare Law: An Overview*, LEGAL INFO. INST., <http://www.law.cornell.edu/wex/medicare> (last visited May 1, 2015).

¹⁸ *What Does Medicare Part A Cover?*, MEDICARE.GOV, <http://www.medicare.gov/what-medicare-covers/part-a/what-part-a-covers.html> (last visited May 1, 2015).

¹⁹ See *When & How To Sign Up For Part A & Part B*, MEDICARE.GOV, <http://www.medicare.gov/sign-up-change-plans/get-parts-a-and-b/when-how-to-sign-up-for-part-a-and-part-b.html> (last visited May 1, 2015).

²⁰ See 42 U.S.C. § 1395s (2006); SOC. SEC. ADMIN., MEDICARE (2013), available at <http://www.socialsecurity.gov/pubs/EN-05-10043.pdf>.

²¹ TERRY S. COLEMAN, MEDICARE LAW 5 (2001).

²² 42 U.S.C. § 1395kk-1 (2006); 42 U.S.C. § 1395u(a) (2012); COLEMAN, *supra* note 21, at 5.

is the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration).²³ The Office of the Inspector General (OIG), provides oversight over the operations of the Department of Health and Human Services, as well as ensuring the health and welfare of program beneficiaries.²⁴ The OIG achieves these means by investigating fraud and abuse allegations, as well as recommending program changes.²⁵

Initially, the structure of Medicare consisted of two programs, Medicare Part A and Medicare Part B, but later included two additional programs—Part C and Part D.²⁶ For purposes of discussion in this Note, the focus will only be on the original two parts. Part A of Title 42 of the SSA, officially known as “Hospital Insurance Benefits for Aged and Disabled,” covers important hospital and other institutional provider care costs.²⁷ More specifically it covers inpatient care including: critical access to hospitals, skilled nursing facilities, hospice, and some home health services.²⁸ Generally, beneficiaries do not need to pay a premium fee, and their benefits depend on whether certain conditions are satisfied.²⁹

Medicare is a costly program. Today, the program covers over fifty million seniors, and that number is likely to grow with an aging baby boomer population.³⁰ Funding for the program comes primarily from the following sources: federal general revenues (40%), payroll tax contributions (38%), and beneficiary premiums (13%).³¹ Other sources include state payments, social security benefit taxes, and interest.³² In general, payroll taxes provide payments for coverage: payments may come directly from employers, employees, or those self-employed.³³ These taxes are invested in trust funds.³⁴

The Hospital Insurance Fund (HI Fund) accumulates funds to cover Part A services, while Part B draws funding from the Supplementary Medical Insurance Trust

²³ 42 U.S.C. § 1395kk-1; 42 U.S.C. § 1395u(a); HARVEY L. MCCORMICK, 1 *MEDICARE & MEDICAID CLAIMS AND PROCEDURES*, at 26 (4th ed. 2005); COLEMAN, *supra* note 21, at 5.

²⁴ *About Us*, OFF. INSPECTOR GEN., <http://oig.hhs.gov/about-oig/about-us/index.asp> (last visited May 1, 2015).

²⁵ See COLEMAN, *supra* note 21, at 5; *About Us*, *supra* note 24.

²⁶ *MEDICARE EXPLAINED*, *supra* note 15, at 15.

²⁷ 42 U.S.C. § 1395c (2006); *MEDICARE EXPLAINED*, *supra* note 15, at 15.

²⁸ COLEMAN, *supra* note 21, at 1.

²⁹ *Medicare Program—General Information*, *supra* note 16.

³⁰ David Morgan, *Medicare’s Political Importance Goes Beyond Seniors*, REUTERS (Aug. 31, 2012), <http://www.reuters.com/article/2012/08/31/us-usa-campaign-medicare-idUSBRE87U06F20120831>.

³¹ See *The Facts on Medicare Spending and Financing*, KAISER FAMILY FOUND. (July 28, 2014), <http://kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/>.

³² *Id.*

³³ COLEMAN, *supra* note 21, at 1.

³⁴ *Id.* at 2 (“[T]rust fund structure and its accumulation of interest are essentially an accounting device to track an obligation to raise funds in future years through taxation or borrowing . . .”).

Fund (SMI Fund).³⁵ The HI Fund collects money from a 2.9% tax on employee earnings. This tax increases for higher-income taxpayers.³⁶ This makes the HI Fund largely dependent on the size of the workforce and at risk of possible insolvency within the next ten years.³⁷ Part B does not face such a risk because the SMI Fund relies primarily on federal general revenues (73%) and enrollee premiums (25%).³⁸ Outside of general revenues, the federal government also makes large contributions as an employer of enrollees who are federal employees.³⁹

Medicare Part B, also known as “Supplementary Medical Insurance Benefits for the Aged and Disabled,” is a voluntary program that covers services and supplies if deemed medically necessary.⁴⁰ Coverage includes physician costs, outpatient care, other healthcare practitioner services like physical therapy or occupational therapy, and items and supplies not covered under the basic program.⁴¹ Enrollees usually pay for coverage through monthly premiums.⁴² Funding is also supported by contributions from the federal government.⁴³ As one could easily gather, presently, Medicare (along with Medicaid⁴⁴) costs the government billions of dollars, but it is an important program servicing millions of American citizens.⁴⁵ Unfortunately, this funding is not readily replaceable and so the well may dry soon.

³⁵ See Emily Robinson, *How Medicare is Funded*, ONLINE NEWSHOUR, <http://www.pbs.org/newshour/health/medicare/financing.html> (last visited May 1, 2015); *The Facts on Medicare Spending and Financing*, *supra* note 31.

³⁶ See HENRY J. KAISER FAM. FOUND., *THE AFFORDABLE CARE ACT THREE YEARS POST-ENACTMENT* (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/04/84291.pdf> [hereinafter KAISER FOUNDATION].

³⁷ Robinson, *supra* note 35. It is expected that by 2026, partially as a result of the baby boomer generation retiring and a shrinking workforce, funds will be either depleted or close to it. *Id.*

³⁸ These numbers are based on a 2014 study. See *The Facts on Medicare Spending and Financing*, *supra* note 31; see also Robinson, *supra* note 35; COMM. WAYS & MEANS, *THE PRESIDENT’S AND OTHER BIPARTISAN PROPOSALS TO REFORM MEDICARE: MODERNIZING BENEFICIARY COST-SHARING* (2013), available at http://waysandmeans.house.gov/uploadedfiles/modernizing_cost-sharing_summary.pdf. The Affordable Care Act has frozen income-related premium thresholds until 2019, likely increasing the number of beneficiaries paying a higher premium. *The Facts on Medicare Spending and Financing*, *supra* note 31.

³⁹ These payments by the government are known as “intragovernmental transfers.” Robinson, *supra* note 35.

⁴⁰ MEDICARE EXPLAINED, *supra* note 15, at 15; *Medicare Part B*, CTRS. MEDICARE & MEDICAID SERVS. (Mar. 5, 2012), <http://www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/Part-B.html>.

⁴¹ MEDICARE EXPLAINED, *supra* note 15, at 15; *Medicare Part B*, *supra* note 40.

⁴² MEDICARE EXPLAINED, *supra* note 15, at 15; *Medicare Part B*, *supra* note 40.

⁴³ MEDICARE EXPLAINED, *supra* note 15, at 15.

⁴⁴ Medicaid will not be discussed in this Note; it is a type of federally mandated health insurance targeting specific population groups, like Medicare, except that States establish and administer the programs themselves. See Vikki Wachino, *About Us*, MEDICAID.GOV, <http://www.medicaid.gov/about-us/about-us.html> (last visited May 1, 2015).

⁴⁵ See MCCORMICK, *supra* note 23, at 7–8.

B. Inpatient Versus Outpatient: What Is Observation Care?

One way the federal government attempts to constrain costs is by restricting coverage of services. A patient's hospital status will affect the amount of coverage available to her, as well as whether that coverage will extend to post-discharge treatments (i.e., nursing care, prescriptions, etc.).⁴⁶ This determination stems from the initial discretion of an examining doctor.⁴⁷ That doctor decides if a patient receives "inpatient" or "outpatient" care.⁴⁸ If labeled as an inpatient, then a physician formally admits the patient to the hospital under a doctor's order.⁴⁹ The length of stay begins on the day of admission and continues until the day before a patient is discharged.⁵⁰ If the services used satisfy Part A provisions, then a patient must only pay a one-time deductible for those services within the first sixty days in the hospital.⁵¹ Under Part B, a deductible constitutes 20% of the Medicare-approved amount for doctor services *after* paying the initial Part B deductible.⁵²

Conversely, outpatient services include emergency department services, observation services, outpatient surgery, lab tests, and x-rays, but the doctor does not write an order to admit the patient to the hospital.⁵³ Therefore, despite receiving similar treatment and services as an admitted inpatient, maybe even joining inpatients in overnight stays and/or having a similar length of stay, one is still deemed an outpatient.⁵⁴ Part B provides provisions to govern the coverage of outpatient services. Patients must pay co-payments for each *individual* service.⁵⁵ Just as in the case of inpatient services covered under Part B, a beneficiary will pay 20% after paying a deductible.⁵⁶ In most cases, coverage will not extend to prescription and over-the-counter drugs.⁵⁷ Also, care from a Skilled Nursing Facility⁵⁸ is only covered if one is admitted as an inpatient and stays

⁴⁶ See *supra* notes 32–34 and accompanying text; CTRS. MEDICARE & MEDICAID SERVS., ARE YOU A HOSPITAL INPATIENT OR OUTPATIENT? 4 (2014), available at <https://www.medicare.gov/Pubs/pdf/11435>.

⁴⁷ ARE YOU A HOSPITAL INPATIENT OR OUTPATIENT?, *supra* note 46, at 1.

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.* at 2.

⁵² *Id.*

⁵³ *Id.* at 1.

⁵⁴ *Id.*

⁵⁵ *Id.* at 2.

⁵⁶ *Id.*

⁵⁷ *Id.* Patients may have coverage under Part D; however, a patient may still have to pay out-of-pocket first and claim refund afterwards. *Id.*

⁵⁸ A Skilled Nursing Facility is a nursing home which provides skilled care for the "injured, sick, or disabled." *What Are Skilled Nursing Facilities?*, SKILLEDNURSINGFACILITIES.ORG, <http://www.skillednursingfacilities.org/resources/what-are-skilled-nursing-facilities/> (last visited May 1, 2015). The care delivered to patients includes chronic illness management, medication monitoring, physical or occupational therapy, and even specialized care for incurable diseases

in the hospital for a minimum of three consecutive days.⁵⁹ Moreover, co-payments per service under Medicare Part B may be greater than inpatient deductibles, and therefore, an outpatient's total co-payment for all services used may still be more than the inpatient's total deductible.⁶⁰

Patients often utilize an outpatient service called "observation care" (also known as observation stay and observation service). Consisting of a well-defined set of specific, clinically appropriate services, observation care involves a physician evaluating whether to decide if a patient should be admitted to hospital as an inpatient or whether to provide observation services only.⁶¹ Physicians use short-term treatments and assessments to make a determination.⁶² Assessments include reviewing a patient's prior medical history, the severity of symptoms, and evaluating the expected care. CMS policy requires physicians to make a conclusive decision within twenty-four hours, and in more difficult cases, within a maximum of forty-eight hours.⁶³ The doctor's final decision will affect the amount of reimbursements for both physicians and patients. Hospitals receive payments for observation service through the Outpatient Prospective Payment System (OPPS).⁶⁴ OPPS bases costs on the number of services used by each individual beneficiary, therefore, the more services used by the beneficiary the more he will need to pay.⁶⁵ In contrast, the Inpatient Prospective Payment System (IPPS) is not dependent on the number of services provided or the length of stay; payment is based on the cost of caring for an average beneficiary.⁶⁶ Policymakers recognize that "[b]eneficiaries who are treated for extended periods of time as hospital outpatients receiving observation services may incur greater financial liability than they would if they were admitted as hospital inpatients."⁶⁷

In instances when observation care is warranted it can serve as an effective way to limit unnecessary medical treatment. On the other hand, without sound basis, it can unfairly disadvantage patients. Several Medicare advocates criticize observation care for just being an arbitrary labeling of patients because both in- and out-patients may

like Alzheimer's. *Id.* Eighty-four percent of the 1.9 million nursing beds are Medicare certified. See *Nursing Home Statistics*, SPECIALTY HOSPITALS AM., www.specialtyhospitalsofamerica.com/news/nursing-home-statistics-2/ (last visited May 1, 2015).

⁵⁹ ARE YOU A HOSPITAL INPATIENT OR OUTPATIENT?, *supra* note 46, at 4.

⁶⁰ *Id.* at 2.

⁶¹ Medicare Program, 78 Fed. Reg. 27,486, 27,644, (proposed May 10, 2013) (to be codified at 42 C.F.R. pts. 412, 462, 485, 489); STUART WRIGHT, OFFICE OF THE INSPECTOR GEN., MEMORANDUM REPORT: HOSPITALS' USE OF OBSERVATION STAYS AND SHORT INPATIENT STAYS FOR MEDICARE BENEFICIARIES 2 (2013), available at <http://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf>.

⁶² WRIGHT, *supra* note 61, at 2.

⁶³ *Id.* at 2.

⁶⁴ *Id.* at 4.

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ Medicare Program, 78 Fed. Reg. 27,466, 27,644 (proposed May 10, 2013) (to be codified at 42 C.F.R. pts. 412, 485, 489).

stay in the hospital for days and nights, while often receiving very similar treatments.⁶⁸ Advocates believe that the “care for . . . outpatients is often indistinguishable from the care provided to individuals who are called inpatients.”⁶⁹ This ambiguity is prevalent enough that most beneficiaries do not know anything about their status until the bill comes in the mail, leaving them with only the option to formally dispute the claim.

C. Appeals: Mechanisms to Dispute Claim Determinations

Sometimes, when a beneficiary receives a processed claim receipt that beneficiary may not agree with the amount of coverage received for use of a particular service. Several mechanisms and procedures allow beneficiaries to dispute any claims determined under Part A and/or Part B. A beneficiary may appeal to either request a service, supply, item, or prescription he feels entitled to, or request a payment for services, supplies, etc. already received, or change the amount he is required to pay.⁷⁰ Provisions found in both the SSA and the Federal Register govern a five-level claim appeals system for beneficiaries.⁷¹ The levels of the appeals process are as follows:

1. Redetermination by a CMS contractor (carrier, fiscal intermediary or Medicare Administrative Contractor),
2. Reconsideration by a Qualified Independent Contractor,
3. Hearings before an Administrative Law Judge within the Office of Medicare Hearings and Appeals in the Department of Health and Human Services,
4. Review by the Appeals Council within the Departmental Appeals Board in the Department of Health and Human Services, and
5. Judicial review in federal district court.⁷²

Beneficiaries can submit a written appeal request only after an initial claim determination has been processed by a Medicare designated billing company.⁷³ The claim receipt and other accompanying documents provide the necessary information about the appeals process to recipients.⁷⁴

⁶⁸ See *CMS Addresses Observation Status Again . . . And Again, No Help for Beneficiaries*, CTRS. MEDICARE ADVOC., INC., <http://www.medicareadvocacy.org/cms-addresses-observations-status-again-and-again-no-help-for-beneficiaries/> (last visited May 1, 2015) [hereinafter *CMS Addresses Observation Status*].

⁶⁹ *Id.*

⁷⁰ CTRS. MEDICARE & MEDICAID SERVS., *MEDICARE APPEALS 5* (2013), available at <http://www.medicare.gov/Pubs/pdf/11525.pdf> [hereinafter *MEDICARE APPEALS*].

⁷¹ Determinations, Redeterminations, Reconsiderations, and Appeals Under Original Medicare (Part A and Part B), 42 C.F.R. § 405, Subpart I (2013); ARE YOU A HOSPITAL INPATIENT OR OUTPATIENT?, *supra* note 46; see Social Security Act, 42 U.S.C. § 1396ff (2012).

⁷² *MEDICARE APPEALS*, *supra* note 70, at 9; *How Do I File An Appeal If I Have Original Medicare?*, MEDICARE.GOV, <http://www.medicare.gov/claims-and-appeals/file-an-appeal/original-medicare/original-medicare-appeals.html> (last visited May 1, 2015).

⁷³ *MEDICARE APPEALS*, *supra* note 70, at 9.

⁷⁴ *Original Medicare Appeals—Level 1: Redetermination by the Company that Handles*

The first level of the process involves a review of the initial claim by contractor staff—a group of new individuals who did not participate in the original claim determination.⁷⁵ The appeal must be made within 120 days of receiving the claim receipt, and usually the contractor staff completes its review within 60 days.⁷⁶ If a beneficiary is not satisfied with the redetermination, then he may appeal to the second level within 180 days.⁷⁷ The Quality Improvement Organization (QIO)⁷⁸ conducts an independent review of both the initial determination and subsequent redetermination.⁷⁹ The QIO may invite an accompanying panel of physicians or other health care professionals to review the issues regarding the medical necessity of care.⁸⁰ The Office of Medical Hearings and Appeals oversees the third level.⁸¹ This stage is only available for claims with \$150 or more left in controversy.⁸² An Administrative Law Judge conducts an independent review of the facts and listens to testimony before making a new or impartial decision.⁸³ The judge may decide the case on-record if the beneficiary waives his right to a hearing or when the evidence supports a finding in clear favor of the beneficiary.⁸⁴

If a beneficiary is not satisfied with the judge's decision, then he can appeal to the Appeals Council within sixty days—the second-to-last appeal level.⁸⁵ The Council will review the judge's decision and the specific issues contested before issuing its own

Claims for Medicare, MEDICARE.GOV, <http://www.medicare.gov/claims-and-appeals/file-an-appeal/original-medicare/original-medicare-appeals-level-1.html> (last visited May 1, 2015).

⁷⁵ *Id.*; MEDICARE APPEALS, *supra* note 70, at 12.

⁷⁶ *Original Medicare Appeals—Level 1: Redetermination by the Company that Handles Claims for Medicare*, *supra* note 74; MEDICARE APPEALS, *supra* note 70, at 10–11.

⁷⁷ *Original Medicare Appeals—Level 1: Redetermination by the Company that Handles Claims for Medicare*, *supra* note 74; MEDICARE APPEALS, *supra* note 70, at 11.

⁷⁸ The Quality Improvement Organization is “[a] group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to people with Medicare.” *Benefits Overview*, FAMILY CARE, INC. (Oct. 29, 2013), <http://www.familycareinc.org/index.php?/01.main/benefits-overview>.

⁷⁹ MEDICARE APPEALS, *supra* note 70, at 11–13.

⁸⁰ *Id.* at 12–13. At this stage, beneficiaries must submit all supporting evidence, otherwise they might waive the opportunity to bring in additional corroborating evidence in later stages without a showing of good cause. *Id.*

⁸¹ *Office of Medical Hearings and Appeals (OMHA)*, U.S. DEPT. OF HEALTH AND HUMAN SERVS., <http://www.hhs.gov/omha/> (last visited May 1, 2015).

⁸² *Third Level of Appeal: Hearing by an Administrative Law Judge*, CMS.GOV, <http://cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/HearingsALJ/html> (last visited May 1, 2015). The threshold of controversy is determined “annually by the percentage in the medical care component of the consumer price index for all urban consumers.” *See Level-Five Appeal*, AM. HOSPITAL ASSOC., <http://www.aha.org/advocacy-issues/medicare/appeals/level-five.shtml> (last visited May 1, 2015).

⁸³ MEDICARE APPEALS, *supra* note 70, at 13. Usually the review is conducted by phone or video teleconference; in some cases the judge may grant an in-person hearing. *Id.*

⁸⁴ *Id.* at 13.

⁸⁵ *Appeals—Level 3: Hearing Before an Administrative Law Judge (ALJ)*, MEDICARE.GOV, <http://www.medicare.gov/claims-and-appeals/file-an-appeal/appeals-level-3.html> (last visited May 1, 2015).

decision.⁸⁶ The final level of appeal is having the claim reviewed in a federal district court.⁸⁷ A beneficiary must file an appeal within sixty days of receiving a decision from the Appeals Council, and at least \$1,460 must be remaining in controversy.⁸⁸ As intricate as this appeals process appears to be, in reality it is not an efficient and desirable process, as discussed later in this Note.

D. Problems with Observation Care: Provisions Lack Clarity

Various reports and studies conclude that the use of outpatient services is increasing, while inpatient admissions are decreasing. The Medicare Payment Advisory Commission,⁸⁹ reported in its March 2013 report to Congress, that “[b]etween 2006 and 2011, observation visits increased from 28 visits per 1,000 Part B beneficiaries to approximately 47 visits per 1,000, a nearly 65 percent increase in visits over the period.”⁹⁰ Also, the Center for Medicare Advocacy supports this observation with its findings that “not only has the percentage of patients in observation nearly tripled, but the total number of observation stays of any duration also increased by nearly 50% over the same five-year period.”⁹¹

The ruckus surrounding the observation care provisions has also caught the attention of several members of Congress. As of March 2013, two bills titled “Improving Access to Medicare Coverage of 2013” were submitted to both the Senate and House of Representatives.⁹² This bipartisan pending legislation proposes that days spent in

⁸⁶ MEDICARE APPEALS, *supra* note 70, at 15–16.

⁸⁷ *Id.* at 16.

⁸⁸ *Id.* at 16. The \$1,460 represents the official current controversy threshold set for 2015. *Id.*

⁸⁹ *About MedPAC*, MEDPAC, <http://www.medpac.gov/-about-medpac-> (last visited May 1, 2015) (“The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act . . . to advise the U.S. Congress on issues affecting the Medicare program.”).

⁹⁰ MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 48 (2013), available at http://www.medpac.gov/documents/Mar13_entirereport.pdf?sfvrsn=0.

⁹¹ *CMS Addresses Observation Status*, *supra* note 68.

⁹² S. 569, 113th Cong. (2013); H.R. 1179, 113th Cong. (2013). Ohio Democrat Senator Sherrod Brown introduced the Senate Bill, and he has already successfully pushed for initiatives that enable seniors to receive free screenings and other preventive services and changes that reduce prescription drug costs. *See generally Standing Up for Seniors*, SHERROD BROWN, <http://www.sherrodbrown.com/issues/standing-up-for-seniors/> (last visited May 1, 2015). Congressman Joe Courtney, a Connecticut Democrat, and Congressman Tom Latham, an Iowa Republican, introduced the House bill. *See* H.R. 1179. Congressman Courtney’s initiatives to make Medicare coverage more inclusive have garnered a lot of attention. *See generally* Press Release, Congressman Joe Courtney, Commission on Long-Term Care Recommends Courtney-Sponsored Modifications to Three-Day Hospital Stay Requirement for Skilled Nursing Care Coverage in Medicare (Oct. 4, 2013), <http://courtney.house.gov/press-releases/commission-on-longterm-care-recommends-courtneysponsored-modifications-to-threeday-hospital-stay-requirement-for-skilled-nursing-care-coverage-in-medicare/>. Also, Congressman Latham has participated in discussions to strengthen Medicare and ensure enrollees continue to receive

observation care should not be excluded from, but count towards inpatient stay requirements instead.⁹³

In 2013, the CMS responded to this growing disparity between inpatient and outpatient services and its effect on beneficiaries' coverage. The CMS acknowledged that "the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours . . . has increased from approximately 3 percent in 2006 to approximately 8 percent in 2011."⁹⁴ The CMS is concerned that despite the readily available information it provides about beneficiaries' financial liability and services, there still seems to be confusion about how governing regulations work.⁹⁵ This is because of its findings that "at least some of these outpatient observation visits would have been short inpatient stays in the past; during the corresponding time period (2006 to 2011), the number of inpatient stays lasting one day declined by more than 15 percent."⁹⁶

The original provisions of the SSA required a prior three-day hospital inpatient stay for coverage of services, including Skilled Nursing Facility care, under Medicare Part A.⁹⁷ A specific number of days and nights seems like a very straight forward, bright line rule for eligibility, but several other factors have made application of the rule not so black and white. In the new proposed rules of 2013, the CMS discussed how the revisions of the old provisions of observation care, "may be attributable in part to hospitals' concerns about Medicare's payment policy for billing under Part B when a Part A hospital inpatient claim is denied because a Medicare review contractor determines that the inpatient admission was not reasonable and necessary under section 1862(a)(1)(A) of the Act."⁹⁸ Why the concern from hospitals? Because provisions limit the number of ancillary inpatient services that can be paid for by Medicare.⁹⁹ The CMS recognized that the drafting of the provisions, coupled with oversight from auditing programs, seemed to be driving hospitals' response to "the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review by electing to treat beneficiaries as outpatients receiving observation services, often for long periods of time, rather than admitting them as inpatients."¹⁰⁰ So, the CMS proposed new clarified rules governing hospital inpatient admissions, "[t]o reduce uncertainty regarding the requirements for payments to hospitals and CAHs

much needed services. *See generally* Press Release, Congressman Tom Latham, Latham Meets With Iowa Representatives of AARP to Discuss Medicare and Social Security (Jun. 20, 2012), <http://www.legistorm.com/stormfeed/view-rss/390302/member/331.html>.

⁹³ S. 569, 113th Cong. (2013); H.R. 1179, 113th Cong. (2013).

⁹⁴ Medicare Program, 78 Fed. Reg. 27,644 (proposed May 10, 2013) (to be codified at 42 C.F.R. pts. 412, 462, 485, 489).

⁹⁵ *Id.* ("[W]e have published educational materials for beneficiaries to inform them of their respective liabilities as a hospital outpatient or inpatient.").

⁹⁶ MEDPAC, *supra* note 90, at 48.

⁹⁷ 78 Fed. Reg. 27,644; Social Security Act, 42 U.S.C. § 1395x(i).

⁹⁸ 78 Fed. Reg. 27,644.

⁹⁹ *Id.*

¹⁰⁰ *Id.*

under Medicare Part A.”¹⁰¹ The goal is that the clarification will “reduce the frequency of extended observation care when it may be inappropriately furnished.”¹⁰²

The new rule proposal of 2013 generously adjusts the time presumption needed to qualify for inpatient admission. The CMS proposes “hospital inpatient admissions spanning [*two*] midnights in the hospital would generally qualify as appropriate for payment under Medicare Part A.”¹⁰³ Moreover, if a stay lasts less than two nights, then such a stay will be deemed as “generally inappropriate for inpatient admission and inpatient payment under Medicare Part A,” unless the surgical procedure is “specified by Medicare as inpatient only under §419.22(n).”¹⁰⁴

One aspect that remains the same is the doctor will still continue to have sole discretion in making the initial determination of a patient’s classification by issuing a completed, signed, and documented certified admission order.¹⁰⁵ Physician certification will require the doctor “to certify the reasons for the hospitalization, the estimated time the patient will remain in the hospital, and ‘plans for post-hospital care, if appropriate.’”¹⁰⁶ However, this certification will not serve as a conclusive determination of a patient’s eligibility; the CMS still reserves the right to review the order “in the context of the evidence in the medical record.”¹⁰⁷

II. DENYING BENEFITS: DUE PROCESS CLAUSE AND PROTECTED PROPERTY INTERESTS

The Fifth Amendment’s Due Process Clause prohibits the federal government from depriving citizens of “life, liberty, or property” without the due process of law.¹⁰⁸ The Due Process Clause ensures citizens justice by shielding them from unlawful acts by the government.¹⁰⁹ Therefore, the government at all times must adhere to enforceable rules and established procedures.¹¹⁰ This includes not creating laws and regulations

¹⁰¹ *Id.* at 27,496.

¹⁰² *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/> [hereinafter *Observation Status*].

¹⁰³ 78 Fed. Reg. 27,496 (emphasis added).

¹⁰⁴ *See Observation Status*, *supra* note 102.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.* (There is no provision which elaborates that “CMS intends to provide additional information about what ‘evidence in the medical record’ means in future instructions and manual revisions.”).

¹⁰⁸ U.S. CONST. amend. V (“No person shall be held to answer for. . . *nor be deprived of life, liberty, or property, without due process of law*; nor shall private property be taken for public use, without just compensation.” (emphasis added)); *see Fifth Amendment: Due Process*, BILL OF RIGHTS INST., <http://billofrightsinstitute.org/resources/educator-resources/americanapedia/americanapedia-bill-of-rights/fifth-amendment/due-process/> (last visited May 1, 2015).

¹⁰⁹ *Fifth Amendment: Due Process*, *supra* note 108.

¹¹⁰ *Id.*

which deny citizens their rights as protected by the Bill of Rights.¹¹¹ In a procedural due process claim, the court will look to see if the facts support three elements: (1) an existing property interest, (2) state action deprived due process, (3) and insufficient procedural protections.¹¹²

A. Procedural Due Process: The Protected Interest

When evaluating procedural Due Process challenges, courts must first determine if a protected interest exists.¹¹³ Such an interest may be a “property” interest. Some Americans consider property the “foundation of every right we have.”¹¹⁴ There are two types of property right claims: (1) a defensive claim which is an act to keep what one already possesses (or has title over), or (2) an offensive claim which is an act to get something being possessed by someone else.¹¹⁵ So, a citizen can demand from the government the release of “property” to whom the government claimed that citizen would be entitled. For several decades, the Supreme Court has held that statutory benefits distributed by the government may constitute a protected property interest.¹¹⁶ For example, in *Goldberg v. Kelly*, welfare recipients challenged termination procedures of their public assistance payments. The Supreme Court deemed federal welfare assistance a property interest—“[s]uch benefits are a matter of statutory entitlement for persons qualified to receive them.”¹¹⁷ Also, in *Mathews v. Eldridge*, the Court found that procedural due process is applicable to the terminations of Social Security disability benefits.¹¹⁸ An individual’s interest “in the continued receipt of [such] benefits is a statutorily created ‘property’ interest protected by the Fifth Amendment.”¹¹⁹

¹¹¹ *Id.*

¹¹² *Mathews v. Eldridge*, 424 U.S. 319 (1975).

¹¹³ *Am. Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 59 (1999) (“The first inquiry in every due process challenge is whether the plaintiff has been deprived of a protected interest in ‘property’ or ‘liberty.’”).

¹¹⁴ CATO INST., HANDBOOK FOR POLICYMAKERS 346 (7th ed. 2009) (“It is no accident that a nation conceived in liberty and dedicated to justice for all protects property rights.”).

¹¹⁵ *Id.*

¹¹⁶ *E.g.*, *Goldberg v. Kelly*, 397 U.S. 254 (1970). The *Goldberg* opinion includes a footnote which explains nicely why in a changing society, property can no longer refer to only *real* property:

It may be realistic today to regard welfare entitlements as more like “property” than a “gratuity.” Much of the existing wealth in this country takes the form of rights that do not fall within traditional common-law concepts of property [S]ociety today is built around entitlement Many of the most important of these entitlements now flow from government: subsidies to farmers and businessmen . . . social security pensions for individuals. Such sources of security . . . to the recipients [] are essentials

Id. at 262 (citations omitted) (quotation marks omitted).

¹¹⁷ *Id.* at 262.

¹¹⁸ 424 U.S. 319, 332 (1976).

¹¹⁹ *Id.*

Medicare beneficiaries can also enjoy similar protected rights to recover their medical benefits from the government. However, that protected property right is only granted when beneficiaries can successfully prove that a “legitimate entitlement” exists. The governing provisions would need to indicate explicitly that a certain outcome must follow from a certain set of satisfied criteria.¹²⁰

B. Procedural Due Process: A State Action

To consider a due process claim, the court must be able to hold a state or federal actor accountable for a private act. Case law states that no formal test has been established to aid courts with determining whether a private act is fairly attributable to a state or federal actor.¹²¹ However, the Supreme Court uses other ways to determine the responsible actor.¹²² For example, in *Blum v. Yaretsky*, the patients had the burden of showing a “close nexus” between the state and the challenged act of the regulated entity.¹²³ Even if a private actor commits an act, the state can still be held responsible if that private actor is subject to the state’s coercive power.¹²⁴ Coercive power may be found if the state overtly or covertly encourages the private actor to such an extent that it might as well be the state doing the action.¹²⁵ State action may also be found if the acts taken are considered to be “traditionally the exclusive prerogative of the State.”¹²⁶ *Monteleone v. United Concordia Companies* summarizes other tests used by the Supreme Court including whether the private actor is a “willful participant in joint activity with the State or its agents,”¹²⁷ whether the actor is an

¹²⁰ See *Bagnall v. Sebelius*, No. 3:11CV703, 2013 WL 5346659, at *20 (D. Conn. Sept. 23, 2013) (“[E]ntitlement to the benefit occurs only when official discretion is so narrowly confined as to virtually guarantee conferral of the benefit.” (quoting *Furlong v. Shalala*, 156 F.3d 384, 3994 (2d Cir. 1998))).

¹²¹ *Monteleone v. United Concordia Cos.*, No. 09-1114, 2010 WL 653928, at *3 (W.D. Pa. Feb. 19, 2010) (“There is no single or uniform test to determine if a private act may be attributable to the state; however, the United States Supreme Court has developed several frameworks for determining this question . . .”).

¹²² *Id.* In *Bowles v. Willingham*, the Supreme Court explained that regardless of whether a claim is for a Fifth Amendment or Fourteenth Amendment violation, the alleged actor will be held to the same standard. 321 U.S. 503, 518 (1944) (“[T]he restraints imposed on the national government in this regard by the Fifth Amendment are no greater than those imposed on the States by the Fourteenth.”).

¹²³ 457 U.S. 991, 1004 (1982).

¹²⁴ *Id.*; *Monteleone*, 2010 WL 653928, at *3 (“[A] challenged activity may be state action when it results from the State’s exercise of ‘coercive power’ . . .” (citations omitted)).

¹²⁵ *Blum*, 457 U.S. at 1004. As *Blum* further explains, this action must be significant and cannot be just “[m]ere approval of or acquiescence in the initiatives of a private party . . .” *Id.* at 1004–05.

¹²⁶ *Id.* at 1005 (citations omitted) (quotation marks omitted).

¹²⁷ *Monteleone*, 2010 WL 653928, at *3 (citations omitted); see *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 941 (1982) (“[W]e have consistently held that a private party’s joint participation with state officials in the seizure of disputed property is sufficient to characterize that party as a ‘state actor’ . . .”).

agency of the state and therefore the agency acts are regarded as state acts,¹²⁸ or whether the private conduct is so “entwined with governmental policies.”¹²⁹

C. Procedural Due Process: Procedural Protection and the Mathews Test

In *Mathews*, the Supreme Court addressed whether the Due Process Clause of the Fifth Amendment requires that prior to any termination of Social Security benefits, the affected beneficiary must be afforded the opportunity to dispute the claim in an evidentiary hearing.¹³⁰ The Supreme Court developed a balancing test to determine whether sufficient protections exist to ensure that procedural due process rights are not unnecessarily violated.¹³¹ The Court’s analysis for deciding whether or not sufficient protections exist, examines the following three factors: (1) the affected private interest, (2) the erroneous deprivation of such interest by existing procedures and probable value of additional or substitute procedural safeguards, and (3) the government’s interest.¹³²

The first element—the affected private interest, describes the injury that the beneficiary would want to avoid as a result of not receiving benefits. For example, in *Mathews* the Supreme Court found that someone receiving Social Security payments would have an interest in an “uninterrupted receipt of this source of income.”¹³³ The private interest is not only limited to a financial need for survival, such as in the case of welfare recipients, but under certain circumstances it may also extend to a need to cover astronomical costs of crucial medical services.¹³⁴

The second element—the risk of erroneous deprivation, examines procedural measures used to give a beneficiary notice of any termination or revocation of benefits.¹³⁵ The court assesses various factors to decide if the degree of deprivation

¹²⁸ *Monteleone*, 2010 WL 635928, at *3; see *Pennsylvania v. Board of Directors*, 353 U.S. 230, 231 (1957) (holding that despite acting as trustees, a board’s actions were discrimination by the state because that board was an agency of the state).

¹²⁹ *Monteleone*, 2010 WL 635928, at *3. In *Evans v. Newton*, the court referred to the same example in *Pennsylvania v. Board of Directors*, where the city could not dissociate its acts from the state merely because it was acting as in the capacity of trustee of a private will. 382 U.S. 296, 299 (1966) (“A town may be privately owned and managed, but that does not necessarily allow the company to treat it as if it were wholly in the private sector.”).

¹³⁰ *Mathews v. Eldridge*, 424 U.S. 319, 323 (1976).

¹³¹ *Id.* at 322; *Grijalva v. Shalala*, 152 F.3d 1115, 1121 (9th Cir. 1998).

¹³² *Shalala*, 152 F.3d at 1121–23.

¹³³ See *Mathews*, 424 U.S. at 340; see also *Shalala*, 152 F.3d at 1121–23.

¹³⁴ See *Mathews*, 424 U.S. at 340 (“[T]he degree of potential deprivation that may be created by a particular decision is a factor to be considered”); *Kraemer v. Heckler*, 737 F.2d 214, 222 (2d Cir. 1984) (holding that if a beneficiary has to solely bear medical costs then it is likely that the beneficiary will not choose to continue receiving medical care); *Vorster v. Bowen*, 709 F. Supp. 934, 946 (C.D. Cal. 1989) (explaining that obtaining reimbursement for medical bills is a fairly great private interest).

¹³⁵ *Mathews*, 424 U.S. at 343.

is unlawful. In the case of Medicare claims, this would involve evaluating the sufficiency of the claim appeals system. For example, the burdening impact of such deprivation may be unnecessarily increased because a lengthy delay exists between a beneficiary's request for a hearing and the rendering of a final decision from the appropriate agent or judge.¹³⁶ Or, sometimes other available forms of assistance or resources for the beneficiary may serve as an adequate substitution for the deprived due process.¹³⁷

The Court also evaluates the sources used by an actor to make a claim determination to see if their use results in fair and reliable procedural measures. For example, the use of written sources is examined for their credibility.¹³⁸ The writing should have an underlying objective basis, like a medical report from a licensed physician, as opposed to being a wholly subjective narrative.¹³⁹ The *Mathews* Court noted though that "procedural due process rules are shaped by the risk of error inherent in the truth-finding process as applied to the generality of cases, not the rare exceptions."¹⁴⁰

The final element of the *Mathews* test is the government's interest, as well as the public's interest.¹⁴¹ Various factors are considered including the administrative burdens and societal costs of requiring an evidentiary hearing before benefits are terminated.¹⁴² Adding additional safeguards must be reasonable and a reflection of the government's interest in using resources efficiently and not overspending public funds.¹⁴³ This must be balanced against the competing interest of not wanting to unjustifiably increase out-of-pocket expenses for recipients who are entitled to receive available benefits.¹⁴⁴

III. DISCUSSION

A. Denying Benefits: Procedural Due Process Violations of Medicare Beneficiaries

As discussed previously, anyone bringing a due process claim must show that government action deprived him of a property interest without due process of law.¹⁴⁵ The Supreme Court has recognized Medicare benefits and other government benefits existing property interests that may be subject to due process.¹⁴⁶ However, such a

¹³⁶ *Id.* at 341–42.

¹³⁷ *Id.*

¹³⁸ *Id.* at 343–44.

¹³⁹ *Id.* at 344.

¹⁴⁰ *Id.*

¹⁴¹ *Id.* at 347.

¹⁴² *Id.*

¹⁴³ *Id.* at 347–48.

¹⁴⁴ *Id.* at 348.

¹⁴⁵ *Bagnall v. Sebelius*, No. 3:11CV1703 MPS, 2013 WL 5346659, at *20 (D. Conn. Sept. 23, 2013).

¹⁴⁶ *Id.*

property interest will only exist if “one has a ‘legitimate claim of entitlement’ to the benefit.”¹⁴⁷ In the case of Medicare benefits, the courts will not necessarily find that simply being enrolled in the program is sufficient to establish that necessary entitlement. As explained in *Perry v. Sindermann*, “mere subjective ‘expectancy’ is [not] protected by procedural due process.”¹⁴⁸ But, the claimant still has the chance to prove to the court otherwise. A property interest may still be recognized if it is proven that “the legitimacy of his claim of such entitlement [exists] in light of ‘the policies and practices [of the particular assistance program]”¹⁴⁹

1. A Legitimate Property Interest with Medicare Benefits

Medicare beneficiaries have a legitimate existing property interest because of the governing provisions’ intent to reimburse beneficiaries’ use of medical services, enrollees’ expectations, and the inability to distinguish easily between outpatients and inpatients.

a. The Intent Behind the Language of the Provisions

In a recent case, *Bagnall v. Sebelius*, where Medicare beneficiaries argued that their procedural due process rights were violated, a federal district court held that the plaintiffs failed to prove that they had an existing property right in formal hospital admission, inpatient status, and Part A benefits.¹⁵⁰ The court held that no legitimate entitlement existed because the distribution of benefits is not mandatory.¹⁵¹ After analyzing the applicable statutes and regulations, the court concluded that the distribution of benefits is only conditional.¹⁵² While the court justified its reasoning by noting that the language in the current governing Medicare provisions fails to include obligatory words like “must” and “shall,” the court should not have interpreted the words solely based on their standalone meanings.

Based on recent statements made by the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services (HHS), it is clear that the intent of the provisions governing inpatient admission does not permit depriving those who receive certain medical services from receiving reimbursements. This is evident from the May 2013 proposed changes that acknowledge that beneficiaries spending a certain amount of time in a hospital and using certain hospital

¹⁴⁷ *Id.* (citation omitted) (internal quotation marks omitted).

¹⁴⁸ *Perry v. Sindermann*, 408 U.S. 593, 603 (1972).

¹⁴⁹ *Id.* As further explained in *Bagnall*, the court will “look to the statutes, regulations, and other ‘rules and understandings’ governing the distribution of particular benefits” 2013 WL 5346659, at *20.

¹⁵⁰ *Bagnall*, 2013 WL 5346659, at *20, *22.

¹⁵¹ *Id.* at *21.

¹⁵² *Id.* at *22 (“[A]bsence of any ‘must’ or ‘shall’ language makes clear that a physician is not required to admit a patient if he or she meets the 24-hour benchmark”).

services should be entitled to benefits. When describing the motivation behind why provisional changes have been considered, CMS and HHS recognized that the number of patients in observation care “has increased from approximately 3 percent in 2006 to approximately 8 percent in 2011,” and how such a trend raises red flags because of the potential detrimental effects on beneficiaries.¹⁵³

In *Bagnall*, the court found that current Medicare policy does not “meaningfully channel official discretion.”¹⁵⁴ However, *Bagnall* could not consider the proposed 2013 changes to the language of the applicable provisions, which CMS and HHS announced at the time. If the court considered the proposals in their analysis of Medicare’s intent, then the court could have reasoned that CMS and HHS would not consider provisional changes to ensure that physicians understand how to correctly use observation status, unless the agencies had both the authority and means to provide meaningful discretion. Furthermore, before *Bagnall* the CMS and HHS decided to “revis[e] hospital inpatient status criteria as one of several policy clarifications or changes suggested by stakeholders to improve [its] policies governing when a Medicare beneficiary should be admitted as an inpatient, and how hospitals should be paid by Medicare for the associated costs they incur.”¹⁵⁵ Therefore, these agencies realized that though initially physicians may make the *ultimate* decision as to whether patients are inpatients or placed on observation care, they do so to fit within the defining parameters of the agencies’ overarching policies.¹⁵⁶

Furthermore, the Secretary is aware that if patients receive care which satisfies payment under Medicare Part A, then she must ensure that they are reimbursed, even if provisional language does not actually use words like “must” and “shall.” The language of the proposed changes describes the intent as “we recognize that it would be helpful to address what the requirements are for Medicare Part A payment and when a beneficiary *should* be admitted as a hospital inpatient.”¹⁵⁷ The use of the word “should” in this context, seems to indicate that if a patient satisfies criteria, then a physician “must” admit that patient as an inpatient and not an observation patient. Other language also suggests an intent to create obligatory action—the new language will “state explicitly in our payment regulations that admission pursuant to this order is the means whereby a beneficiary becomes a hospital inpatient and, therefore, is

¹⁵³ Medicare Program, 78 Fed. Reg. at 27,644 (proposed May 10, 2013) (to be codified at 42 C.F.R. pts. 412, 462, 485, 489) (“This trend concerns us because of the potential financial impact on Medicare beneficiaries.”); e.g., Wachter, *supra* note 9 (“The result of all this angsty wheel-spinning: the number of obs[ervation] cases in the U.S. went up by 50 percent between 2006 and 2011, with a more-than-400 percent (!) increase in Medicare patients staying more than 48 hours under observation.”).

¹⁵⁴ 2013 WL 5346659, at *23.

¹⁵⁵ 78 Fed. Reg. at 27,645.

¹⁵⁶ In *Bagnall*, the court held that “[u]ltimately the decision to admit is up to the physician based on his or her medical judgment.” 2013 WL 5346659, at *23.

¹⁵⁷ 78 Fed. Reg. at 27,645 (emphasis added).

required for payment.”¹⁵⁸ The use of the word “required” in this context indicates that once a patient is deemed an inpatient and the applicable order is signed by the physician, the benefit must be applied. If one looks up the definition of the word “require”, it will be clear that its meaning is synonymous with that of words like “must” and “shall” because it creates an obligatory action.¹⁵⁹

b. The Expectations of Enrollees

Medicare beneficiaries expect that they will receive benefits upon use of an applicable medical service. A property interest in Medicare should be recognized because the program is similar to other benefit programs like welfare. While the court has found that the similarity does not exist, that is based on superficial comparison between a complex program and a financial need-based assisted program.

In healthcare, it is not easy to use only objective criteria for eligibility, like income and welfare programs, without allowing a physician to exercise some discretion. Therefore, a Medicare beneficiary’s entitlement to a property interest should not be as strictly construed as that of a financial need-based benefit recipient. The only similarity between the two types of programs is the expectation of enrollees. An individual enrolls into Medicare with the expectation that if he falls ill and needs certain medical attention, then he will be reimbursed. That is no different from the individual who enrolls into a welfare program expecting that as long as her income falls within a given range, she will receive social assistance. In both situations, the enrollee is aware that mere enrollment does not always guarantee benefits, but enrollment coupled with satisfying certain criteria creates a right to benefits.

Medicare enrollees also expect a *continuing* property interest. In a claim for workers’ compensation payments, the Supreme Court tried to differentiate claims from *continuous* payments from claims for payments for a particular incident.¹⁶⁰ The court held that “the law expressly limits an employee’s entitlement to ‘reasonable’ and ‘necessary’ medical treatment, and . . . must be resolved *before* . . . an employee’s entitlement to benefits [] arise.”¹⁶¹ Like the plaintiffs in *American Manufacturers Mutual Insurance Company v. Sullivan*, the Court will recognize eligibility for Medicare benefits, but not instant entitlement for Medicare beneficiaries.¹⁶² However, the Court’s concern with necessary and reasonable treatment is a thing in which the case of Medicare is easily resolvable. Both CMS and HHS state, “hospital inpatient admissions are reasonable and necessary based on how long beneficiaries have spent, or are

¹⁵⁸ *Id.* at 27,646 (emphasis added).

¹⁵⁹ *See, e.g., Require*, MERRIAM-WEBSTER, <http://www.merriam-webster.com/dictionary/require> (last visited May 1, 2015) (“to make it necessary for someone to do something”); *Require*, OXFORD DICTIONARIES, http://www.oxforddictionaries.com/us/definition/american_english/require (last visited May 1, 2015) (“specify as compulsory”).

¹⁶⁰ *Am. Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 60 (1999).

¹⁶¹ *Id.*

¹⁶² *See id.* at 61.

reasonably expected to spend, in the hospital.”¹⁶³ The proposed benchmarks for eligibility specify that “Medicare’s external review contractors would presume that hospital inpatient admissions are reasonable and necessary for beneficiaries who require more than 1 Medicare utilization day (defined by encounters crossing 2 ‘mid-nights’) in the hospital receiving medically necessary services.”¹⁶⁴

Furthermore, unlike the plaintiffs in *Sullivan*, a physician assesses Medicare beneficiaries’ use of services *simultaneously*, not *after* like in the case of worker’s compensation after an accident. When a physician evaluates an incoming patient, if that patient is enrolled in a Medicare program, the use of medical services should suffice to create a valid potential property interest.¹⁶⁵ Such a potential property interest should only be deemed invalid *after* it is found that a patient did not need the applicable treatment. The court should exercise greater concern for those treated for extended periods, but then unable to recover the important financial assistance to subsidize costs due to trivial decisions.

c. The Public Policy Behind the Provisions

Public policy is another reason why a property interest should not be denied merely due to the plain language meaning of provisions. During a time when various stakeholders, agencies, and medical professionals are all unsure as to how to carry out the applicable provisions fairly, the court should not rely solely on what is written. If very few beneficiaries, administrators, and facilitators can clearly convey the distinction between two types of patients, then it is highly unlikely that non-medical professionals like judges could miraculously do so easily. The medical judgment exercised by physicians to determine who is admitted as an inpatient and who is placed on observation status is not as objective as the court would like to believe. In fact, in a report released by the Office of the Inspector General, a study found that the difference between beneficiaries who were classified as inpatients and those as observation patients was “clinically indistinguishable.”¹⁶⁶ If it is true that inpatient and observation patients are virtually indistinguishable, then the court should not deny a property interest merely because some individuals had the unfortunate luck of not

¹⁶³ 78 Fed. Reg. at 27,645.

¹⁶⁴ *Id.*

¹⁶⁵ *See, e.g., Sullivan*, 526 U.S. at 63 (Stevens, J., dissenting) (“The claimant’s injury created a right to have payment despite the fact that it was only a claim for payment, there still is a valid potential property interest. So the focus should be on whether or not claim procedures are fair.”).

¹⁶⁶ *See* WRIGHT, *supra* note 61, at 11 (“Short inpatient stays were often for the same reasons as observation stays.” Similar to beneficiaries in observation stays, “those in short inpatient stays were most commonly treated for chest pain.”); Wachter, *supra* note 9 (“To underscore just how arbitrary the rules regarding observation are, an investigation by the Inspector General of the U.S. Department of Health and Human Services released today found that ‘obs patients’ and ‘inpatients’ were clinically indistinguishable.”).

being categorized correctly due to error. Therefore, Medicare beneficiaries should have a valid existing property interest in their benefits due to the intent of provisions, beneficiaries' expectations, and unclear differentiation between inpatient admission and observation status.

2. The Secretary of HHS as a Federal Actor

Now, let us assume that a court could find that a legitimate property interest exists; the next issue is whether the court could hold the Secretary of HHS responsible for any procedural due process violations of beneficiaries.¹⁶⁷ The Secretary of HHS is a liable federal actor because, under the “coercive” test, federal oversight plays a significant role in affecting how physicians classify patients. When a beneficiary initially enters a hospital, the first person to take a medical evaluation is a licensed physician. That physician will engage in private action by using his medical knowledge to determine the patient’s classification. The question is then “whether the private motives which triggered the enforcement of those laws can fairly be attributed to the State.”¹⁶⁸

In *Blum*, the Supreme Court laid out three tests to determine when a state or federal actor should be held responsible for the actions of a private actor and therefore be subject to the Fifth or Fourteenth Amendment.¹⁶⁹ Under the first test, the plaintiff must show a “close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself.”¹⁷⁰ Alternatively, a connection can be established under the “coercive power” test: a showing that the government “exercised coercive power or has provided such significant encouragement, either overt or covert, that the choice must in law be deemed to be that of the State.”¹⁷¹ The final test is whether a private party is exercising powers that are “traditionally the exclusive prerogative of the State.”¹⁷² This test is not applicable in this analysis because there is no evidence showing that physicians make decisions traditionally made exclusively by HHS. So, the responsibility of the state would need to be found under the first or second test.

a. Satisfying the “Coercive” Test

Under the first test, one could say that physicians act as agents of HHS. However, the decisions of a patient classifications utilizes their independent medical judgment, so it is difficult to argue that their thought process is an action that might

¹⁶⁷ The Secretary would be a defendant in due process suits because of the role to oversee agencies administering Medicare. *See supra* notes 21–22 and accompanying text.

¹⁶⁸ *Blum v. Yaretsky*, 457 U.S. 991, 1004 (1982).

¹⁶⁹ *Id.* at 1004–05.

¹⁷⁰ *Id.* at 1004 (“[T]he question typically is whether the private motives which triggered the enforcement of those laws can fairly be attributed to the State.”).

¹⁷¹ *Id.*

¹⁷² *Id.* at 1005 (citation omitted) (internal quotation marks omitted).

as well be conducted by HHS itself. The government could be held responsible under the second test of “coercive power.” The Court has held that coercion cannot be “[m]ere approval . . . or acquiescence.”¹⁷³

A physician must classify incoming patients within the criteria established by federal regulations. This obligation extends to also complying with hospital protocol and federal oversight. The government’s oversight of a physician’s diagnosis includes attaching financial implications on the physician and the hospitals that employ them.¹⁷⁴ So, the federal oversight goes beyond “mere approval” and directly affects physicians’ adherence to the overarching regulation of medical services reimbursements by the government.

Coercive power can also derive from state action that is “‘entwined in [the] management or control’ of the private actor . . . or is ‘entwined with governmental policies.’”¹⁷⁵ Regulations enforced by Medicare officials and policing bodies, such as the Recovery Audit Program,¹⁷⁶ influence how physicians exercise their medical judgment. “The reality, however, is that hospitals and doctors have been strongly pressured by Medicare to classify more and more people *in* the hospital as *outpatients*.”¹⁷⁷ This pressure creates structural parameters in which the physicians must exercise their judgment.¹⁷⁸

These parameters derive partly from the financial penalties that burden hospitals if audits reveal incorrectly distributed reimbursements. While the *Blum* Court held that regulations imposing penalties are not sufficient to show state action, the assumption was that government officials have no power to approve or disapprove physicians’ determinations—they only have the power to disapprove or approve the distribution of benefits.¹⁷⁹ However, physicians have complained that their medical judgment does not enable them to distinguish clearly between inpatients and outpatients at all times.¹⁸⁰ As a result, if medical judgment fails them, their determinations are likely

¹⁷³ *Id.* at 1004–05.

¹⁷⁴ *Id.* at 1005–06.

¹⁷⁵ *Cranley v. Nat’l Life Ins. Co. of Vt.*, 318 F.3d 105, 112 (2d Cir. 2003).

¹⁷⁶ *Recovery Audit Program*, CMS.GOV (Sept. 26, 2014), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/?redirect=/recovery-audit-program/>.

¹⁷⁷ *Disappointing Decision from Court in Challenge to “Observation Status” Highlights Need To Pass Legislation*, CTR. FOR MEDICARE ADVOCACY, <http://www.medicareadvocacy.org/disappointing-decision-from-court-in-challenge-to-observation-status-highlights-need-to-pass-legislation/> (last visited May 1, 2015).

¹⁷⁸ *See id.* (“Medicare also relies on outside corporations’ proprietary guidelines to determine whether inpatient admissions are ‘appropriate.’ It is these guidelines and Medicare’s enforcement of them that determine admissions in reality.”).

¹⁷⁹ *Blum v. Yaretsky*, 457 U.S. 991, 1008–10 (1982) (“[D]ecisions ultimately turn on medical judgments made by private parties according to professional standards that are not established by the State.”).

¹⁸⁰ *See, e.g.*, Susan Jaffe, *Growing Number of Patients Find a Hospital Stay Does Not Mean They’re Admitted*, KAISER HEALTH NEWS (Sept. 7, 2010), <http://kaiserhealthnews.org>

to favor the penalty-free option of just admitting more patients under observation care. This allows them, along with employing hospitals, to avoid penalization for incorrectly admitting patients for inpatient care. Therefore, it cannot be assumed that judgment is confined to only a medical diagnosis. Regulators have intertwined oversight with the decision-making process of physicians by heavily scrutinizing the frequency of inpatient admissions in a particular classification and the resulting systemic costs.

The increasing trend of physicians labeling patients more frequently with observation status as a means to avoid penalties also supports the notion of oversight affecting judgment.¹⁸¹ When the government attaches financial penalties to the classification process of patients, the government is no longer playing the *indecisive* role of “merely responding to the independent medical judgment of physicians.”¹⁸² For example, a recent study on trends in observation care suggested that between 2007 and 2009 critical access hospitals were increasingly providing more observation care than other short-term general hospitals.¹⁸³ The study concluded that such findings were likely driven by policies governing hospital reimbursements and patients’ length of stay.¹⁸⁴

Another telling sign of this coercive oversight would be the CMS’s own admission that revision of the applicable provisions was necessary because hospitals were likely concerned with increasing penalties for failure to administer properly observation services.¹⁸⁵ The CMS explained:

[W]e discussed how the trend towards the provision of extended observation services may be attributable in part to hospitals’ concerns about Medicare’s payment policy for billing under Part B

/news/hospital-observation-care/ (“Under a set of rather arbitrary definitions, which are very vague and difficult to understand and apply, [doctors] have to decide who’s an inpatient and who’s an outpatient” (quotation marks omitted)).

¹⁸¹ 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, 1256 (2012), available at <http://content.healthaffairs.org/content/31/6/12251.full?ikey=on49LSyrsLkwm&keytype=ref&siteid=healthstaff> (“The rising trend of hospital observation services is consistent with a broader ongoing shift of medicare-covered healthcare services from inpatient to outpatient settings, fueled in part by Medicare policy measures for cost containment, such as efforts to crack down on avoidable hospital readmissions.”).

¹⁸² *Blum*, 457 U.S. at 1014–15 (Brennan, J., dissenting) (arguing that the level-of-care decisions made in nursing homes had “far less to do with the exercise of independent professional judgment than they do with the *State’s* desire to save money”).

¹⁸³ Brad Wright et al., *Trends in Observation Care Among Medicare Fee-for-Service Beneficiaries at Critical Access Hospitals, 2007–2009*, 29 J. RURAL HEALTH s1, s5 (2013) (“Clinical decision-making should guide the use of observation care, but the trends we observe in these data suggest that payment policy may also play a significant role.”).

¹⁸⁴ *Id.* at s3–s4.

¹⁸⁵ 78 Fed. Reg. at 27,486, 27,644 (proposed May 10, 2013) (to be codified at 42 C.F.R. pts. 412, 462, 485, 489).

when a Part A hospital inpatient claim is denied because a Medicare review contractor determines that the inpatient admission was not reasonable and necessary under section 1862(a)(1)(A) of the Act.¹⁸⁶

The CMS acknowledged that:

[V]arious stakeholders [informed them] that hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review by electing to treat beneficiaries as outpatients receiving observation services, often for long periods of time, rather than admitting them as inpatients.¹⁸⁷

State participation was analyzed in the Sixth Circuit. In *Wilcher v. City of Akron*, the court held that the plaintiff failed to establish state action because the new cable television regulations proposed after public complaints were independently proposed by the cable television company, not city officials.¹⁸⁸ The court reasoned that the company could only be held a state actor if the plaintiff showed actual participation by the city officials in the company's decisionmaking.¹⁸⁹ In the present issue, regulators are proposing and implementing regulatory changes due to public pressure; it is not just encouraging physicians to independently practice more concise medical judgment. This serves as further evidence that the Secretary of HHS plays a determinative role in patients' classifications as a liable federal actor.

3. Due Process: The Claims Appeal Process and the *Mathews* Test

In *Mathews*, the Court established a three element test to analyze whether a federal actor has created sufficient protections to avoid the deprivation of procedural due process rights: (1) private interest, (2) sufficient procedural safeguards, and (3) the government's interest.¹⁹⁰ Unfortunately, Medicare beneficiaries' due process rights are not sufficiently protected by current procedural safeguards. Beneficiaries have the private interest of recovering for medical services they use, as well as for follow-up care plans prescribed. The current appeals process on paper looks exhaustive, however it functions with extensive delays that inhibit timely resolution of claim disputes. Last, the government's interest is for Medicare to be a viable healthcare coverage option for eligible enrollees.

¹⁸⁶ *Id.*

¹⁸⁷ *Id.*

¹⁸⁸ 498 F.3d 516, 520 (6th Cir. 2007).

¹⁸⁹ *Id.*

¹⁹⁰ *Mathews v. Eldridge*, 424 U.S. 319, 321 (1976).

a. Medicare Beneficiaries' Private Interest

The first element is what private interest exists for Medicare beneficiaries regarding their entitlement to reimbursements for medical services. In *Healey v. Thompson*, a district court found that Medicare beneficiaries do have a “substantial interest in continued receipt of Medicare benefits.”¹⁹¹ While not involving the absolute termination of benefits like the plaintiff in *Healey*, a beneficiary still has the reasonable expectation that they will continue to receive benefits in the same manner with previous hospital visits where they sought similar care.¹⁹² The potential loss of benefits after incurring medical expenses may result in a beneficiary’s inability to pay for such expenses without suffering great financial burden. As discussed in *Healey*, a “denial in coverage amounts to denial of services, because [some beneficiaries] may not have the means to pay for the services.”¹⁹³ The loss does not only extend to inability to pay for services, it also extends to denial of continuing care services such as skilled nursing care, or may affect the ability to afford prescribed pharmaceutical drugs. For the reasons outlined above, it is clear that Medicare beneficiaries have a strong private interest in receiving benefits for their use of particular medical services.

b. Erroneous Deprivation Versus Procedural Safeguards

The next element is whether the erroneous deprivation of such interest is sufficiently balanced by the claims appeal process, which is not outweighed by alternative or substitute procedural safeguards.¹⁹⁴ Generally, after a beneficiary’s claim for benefits has been processed, a notice will be mailed to her regarding the amount of benefits she recovered. This results in a delay between the time when the beneficiary receives services and when she is put on notice of the possible reimbursement. To determine if there is sufficient balance, courts look at the length of the delay and its reasonableness.¹⁹⁵ Due to claims being processed via an outside contractor, a delay does not seem unreasonable. Furthermore, the CMS has established a five-level claims appeal system where individuals, hospitals, and other healthcare providers can dispute claims.¹⁹⁶ But, while the system may be a reasonable safeguard to ensure that errors can be reversed, the practicality of the system is under immense scrutiny.

¹⁹¹ 186 F. Supp. 2d 105, 122 (D. Conn. 2001).

¹⁹² *See id.* at n.13 (explaining that an interest can be deemed stronger if the plaintiff had received such benefits under similar circumstances).

¹⁹³ *Id.* at 123.

¹⁹⁴ *See supra* Part V.

¹⁹⁵ *Mathews*, 424 U.S. at 341 (“[T]he possible length of wrongful deprivation of . . . benefits [also] is an important factor in assessing the impact of official action on the private interests.” (quoting *Fusari v. Steinberg*, 419 U.S. 379, 389 (1975)) (internal quotation marks omitted)).

¹⁹⁶ *See supra* notes 73–74 and accompanying text.

First, the Chief Judge of the Office of Medicare Hearings and Appeals (OMHA) stated that in 2013, there was a backlog of approximately 357,000 claims.¹⁹⁷ The backlog has burdened the system to the point where the OMHA had to freeze the processing of all new claims from healthcare providers and hospitals to increase efficiency.¹⁹⁸ To afford protection to individual beneficiaries, who constitute the minority of appeals claims, the OMHA will prioritize its needs by continuing to review both backlogged and new appeals claims.¹⁹⁹

Though the temporary freeze does not extend to individual Medicare beneficiaries, the OMHA still expects that even with a reduced docket, wait times for hearings will continue to take up to as long as a full year.²⁰⁰ Such a delay is unreasonable and discouraging for needy individual beneficiaries. For example, the *Healey* court noted that, “[g]iven the costs of healthcare, and the meager financial resources of many Medicare beneficiaries, a period of four months without benefits is not insignificant.”²⁰¹ The *Mathews* Court also acknowledged that lengthy delays between the different levels of the appeals system can be quite significant for those whose benefits are erroneously terminated.²⁰²

Continuing to face delays also burdens beneficiaries because Medicare is their primary source of benefits. Many individuals do not have alternative funding sources to supplement denied coverage of healthcare services. This is unlike the terminated disability recipient who *Mathews* considers to face hardships, but not to the extent of other benefit recipients, like welfare recipients, because of access to “private resources [and] other forms of government assistance.”²⁰³ So, notice should not be limited to an evidentiary hearing to assess errors; initial upfront information regarding admission status should be mandatory.

Next, the Court found that the “reliability and probative worth of written medical reports” should be sufficient to support the claim processing decision.²⁰⁴ Physicians’

¹⁹⁷ OFFICE OF MEDICARE HEARINGS & APPEALS, MEMORANDUM TO OMHA MEDICARE APPELLANTS RE: ADMINISTRATIVE LAW JUDGE HEARINGS FOR MEDICARE CLAIM AND ENTITLEMENT APPEALS (2014), available at <http://capsules.kaiserhealthnews.org/wp-content/uploads/2014/01/nancy-griswold-Medicare-appeals.pdf>.

¹⁹⁸ *Id.*; see also Appellant Forum Regarding the Administrative Law Judge Hearing Program for Medicare Claim Appeals, 79 Fed. Reg. 394 (2014) (stating that the available adjudication resources is insufficient to meet the demands and workload of addressing appeals).

¹⁹⁹ OFFICE OF MEDICARE HEARINGS & APPEALS, *supra* note 197, at 1.

²⁰⁰ *Id.* (“[A]verage wait time for a hearing . . . has risen to 16 months and is expected to continue to increase as the backlog grows.”); see, e.g., Zack Budryk, *Hospitals Push To Clear RAC Appeals Backlog*, FIERCEHEALTHCARE (Jan. 16, 2014), <http://www.fiercehealthcare.com/story/hospitals-push-clear-rac-appeals-backlog/2014-01-16#ixzz2t4zhXUIZ> (explaining that while steps are now being taken to effectuate a speedier process, beneficiaries must still endure a lengthy wait).

²⁰¹ *Healey v. Thompson*, 186 F. Supp. 2d 105, 124 (D. Conn. 2001).

²⁰² *Mathews v. Eldridge*, 424 U.S. 319, 342 (1976).

²⁰³ *Id.* at 342.

²⁰⁴ *Id.* at 344 (citation omitted) (quotation marks omitted).

objective medical judgments are used to justify reimbursing benefits.²⁰⁵ However, as already discussed, many physicians state that differentiating inpatient from those only requiring observation care is not based on any accurate medical measurement.²⁰⁶ This has resulted in a lot of erroneous classifications. *Mathews* set the standard that due process should be based on “the risk of error inherent in the truthfinding process as applied to the generality of cases, not the rare exceptions.”²⁰⁷ Here, the risk of error is high because physicians must finalize their classification arbitrarily without adequate means to distinctly separate those only needing observation care and those who do not.

Last, further proof that the structured procedures cannot properly review claims is that different levels of the appeals system, like the Qualified Independent Contractor (QIC) and the Administrative Law Judge (ALJ), interpret Medicare policies with different levels of scrutiny. In a 2012 study, the Office of the Inspector General found that ALJ staff construed provision language less strictly and often favored appellants “when the intent, but not the letter, of a Medicare policy was met.”²⁰⁸ In contrast, QICs took the opposite approach and construed language more strictly, only “expecting to uphold prior-level decisions unless the evidence to reverse [was] compelling.”²⁰⁹ Different scrutiny disadvantages the beneficiary who cannot afford to spend additional fees and time to keep appealing their dispute until it reaches a more favorable review stage like the ALJ. Overall, extreme delays and a lack of uniform assessment of disputes show an insufficient balance of procedural safeguards.

c. The Government’s Interest

The last factor is the government’s interest. The government’s interest in Medicare strongly favors ensuring eligible beneficiaries receive benefits. One interest concerns the financial implications of allowing beneficiaries to collect benefits that they may not necessarily be entitled to. Observation status not only serves as a tool to aid hospitals with resource distribution, but it also helps limit the amount of government spending on Medicare.²¹⁰ On the other hand, if too many beneficiaries are erroneously denied benefits, then the financial burden shifts to them. This is of great concern because

²⁰⁵ *Id.*

²⁰⁶ See Jaffe, *supra* note 180.

²⁰⁷ *Mathews*, 424 U.S. at 344.

²⁰⁸ OFFICE OF THE INSPECTOR GENERAL, IMPROVEMENTS ARE NEEDED AT THE ADMINISTRATIVE LAW JUDGE LEVEL OF MEDICARE APPEALS 10–11 (2012), available at <https://oig.hhs.gov/oei/reports/oei-02-10-00340.pdf>.

²⁰⁹ *Id.* at 11.

²¹⁰ For example, in 2011 auditing contractors “identified 888,000 incorrect payments to hospitals, totaling about \$800 million in overpayments . . . \$488 million was returned to the Medicare Trust Fund . . .” Joe Carlson, *RAC Appeals Backlog Cause For Frustration*, MODERN HEALTHCARE (Jan. 10, 2014), <http://www.modernhealthcare.com/article/20140110/NEWS/301109953>.

Medicare beneficiaries are primarily the elderly, and a significant number live with chronic illnesses.²¹¹ In addition, almost half of beneficiaries live below the 200% federal poverty line (i.e., 2014 single household income below \$23,340).²¹²

The government most likely has an interest in ensuring that Medicare continues to fulfill its goal by providing reasonable benefits for medical services to alleviate financial burdens. OMHA already conceded this notion by expressing commitment to appeals reform to make itself “as responsive as possible to the Medicare beneficiary community, regardless of the challenges presented.”²¹³ Based on an intent to relieve the pressure of increasing cases on appeal, and the inability of the different levels of the appeals to handle a high volume of cases, it is clear that the current system is ineffective on its own to properly give beneficiaries’ reasonable opportunity to have a disputable claim reviewed in a timely manner.

B. Next Steps: Making the Provisions Implementation More Effective

It should now be clear how arbitrary and confusing Medicare Part A and Part B provisions can get. The result is unfair financial burdens on Medicare beneficiaries, and even healthcare providers as well. While some advocates have cried for the removal of observation care altogether, the process of triaging patients early on in their hospital visit is an important way to increase the efficiency of delivery and quality of healthcare services.²¹⁴ Fortunately, certain actions may improve this classification process.

More detailed drafting and mandatory notice to beneficiaries while they are in hospital can clarify provisional intent. The provisions’ lack of clarity is a major negative aspect. While the change to use of an objective measurement of time to differentiate patients is clearer, in the realm of medicine it is still a very superficial and arbitrary means to differentiate the level of a patient’s medical need. The CMS and HHS could be even more definitive by listing specific types of diagnoses and treatments that would make one eligible for inpatient status. Categorization of the different kinds of diagnosis will allow physicians to use their medical judgment effectively, but still objectively identify whether inpatient services are necessary. For example, person A and B could both have stayed in the hospital for less than 48 hours because of high blood pressure, but A needed a more extensive prescription due to poorer health. Such factors could be used to take someone out of observation status despite

²¹¹ See AARP PUB. POLICY INST., THE MEDICARE BENEFICIARY POPULATION (2009), available at http://assets.aarp.org/rgcenter/health/fs149_medicare.pdf.

²¹² *Federal Poverty Guidelines*, FAMILIESUSA (Feb. 2014), <http://www.familiesusa.org/resources/tools-for-advocates/guides/federal-poverty-guidelines.html>.

²¹³ Susan Jaffe, *As HHS Moves to End Overload of Medicare Claims Appeals, Beneficiaries Will Get Top Priority*, KAISER HEALTH NEWS (Jan. 21, 2014), <http://www.kaiserhealthnews.org/stories/2014/january/21/medicare-claims-appeals-backlog-after-suspension/>.

²¹⁴ But see LAN ZHAO ET AL., AARP PUB. POLICY INST., RAPID GROWTH IN MEDICARE HOSPITAL OBSERVATION SERVICES: WHAT’S GOING ON?, (2013) (arguing that this efficiency is only in “relatively short observation stays of 12–24 hours in dedicated units”).

having stayed in hospital for less than the two night requirement.²¹⁵ Furthermore, auditing contractors will have a harder time over-scrutinizing admissions because of a clearly outlined medical basis.²¹⁶

The *Bagnall* court has indicated that entitlement is more than meeting certain requirements.²¹⁷ Though this Note argues that a legitimate entitlement to Medicare benefits already exists, the CMS should make the applicable provisional language more definitive of the programs intent. This means using language like “a doctor ‘*must*’ or ‘*shall*’ if a patient exhibits x, y, and z.” Therefore, when adjudicating claims, beneficiaries’ suits will not be dismissed prematurely. The provisions should also allude to another important step in the classification process—formal notice from physicians to beneficiaries. It is important that beneficiaries receive notice on their status and its implications *before* discharge from the hospital. Many patients express shock when they learn that the services they received did not constitute inpatient care *subsequent* to their discharge.²¹⁸ A simple solution would be to create a standard form relaying information to the patient about their classification and the coverage effects. The positive result of formal notification is that beneficiaries are likely to accept the physician’s determination. Just like in the case of informed consent, studies show when there is more transparency regarding a patient’s treatment, the physician faces less instances of liability.²¹⁹ By enabling beneficiaries to participate in the classification process earlier on, it is likely that they will not feel cheated or misled.

Overall, by increasing clarity of language to show exact intent, by expanding the language to accommodate various health conditions, and by creating a formal process to relay preliminary information to beneficiaries, observation status can be used effectively.

CONCLUSION

Covering over fifty million seniors, Medicare’s wide-ranging coverage should continue to administer benefits that are fair and just, and of valuable assistance to

²¹⁵ See, e.g., Wachter, *supra* note 9 (suggesting remodeling the payment systems by codifying services instead of merely relying on hours spent in the hospital).

²¹⁶ See, e.g., *id.* (“After all, with the two-midnight rule, it’s likely that RAC auditors will be suspicious (potentially with some justification) that hospitals will keep some patients an extra midnight.”).

²¹⁷ *Bagnall v. Sebelius*, No 3:11CV1703 (MPS), 2013 WL 5346659, at *20 (D. Conn. Sept. 23, 2013).

²¹⁸ See, e.g., Schorsch, *supra* note 1 (quoting the daughter of an eighty-three-year-old who “got caught in the loophole” when he unknowingly was forced to pay \$7,360 out of his own pocket).

²¹⁹ See, e.g., Lawrence H. Brenner et al., *Beyond Informed Consent: Educating the Patient*, 467 CLINICAL ORTH. & RELATED RES. 348 (2009) (concluding that studies involving informed consent do not take into account patients’ education level); R.A. Caplan, *Informed Consent: Patterns of Liability from the ASA Closed Claims Project*, 64 ASA NEWSLETTER 7 (2000) (explaining studies involving inability in informed consent cases).

beneficiaries. The current provisions for inpatient admission violate procedural due process rights because all Medicare beneficiaries have an existing property interest. Strong federal oversight of the distribution of benefits shows federal action in the violation. Furthermore, the appeals claim system is an inadequate procedural safeguard due to its inability to review claims in a timely manner and with consistent scrutiny. While observation care serves an important means to increase the efficiency of health-care delivery, it should not be used to disadvantage beneficiaries. To avoid viable due process claims, regulators should clarify provisional language, codify health conditions, as well as mandate initial notice to make the observation care nightmare go away.