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Court: Patients Must Be Able to Appeal Status Change from Inpatient to Observation

By Nina Youngstrom

In a development that will shake up hospital compliance and utilization management, the U.S. Court of Appeals for the Second Circuit said Jan. 25 that the constitutional rights of Medicare beneficiaries are violated when they can't appeal a hospital's decision to change their status from an inpatient to an outpatient receiving observation services.[1] The court ordered CMS to allow an appeals process for denials of inpatient status under certain circumstances, according to the decision, which has national reach.

It remains to be seen whether HHS asks for a stay pending an appeal, however, although the next level of appeal is to the Supreme Court.

"It's a very dramatic result," said San Francisco attorney Judy Waltz, with Foley & Lardner LLP. But there are still some unknowns. "It's uncertain how CMS will apply it," she said. CMS could open appeal doors to other beneficiaries who don't check every box in the court decision, which would simplify life for hospitals, said Edward Hu, M.D., system executive director of physician advisor services at UNC Health in North Carolina. "It makes it harder to properly inform patients who have appeal rights without mistakenly informing patients who don't have appeal rights," he said. What that distinction is won't be clear without hearing more from CMS, Waltz noted.

The appeals court decision came down in a class-action lawsuit filed by beneficiaries with Medicare Part A coverage who were admitted as inpatients but changed to outpatients receiving observation services. They alleged HHS violated their due process rights because they have no administrative procedure to appeal the hospital's reclassification.

They will have one soon, and it will be available to all Medicare beneficiaries in the same boat, Waltz said. The Center for Medicare Advocacy, which spearheaded the lawsuit, reinforced that "the class is open-ended," according to its website.[2] That means beneficiaries who aren't part of the lawsuit also are eligible to appeal. As explained in the federal district court decision that was affirmed by the Circuit Court, the appeal rights apply to:

"All Medicare beneficiaries who, on or after January 1, 2009: (1) have been or will have been formally admitted as a hospital inpatient, (2) have been or will have been subsequently reclassified as an outpatient receiving 'observation services'; (3) have received or will have received an initial determination or Medicare Outpatient Observation Notice (MOON) indicating that the observation services are not covered under Medicare Part A; and (4) either (a) were not enrolled in Part B coverage at the time of their hospitalization; or (b) stayed at the hospital for three or more consecutive days but were designated as inpatients for fewer than three days, unless more than 30 days has passed after the hospital stay without the beneficiary's having been admitted" to a skilled nursing facility (SNF).

There was a touch of what's good for the goose is good for the gander in the court ruling. "The appeals process currently afforded to hospitals substantially mitigates the risk that their inpatient claims are improperly denied

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for reimbursement," the court said. "An appeals process for the URC [utilization review committee] reclassification decision would similarly likely improve the accuracy of properly covering patients' care under Part A."

What if Medicare Denies Part A Claim Anyway?

But the real-world mechanics are worrisome, Waltz said. "It's going to be hard to design a fair and effective appeal process," she said. Appeals must be decided while patients are still in the hospital and perhaps feeling very sick. "They might not be their own best advocates, given their medical condition, so there will need to be some sort of protection to preserve their interests," Waltz noted. "Even if the patient is up to it, it will take time to pull an appeal together. What happens while the patient is waiting on a decision? Does the hospital have to pay? Is the beneficiary at risk of having to pay even more for what might turn out to be services not covered under Part A?"

Also, it's unclear who will hear the appeal. Odds are it will be quality improvement organizations, which decide beneficiary appeals of hospital discharges and were referenced in the district court decision, Hu said. Waltz thinks CMS may have hospitals run with the ball, or perhaps appeals will be assigned to a Medicare administrative contractor. She's concerned that even if a patient wins the appeal, Medicare could later deny payment for the hospital's Part A claim, which would nullify the SNF admission. This could translate into a lot of drama over an "artificial distinction" between inpatient and outpatient status that is mostly about reimbursement and has little to do with the clinical care patients receive, Waltz said.

The wild card is how narrowly CMS interprets the court decision, Hu said. Will the appeals process be available to "all patients downgraded from inpatient to outpatient observation, or only those without Medicare Part B coverage and those who could have qualified for Part A SNF coverage?" The answer to that question has "significant operational hurdles for hospitals," he noted. The smaller the subset, the harder things will get for hospitals. They "may not know whether the patient will be part of the modified class of beneficiaries. At the time of reclassification, it may not be known yet if the patient will end up requiring three consecutive days in the hospital, as these reclassifications often occur early during a stay," Hu said. And the MOON doesn't have to be delivered until patients are in observation for 24 hours, so hospitals have to worry about saying no to patients who were only there for 18 hours. "I hope CMS considers expanding the appeal rights to anyone in outpatient status," Hu said.

CMS did not respond to a request for comment on the court decision and its plans for an appeal process by press time.

Eleven Years in the Making

The class action lawsuit began 11 years ago, when the Medicare beneficiaries sued HHS over observation status in the U.S. District Court for the District of Connecticut. After legal skirmishing, the case came down to whether HHS violated the due process rights of Medicare beneficiaries by depriving them of an administrative avenue for review after reclassifying them from inpatients to outpatients receiving observation services. The court noted the financial impact of the change. Beneficiaries pay a deductible for Medicare Part A hospital stays, but otherwise the program reflects an entitlement they have paid into over the course of their lives. In contrast, beneficiaries pay a monthly fee for Part B, plus 20% copays for the services.

After an August 2019 bench trial, the federal district court granted the plaintiffs an injunction and ordered HHS to establish an appeal process.[3] HHS appealed, challenging, among other things, that the due process rights of the Medicare beneficiaries were violated. The appeals court didn't buy HHS's arguments and affirmed the lower court's findings.

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To establish a violation of their constitutional due process rights, the plaintiffs had to demonstrate that "(1) state action (2) deprived them of a protected interest in liberty or property (3) without due process of law."

The appeals court found enough of a nexus between hospitals and the "State" (i.e., CMS). "To start, the Medicare statute expressly requires hospitals to form and utilize URCs in admission decisions. Furthermore, the decision-making process that URCs engage in is governed largely by statute and regulation, a factor that weighs in favor of finding state action," the decision noted. "Moreover, CMS pressures URCs to adhere closely to those regulations so that hospitals only submit claims for reimbursement that the regulations direct are appropriate for payment by Medicare (for inpatient admissions and thus Part A payment, those patients who satisfy the Two Midnight Rule). CMS applies that pressure in part by engaging in audits and post-payment reviews of a hospital's inpatient claims."

Because of the pressure from CMS about reimbursement, hospitals have a big incentive to adhere to its guidance, the court noted. Proof came partly in the form of CMS's education on the two-midnight rule.

Court: Reclassifying Patients May Harm 'Well-Being'

HHS challenged the notion that the plaintiffs have a property interest in Medicare Part A coverage, but the district court disagreed and the appeals court seconded that emotion. "Upon review of the evidence, we agree with the district court that the Two Midnight Rule (and the 24-hour rule in the period before the Two Midnight Rule was promulgated) adequately channels official discretion such that if a patient meets this benchmark, Medicare will provide coverage under Part A for services provided to him. The record demonstrates that CMS's guidelines require its contractors to approve claims that satisfy the Rule. In addition, CMS expresses to hospital providers that if the Rule is satisfied, a claim for Part A benefits will be granted."

Finally, the court looked at whether the Medicare beneficiaries have been deprived of their property interest without due process. "We first conclude that there is a substantial private interest at stake in this case," the decision said. The record is full of evidence of the expenses shouldered by patients whose costs aren't paid by Medicare Part A.

The court also noted that "the decision to reclassify a hospital patient from an inpatient to one receiving observation services may have significant and detrimental impacts on plaintiffs' financial, psychological, and physical well-being. That there is currently no recourse available to challenge that decision also weighs heavily in favor of a finding that plaintiffs have not been afforded the process required by the Constitution."

The burdens on CMS of adding an appeal process did not go unrecognized by the court. CMS will have to issue new regulatory and subregulatory guidance and draft new contracts.

The court required HHS to take several steps related to beneficiary appeal rights. HHS must let all members of the modified class appeal Part A denials of their coverage but also is welcome to "provide greater procedural protections."

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1 Barrows v. Becerra, No. 20-1642-cv (2nd Cir. January 25, 2022), https://bit.ly/3fZFcGr.
2 "Frequently Asked Questions about the 'Observation Status' Court Decision," Center for Medicare Advocacy, April 7, 2020, https://bit.ly/340Apls.
3 Christina Alexander et al. vs. Alex Azar, No. 3:11-cv-1703 (MSP) (D.Conn. March 24, 2020).

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