

DISTINCTION WITHOUT A DIFFERENCE: REFORMING THE MEDICARE THREE-DAY QUALIFYING STAY RULE FOR SNF CARE

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The three-day qualifying stay rule for skilled nursing facility (SNF) care has gone unchanged since the 1960s. Advancements in medicine have vastly improved the level of care afforded to Medicare beneficiaries; however, Medicare coverage rules for SNF care have not changed in step with these medical advancements. The need for a change to the three-day qualifying stay rule for SNF care is highlighted by stories of Medicare beneficiaries being denied coverage for SNF care and calls for reform by medical industry participants and public officials. This Note describes the problem with the current rule, evaluates current rule reform proposals, and proposes a potential solution to the problem. Specifically, this Note suggests that the Centers for Medicare and Medicaid Services (CMS) remove the current rule and replace it with one that places a greater emphasis on the treating physician's opinion of the patient. Doing so would offer a workable standard for SNF care coverage while providing needed medical treatment to elder Americans

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I. Introduction

When Jean Arnau spent five days in a hospital while recovering from a fractured spine, she believed that she was admitted as an inpatient at the hospital.¹ After all, she spent three days in a hospital bed, wore a hospital gown and ID bracelet, ate hospital food, and received regular nursing care during her stay at the hospital.² However, when she was discharged and needed to transfer to a skilled nursing facility for rehabilitative care, she discovered that the hospital never formally admitted her as an “inpatient”; instead, she was classified as an outpatient under “observation,” and, consequently, would not receive Medicare coverage for her rehabilitation at the skilled nursing facility.³

Some senior advocacy groups argue that the regulation requiring a minimum three-calendar-day qualifying inpatient stay prior to Medicare coverage for services rendered by a skilled nursing facility, also known as the “SNF qualifying stay rule,” is “ripe for elimination” in light of medical advances that have shortened patients’ hospital stays and potential coding terminology issues.⁴ Indeed, one of the highly problematic consequences of the regulation is that patients and hospitals are forced to game the system to obtain reimbursement coverage or avoid having to deal with inefficient reimbursement schemes.⁵ The end result is that both patients and hospitals end up losing out on appropriate Medicare cost coverage and reimbursement.⁶

Most patients would regard the seemingly slight distinction between the two labels of “inpatient” and “outpatient” as meaningless, since the patients are receiving the exact same type of care under both

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

2. *Id.*

3. *Id.*

4. Amanda Gengler, *The Painful New Trend in Medicare*, CNN MONEY (Aug. 7, 2012, 5:22 AM), <http://money.cnn.com/2012/08/07/pf/medicare-rehab-costs.money/mag/index.htm>; Alyssa Gerace, *Medicare’s 3-Day Stay Rule for Skilled Nursing Coverage “Ripe for Elimination,”* SENIOR HOUSING NEWS (Aug. 8, 2012), <http://seniorhousingnews.com/2012/08/08/medicares-3-day-stay-rule-for-skilled-nursing-coverage-ripe-for-elimination/>.

5. Julian Gray & Frank Petrich, *Elder Law: ‘Observation Status’ Due for a Change*, PITTSBURGH POST-GAZETTE Aug. 26, 2012, available at <http://www.post-gazette.com/stories/business/news/elder-law-observation-status-due-for-a-change-650517/>.

6. *Id.*

labels. However, the distinction can have costly consequences.⁷ Because of her designation as an outpatient under “observation,” Jean Arnau was forced to pay \$3,900 for her two-week stay at the skilled nursing facility and her supplemental medical insurance did not cover the out-of-pocket expenses because such plans do not cover the cost of services that Medicare does not cover.⁸

Stories like those of Jean Arnau are all too familiar with respect to receiving Medicare coverage for skilled nursing facility care. Multiple senior advocacy groups have reported that an increasing number of Medicare beneficiaries are receiving what might outwardly be viewed as inpatient care but are being coded as “outpatients” in observation status instead of actually being admitted as “inpatients.”⁹ Analyzing Medicare claims data between 2007 and 2009, one recent academic study further substantiated this classification trend, noting that “observation status is increasingly replacing inpatient stays in acute hospital care.”¹⁰ While the number of outpatient observation stays for Medicare beneficiaries increased over that time period, inpatient admissions decreased.¹¹ Moreover, the study reported a 34 percent increase in observation stays during the three-year period, which suggests “a substitution of outpatient observation services for inpatient admissions.”¹²

With advancements in medical technology, Americans are living longer and sometimes require extended medical care for medical

7. Barry, *supra* note 1. “Under the rules, Medicare picks up the whole tab for the first 20 days in an approved skilled nursing facility for rehab or other care, but only if someone has spent at least three full days in the hospital as an admitted patient. If instead a patient has been under observation – for all or part of that time – he or she is responsible for the entire cost of rehab.” *Id.*

8. *Id.*

9. See CTR. FOR MEDICARE ADVOCACY, *Brown University Confirms Observation Continues to Replace Hospital Admission Status*, <http://www.medicareadvocacy.org/2012/06/07/brown-university-confirms-observation-continues-to-replace-hospital-admission-status-2/> (last modified June 14, 2012); Dan Diamond, *Inpatient v. Observation: A Medicare Change That Actually Matters*, CAL. HEALTHLINE (Aug. 22, 2012), <http://www.californiahealthline.org/road-to-reform/2012/inpatient-v-observation-a-medicare-change-that-actually-matters.aspx>; Bernice Young, ‘Observation Stays’ for Medicare Patients Create Coverage Problems, CAL. WATCH (June 4, 2012), <http://californiawatch.org/dailyreport/observation-stays-medicare-patients-create-coverage-problems-16444>.

10. CTR. FOR MEDICARE ADVOCACY, *supra* note 9.

11. *Id.*

12. 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, 1255–56 (2012).

treatment.¹³ Health care plays a significant role in the increased life expectancy for elder Americans, and Medicare is a government health care program that can take much of the credit for that increase.¹⁴ Within the spectrum of extended medical care available through Medicare is care provided by a Skilled Nursing Facility (SNF). SNFs provide 24 hour “skilled medical care for both acute and chronic conditions, as well as additional help for daily activities of living.”¹⁵ Medicare provides payment coverage to its beneficiaries for the cost of SNF services;¹⁶ however, there are many regulatory restrictions on how and when these services are reimbursed.¹⁷ The current regulation governing reimbursement of SNF costs requires patients to stay in hospital inpatient care for a minimum of three consecutive calendar days; this requirement has not changed since 1965,¹⁸ despite significant advances in medical technology.¹⁹

13. See FED. INTERAGENCY FORUM ON AGING-RELATED STATISTICS, *OLDER AMERICANS 2012: KEY INDICATORS OF WELL-BEING* 24 (2012), available at http://www.agingstats.gov/Main_Site/Data/2012_Documents/docs/EntireChartbook.pdf.

14. *Id.* at 52; see also HEALTH CARE FIN. ADMIN., *MEDICARE 2000: 35 YEARS OF IMPROVING AMERICANS' HEALTH AND SECURITY* 7 (2000), available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/TheChartSeries/Downloads/35chartbk.pdf>.

15. Emma Nochomovitz, *Skilled Nursing Facilities and Other Long Term Care Facilities: Addressing Issues of Cost and Quality*, http://www.cwru.edu/med/epidbio/mphp439/nursing_homes.pdf (last visited Nov. 30, 2013).

16. CTRS. FOR MEDICARE & MEDICAID SERVS., CHAPTER 8- COVERAGE OF EXTENDED CARE (SNF) SERVS. UNDER HOSP. INS., *MEDICARE BENEFITS POLICY MANUAL* § 20 (Oct. 26, 2012), available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf>. “In order to qualify for post-hospital extended care services, the individual must have been an inpatient of a hospital for a medically necessary stay of at least three consecutive calendar days.” *Id.*

17. See generally CTRS. FOR MEDICARE & MEDICAID SERVS., CMS PROD. NO. 11435, *ARE YOU A HOSPITAL INPATIENT OR OUTPATIENT? IF YOU HAVE MEDICARE – ASK!*, available at <http://www.medicare.gov/Pubs/pdf/11435.pdf> (last modified Feb. 2011) [hereinafter *ARE YOU A HOSPITAL INPATIENT OR OUTPATIENT?*].

18. See Kelli O’Laughlin & Andrew Shin, *The Disposition Dilemma*, *EMERGENCY PHYSICIANS MONTHLY* (June 8, 2009), <http://www.epmonthly.com/subspecialties/management/the-disposition-dilemma/>.

19. On August 1, 2013, CMS finalized a rule that effectively cuts down the old 72-hour inpatient stay requirement to a “hospital inpatient admission spanning 2 midnights in the hospital.” Proposal Relating to Admission and Medical Review Criteria for Hospital Inpatient Services Under Medicare Part A, 78 Fed. Reg. 27486, 27496 (proposed May 10, 2013, to be codified at 42 C.F.R. pt. 412, 482, 485, and 489). While this rule may potentially make it easier for patients to be coded as “inpatients” by hospitals for the purpose of Medicare Part A reimbursement to hospitals, it does not directly affect the Medicare rule requiring “hospitaliz[ation] for medically necessary inpatient . . . care, for at least 3 consecutive calendar days, not counting the date of discharge.” 42 C.F.R. § 409.30(a)(1) (2005). The new rule does not affect the arbitrary timing requirements of 42 C.F.R. § 409.30(a)(1) directly, and

Medical professionals have advocated the need for reform in many of Medicare's various payment programs, especially in light of political calls for various deficit-reduction proposals that might be detrimental to Medicare itself.²⁰ This Note, however, will focus specifically on the reform of the SNF qualifying stay rule. As such, Part II presents an overview of Medicare, a description of the rules concerning medical expense payment, and a description of the current three-calendar-day qualifying stay rule with respect to SNF services coverage and reimbursement. Additionally, Part II will discuss the technical billing terms pertinent to the SNF qualifying stay rule, such as "inpatient" and "outpatient" under observation status. Part III analyzes the implementation of the current SNF qualifying stay rule, as well as current suggestions and proposals to reform the rule. This analysis will focus on the issues of improper hospital-billing coding, patient need for SNF services, quality of care concerns, Medicare financial concerns, and overall effects on the health care system. To ensure that elder Americans receive adequate medical care, Part IV recommends that Medicare remove the hard-and-fast three-calendar-day inpatient stay requirement. In its place, this Note recommends a standard that focuses on the individual patient's prognosis and whether, following an inpatient stay, the individual patient has reached a "functional level" with respect to daily life activities to permit discharge. Part V concludes that this alteration to the SNF qualifying stay rule will prevent hospitals and patients from "gaming" the system and provide a level of care that is in the best interest of patients without causing undue financial burden on hospitals or Medicare.

II. Background and History

A. A General Overview of Medicare

"Medicare is the federal health insurance program created in 1965 for all people age 65 and older regardless of their income or medical history," and as of November 2008, it covered 45 million Ameri-

Medicare beneficiaries will still need to satisfy the three-day SNF qualifying stay rule.

20. Ryan Crowley, *Reforming Medicare in the Age of Deficit Reduction*, AM. COLL. OF PHYSICIANS (2012), available at http://www.acponline.org/advocacy/current_policy_papers/assets/reforming_medicare.pdf (last visited Nov. 30, 2013).

cans.²¹ The Medicare Program, which was established through the Social Security Act, pays for covered medical care to individuals who are eligible as beneficiaries.²² The Department of Health and Human Services administers the program and has delegated administration of the program to the Centers for Medicare and Medicaid Services (CMS).²³ Medicare is structured around four separate "Parts," or programs that are labeled alphabetically from A through D.²⁴ Part A, which covers SNF stays, inpatient hospital stays, home health visits, and hospice care, accounted for 32 percent of all Medicare benefit spending in 2011.²⁵ A major aspect of Part A, also known as "Hospital Insurance," is the "benefit period," defined as "the measurement of time-duration for inpatient care, starting when the beneficiary first enters a hospital, and ending when there has been a break of at least 60 consecutive days since inpatient hospital or skilled nursing care was provided."²⁶ While Medicare covers the cost of many health care services, it also has many benefit gaps. Consequently, many Medicare beneficiaries have supplemental coverage, often in the form of employer-sponsored plans or Medicare supplemental insurance policies.²⁷ In theory, this option to carry supplemental coverage should allow beneficiaries to receive medical services without being unduly burdened in their finances.

Knowing the profile of Medicare beneficiaries is vital in trying to gauge the importance of adequate Medicare payment coverage for this

21. THE HENRY J. KAISER FAMILY FOUND., *Medicare at a Glance: Overview of Medicare* (Nov. 14, 2012), <http://www.kff.org/medicare/upload/1066-14.pdf>. [hereinafter Fact Sheet]. "Most people age 65 and older are entitled to Medicare Part A if they or their spouse are eligible for Social Security payments and have made payroll tax contributions for 10 or more years. Medicare was expanded in 1972 to include people under age 65 with permanent disabilities. Nonelderly people who receive Social Security Disability Insurance (SSDI) generally become eligible for Medicare after a two-year waiting period, while those diagnosed with end-stage renal disease (ESRD) and amyotrophic lateral sclerosis (ALS) become eligible for Medicare with no waiting period." *Id.*

22. *Rapport v. Leavitt*, 564 F. Supp. 2d 186, 188 (W.D.N.Y. 2008) (providing the statutory and regulatory background of Medicare).

23. *Id.*

24. Fact Sheet, *supra* note 21.

25. Additionally, "Part A benefits are subject to a deductible (\$1,184 per benefit period in 2013) and coinsurance." *Id.*

26. CTR. FOR REGULATORY EFFECTIVENESS, *Overview of Medicare* (June 24, 1995), <http://www.thecre.com/fedlaw/legal17/medicare.htm>.

27. Fact Sheet, *supra* note 21. While many beneficiaries have supplemental coverage, fewer seniors are expected to receive employee-sponsored retiree health benefits and some beneficiaries have no supplemental coverage. *Id.*

subset of the American population.²⁸ As of 2013, Medicare provided benefits coverage to over 50 million Americans age 65 and older.²⁹ In fact, the majority of individuals receiving Medicare benefits are eligible for Medicare simply by virtue of being age 65 or older.³⁰ Individuals receiving health coverage through Medicare are generally from a population that has low-to-moderate income and is in relatively poor health.³¹ To illustrate, in 2010 half of all Medicare beneficiaries had annual incomes below \$22,000, or below 200 percent of the federal poverty level, and 15 percent of all Medicare beneficiaries required assistance with two or more daily living activities.³² Also, Medicare beneficiaries may require the assistance of family members, such as their children, to help them in making decisions as to obtaining proper care and apprising themselves of the financial aspects of their care.³³

B. Medicare Coverage and Reimbursement for SNF Services

Medicare Part A covers skilled nursing facility services for up to 100 days per benefit period after the Medicare beneficiary has completed at least a three-day inpatient hospital stay.³⁴ It is important to note that Medicare Part A only covers “inpatient” care, as opposed to what is classified as “outpatient” care.³⁵ As such, Medicare Part A would not cover a Medicare beneficiary that is coded as an “outpatient” under observation status.³⁶ As seen with the situation encountered by Jean Arnau, it is this hospital coding distinction that leads to billing situations which can adversely affect Medicare beneficiaries.³⁷ A Skilled Nursing Facility is one that offers a level of care requiring

28. *Id.*

29. *Id.*

30. Megan Multack, *The Medicare Program: A Brief Overview*, AARP PUB. POL’Y INST. 2 (Mar. 2012), available at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/medicare-program-brief-overview-fs-AARP-ppi-health.pdf.

31. *Id.*

32. *Id.*

33. See Amanda Gengler, *Medicare: Avoid Big Rehab Bills*, CNN MONEY (Aug. 7, 2012, 5:28 AM), <http://money.cnn.com/2012/08/07/pf/medicare-rehab-bills.moneymag/index.htm?iid=EL>.

34. Multack, *supra* note 30.

35. Barry, *supra* note 1.

36. *Id.*

37. *See id.*

“the daily involvement of skilled nursing or rehabilitation staff.”³⁸

“Medicare covers semi-private rooms, meals, skilled nursing and rehabilitative services, and other medically-necessary services and supplies after a minimum three-calendar day, medically-necessary inpatient hospital stay [i.e. the SNF qualifying stay rule] for a related illness or injury.”³⁹ One Medicare publication for current and potential beneficiaries explicitly states that Medicare does not cover long-term care or custodial care, even if such care is administered by a skilled nursing facility.⁴⁰

1. “INPATIENT” VERSUS “OBSERVATION” HOSPITAL ADMISSIONS STATUS

Currently, 42 C.F.R. § 422.101(c), which was recently changed for the 2014 fiscal year (FY) by CMS, requires that Medicare beneficiaries stay in a hospital for inpatient care for a period spanning two midnights⁴¹ before qualifying for reimbursement for rehabilitation or other services in an SNF.⁴² Under the old rule, patients had to meet a requisite 72 hour period for an inpatient hospital stay, beginning the day the Medicare beneficiary was formally admitted under a doctor’s order but not including the day on which the patient was discharged.⁴³ Through the newest version of 42 C.F.R. § 422.101(c), a patient whom a physician believes will require a stay spanning two midnights is presumed to be an “inpatient”; however, the rule still requires a “formal order of inpatient admission to begin inpatient status.”⁴⁴ While the new rule clarifies and redefines inpatient coding, it does not directly affect the requirement that Medicare beneficiaries seeking subsequent SNF care spend three calendar days in inpatient

38. CTRS. FOR MEDICARE & MEDICAID SERVS., *Medicare Coverage of Skilled Nursing Facility Care* 45, (on file with author) [hereinafter *Medicare Coverage of Skilled Nursing Facility Care*].

39. CTRS. FOR MEDICARE AND MEDICAID SERVS., *Medicare & You* 33 (2013), <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf> [hereinafter *Medicare & You*]. “An inpatient hospital stay begins the day you’re formally admitted with a doctor’s order and doesn’t include the day you’re discharged. To qualify for care in a skilled nursing facility, your doctor must certify that you need daily skilled care like intravenous injections or physical therapy.” *Id.*

40. *Id.*

41. CTRS. FOR MEDICARE & MEDICAID SERVS., *Final FY 2014 Inpatient and SNF Payment Rules* (Aug. 2, 2013), <http://www.cms.gov/Outreach-and-Education/Outreach/FFSPProvPartProg/Downloads/2013-08-01-EnewsStandalone.pdf> [hereinafter *Final FY 2014*].

42. 42 C.F.R. § 409.30 (2012).

43. ARE YOU A HOSPITAL INPATIENT OR OUTPATIENT?, *supra* note 17.

44. *Final FY 2014*, *supra* note 41.

care.⁴⁵ Indeed, the rule potentially increases the likelihood of a patient being coded under inpatient status, although some health organizations have already expressed doubt over any meaningful change to the problematic distinction between inpatient and observation status.⁴⁶

One key aspect of Medicare coverage for SNF care is that the Medicare beneficiary must be correctly coded as “inpatient”; the use of any other terminology⁴⁷ in coding the patient will result in a denial of Medicare cost coverage. For example, Medicare will not provide coverage for outpatient care when an individual is placed under observation.⁴⁸ This technical differentiation—namely the difference between an inpatient and an outpatient who is under observation—is not applied in a common-sense fashion. Rather, there is little regulatory guidance as to what constitutes inpatient admission and observation status once a patient satisfies the requisite two-midnight stay period set forth in the regulation.⁴⁹ In fact, at least one legal scholar argues that Medicare’s inpatient hospital system from its inception was “a mass of contradiction and . . . as a result, it has been growing increasingly complex.”⁵⁰

45. Toby Edelman, a senior policy attorney for the Center for Medicare Advocacy, stated that the proposed rule does not help observation patients because it maintains the three-calendar-day requirement, does not require hospitals to inform patients that they have been admitted as under “observation,” and does not give patients a right to appeal their observation status. Susan Jaffe, *Doctors, Others Criticize Medicare’s Proposal on Hospital Admissions Rules*, WASH. POST (May 2, 2013), http://www.washingtonpost.com/politics/doctors-others-criticize-medicare-proposal-on-hospital-admissions-rules/2013/05/02/d78cba1a-b36b-11e2-9a98-4be1688d7d84_story.html.

46. For example, BKD National Health Care Group indicated that the rule, which does not lend significant weight to the physician’s opinion, could lead to determinations of admission status based solely on length of stay. Sally Hardgrove, *IPPS Proposed Rule for FY 2014 Changes Inpatient Status Criteria*, HEALTH CARE REFORM INSIGHTS (June 19, 2013), <http://www.healthcarereforminsights.com/2013/06/19/ipps-proposed-rule-for-fy-2014-changes-inpatient-status-criteria/>.

47. See, e.g., Barry, *supra* note 1.

48. See CTR. FOR MEDICARE ADVOCACY, *Senators Kerry and Snowe, with Representatives Courtney and Latham, Introduce Legislation to Ensure Skilled Care for Seniors*, (Sept. 14, 2012, 1:11 PM), <http://www.medicareadvocacy.org/senators-kerry-and-snowe-with-representatives-courtney-and-latham-introduce-legislation-to-ensure-skilled-care-for-seniors/> (last modified Apr. 26, 2011) (describing problem with billing technicalities).

49. The controlling statute provides in detail what constitutes an inpatient hospital stay; however, the regulation does not clarify when a patient, who has stayed in a hospital for three consecutive days, should be classified as an “inpatient” for admissions purposes. Compare 42 U.S.C. § 1395x(i) (2012) with 42 C.F.R. § 409.30(a) (2013).

50. For an in-depth analysis of the general complexities of the hospital inpatient reimbursement system, see David M. Frankford, *The Complexity of Medicare’s*

2. ABUSE OF THE HOSPITAL CODING SYSTEM

One major result of the regulation is that hospitals “game” the system by coding patients as outpatients under observation so as to defeat a future claim for skilled nursing facility care coverage.⁵¹ Unlike with inpatient admissions, Medicare reimburses hospitals far less for observation stays.⁵² Given CMS’s increasing concern with the need to cut Medicare costs,⁵³ a growing number of Medicare auditors use an automated screening system to second-guess hospital admissions decisions, which in turn causes a hospital that has its admissions decision rejected to lose all of its revenue for the duration of the Medicare beneficiary’s stay.⁵⁴ As a result, Medicare beneficiaries may spend days in the hospital under observation status, which contradicts Medicare’s own guidelines.⁵⁵ Indeed, the controlling statute, the Social Security Act, delineates in Chapter 7 the characteristics of an inpatient hospital stay, including bed and board, the provision of nursing and other related services, and the use of diagnostic and therapeutic items.⁵⁶ Also, while physicians may claim that the Medicare beneficiaries are ultimately receiving the same quality of care during their outpatient stay under “observation,” the end result is that Medicare beneficiaries, who should otherwise be covered under Medicare Part A for their subsequent skilled nursing facility care, are left to foot the bill for care that can easily cost tens of thousands of dollars.⁵⁷

Hospital Reimbursement System: Paradoxes of Averaging, 78 IOWA L. REV. 517, 518 (1993).

51. See, e.g., 2-Midnight Rule: Medicare’s New 2013 Inpatient Hospital Payment Policy Explained (CMS 1599-P, now 1599-F), HAPPY HOSPITALIST, <http://thehappyhospitalist.blogspot.com/2013/05/2-Midnight-Rule-Medicare-Inpatient-Payment-Policy-Explained.html> (last updated Nov. 14, 2013) (discussing improper admissions status coding to allow patients to qualify for subsequent SNF care).

52. Gengler, *supra* note 4.

53. See generally Fact Sheet, *supra* note 21 (discussing current Medicare spending and future Medicare spending).

54. Gengler, *supra* note 4 (describing how Medicare auditor’s rejection of admissions decision leads to denial of hospital’s Medicare reimbursement claim).

55. *Id.* Between 2007 and 2009, outpatient observation stays increased by 25 percent. Half of these stays were for longer than 24 hours and about one in seven extended beyond 48 hours. *Id.* Medicare coding guidelines suggest that most observation stays should be no more than 24 hours long and only “in rare and exceptional” circumstances go beyond 48 hours. *Id.*

56. 42 U.S.C. § 1395x(b) (2012) (defining “inpatient hospital services”).

57. Gengler, *supra* note 4 (describing how Medicare’s rejection of admissions decision leads to denial of hospital’s Medicare reimbursement claim). As an attorney for the Center for Medicare Advocacy noted, “[w]hat seems like it should be a technical billing issue has turned into something that can have pretty disastrous financial consequences.” *Id.*

Similarly, patients are left in an undesirable situation with respect to the distinction between inpatient and observation admissions status.⁵⁸ In one publicized incident, a 99-year-old patient's daughter had to demand that hospital staff allow her mother to stay the requisite three days in the hospital so that she might receive Medicare Part A reimbursement for her subsequent skilled nursing facility care.⁵⁹ Patients might also attempt to have their status as an outpatient under observation switched to inpatient while they are still in the hospital.⁶⁰ Patients are advised to specifically ask their doctor and case manager about the type of status designation they received, provide a detailed medical history to meet Medicare's inpatient guidelines, and request that their primary physician contact hospital staff to stress the need for a higher level of care (i.e. inpatient care).⁶¹ If the Medicare beneficiary is unable to obtain inpatient designation, his or her only recourse is to appeal the case to Medicare—a process that is highly convoluted and may ultimately be denied by a reviewing court.⁶² However, the hospital alone makes the final decision as to whether a patient is coded as inpatient or under observation.⁶³ Thus, even a patient's attempts to "game" the system in their favor may prove unsuccessful, leaving them to foot the bill for what may be extremely costly skilled nursing facility services.

3. THE SPECIAL SITUATION POSED BY MEDICARE ADVANTAGE PROGRAMS

It should be noted that Medicare Advantage (MA) programs, which are run by Medicare-approved private insurance companies,⁶⁴ present a special situation with respect to Medicare coverage for

58. *Id.*

59. See Barbara Peters Smith, *Medicare Initiative Puts Pressure on Hospitals and Patients*, HERALD-TRIB. (Nov. 10, 2012, 10:23 PM), <http://www.heraldtribune.com/article/20121110/ARTICLE/121119963?p=1&tc=pg> (providing example of patient's family having to fight to keep patient in hospital for requisite three-day qualifying hospital stay).

60. Gengler, *supra* note 33.

61. *Id.*

62. See *id.*; see also *Estate of Landers v. Leavitt*, 545 F.3d 98, 111 (2d. Cir. 2008) (holding plaintiff Medicare beneficiaries not entitled to coverage because the durations of their hospital stays did not satisfy the three-day stay rule). Interestingly, the appeals process is so convoluted that, in one instance, Medicare sent a letter to a patient suggesting that they ask the hospital to change their "observation" designation to "inpatient," even though hospitals are not allowed to change a coding designation after the fact. Gengler, *supra* note 4.

63. See generally Gengler, *supra* note 33.

64. *Medicare Coverage of Skilled Nursing Facility Care*, *supra* note 38, at 59.

skilled nursing facility care. Medicare Advantage plans “may include supplemental benefits not covered by the Medicare program,”⁶⁵ such as coverage of post-hospital SNF care without the need of a prior qualifying hospital stay—namely a three-calendar-day qualifying stay with proper hospital coding of an individual as inpatient—that would otherwise be required for Medicare coverage of SNF care.⁶⁶ Generally, elder Americans can take advantage of participation in MA plans as long as they are entitled to benefits under Medicare Part A and enrolled in Medicare Part B.⁶⁷

However, MA plans are not required to include supplemental coverage that would provide payment for skilled nursing facility services when the policyholder does not meet the requirements of the two-midnight rule.⁶⁸ Indeed, the language of the CMS regulation is such that any potential exception to the two-midnight rule “is applicable *only if* the plan ‘offers the benefits described in [42 C.F.R.] § 422.101(c) (i.e. coverage of SNF services in the absence of a qualifying hospital stay).’”⁶⁹ Thus, even if a Medicare beneficiary attempts to seek coverage for SNF services through an MA plan, he or she may not necessarily be able to obtain coverage when they do not meet the general requirements for a prior qualifying hospital stay under 42 C.F.R. § 422.101(c).

III. Analysis

A. The Viability of Reform Proposals

1. AN OVERVIEW OF THE CURRENT ALTERNATIVES

Currently, there have been only a handful of viable proposed changes to the SNF three-day qualifying stay regulation.⁷⁰ While the federal government instituted a diagnosis-related groupings (DRG)

65. *Rapport v. Leavitt*, 564 F. Supp. 2d 186, 188 (W.D.N.Y. 2008).

66. *Id.* at 188–89.

67. *Id.* at 188.

68. *See, e.g., id.* at 193 (finding MA plan in question did not include any exception to the requirement for a qualifying hospital stay to receive coverage for post-hospital SNF care).

69. *Id.*

70. *See* Howard Gleckman, *What the Ongoing Battle over Medicare’s Observation Stays Means for Seniors*, FORBES (Sept. 5, 2012, 3:54 PM), <http://www.forbes.com/sites/howardgleckman/2012/09/05/what-the-ongoing-battle-over-medicare-observation-stays-means-for-seniors/>.

program that effectively reduced the number of days that Medicare would cover for specified medical conditions back in 1983, the SNF qualifying stay regulation was not altered to reflect the new DRG rules. As a result, a Medicare beneficiary's hospital stay is increasingly likely to not meet the three-calendar-day requirement to warrant coverage of SNF costs.⁷¹ The increasing likelihood that a Medicare beneficiary's inpatient hospital stay will not satisfy the three-day qualifying stay is becoming the new norm.⁷²

Any viable reform proposal would likely need to satisfy CMS's rationale for the three-calendar-day stay requirement; namely, ensuring that a beneficiary had a significant change in his or her condition which resulted in an acute health need, thus requiring post-hospital care.⁷³ A viable proposal should also consider budgetary considerations inherent in the current rule, which seeks to limit payments for skilled nursing facility care by the Medicare Trust Fund.⁷⁴ At the same time, a viable proposal should not outright eliminate observation status entirely because doing so would deny physicians the option to hold patients overnight to "keep an eye on [them]."⁷⁵ Indeed, admitting a patient to a hospital can be expensive and allowing a patient who does not require hospitalization to stay in a hospital for observation can be a cost-effective option.⁷⁶ In addition, a viable reform proposal should include a provision to fight Medicare billing fraud; however, such a provision should not rise to the level that observation decisions are driven entirely by Medicare fraud auditors as opposed to doctors.⁷⁷

71. Richard L. Kaplan, *Symposium: Cracking the Conundrum: Toward a Rational Financing of Long-Term Care*, 2004 U. ILL. L. REV. 47, 60–61 (2004).

72. See Richard L. Kaplan, *Medicare*, 41, 47 UNIV. OF MIAMI L. CTR. ON ESTATE PLANNING ¶ 1702, 1702.2 (2012).

73. STEPHEN T. HOUSE, REPORT A-A-08, *REPORT OF THE ORGANIZED MEDICAL STAFF SECTION: EQUAL ACCESS FOR MEDICARE PATIENTS TO SKILLED NURSING FACILITIES*, AM. MED. ASS'N., available at www.ama-assn.org/ama1/pub/upload/mm/21/reporta.doc.

74. *Id.*

75. See Gleckman, *supra* note 70.

76. See *id.*

77. See *id.* "[T]here have been abuses by nursing homes that send patients to the hospital so they can restart the three-day clock and get another round of Medicare payments." *Id.*

2. THE AMA PROPOSAL TO ELIMINATE THE THREE-DAY QUALIFYING STAY

The American Medical Association (AMA) presented one of these proposed changes. The AMA proposal is to effectively remove the requirement.⁷⁸ The AMA notes that elimination of the three-day stay rule “would avert hospitalization and generate overall cost savings” for certain subsets of patients, or DRGs, by allowing Medicare coverage for direct admission of Medicare beneficiaries to a skilled nursing facility regardless of a prior qualifying hospital stay. Comparatively, the current rule requiring a stay of three consecutive calendar days essentially shifts the initial cost of SNF care to hospitals for the sake of satisfying a billing formality.⁷⁹ The AMA also notes that elimination of the three-calendar-day stay rule would remove billing and implementation inconsistencies, which often plague treating physicians, hospitals, and health facilities, in coverage for SNF care between traditional Medicare and Medicare Advantage plans.⁸⁰ In addition, removal of the rule would forgo mandatory hospitalization for SNF care; the AMA argues that, as a result, removing the three-day qualifying stay requirement would prevent ineffective and wasteful use of hospital resources since certain medical treatment renders prior hospitalization not medically necessary.⁸¹

The AMA proposal is not without criticism. One problem with the AMA proposal is that it does not provide a workable regulatory alternative; instead, it simply removes the statutory and regulatory requirements that a patient seeking skilled nursing facility services be previously admitted as an inpatient for three days.⁸² Through broadly removing the distinction between inpatient and observation care, the AMA proposal complicates other aspects of Medicare Part A coverage that rely on the distinction for reimbursement, such as the hospital stays preceding skilled nursing facility treatment.⁸³ And, as a matter of implementation, it would likely be difficult to have the proposal apply only to the context of skilled nursing facility services following a hospital visit, since other services covered by Medicare Part A

78. See Charles Fiegl, *AMA Seeks Changes to Medicare Hospital Observation Policy*, AM. MED. NEWS (Apr. 16, 2012), <http://www.amednews.com/article/20120416/government/304169961/6/> (last visited Sept. 30, 2013).

79. See HOUSE, *supra* note 73, at 3.

80. *Id.*

81. *Id.*

82. See generally Fiegl, *supra* note 78.

83. See generally Frankford, *supra* note 50, at 518–19.

would still be subject to an inpatient coding determination.⁸⁴ Another concern is that the proposal could lead to an increase in the Medicare payroll tax, raising taxes as a result of the need to fund new subsidies for private health insurance and Medicaid expansion pursuant the Patient Protection and Affordable Care Act.⁸⁵ Some policy experts note that raising the payroll tax rate would slow economic growth by taxing individuals, adversely affect future generations of American taxpayers by forcing them to pay a higher tax rate at an earlier date, and permit lawmakers to alleviate political pressure while avoiding difficult policy decisions.⁸⁶ In addition, eliminating the prior three-day qualifying stay requirement could lead to increases in Medicare premiums for higher-income seniors seeking Medicare coverage for SNF care; this specific concern was the reason why the Medicare Catastrophic Coverage Act, which eliminated the three-day stay rule, was repealed in 1989—the same year the law went into effect.⁸⁷ The fact that the three-day stay requirement was previously eliminated and almost immediately reinstated underscores the need for a workable standard to replace the existing rule.

3. PROFESSOR RICHARD L. KAPLAN'S SUGGESTED ELIMINATION OF THE RULE

As one of the foremost experts on Medicare policy and Medicare reform, Professor Richard L. Kaplan, at the University of Illinois College of Law, also advocates for the elimination of a preceding three-calendar-day hospital stay prior to obtaining coverage for SNF care.⁸⁸

84. See generally Fiegl, *supra* note 78.

85. See Grace-Marie Turner, *As 2013 Begins, Get Ready for an ObamaCare Tax Onslaught*, FORBES (Jan. 2, 2013, 11:35 AM), available at <http://www.forbes.com/sites/gracemarieturner/2013/01/02/as-2013-begins-get-ready-for-an-obamacare-tax-onslaught/>. For example, high-income earners will see their Medicare payroll tax rate increase from 2.9 percent to 3.8 percent effective January 2013. *Id.*

86. See Henry Aaron & Stuart Butler, *Option: Generate New Revenue by Increasing the Payroll Tax Rate*, AARP PUB. POL'Y INST., June 5, 2012, at 2–3, http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/option-generate-revenue-by-increasing-payroll-tax-AARP-ppi-health.pdf.

87. HOUSE, *supra* note 73, at 2. “In 1988, the Medicare Catastrophic Coverage Act was signed into law, which altered eligibility and coverage for skilled nursing facility care. *Id.* This legislation included the elimination of the requirement for a prior hospitalization of at least three days before Medicare coverage of skilled nursing care could commence. *Id.* These changes went into effect at the beginning of 1989. *Id.* However, by the end of that year, the Medicare Catastrophic Coverage Act was repealed due to concerns with increases in Medicare premiums for higher-income seniors.” *Id.*

88. See Kaplan, *supra* note 71, at 82. To read more of Professor Kaplan’s work on Medicare and elder law issues generally, see LAWRENCE A. FROLIK & RICHARD

Kaplan notes that eliminating the three-day stay rule would provide Medicare coverage for many nursing facility costs that are not covered by the current rules while recognizing that nursing facility stays are often used as substitutes for hospital stays because medical care that was previously only available in hospitals can now be administered in nursing facilities, thereby reflecting a shift in the implementation of medical care.⁸⁹ In addition, Kaplan argues that elimination of the three-day stay rule responds to the increasing number of DRG-shortened hospital stays, which release Medicare beneficiaries before they can cope at home and often require admission into a nursing facility to receive the medical care that they would have received in a hospital.⁹⁰ Kaplan's recommendation goes further than the AMA proposal by outlining a viable financing structure which suggests that the Medicare program, in its entirety, be funded in the same manner as Medicare Part B—general tax revenues plus premiums paid by enrollees.⁹¹ Additionally, Kaplan's recommendation suggests that the Medicare payroll tax, which taxes individuals' earned income,⁹² be repealed.⁹³

As with any move that will expand Medicare payment coverage, this reform measure would likely encounter political pushback from lawmakers. It is often difficult to find political support for bills affecting entitlement spending and much political capital is at stake when voting on such bills (as is the case with any proposed law that will affect Medicare).⁹⁴ Indeed, the Patient Protection and Affordable Care Act advanced by President Barack Obama and many congressional Democrats caused a great amount of consternation in grassroots organizations and political groups.⁹⁵ Kaplan's recommendation is likely

L. KAPLAN, *ELDER LAW IN A NUTSHELL*, (4th ed. 2006), and Richard L. Kaplan, *Top Ten Myths of Medicare*, 20 *ELDER L.J.* 1 (2012).

89. Kaplan, *supra* note 71, at 83.

90. *Id.* ("Medicare has a moral imperative to pay for nursing home stays that result from DRG-shortened hospital stays.").

91. Compare Fiegl, *supra* note 78 with Kaplan, *supra* note 71, at 88.

92. See FIDELITY VIEWPOINTS, *The New Medicare Tax and You* (Sept. 12, 2013), <https://www.fidelity.com/viewpoints/personal-finance/new-medicare-taxes>.

93. Kaplan, *supra* note 71.

94. Aaron Blake & Chris Cillizza, *Medicare: The New Third Rail of Politics?*, WASH. POST (May 26, 2011), http://www.washingtonpost.com/blogs/the-fix/post/medicare-the-new-third-rail-of-american-politics/2011/05/25/AGzWLuBH_blog.html.

95. See generally Kevin A. Hassett, *Obamacare Tax Frays Middle-Class Vow*, AM. ENTER. INST. (Oct. 12, 2009), <http://www.aei.org/article/health/healthcare-reform/obamacare-tax-frays-middle-class-vow/>; Dani Doane, *10,000 Rally Against Obamacare*, THE FOUNDRY (Nov. 5, 2009, 12:56 PM), <http://blog.heritage.org/>

to encounter opposition from budget-conscious lawmakers, as elimination of payroll taxes (which include the Medicare payroll tax) absent the creation of an additional source of revenue, would lead to a budget shortfall of an estimated \$1.4 trillion in 2020.⁹⁶ As it stands, CMS anticipates that aggregate payments to skilled nursing facilities will increase by \$470 million in Fiscal Year 2014 (when compared with aggregate payments made in Fiscal Year 2013).⁹⁷ Additionally, some policy analysts believe that the Medicare payroll tax should be increased to offset the Hospital Insurance funding gap, which is caused by Medicare spending exceeding revenues and has been accelerated in light of the retirement of the Baby Boomer generation.⁹⁸ Still, eliminating payroll taxes is an option, as even those opposed to eliminating payroll taxes admit that alternatives are readily available, including borrowing, creating new taxes, and keeping current payroll taxes while offsetting them with tax credits.⁹⁹ Kaplan's recommendation, however, could potentially garner broad support by allocating tax revenue to pay for the increase in costs for SNF care coverage and requiring premium payments by Medicare enrollees while also eliminating the Medicare payroll tax, appeasing lawmakers who might be unwilling to increase taxes on individuals.

4. MANDATORY INPATIENT CODING

Alternatively, some lawmakers have proposed legislation that would require hospitals to code patients receiving treatment during a stay at the hospital as inpatients instead of outpatients under observation, thereby giving congressional guidance as to how hospital-billing procedures should operate.¹⁰⁰ Because the statute allows for Health and Human Services and CMS to provide further regulatory guidance, the vague language of the statute may be construed so as to ef-

2009/11/05/10000-rally-against-obamacare/; Paul Bedard, *Tea Party Plans March Obamacare Protest*, USA NEWS (Mar. 9, 2010), <http://www.usnews.com/news/washington-whispers/articles/2010/03/09/tea-party-plans-march-obamacare-protest->.

96. See Dylan Matthews, *Want to Eliminate the Payroll Tax? Better Find \$12 Trillion to Replace It*, WASH. POST: WONK BLOG (Nov. 26, 2012, 11:44 AM), <http://www.washingtonpost.com/blogs/wonkblog/wp/2012/11/26/want-to-eliminate-the-payroll-tax-better-find-12-trillion-to-replace-it/>. The Congressional Budget Office estimates that payroll taxes will generate approximately \$1.4 trillion in 2020. *Id.*

97. *Final FY 2014 Rules*, *supra* note 41.

98. Aaron & Butler, *supra* note 86.

99. See, e.g., Matthews, *supra* note 96.

100. CTR. FOR MEDICARE ADVOCACY, *supra* note 48.

fectively eliminate Medicare funding for what would normally be categorized as outpatient services. There is also a risk that hospitals, which are already under scrutiny for their inpatient admissions decisions, may simply refuse to accept Medicare patients.¹⁰¹ Another problem with a proposed mandatory inpatient coding law is that it is often difficult to find political support for these bills, and much political capital is at stake by voting on such bills (as is the case with any proposed law that will affect Medicare).¹⁰² However, some experts argue that beliefs that Medicare reform is politically untouchable are overstated; for example, both Republicans and Democrats have voted to reduce Medicare's budget over the past twenty years.¹⁰³

5. REFORM BY LEGISLATIVE EFFORTS

There are many critical assessments of the Medicare three-day stay rule but few viable alternatives to replace the rule itself. Generally, many health advocacy groups agree that the three-day stay rule should be changed or replaced;¹⁰⁴ indeed, one proposal by legislators to mandate inpatient coding was the result of a bipartisan political effort between Republicans and Democrats in the U.S. Senate.¹⁰⁵ Thus, the real battle is to craft a workable alternative to the current regulation that can be properly enforced by CMS. Indeed, ineffective enforcement of current rules and regulations is one of the main reasons why the application of the three-day stay rule has adversely affected Medicare beneficiaries and, consequently, has not focused on the best interest of the patient.¹⁰⁶

101. See, e.g., *Medicare and the Mayo Clinic: The Famous Hospital Will No Longer Take Some Senior Patients*, WALL ST. J., <http://online.wsj.com/article/SB10001424052748703436504574640711655886136.html> (last updated Jan. 8, 2010, 12:01 AM) (describing 2010 Mayo Clinic two-year pilot program to determine whether the health-care provider should drop Medicare patients at facilities in other states).

102. See generally *id.*; Phil Ciciora, *Retirement Expert: Medicare Woes Mostly Rooted in Myth*, UNIV. OF ILL. (Aug. 8, 2012), http://news.illinois.edu/news/12/0808medicare_RichardKaplan.html.

103. Ciciora, *supra* note 102.

104. See, e.g., HOUSE, *supra* note 73; *Observation Stay Talking Points*, AM. HEALTH CARE ASS'N., http://www.ahcancal.org/facility_operations/Documents/AHCA%20Media%20Toolkit%20-%20Observation%20Stays.pdf (last visited Dec. 1, 2013).

105. See Press Release, [STATE] Skilled Nursing Facilities Herald Bill on Observation Stays, AM. HEALTH CARE ASS'N (Apr. 14, 2011), http://ahcancal.org/facility_operations/Documents/AHCA%20Media%20Toolkit%20-%20Observation%20Stays.pdf.

106. See AM. HEALTH CARE ASS'N, *supra* note 104.

In recent years, federal legislators have offered a handful of proposals directly affecting the SNF qualifying stay rule.¹⁰⁷ For example, in 2011, Democratic Representative Joe Courtney of Connecticut called for changing the three-consecutive-days requirement to allow days in observation to count toward the requisite three-day hospital stay, doing away with the inpatient observation admissions status distinction during hospital stays.¹⁰⁸ His bill, “Improving Access to Medicare Coverage Act of 2011,” received bipartisan political support; in fact, Republican Representative Tom Latham co-sponsored Representative Courtney’s legislation.¹⁰⁹ Despite bipartisan backing, Courtney’s legislation failed to advance beyond being introduced to the House of Representatives.¹¹⁰ Though the bill did not become law, it did receive sizeable support. For example, Courtney’s legislation was endorsed by the American Association of Retired Persons, the AMA, the American Health Care Association (a nursing home industry trade group), and other diverse organizations while a similar bill was introduced in 2011 in the Senate by Senators John Kerry and Olympia Snowe (a Democrat and Republican, respectively).¹¹¹

As of March 2013, Representatives Courtney and Latham reintroduced the “Improving Access to Medicare Coverage Act of 2013” in the House, with a similar bill being introduced in the Senate by Senator Sherrod Brown.¹¹² In support of the “Improving Access to Medicare Coverage Act of 2013,” prominent politicians have publicly called for changes in the current Medicare SNF coverage regulations.¹¹³ In addition, the American public has kept the debate over reforming the

107. See, e.g., H.R. 1543, 112th Cong. (1st Sess. 2011).

108. H.R. 1543, 112th Cong. (1st Sess. 2011).

109. See Susan Jaffe, *Rep. Courtney Pushes Bill to Expand Medicare Coverage of Nursing Home Stays*, CAPSULES: THE KHN BLOG (Aug. 9, 2012, 6:00 AM), available at <http://capsules.kaiserhealthnews.org/index.php/2012/08/rep-courtney-pushes-bill-to-expand-medicare-coverage-of-nursing-home-stays/>.

110. H.R. 1543, 112th Cong. (1st sess. 2011).

111. See Jaffe, *supra* note 109.

112. Alyssa Gerace, *New Bill Would Close “3-Day-Stay” Loophole for Medicare Coverage*, SENIOR HOUS. NEWS (Mar. 15, 2013), <http://seniorhousingnews.com/2013/03/15/new-bill-would-close-3-day-stay-loophole-for-medicare-coverage/>. When describing his legislative proposal, Representative Courtney stated, “My legislation says, ‘Three days is three days.’ We don’t care how it gets coded between the government [and] the hospitals—that’s an issue for them to work out between themselves But Medicare should be able to cover rehabilitative services.” *Id.*

113. James Post, *Schumer Blasts Medicare Loophole*, THE LEADER (July 2, 2013, 2:22 AM), <http://www.the-leader.com/x1806115782/Schumer-blasts-Medicare-loophole>.

rule alive, spurring on legislators to reform the rule. In one notable instance, Representative Mike Fitzpatrick learned from a vocal constituent during one of the first town hall meetings of 2013 that Medicare refused to cover costs related to her husband's hospital visit, which lasted three-and-a-half days, because he was coded as an outpatient and was never technically admitted to the hospital.¹¹⁴ Thus, there still exists public interest in reforming the Medicare SNF qualifying stay rule in the current session of Congress. Additionally, the identification of problems in the implementation of the Patient Protection and Affordable Care Act may invite legislators to address existing issues like reforming the SNF qualifying stay rule.¹¹⁵

6. REFORMS BY JUDICIAL MEASURES

As recent as within the past decade, there have been attempts in the judicial system to alter the requirements of the controlling statute or to alter the CMS regulation itself. However, at least one federal court found that Medicare plans are not obligated to cover SNF services absent the requisite three-day qualifying stay.¹¹⁶ In 2008, the U.S. District Court for the Western District of New York found that a Medicare program, Medicare Advantage, was not required to reimburse SNF costs absent a three-calendar-day qualifying stay per the regulation.¹¹⁷ On appeal, the Second Circuit upheld Medicare's denial of coverage for skilled nursing facility care for individuals who stayed in a hospital for three days prior to seeking treatment at a nursing facility but who were coded as being in emergency care or under observation during portions of their stay.¹¹⁸ In upholding Medicare's application

114. See Bob Keeler, *Congressman Mike Fitzpatrick Holds Town Hall Meeting at Indian Valley Public Library*, MONTGOMERY MEDIA (Jan. 11, 2013), http://www.montgomerynews.com/articles/2013/01/11/souderton_independent/news/doc50ef55bf783e8044868785.txt?viewmode=fullstory.

115. See, e.g., Ricardo Alonso-Zaldivar, *Obamacare 'Glitch' Allows Some Families to Be Priced Out of Health Insurance*, HUFFINGTON POST (Jan. 30, 2013, 6:29 PM), http://www.huffingtonpost.com/2013/01/30/obamacare-glitch-priced-out-of-health-care_n_2585695.html. However, there may be little support for an immediate solution from the Republican-controlled House, whose Republican members would like to repeal the Patient Protection and Affordable Care Act. *Id.*

116. *U.S. Court in New York Finds MA Plan Not Obligated to Cover SNF Services Without Required Three-Day Hospital Stay*, AM. HEALTH LAWYERS ASS'N (July 18, 2008) (on file with author).

117. *Id.*

118. *Second Circuit Upholds HHS' Denial of Medicare Coverage for Post-Hospital SNF Stays*, AM. HEALTH LAWYERS ASS'N (Oct. 10, 2008) (on file with author) (discussing the Second Circuit's decision in upholding Medicare's denial of coverage

of the three-day qualifying stay rule, the Second Circuit granted great administrative deference to CMS's interpretation of the statutory language, noting that the rule is consistent with CMS's statutory interpretation in other contexts; the court ultimately found that the individuals seeking reimbursement did not satisfy the rule and were not deprived equal protection because CMS could have rationally concluded that a bright-line three-day stay test is needed for the sake of administrative efficiency.¹¹⁹ By evaluating the Second Circuit's decision, it becomes apparent that any judicial challenge to the three-day qualifying stay rule would encounter significant administrative law challenges, as courts generally grant substantial deference to administrative interpretations of statutory language when crafting agency rules.¹²⁰

Despite the aforementioned Second Circuit decision, the Center for Medicare Advocacy filed a class action lawsuit in 2011 against the head of the U.S. Department of Health and Human Services in an attempt to eliminate observation status on the theory that coding patients as under observation or outpatient status denies them rehabilitation coverage once they leave the hospital.¹²¹ In response to the lawsuit, the government filed a Motion to Dismiss arguing, among other theories, that an appeals process is already in place for Medicare beneficiaries who dispute their admissions status and that the court lacks jurisdiction over the matter per administrative law deference.¹²² While the case has yet to be decided, Second Circuit case law suggests that the petitioners in *Bagnall v. Sebelius* have an uphill battle.

As such, it seems that any change to the SNF qualifying stay rule will have to be initiated by CMS by way of an internal regulatory reform or through a legislative change in the language of the controlling statute.¹²³ Also, with respect to changes to agency regulations, the

for SNF reimbursement for failing to meet three day stay requirement in *Landers v. Leavitt*, 545 F.3d 98 (2d. Cir. 2008)).

119. *Id.*

120. *See Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 844–45 (1984) (setting forth the legal standard of administrative deference to a federal agency's interpretation of an administered statute).

121. *Bagnall v. Sebelius*, No. 3:11-cv-1703-AWT (D. Conn. filed Nov. 3, 2011).

122. Mem. in Supp. of Mot. to Dismiss *Bagnall v. Sebelius*, No. 3:11-cv-1703-AWT (D. Conn. filed Jan. 9, 2012).

123. *See generally* OFFICE OF THE FED. REG., A Guide to the Rulemaking Process, available at https://www.federalregister.gov/uploads/2011/01/the_rulemaking_process.pdf (providing an overview of the process for changing federal rules and regulations).

courts are hamstrung when attempting to change the language of regulations, as agency regulations are afforded vast deference by the courts.¹²⁴ In *Estate of Landers v. Leavitt*, which dealt with CMS's interpretation of what counts towards an SNF-qualifying stay, the Second Circuit explicitly raised the issue of administrative deference.¹²⁵

There, the Second Circuit found that, even though CMS's policy interpretation did not necessarily warrant *Chevron* deference, CMS's interpretation should still be granted *Skidmore* deference.¹²⁶ Courts following the Second Circuit's approach to CMS's interpretation of the statute—that is, the three-day qualifying stay rule—would thus grant substantial deference to the rule.¹²⁷ As such, it is not likely that a judicial challenge to the current rule will successfully lead to a reform of the rule; instead, a successful reform will likely result only from CMS changing the rule itself or Congress modifying the statutory language.

B. Hospital-Billing Coding and the Problem with “Gaming” the System

One of the primary problems with the current SNF qualifying stay rule is the adverse effect on Medicare beneficiaries with respect to coverage for skilled nursing facility services after a visit to the hospital. At the heart of this problem lies a concern over the prevalence of Medicare fraud. In response to pervasive Medicare fraud, the Department of Health and Human Services has implemented cost-cutting and fraud detection initiatives like the Recovery Audit Contractor program.¹²⁸ However, such programs have caused hospitals to

124. See *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. at 844–45 (1984).

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

126. *Id.* (recognizing an agency's statutory interpretation that does not warrant *Chevron* deference is still entitled to deference based on its persuasiveness, as demonstrated by “the thoroughness evident in [the agency's] consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade.” (citing *Skidmore v. Swift & Co.*, 323 U.S. 124, 140 (1944)).

127. *Id.*

128. *Preventing and Recovering Medicare Payment Errors: Hearing Before the Fed. Fin. Mgmt., Gov't Info., Fed. Servs., and Int'l Sec. Subcomm. of the Comm. on Homeland Sec. and Gov't Affairs*, 111th Cong. 2–5 (2010) (statement of Sen. Tom Carper, Chairman, S. Comm. on Homeland Sec. and Governmental Affairs). Medicare has been designated as being at a “high risk” for fraud because of its size, complexity, and susceptibility for improper payments; consequently, the Recovery Audit Contractor Program was implemented (in an experimental fashion at first, then adopted nationwide) to recover fraudulently disbursed funds. *Id.*

“game” the system by coding patients as outpatients under observation instead of coding them as inpatient for hospital Medicare reimbursement purposes.¹²⁹ Such programs are more likely to completely deny a hospital’s claim for inpatient services but are less likely to deny a claim for observation care, due in large part to the lower reimbursement rate at which Medicare pays hospitals for observation care.¹³⁰

One shortcoming of the Recovery Audit Contractor program is that the contracted Medicare auditors working under the program get a contingency fee portion of the savings that they are able to detect through allegedly fraudulent hospital reimbursement claims. Since the reimbursement rate (and thus the amounts of money implicated) is higher for inpatient services, the auditors are incentivized to target “inpatient” reimbursement claims as opposed to observation care claims.¹³¹ Since there is more money in detecting fraud stemming from inpatient reimbursement claims, the auditors focus disproportionately on those claims as opposed to observation claims.¹³² While hospitals have the ability to appeal audit findings, the appeals process is a resource-intensive one.¹³³ Because of the resource-taxing and lengthy reimbursement appeals process that hospitals must undertake to challenge such audits, hospitals sometimes preemptively cut their losses and code a patient as an outpatient under observation to at least be guaranteed some amount of money from Medicare.¹³⁴

Medicare provides its own definition of “outpatient observation services.” However, the ultimate determination as to whether or not a patient is an inpatient or an outpatient under observation rests with the hospital receiving and treating the patient.¹³⁵ The guidance lan-

129. See Smith, *supra* note 59, at 3.

130. *Id.* Also, some Medicare experts note that Recovery Audit Contractor Program auditors are “overly aggressive” and, because of the nature of the program, judge hospitals for admissions decisions after the fact, which fails to take into account care decisions made at the time of the need for care. *Id.*

131. *Id.*

132. See *id.*; Mark A. Stanley, *AHA Survey Identifies Continuing Problems with Medicare RAC Program*, JD SUPRA (Jan. 25, 2013), <http://www.jdsupra.com/legal-news/payment-matters-aha-survey-identifies-c-06830/>.

133. See Duane C. Abbey, *Of Physician Supervision, RAC Appeals and Cost Reports*, New Perspectives On Healthcare Risk Mgmt., Control and Governance at 32–33 (on file with author) (describing the need for extensive documentation, position papers, technical analyses, and general regulatory guidance to complete the appeal process).

134. See generally Smith, *supra* note 59, at 3–4.

135. See generally ARE YOU A HOSPITAL INPATIENT OR OUTPATIENT?, *supra* note 17.

guage of the applicable statute and regulation has given hospitals wiggle room to determine when a patient is an “inpatient” or outpatient under “observation” status.¹³⁶ This lack of structured guidance, coupled with the specter of auditors second-guessing post hoc the decisions of hospitals when coding patients, may contribute to the increased rate of coding of Medicare beneficiaries as an outpatient under observation as opposed to an inpatient, which would allow the beneficiary to receive coverage for subsequent skilled nursing facility care.¹³⁷ Considering the significant amount of time devoted to reviewing whether a beneficiary meets the required three-day qualifying stay to warrant SNF care coverage by Recovery Audit Contractors, health care providers are “well-advised to implement compliance measures” to reduce the risk of audit for past and current reimbursement requests and future audits as well.¹³⁸ Such stringent compliance efforts may take financial and manpower resources away from health care providers’ ability to provide care to Medicare beneficiaries.¹³⁹

To be clear, it is not the case that hospitals deliberately code patients as under observation for the purpose of preventing them from obtaining subsequent skilled nursing facility care; rather, it is a matter of hospitals receiving adequate reimbursement for the care that they disburse to Medicare beneficiaries. The frustration of hospitals with the auditing process through the Recovery Audit Contractor program and other cost-cutting or cost-saving measures is apparent in the number of judicial challenges and legislative reform efforts advanced by hospital administrators and physicians.¹⁴⁰ Moreover, physicians and hospital staff acknowledge that the emphasis on coding patients in a way that is beneficial to the hospital, namely coding patients as

136. See generally John Hilton, *Inpatient or Outpatient? More Often, Hospitals Decide Not to Admit Patients—Which Can Mean the Patient Gets Hit with More of the Cost*, DAILY REC. (Apr. 14, 2013, 6:36:57 AM), http://www.ydr.com/local/ci_23012811/inpatient-or-outpatient-63-more-often-hospitals-decide.

137. See generally Smith, *supra* note 59.

138. See Amy K. Fehn, et al., *RACs, SNFs, Audits and Vulnerabilities*, RACMONITOR (Nov. 17, 2010), <http://www.racmonitor.com/news/33-top-stories/463-racs-snfs-audits-and-vulnerabilities.html>. “Compliance efforts should be directed toward documenting in a manner that clearly links skilled services provided to a condition for which a beneficiary received inpatient services, or which arose during a hospitalization or associated SNF stay.” *Id.*

139. See *id.*

140. See Smith, *supra* note 59.

under observation as opposed to inpatient, poses a barrier to providing adequate health care to patients.¹⁴¹

Conflicting and counterintuitive regulatory standards related to the distinction between inpatient and observation admissions coding also frustrates the ability of hospitals to comply with the three-calendar-day requirement of the SNF qualifying stay rule.¹⁴² Some medical professionals have questioned what constitutes the appropriate standards concerning hospital admission, which implicates the SNF qualifying stay rule, in light of conflicting CMS guidance on the issue.¹⁴³ Indeed, the varying situations that lead to different admissions dates are not intuitive; for example, “if a physician orders an admission at 10:00 p.m. Saturday and a bed is not available until 1:00 a.m. Sunday . . . the hospital would have to include all qualifying services provided Wednesday, Thursday and Friday on its inpatient claim (rather than Thursday, Friday and Saturday).”¹⁴⁴ Unclear statutory and regulatory distinctions contribute to health care providers’ frustration with patient coding as it relates to Medicare reimbursement and SNF regulations. Modern efforts by CMS to clarify the distinction only have the effect of devaluing the treating physician’s medical opinion, despite the detriment to most Medicare beneficiaries in observation status.¹⁴⁵

141. CTR. FOR MEDICARE ADVOCACY, *Extended Observation Stays in Acute Care Hospitals: Criticism, Legislation and Discussion*, http://140.174.89.214/InfoByTopic/ObservationStatus/10_08.26.ObservationStatusCriticismEtc.htm (last visited Dec. 1, 2013) (noting that most hospital industry representatives, during a CMS listening session on the three-day qualifying stay rule, oppose use of the SNF regulation).

142. See Posting of E. Zachary Dinardo to Reimbursement Listserv Hosted by American Health Lawyers Association (on file with author) (in this practitioner’s discussion concerning conflicting CMS policies about hospital Medicare reimbursement, Mr. Dinardo discusses a series of issues raised by the regulatory rules related to hospital admission dates).

143. See Posting by Richard T. Nagy to Reimbursement Listserv Hosted by American Health Lawyers Association (on file with author).

144. See, e.g., Dinardo, *supra* note 142.

145. See CTR. FOR MEDICARE ADVOCACY, *CMS Addresses Observation Status Again . . . And Again, No Help for Beneficiaries*, <http://www.medicareadvocacy.org/cms-addresses-observation-status-again-and-again-no-help-for-beneficiaries/> (last modified May, 29, 2013).

C. Quality of Care and Patient Need for Skilled Nursing Facility Services

Interestingly, hospitals' tendency to code patients as under observation does not adversely affect their ability to receive high quality medical care while they are in the hospital itself.¹⁴⁶ The problem arises when Medicare beneficiaries, subsequent to their hospital stay, attempt to obtain Medicare coverage for skilled nursing facility care.¹⁴⁷ A patient coded as being under "observation," even if for only part of the duration of his or her hospital stay, is responsible for the entire cost of rehabilitative services offered by the skilled nursing facility from which he or she receives care.¹⁴⁸ For many Medicare beneficiaries, paying for skilled nursing facility services out-of-pocket is not financially feasible;¹⁴⁹ as such, their quality of care is adversely affected. Medicare beneficiaries that are unable to afford to pay for skilled nursing facility services out-of-pocket have no choice but to go home and deal with the prospect of having to return to the hospital when they are unable to fully recover.¹⁵⁰

D. Financial Concerns Stemming from the Rising Cost of Medicare

Further complicating matters is the reality that, in an effort to cut soaring Medicare costs, programs designed to prevent unnecessary or unwarranted Medicare reimbursements may actually pressure hospitals to shorten Medicare patients' hospital stays and cut down on transfers to skilled nursing facilities.¹⁵¹ The increase in Medicare spending is a major concern for the future of the Medicare program; while Medicare will not be "broke" in the coming years, there will be a shortfall that will lead to decreased funding, and thus reduced health care cost coverage.¹⁵² Currently, "Medicare spending is pro-

146. See generally Barry, *supra* note 1 (noting patients coded as inpatient or under observation are "getting exactly the same kind of care.").

147. *Id.*

148. *Id.*

149. See Smith, *supra* note 59. When patients cannot afford to pay for skilled nursing facility care out of pocket, they are forced to go home; subsequently, they may end up back at the hospital instead of getting better. *Id.*

150. *Id.*

151. *Id.*

152. See Glenn Kessler, *A Bipartisan Foul: 'Medicare Is Going Broke'*, WASH. POST (Sept. 21, 2012, 6:02 AM), available at http://www.washingtonpost.com/blogs/fact-checker/post/a-bipartisan-foul-medicare-is-going-broke/2012/09/20/7237057e-0373-11e2-91e7-2962c74e7738_blog.html. "[T]he

jected to grow from \$551 billion in 2012 to over \$1 trillion in 2022.”¹⁵³ And, while spending is growing, there is the potential that federal funding for Medicare may experience sharp cuts over the course of the next few years.¹⁵⁴ Lawmakers are well aware of the need to deal with skyrocketing Medicare costs, as evidenced by public statements by members of Congress, election platforms of political candidates, and proposed legislation.¹⁵⁵

One effort designed by Medicare to reduce waste and fraud is to pressure hospitals into cutting short the stay of Medicare beneficiaries and transfer them to post-hospital care facilities.¹⁵⁶ This effort, known as the Recovery Audit Contractor program, saved \$655 million in 2011 by having auditors evaluate past Medicare claims to detect and correct Medicare fraud.¹⁵⁷ Unfortunately, the program has had the adverse effect of causing seniors receiving Medicare benefits to incur a 20 percent co-pay for medical treatment and pay outpatient rates, which are higher than inpatient rates, for medicine.¹⁵⁸ However, the fact remains that, on paper, the Recovery Audit Contractor program does ultimately save money by detecting and combating fraudulent reimbursement claims.¹⁵⁹

Cost-saving efforts like the Recovery Audit Contractor program are not free from condemnation. Many hospital administrators are highly critical of the Recovery Audit Contractor program due to the sheer number of hours hospitals spend dealing with Recovery Audit Contractor audits; for example, one hospital CEO explained that his large hospital spent 500 hours, equating to over 121 40-hour work

government could still cover 87 percent of estimated expenses in 2024—and 67 percent in 2050.” *Id.*

153. Fact Sheet, *supra* note 21.

154. See generally KAISER HEALTH NEWS, *Labor, Business Groups Step Up Efforts to Shape ‘Fiscal Cliff’ Debate Over Medicare Medicaid, and Social Security* (Nov. 13, 2012), <http://www.kaiserhealthnews.org/daily-reports/2012/november/13/scaling-the-fiscal-cliff.aspx> (evaluating potential adverse effect on Medicare funding in light of the possible implementation of the package of tax increases and spending cuts known as the “fiscal cliff”).

155. See generally Linda Feldmann, *Obama vs. Romney 101: 6 Ways They Differ on Health-Care Reform*, CHRISTIAN SCI. MONITOR (Aug. 30, 2012), <http://www.csmonitor.com/USA/DC-Decoder/2012/0830/Obama-vs.-Romney-101-6-ways-they-differ-on-health-care-reform/Repeal-and-replace-vs.-holding-firm> (describing legislative attempts to reform Medicare and health care generally, and comparing health care reform platforms of 2012 presidential candidates).

156. Smith, *supra* note 59.

157. *Id.*

158. *Id.*

159. *Id.*

weeks, defending reimbursement claims.¹⁶⁰ The perception of hospital administrators is that their hospitals spend a significant amount of time handling audits of their reimbursement requests—audits that are overturned a vast majority of the time.¹⁶¹ For example, Sarasota Memorial hospital won 92 percent of its billing appeals against auditors.¹⁶² The concern held by hospital administrators regarding overzealous audits alleging fraudulent reimbursement requests was raised during Congressional hearings on the effectiveness of the Recovery Audit Contractor program.¹⁶³ Although designed to increase the quality of care for Medicare beneficiaries, cost-cutting measures like the Recovery Audit Contractor program decrease the quality of care that hospitals can provide to Medicare beneficiaries because “the program pressures hospitals to cut Medicare patients’ stays and transfers to [skilled] nursing homes, thereby suppressing skyrocketing federal health care costs.”¹⁶⁴ Additionally, the Office of Inspector General of the Department of Health and Human Services raised concerns over the performance of these contractors (RACs); specifically, an October 2006 report indicated that none of the 241 allegedly duplicate payments investigated by one particular RAC were actually duplicative, calling into question the effectiveness of RACs with respect to audit performance.¹⁶⁵

160. John D. Thomas, *RAC ‘Em Up: Have Hospital Payment Audits Finally Crossed the Common-Sense Line?*, MODERN HEALTHCARE 37 (Oct. 22, 2012, 12:01 AM), available at <http://www.modernhealthcare.com/article/20121020/MAGAZINE/310209989>.

161. *Id.*

162. Smith, *supra* note 59. Sarasota Memorial was charged with \$9.4 million in overbilling for Medicare inpatient expenses on 1,537 claims dating back to 2003, but won 92 percent of its appeals and reduced the \$9.4 million in overbilling levied against it to \$5.6 million. *Id.*

163. *Preventing and Recovering Medicare Payment Errors: Hearing Before the Fed. Fin. Mgmt., Gov’t Info., Fed. Servs., and Int’l Sec. Subcomm. of the Comm. on Homeland Sec. and Gov’t Affairs*, 111th Cong. 6 (2010) (statement of Kathleen M. King, Dir., Health Care, U.S. Gov’t Accountability Office). “Many providers expressed concerns about the operation of the [Recovery Audit Contractor program]. In particular, they were concerned about the use of contingency fees because they thought it created an incentive for RACs to be too aggressive in determining improper payments.” *Id.*

164. Smith, *supra* note 59.

165. DEP’T OF HEALTH & HUMAN SERVS., REVIEW OF POTENTIAL DUPLICATE PAYMENTS IDENTIFIED BY A CENTERS FOR MEDICARE AND MEDICAID SERVICES RECOVERY AUDIT CONTRACTOR (2006), http://www.healthlawyers.org/SiteCollectionDocuments/Content/ContentGroups/News1/Health_Law_Documents_ASK_/20063/30600004.pdf.

E. Problems Associated with the Inpatient and Observation Coding Distinction

Although designed to set workable minimum requirements for Medicare to cover the cost of skilled nursing facility services following a hospital visit, the three-day stay rule effectively prevents a large number of Medicare beneficiaries from being covered for services that they need to adequately recover from medical maladies.¹⁶⁶ The end result is that elder Americans, who are colloquially thought to be inpatients given the nature of their overnight hospital stays for the purpose of hospital admissions, are denied coverage for the best care that Medicare may afford to them in skilled nursing facilities.¹⁶⁷ Moreover, as hospitals and patients grapple with distinguishing between technical medical terms of art, the focus of physicians, who should spend their time treating patients, shifts from disbursing medical care to debating whether certain medical procedures should be ordered so as to ensure the highest Medicare reimbursement possible for the hospital.¹⁶⁸

Additionally, by denying patients coded as under observation from receiving Medicare coverage for skilled nursing facility care, the three day stay rule creates a risk that patients who would otherwise seek treatment at a skilled nursing facility will simply go home without fully recovering. Consequently, that risk creates the possibility that the patient will be forced to return to the hospital for additional treatment.¹⁶⁹ Not only does this burden the individual patient and the treating hospital, it may adversely affect other individuals requiring hospital treatment by denying an open hospital bed to a potential patient and restricting physicians' and nurses' ability to treat other patients.¹⁷⁰ Thus, it may be the case that the current SNF qualifying stay rule, by "kicking the can down the road" (and creating subsequent hospital stays for the patient), negatively affects all individuals seeking treatment at a hospital.¹⁷¹ Indeed, regulations like the SNF qualify-

166. *Id.*

167. *Id.*

168. *See generally* Smith, *supra* note 59.

169. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *Listening Session: Hospital Observation Beds* (2010), available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/94244031HospitalObservationBedsListeningSession082410.pdf> [hereinafter *Listening Session*].

170. *See id.*

171. *See id.*

ing stay rule have an effect on quality of care, admissions, treatments, and discharges.¹⁷²

IV. Resolution and Recommendation

After speaking with friends and family who work in the health care industry, the author was able to gain a better understanding of the problems caused by the SNF qualifying stay rule and its three-calendar-day requirement and discuss potential alterations to the rule. Medicare reimbursement for skilled nursing facility care costs should be based primarily on two separate considerations: the individual patient's diagnosis and whether the patient has reached a "functional level" to permit discharge from skilled nursing facility care. Individual patient diagnoses are already utilized in determining reimbursement rates for other Medicare coverage areas, such as surgery.¹⁷³ The more difficult task is creating a standard to determine whether an individual patient has reached a "functional level" to permit discharge. Moreover, this proposal includes an elimination of the hard-and-fast requirement that a patient stay in a hospital for three consecutive calendar days for qualifying hospital stays, and instead relies on the two separate considerations mentioned above. This proposal can be summarized as follows: (1) Medicare should grant reimbursement requests for skilled nursing facility services in light of a prior hospitalization (irrespective of the specific number of days a Medicare beneficiary has spent in a hospital); (2) instead of the requirement that patients spend a specific number of days in a hospital, skilled nursing facility care coverage should be based on the individual patient's diagnosis as provided by his or her treating physician at the time of discharge from the hospital; and (3) the underlying goal of hospitaliza-

172. See DEP'T OF HEALTH & HUMAN SERVS., CONSECUTIVE MEDICARE STAYS INVOLVING INPATIENT AND SKILLED NURSING FACILITIES (2007), http://www.healthlawyers.org/SiteCollectionDocuments/Content/ContentGroups/News1/Health_Law_Documents_ASK_/20073/oei-07-06-00340.pdf. In 2007, the Office of the Inspector General for the Department of Health and Human Services assessed quality-of-care problems and fragmentation of services issues during Medicare stays involving at least one SNF stay, finding that "[e]leven percent of individual stays within consecutive stay sequences involved problems with quality of care, admissions, treatments, and discharges," at a cost of \$1.4 billion to Medicare in 2004. *Id.*

173. See, e.g., *Glossary*, MEDICARE.GOV, <http://www.medicare.gov/hospitalcompare/Resources/Glossary.html?AspxAutoDetectCookieSupport=1> (last visited Dec. 2, 2013) (describing reimbursement rates based on patient diagnosis, surgical procedures, age, and other information per Medicare Severity-Diagnosis Related Groups).

tion and skilled nursing facility care should be to allow the patient to reach a level of normal functioning as would permit the patient to complete daily life tasks.

A. Expanding on Kaplan's Proposal

Professor Kaplan's proposed reform of the three-day stay rule lays out a workable framework for a new rule; however, CMS will still need to implement a new regulation to take the place of the current rule. As such, CMS should create a rule that evaluates an individual patient's diagnosis and a physician's decision as to whether inpatient admission and subsequent skilled nursing facility care is necessary to return the patient to a "functional level" with respect to completing daily life skills. CMS already has regulations in place to analyze patients' diagnoses, with classifications schemes like DRGs.¹⁷⁴ Also, some federal courts have already adopted "treating physician" standards that place an emphasis on the medical opinion of the patient's treating physician when assessing the patient's health and medical needs.¹⁷⁵ Indeed, the lack of weight given to the treating physician's opinion was one of the biggest criticisms of the FY 2014 CMS rule redefining inpatient admission status.¹⁷⁶ Additionally, CMS can work with skilled nursing facilities to determine whether a patient requires medical treatment, such as rehabilitative services, to be able to complete daily life skills in order to safely return home as a means to provide an additional layer of scrutiny of a physician's admissions decision and a patient's skilled nursing facility care.¹⁷⁷ Indeed, such considerations are already established in CMS's requirements for

174. See, e.g., *3M APR DRG Classification System and 3M APR DRG Software*, HEALTH INFO. SYS. (July 2013), http://multimedia.3m.com/mws/mediawebserver?mwsId=44444OoTd8_MFRNngrGzgRUuzPoKz8oTaPm4zPm4z44444-- (providing an overview of one type of diagnosis-related group classification system by a health care contractor).

175. See, e.g., *Estate of Landers v. Leavitt*, 545 F.3d 98 (2d. Cir. 2008).

176. See *Opinion, Medicare Definition of Hospital Stay Hurts Seniors*, THE MERCURY, available at http://www.pottsmmerc.com/article/20130801/OPINION01/130809993/medicare-definition-of-hospital-stay-hurts-seniors#full_story (last updated Aug. 1, 2013) (discussing how the opinion of non-medical Medicare auditors have the same weight as that of the treating physician under the FY 2014 two-midnight inpatient admissions rule).

177. See *CTR. FOR MEDICARE ADVOCACY, CMS Addresses Observation Status Again . . . And Again, No Help for Beneficiaries*, <http://www.medicareadvocacy.org/cms-addresses-observation-status-again-and-again-no-help-for-beneficiaries/> (last updated May 29, 2012).

skilled nursing facility coverage.¹⁷⁸ By working with the skilled nursing facility, CMS will also be able to interact with skilled nursing facility staff to determine when a patient is able to return home in order to prevent the patient from having an unnecessarily long stay while still assuring that the patient is able to complete daily life skills free of inhibition.

The current focus on Medicare fraud detection likely inhibits the program's ability to effectively treat patients who require subsequent skilled nursing facility care following an acute hospital stay.¹⁷⁹ For example, some of the common situations that Medicare auditors find suspicious include: (1) social admissions that occur when the caregiver can no longer manage a patient's declining health; (2) Friday or weekend admissions, which might allow a patient to stay an entire weekend without meeting the medical necessity requirements; and (3) physician reluctance to order discharge, which may occur when a physician is covering for a colleague in order to allow the primary physician, who is familiar with the patient's needs, to return and make the actual discharge decision.¹⁸⁰ Coupled with the increased use of independent Medicare fraud monitors,¹⁸¹ the atmosphere of Medicare reimbursement application is one that focuses on fraud, as opposed to one that focuses on the medical decisions of physicians and the medical needs of Medicare beneficiaries.¹⁸² This problem is likely exacerbated by the Fiscal Year 2014 CMS rule redefining inpatient admissions status.¹⁸³

B. Shifting the Focus from Fraud to Treatment of Beneficiaries

When evaluating these decisions individually, it becomes apparent that a focus on fraud, rather than providing deference to physicians, leads to closer scrutiny by treating physicians and hospitals and inevitably situations where Medicare beneficiaries are preemptively

178. See 42 C.F.R. § 409.31 (2005) (providing regulatory requirements for Medicare coverage of SNF care).

179. See generally *Listening Session*, *supra* note 149.

180. CTR. FOR MEDICARE ADVOCACY, *supra* note 177.

181. See Smith, *supra* note 59.

182. *Id.*

183. Mary C. Malone et al., *Proposed Rule Targets Short Stay Admissions: CMS Seeks to Define "Inpatient" in FY 2014 IPPS Rule*, AM. HEALTH LAWYERS ASS'N (May 24, 2013) (discussing how the new CMS rule redefining inpatient status provides Recovery Audit Contractors with the regulatory authority to uphold inpatient claim denials).

coded as being under “observation” status to avoid scrutiny by Medicare fraud auditors.¹⁸⁴ As such, the author recommends that Medicare shift its focus from fraud detection to greater deference for the treating physicians to ensure that Medicare beneficiaries are subject to admissions decisions that are medically appropriate and are not solely the result of billing decisions made by hospitals to “game” the system and avoid denial of a Medicare reimbursement claim. Indeed, while some policymakers decry rampant fraud in Medicare payments, this fraud affects only a minor portion of Medicare spending;¹⁸⁵ the problem is a result of the system more so than anything else and, consequently, the system should be altered to return to its goal of providing medical insurance coverage to its beneficiaries.

Instead of focusing primarily on combating Medicare fraud, CMS should enact a rule that analyzes Medicare beneficiaries individually, based on the treating physician’s diagnosis of the particular beneficiary, to determine whether an inpatient admission decision was medically necessary. Because the physician who treated the Medicare patient has the ability to physically meet with and assess the patient’s health, CMS should give greater deference to the physician in their admissions decisions. Indeed, a “treating physician” rule, which grants deference to the medical opinion of a patient’s treating physician when compared with other relative medical evidence, has already been adopted in the medical disability context.¹⁸⁶ For example, it is difficult to gauge precisely the condition of a patient based exclusively on a doctor’s handwritten notes and lab results, because such information alone cannot convey all of the circumstances surrounding a physician’s decision to admit a patient.¹⁸⁷ The notion of providing skilled nursing facility care to Medicare beneficiaries until they are able to achieve a certain level of functioning is not unheard of; indeed,

184. *See id.*

185. *See Smith, supra* note 59 (discussing how auditors are paid a percentage of overpayments they discover, implying that fraud are likely to have been over-reported).

186. *See Havas v. Bowen*, 804 F.2d 783, 785 (2d Cir. 1986). Under the “treating physician” rule followed by the Second Circuit, “the medical opinion of the doctor who treated the claimant is given greater weight relative to other medical evidence” in a medical disability context. *Id.* However, the Second Circuit later declined to extend that rule to SNF benefits in a Medicare reimbursement context, at least when the facts of the underlying case were not supportive of implementation of the rule to those facts. *See Friedman v. Sec’y of Dep’t of Health & Human Servs.*, 819 F.2d 42 (2d Cir. 1987).

187. *See generally id.*

the Department of Health and Human Services, under a proposed lawsuit settlement, agreed to relax Medicare reimbursement requirements for skilled nursing facility coverage in institutional or home care settings.¹⁸⁸ Specifically, the proposed settlement would revise Medicare policies that considered the patient's level of functioning with respect to reimbursement claims.¹⁸⁹ Medicare's SNF reimbursement policy could be based largely on its currently-implemented requirements for SNF care coverage: (1) requirement of skilled nursing or rehabilitative services; (2) requirement of these skilled services on a daily basis; (3) daily skilled services can be provided only in an inpatient SNF setting; and (4) the services rendered are reasonable and necessary for the treatment of the Medicare beneficiary's illness or injury.¹⁹⁰ The use of the "treating physician" rule in a Medicare coverage context, combined with an expansion of the current SNF care requirements, could possibly lead to an easy implementation of this proposal.¹⁹¹ After all, the Social Security Act, as a matter of principle, is to be construed liberally in favor of beneficiaries.¹⁹²

C. Potential Issues with This Recommendation

This proposal, however, is not without criticism. First, comparable health insurance schemes implement bright-line qualifying stay rules similar to or exactly the same as the CMS rule.¹⁹³ TRICARE, which is a government entitlement program that provides health insurance to U.S. service members and veterans, specifically requires a three-day prior qualifying stay for SNF care coverage.¹⁹⁴ There may also be concern that an interpretation of SNF coverage rules that grants greater deference to the medical opinion of the beneficiary's treating physician will be subject to abuse and arbitrariness. Addi-

188. Diane M. Walsh, *HHS Proposed Settlement of Medicare Case Would Lead to Expanded Reimbursement for Skilled Nursing and Therapy Services*, NAT'L L. REV. (Oct. 27, 2012), <http://www.natlawreview.com/article/hhs-proposed-settlement-medicare-case-would-lead-to-expanded-reimbursement-skilled-n> (discussing the three main provisions of the settlement agreed to in *Jimmo v. Sebelius*, No. 5:11-cv-17, 2011 WL 5104355 (D. Vt. Oct. 25, 2011)).

189. *Id.*

190. See 42 C.F.R. § 409.31 (2005).

191. See *supra* notes 156 and 165 and accompanying text.

192. *Friedman v. Sec'y of Dep't of Health & Human Servs.*, 819 F.2d 42, 45 (2d Cir. 1987).

193. See Heather Overholser Berchem, *Navigating the TRICARE Claims and Appeals Processes*, <http://www.healthlawyers.org/Events/Programs/Materials/Documents/LTC10/berchem.pdf> (last visited Dec. 2, 2013).

194. See *id.*

tionally, policymakers are concerned that increasing Medicare expenditures will add to the allegedly unsustainable spending rates currently facing the Medicare program; some specifically criticize SNFs for receiving too much money from Medicare.¹⁹⁵

While some health insurance schemes like TRICARE utilize an SNF qualifying stay rule similar to the one used by CMS in the Medicare context, many of those health insurance providers explicitly follow or largely follow Medicare guidelines as to SNF coverage.¹⁹⁶ Thus, if Medicare were to alter its SNF coverage guidelines, it stands to reason that the health insurance providers that currently follow Medicare coverage guidelines would adopt any modifications to the Medicare coverage rules.¹⁹⁷ Also, while fraud is a real concern for any regulatory reform that expands Medicare coverage, programs like the Recovery Audit Contractor program and the Health Care Fraud Prevention & Enforcement Action Team are already in place to prevent waste, fraud, and abuse in Medicare.¹⁹⁸ Those existing oversight programs could simply be re-tooled to address potential fraud that may arise from changes in the rate of inpatient admissions claims. There is also some skepticism over whether Medicare fraud rates are overstated by policymakers, as the extent of Medicare fraud is hard to calculate.¹⁹⁹ And, while some fear that Medicare spending rates are unus-

195. See Maggie Mahar, *Why Medicare Should Cut Payments to Nursing Homes*, HEALTH BEAT (July 5, 2011), <http://www.healthbeatblog.com/2011/07/why-medicare-should-cut-payments-to-nursing-homes/> (noting that, in 2009, the average Medicare profit margin for SNFs was 18.1 percent).

196. See, e.g., TRICARE; Sub-Acute Care Program; Uniformed Skilled Nursing Facility Benefit; Home Health Care Benefit; Adopting Medicare Payment Methods for Skilled Nursing Facilities and Home Health Care Providers, 70 Fed. Reg. 61,368 (Oct. 24, 2005) (to be codified at 32 C.F.R. pt. 199) (noting that TRICARE SNF benefits will be modeled after those of the Medicare program); *Frequently Asked Questions*, RELIANT SENIOR CARE, <http://www.reliantsc.com/faqs#bill-nursing-care> (last visited Dec. 2, 2013) (“[Private insurance companies] generally follow the same skilled care requirements as Medicare.”). See also *Alabama Nursing Home Association Consumer Guide*, ALA. NURSING HOME ASS’N, http://www.anha.org/consumer_info_guide.html (last visited Dec. 2, 2013) (noting most private insurers do not provide coverage for nursing facility care).

197. See *id.*

198. See *supra* Part II.B; Press Release, Health Care Fraud Prevention and Enforcement Efforts Recover Record \$4 Billion; New Affordable Care Act Tools Will Help Fight Fraud, DEPT. OF HEALTH & HUMAN SERVS. (Jan. 24, 2011), <http://www.hhs.gov/news/press/2011pres/01/20110124a.html>.

199. See Truth-O-Meter, *Coburn Says 20 Percent of Every Medicare Dollar Goes to Fraud*, TAMPA BAY TIMES (Aug. 27, 2009), <http://www.politifact.com/truth-o-meter/statements/2009/aug/27/tom-coburn/coburn-says-20-percent-every-medicare-dollar-goes-/>. The executive director of the National Health Care Anti-Fraud Association, Louis Saccoccio, stated that a fraud rate of 20 percent of total

tainable and will soon cause Medicare to become insolvent,²⁰⁰ others dismiss such fears as motivated by popular myths.²⁰¹ As such, CMS should craft a rule, based on existing level of functioning considerations, that provides greater deference to the treating physician's admission decision as opposed to focusing on whether or not the physician is committing billing fraud.

V. Conclusion

The current SNF qualifying stay rule is detrimental to both Medicare patients, who are seeking appropriate medical care through SNFs, and hospitals, who deserve adequate reimbursement for the rendering of medical services prior to a patient's transfer to skilled nursing facilities. Past and present proposals to correct the three-consecutive-calendar-days requirement of the SNF qualifying stay rule are either inadequate as a matter of workability or have been declared judicially impermissible under the current statutory and regulatory scheme. As such, agency officials should strongly consider a shift from the hard-and-fast three-day qualifying inpatient stay requirement to a rule based on the individual patient's diagnosis that grants greater deference to the admissions decisions of treating physicians and ultimately considers whether the patient seeking coverage for SNF care has reached a "functional level" with respect to completing daily life skills to permit discharge from a skilled-nursing facility.

Medicare expenditures is possible, but not very plausible, which suggests that allegations of a 20 percent fraud rate may be overstated. *Id.*

200. See, e.g., Scott W. Atlas, *Let's Be Honest—Medicare Is Insolvent and Doctors Soon Won't Accept It*, FORBES (Dec. 18, 2012, 12:41 PM), available at <http://www.forbes.com/sites/scottatlas/2012/12/18/lets-be-honest-medicare-is-insolvent-and-doctors-soon-wont-accept-it/>.

201. See, e.g., Kaplan, *supra* note 71; see also Ciciora, *supra* note 102; Paul N. Van de Water, *Medicare Is Not "Bankrupt": Health Reform Has Improved Program's Financing*, CTR. ON BUDGET & POL'Y PRIORITIES, <http://www.cbpp.org/cms/index.cfm?fa=view&id=3532> (last updated June 3, 2013).