Observing the NOTICE Act
By Professor Leigh Melton, JD, Amanda Bird, JD, and Lauren Ritter, JD
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I. Introduction

In September 2014, after fainting in her bathroom, 76-year-old Caroline Giada suffered a severe injury, was rushed to an emergency room, and was placed under “observation status” while medical staff conducted various tests to diagnose her injury. Six days later, health care providers finally discovered that Giada had a fractured lower spine. Giada required surgery, but the necessary specialist could not operate on her for about a week. The hospital could not provide additional care in the interim, forcing Giada to choose between returning home alone or temporarily staying at a costly private nursing facility. Because she was in pain and needed assistance, Giada choose the latter under the assumption that Medicare would reimburse her for her stay. Only then did the hospital explain to Giada that she was under observation for the entirety of her 6-day stay.

The experience of Giada and thousands like her inspired a new Medicare law that requires hospitals to notify patients that they may incur huge out-of-pocket expenses if they stay more than 24 hours without being formally admitted. On August 6, 2016, Congress passed the Notice of Observation Treatment and Implication for Care Eligibility Act (the NOTICE Act or the Act), which requires hospitals to provide oral and written notification to patients who are under observation for more than 24 hours of their observation status within 36 hours of being placed under observation. The purpose of the Act is to “provide [Medicare] beneficiaries with accurate real-time information with respect to their classification, the services and benefits available to them, and the respective cost-sharing requirements they are subject to.” However, the NOTICE Act, as enacted, fails to adequately address many problems stemming from the observation status classification.

II. The NOTICE Act

A. Observation Status Generally

In October 2013, the problematic consequences of Medicare’s observation status made their way into the public consciousness. The New York Times and The Wall Street Journal published articles focusing on the admission status of hospitalized Medicare recipients. The articles describe how crucial it is not to receive the observation status label, which forces pa-

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2. *Id.*
3. *Id.*
4. *Id.*
5. *Id.*
patients to spend thousands of dollars out of pocket. The touchstone for these articles was a 2012 Brown University study that identified a nationwide increase in hospital patients being kept under observation status as opposed to being admitted as inpatients.

Under Medicare rules, when a Medicare recipient occupies a hospital bed under observation status, the patient is considered an outpatient. As an outpatient, Medicare Part A does not cover the hospital stay; Medicare Part B only pays for the medical costs that accrue during the patient’s hospital stay. Observation status also affects an elderly patient’s eligibility to receive Medicare support for rehabilitative care after hospital treatment. Inpatient status versus observation status has a huge impact on what medical expenses the patient will incur, as well as eligibility for skilled nursing facility care.

B. Case Law

Alongside the Centers for Medicare & Medicaid Services (CMS) policy manuals, the courts have weighed in on how observation status should be understood with respect to guarantees of notice and procedural due process. Bagnall v. Sebelius was the first case to specifically address the question of whether failure to notify patients of their observation status violates the Due Process Clause of the Fifth Amendment. Bagnall was a class action suit brought by plaintiffs who were placed under observation status during their hospital visits but did not receive notice of their status and subsequently incurred extremely large bills.

The plaintiffs argued that the “[observation status] classification operate[d] to deny them Part A coverage to which they [were] entitled, and also violate[d] various procedural requirements.” The U.S. District Court for the District of Connecticut disagreed.

The Connecticut District Court in Bagnall interpreted the plaintiffs’ attempt to use observation status as a subterfuge to get around the ruling in Estate of Landers v. Leavitt, which was concerned with the Department of Health and Human Services (HHS) interpretation of “inpatient” and “formal hospital admission.” In Landers, the U.S. Court of Appeals for the Second Circuit held that the CMS interpretation of “inpatient” in its own policy manuals was entitled to Skidmore deference and therefore preformal admission to a hospital does not count toward the hospital time required to qualify for Medicare coverage in a skilled nursing facility.

Similarly, the court in Barrows v. Burwell — another class action lawsuit against the HHS secretary that is pending in the litigation pipeline

9 Span, supra n. 8; Tergesen, supra n. 8.
12 Id.
14 Id.
15 Id. at *5.
16 Id. at *9.
17 Id.
18 Id.; see also Skidmore v. Swift & Co., 323 U.S. 134, 140 (1944) (finding that agency interpretations should be given deference based on the thoroughness of the agency’s consideration and its power to persuade).
19 Bagnall, 2013 WL 5346659 at *1; see Est. of Landers v. Leavitt, 545 F.3d 98, 109–111 (2d Cir. 2008).
— saw no distinguishable difference between the arguments posed in *Landers* and the plaintiffs’ case. Barrows, similar to *Landers*, hinged on the level of deference the CMS policy manuals and interpretations were to receive and whether the plaintiffs had spent the requisite amount of time as patients formerly admitted to a hospital to receive Medicare subsidies for skilled nursing facility care.

The Second Circuit ultimately affirmed the Connecticut District Court’s decision in the Barrows case but vacated the District Court’s ruling that, as a matter of law, the plaintiffs did not demonstrate that they had a property interest in being admitted as inpatients and thus were not entitled to due process protections. The Second Circuit’s decision can ultimately be distilled to the following issue:

Therefore, the dispositive issue — whether plaintiffs possess a property interest sufficient to state a Due Process claim — turns on facts that are, at this stage, contested. If plaintiffs are able to prove their allegation that CMS “meaningfully channels” the discretion of doctors by providing fixed or objective criteria for when patients should be admitted, then they could arguably show that qualifying Medicare beneficiaries have a protected property interest in being treated as “inpatients.” However, if the Secretary is correct and, in fact, admission decisions are vested in the medical judgment of treating physicians, then Medicare beneficiaries would lack any such property interest. At this stage, it is simply unknown how, in practice, the relevant admissions decisions are made.

The Second Circuit held that the question of whether the plaintiffs had a property interest in their Medicare Part A benefits constituted a factual matter that could not be resolved on a motion to dismiss and remanded the issue to the trial court for limited discovery.

The parties were ordered to complete discovery on the issue of whether the plaintiffs had a “protected property interest” in being admitted to the hospital as inpatients, which ultimately hinged on whether the decision to admit these patients was a “complex medical judgment” left to the treating physician or a decision directed by fixed criteria from the government. After briefs were presented on the issue and a hearing was conducted on cross motions for summary judgment, the District Court issued a decision on February 8, 2017, which denied the motions and found that summary judgment was inappropriate because there were “widely divergent views of how the ultimate decisions [were] made — in particular, whether ‘fixed and objective’ criteria in the form of commercial screening tools effectively [overrode] the treating physicians’ medical judgment.” Importantly, the District Court found that the plaintiffs, including representatives of deceased plaintiffs, had standing to bring this case because all plaintiffs were injured by the continuing lack of an administrative appeals process. The District Court also found that although a treating physician’s status order plays a “role” in Medicare’s administrative review of a hospital claim, it is not dispositive or even presumed to be correct.

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21 Id.
22 Id. at 115.
23 Id.
24 Id.
25 Id.
27 Id. at *8.
28 Id. at *13.
After oral arguments on June 13 and June 28, 2017, and the submission of extensive briefs on the issue, on July 31, 2017, the District Court issued an order certifying a class composed of all Medicare beneficiaries who, since January 1, 2009, have received “observation services” as an outpatient during a hospitalization.\(^{29}\) This certification of the class was a critical step for creating the opportunity for hospital patients placed under observation status to be heard. Presently, the Center for Medicare Advocacy, along with co-counsel Justice in Aging and Wilson Sonsini Goodrich & Rosati, are pursuing the nationwide class action lawsuit, seeking members of the class, and encouraging those people to tell their stories.\(^{30}\)

### III. Legislative History

In 2016, Congress presented President Barrack Obama with a bill for his signature requiring hospitals and critical access hospitals\(^ {31}\) to provide oral and written notification to patients who receive observation services for more than 24 hours of their observation status. These notifications must explain the reasons and implications of observation status as opposed to inpatient status.\(^ {32}\) Also, receipt of the notifications must be acknowledged by the signature of the patient or the patient’s representative.\(^ {33}\) The bill, H.R. 876, titled Notice of Observation Treatment and Implication for Care Eligibility Act, or NOTICE Act, was unanimously passed by both chambers (by the House of Representatives on March 16, 2015, and by the Senate on July 27, 2015). H.R. 876 was introduced on February 11, 2015, by Rep. Lloyd Doggett (D-Tex.) and referred to the Committee on Ways and Means.\(^ {34}\)

H.R. 876 amended Title XVIII of the Social Security Act by requiring hospitals to provide written and oral notification to patients who are under observation for more than 24 hours.\(^ {35}\) Within 36 hours of placing such patients under observation, the hospital is required to provide notification that (a) explains the patient’s status as an outpatient under observation and not as an inpatient; (b) explains the reason for that classification; (c) explains the implications of the classification on eligibility for Medicare coverage of items and services, as well as cost-sharing requirements; (d) includes the name and title of the hospital staff member who gave an oral notification and its date and time; and (e) is signed by the patient to acknowledge its receipt.\(^ {36}\)

Before the passage of the bill, a hospital could either admit a patient as an inpatient or keep that patient under observation. To most people, the difference in status is often impossible to determine; however, the economic implications can be extreme. While a patient is in a hospital bed under observation, substantial hospital bills

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\(^{32}\) Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, H.R. 876, 114th Cong. (August 6, 2015).

\(^{33}\) Id.

\(^{34}\) Id.

\(^{35}\) Id.

\(^{36}\) Id.
can accrue. After the patient’s discharge, Medicare will not pay for nursing facility care unless the patient stayed in the hospital as an inpatient for 3 consecutive days, including 2 middnights. Medicare will not pay if the beneficiary stayed in the hospital under observation.\(^{37}\) Unfortunately, Medicare patients can be under observation and consequently outpatients for extended hospital stays of 3 days or more. As a result, thousands of vulnerable older adults and people with disabilities, much to their surprise, are denied Medicare benefits for rehabilitation in skilled nursing facilities.

IV. The NOTICE Act Benefits and Shortcomings

The NOTICE Act requires hospitals to provide written and oral notice to patients who are under observation status. The notice must be provided to “each individual who receives observation services as an outpatient” at a hospital if the individual has been under observation status for more than 24 hours.\(^{38}\) The notice must explain the reason that the patient is under observation status and describe the implications of that status for cost-sharing in the hospital and for subsequent “eligibility for coverage” in a skilled nursing facility.\(^{39}\)

Providing notice is essential to ensuring that older patients have continuing autonomy over their medical decision-making.\(^{40}\) However, the Act leaves many issues stemming from observation status and the 2-midnight rule unresolved. The Act provides no retroactive relief. It does not discourage hospitals from using observation stays as a cost-saving measure. It does not change the rule that observation stays do not trigger skilled nursing facility benefits. It does not give patients the right to administratively appeal their observation status once they receive notice. And the Act lacks bite because it does not specify the consequences of a hospital’s failure to comply.

A. Resolving Lingering Constitutional Concerns

In addition to providing the obvious benefit that information yields when making medical and financial choices, the NOTICE Act partially resolves due process issues on which courts are still undecided. Prior to implementation of the NOTICE Act, the Medicare Act was subject to several due process challenges for its failure to require any form of notice to patients that even remotely insinuated the costs of remaining an outpatient.\(^{41}\) The Second Circuit in Barrows recently held that Medicare beneficiaries placed under observation are not entitled to expedited notice or administrative review.\(^{42}\) As the plaintiffs in Barrows continue to litigate in the District Court since the case was remanded, the NOTICE Act provides protections for future patients by guaranteeing that patients placed under observation status have a statutory right to notice of their classification as well as the denial of their hospital admission.

The Act was implemented 12 months


\(^{39}\) Id.

\(^{40}\) See generally Frolik & Barnes, supra n. 11, at 20.

\(^{41}\) See generally Barrows, 777 F.3d at 112; Bagnall, 2013 WL 5346659 at *1, *5.

\(^{42}\) Barrows, 777 F.3d at 112.
after its enactment, and since March 8, 2017, all hospitals have been required to present the Medicare Outpatient Observation Notice (MOON) advisory to Medicare beneficiaries who receive at least 24 hours of hospital services under observation status. Although it does not provide a constitutional guarantee of notification of patients of their observation status, the NOTICE Act does provide guidance as to the amount of discretion involved in the admission decision process because the Act requires a written explanation of the reasons for a patient’s observation status.

B. Problems the NOTICE Act Does Not Cure

1. The NOTICE Act Does Not Apply Retroactively

The NOTICE Act does not apply retroactively. The Act does not provide any relief or cause of action for patients who are left with onerous medical debt that accumulated while they unknowingly remained under observation. Thus, the plaintiffs in Barrows are at the mercy of the District Court to recover thousands of dollars in medical bills. Similarly, there is no relief for Medicare beneficiaries such as 74-year-old Rosalie Winkworth, whose family cashed in her life insurance policy to pay for the skilled nursing facility care Rosalie needed following a 4-day hospital stay under observation status, and 85-year-old Elizabeth Cannon, who owed more than $40,000 for nursing home care after a 6-day hospital observation stay.

2. The NOTICE Act Does Not Discourage Hospitals’ Use of Cost-Shifting Measures

The NOTICE Act also does not discourage the use of the cost-shifting measures that hospitals employ to dodge multimillion-dollar audit charges. In 2005, Congress tested and eventually codified the Medicare Recovery Audit Contractor (RAC) Program, which sends independent contractors to hospitals to identify and correct improper payments under Medicare Parts A and B. These auditors are paid a contingent fee based on the amount of overpayments recovered, and they are “eager to pursue the recovery of funds paid under [Medicare] Part A for post-hospitalization skilled care.”

Risk-averse hospitals have an incentive to place patients under observation to avoid the costly audit penalties resulting from incorrect hospital admissions. Medicare covers fewer services and medications for observation patients versus inpatients,
and observation patients are responsible for Medicare Part B’s 20-percent copayment. To put the increased cost of observation stays in perspective, a Medicare observation patient suffering from syncope, a condition that causes temporary loss of consciousness, pays over $1,000 more for a 3-night stay than an inpatient stay for the same amount of time.

Even though the NOTICE Act eliminates the initial shock Medicare observation patients feel when they receive their bill, it does not alleviate the excess costs they incur. In addition to the denial of skilled nursing facility benefits, observation “patients pay a la carte for every X-ray, blood test or scan” compared with the single copayment that inpatients pay. Medicare also does not cover all routine drugs that observation patients need for conditions such as diabetes, high blood pressure, and high cholesterol.

This is especially troubling in light of spiking drug prices in hospitals around the country. According to Ruth Dockins, a senior advocate at the Southeast Missouri Area Agency on Aging, several Medicare beneficiaries placed under observation in Missouri were billed $18 for a single baby aspirin.

Following notice that they are under observation status, patients are presented with two equally undesirable options — stay in the hospital under observation and continue to incur the extra costs or leave the hospital and forego necessary treatment and recovery services. The latter undesirable option heightens the likelihood of reinjury. When their budgets are tight, however, patients with broken hips and other serious conditions may place financial stability over physical well-being.

This Heinz dilemma is illustrated by the plight of Caroline Giada, the 76-year-old woman who fainted in her bathroom and fractured her spine. Giada spent 6 days in the hospital under observation status in 2014, prior to the passage of the NOTICE Act. When the hospital could no longer provide care to Giada, she chose to go to a skilled nursing facility for necessary assistance rather than return home where she would be in pain and alone. Unaware that she was under observation during her entire 6-day hospital stay, Giada believed that Medicare would cover the costs of the nursing facility, only to be hit with a bill for more than

52 Am. Heart Assn., Syncope (Fainting) (last reviewed June 30, 2017), http://www.heart.org/HEARTORG/Conditions/Arrhythmia/SymptomsDiagnosisMonitoringofArrhythmia/Syncope-Fainting_UCM_430006_Article.jsp#V_WRHdwn9Ko (accessed Dec. 16, 2018).
53 Baugh & Schuur, supra n. 51, at 304. This statistic is based on “traditional fee-for-service Medicare without a second payer.” Id.
54 Id. (noting that “patients have been surprised when they receive an observation bill for what was perceived as an inpatient stay, particularly when out-of-pocket costs exceed the Medicare inpatient deductible.”).
55 Andrews, infra n. 70.
57 Id.
58 The Heinz dilemma is a scenario developed by psychologist Lawrence Kohlberg that focuses on ethics and moral development and reasoning.
59 See Wolfson, supra n. 1.
60 Id.
61 Id.
Regretting her decision, Giada said, “When you’re in a lot of pain, you really don’t think too clearly.”63 With those sentiments in mind, it is unclear whether Giada would have willingly chosen skilled nursing facility care if she had been notified that she would bear the full cost of that care.

3. Observation Stays Do Not Trigger Skilled Nursing Facility Benefits

Giada’s quandary would have been avoided if Medicare had allowed her 6-day observation stay to trigger skilled nursing facility benefits. Providing notice does not change the troubling fact that none of the time spent under observation can be applied to the 2-midnight inpatient stay that is necessary to qualify for Medicare’s skilled nursing facility benefits.64 Using Giada as an example, following a 3-day stay under observation status, she would pay $248 per day for 7 days of needed skilled nursing facility care, totaling $1,736.65 In contrast, following a 3-day stay as an inpatient, she would pay nothing for the week spent in the skilled nursing facility because the 2-midnight inpatient stay triggered Medicare Part A benefits.66 The only difference between zero-cost skilled nursing facility services and a nearly $2,000 charge is the patient’s admission status.67

“Protocolized observation” is aimed at providing high-value care at a cost that is lower or equal to the cost of an inpatient stay.68 Hospitals achieve this by establishing separate observation units where patients suffering from chest pain, asthma, or less serious conditions spend 24 hours or less under observation before a determination is made regarding the need to admit them for an inpatient stay.69 One study examining emergency department patients suffering from transient ischemic attack (an illness that causes stroke-like symptoms) found that patients referred to observation were discharged almost 38 hours sooner than inpatients.70 The study also revealed that utilizing observation units cost the hospitals roughly one half the cost of inpatient care.71 The low-cost benefits of observation are lost when, instead of using short stays and separate units, hospitals prolong patients’ stays under observation status.72 Just as the NOTICE Act does not assuage hospitals’ desire to use observation stays to cut costs

62 Id.
63 Id.
64 Id.
65 Id.
66 Id.
67 See generally Parker, supra n. 48, at 90–91 (describing the “amorphous” nature of observation status and lack of guidelines used to distinguish between observation and inpatient services).
69 Baugh & Schuur, supra n. 51, at 304.
71 Id. In addition, the study found that hospitals spent $2,092 per patient in observation care compared with $4,992 per patient in inpatient care.
72 Christopher W. Baugh et al., Making Greater Use of Dedicated Hospital Observation Units for Many Short-Stay Patients Could Save $3.1 Billion a Year, 31 Health Affairs 2314, 2319 (2012).
and avoid penalties, it does not change the 2-midnight rule.\(^73\)

4. Medicare Beneficiaries Lack Appeal Rights Under the NOTICE Act

As Barrows makes clear, Medicare beneficiaries are not entitled to an expedited administrative review while under observation status.\(^74\) Congress codified this denial of appeal rights in the MOON, which is the standard written and oral notice of a patient’s observation status required under the NOTICE Act.\(^75\) The MOON expressly denies appeal rights under the NOTICE Act.\(^76\) The version of the MOON implemented by the Centers for Medicare and Medicaid Services explains, “[I]ssuance of the MOON by a hospital … does not constitute an initial determination and therefore does not trigger appeal rights.”\(^77\)

Pursuant to the Jimmo v. Sebelius settlement, Medicare beneficiaries are entitled to appeal denied claims. The plaintiffs in Jimmo, individual Medicare beneficiaries, brought suit against the HHS secretary, alleging that the secretary imposed a “covert rule of thumb that operates as an additional and illegal condition of coverage.”\(^78\) Specifically, the plaintiffs took issue with the “Improvement Standard” used at the lower levels of Medicare’s administrative review process.\(^79\) Under this standard, according to the plaintiffs, the beneficiaries were allegedly denied coverage because their conditions were chronic, because their conditions had stabilized or plateaued, or because the beneficiaries were unlikely to improve or failed to improve.\(^80\) The case was ultimately settled, and the Medicare policy manuals now make clear that improvement is not required to obtain Medicare coverage.\(^81\) Pursuant to the settlement agreement, the parties agreed to a “maintenance coverage standard,” which provides that “[s]killed nursing services would be covered where such skilled nursing services are necessary to maintain the patient’s current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.”\(^82\) The settlement also created a re-review opportunity for Medicare beneficiaries who received a denial of skilled nursing facility care, home health care, or outpatient therapy services that became final and non-appealable after January 18, 2011, due to a prior application of the Improvement Standard.\(^83\)

\(^73\) Moreover, the Act only serves to notify Medicare beneficiaries of their observation status. It does not provide notice to beneficiaries immediately admitted to the hospital as inpatients that their Medicare Part A benefits are not triggered until they have spent at least 2 midnights in the hospital. See Abbey, infra n. 93.

\(^74\) Barrows, 777 F.3d at 112.


\(^76\) Id.; 81 Fed. Reg. 24945, 25134 (Apr. 27, 2016).

\(^77\) 81 Fed. Reg. at 25134.


\(^79\) Id.

\(^80\) Id.


\(^83\) Ctr. for Medicare Advoc., supra n. 81.
To apply for an appeal, patients must complete a six-question form that is published online by CMS.84 On the form, patients must check boxes confirming that they are Medicare beneficiaries, they received skilled nursing or therapy services as an outpatient or from a skilled nursing facility, and they were denied services because their conditions did not improve.85 Even though the re-review form and process helps ensure that the Improvement Standard is not improperly applied to deny coverage, the process may be time-consuming and does not guarantee protection to persons incorrectly placed under observation status for reasons other than failure to improve. The Jimmo settlement did not solve the observation status problem and arguably muddied the waters further.

On August 17, 2016, the U.S. District Court for the District of Vermont issued an order requiring CMS to remedy the inadequate Educational Campaign that was a cornerstone of the original settlement agreement.86 The Court stated, “Plaintiffs bargained for the accurate provision of information regarding the maintenance coverage standard and their rights under the Settlement Agreement would be meaningless without it.”87 Ultimately, on February 1, 2017, the Court ordered CMS to propose a Corrective Action Plan to address the deficient Educational Campaign, which was noncompliant with the original settlement agreement.88 One of the most important parts of the plan includes a new webpage by CMS that is dedicated to the Jimmo settlement and includes frequently asked questions and a statement that affirmatively disavows the Improvement Standard.89 The government was also required to certify its compliance with the Corrective Action Plan by September 4, 2017.90 On the CMS webpage for the Jimmo settlement, the following statement appears:

The Jimmo Settlement Agreement may reflect a change in practice for those providers, adjudicators, and contractors who may have erroneously believed that the Medicare program covers nursing and therapy services under these benefits only when a beneficiary is expected to improve. The Jimmo Settlement Agreement is consistent with the Medicare program’s regulations governing maintenance nursing and therapy in skilled nursing facilities, home health services, and outpatient therapy (physical, occupational, and speech) and nursing and therapy in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide.91

5. Implementation and Enforcement of the NOTICE Act Are Not Guaranteed

Since March 8, 2017, all hospitals have been required to provide the MOON to patients.92 However, there is still no guar-

85 Ctrs. for Medicare & Medicaid Servs., supra n. 75.
87 Id.
89 Id.
90 Id.
92 Ctrs. for Medicare & Medicaid Servs., Hospitals Must Give Patients Notice of Their Observation Status.
antee that the notice requirements will be strictly implemented and enforced. Potential implementation issues stem from a lack of guidance from CMS regarding when observation status begins and ends, as well as whether observation services are continuous. Enforcement problems may arise as a result of the NOTICE Act’s failure to designate penalties for noncompliant hospitals and the absence of a private right of action for Medicare beneficiaries who suffer adverse financial consequences resulting from not receiving notice of observation status. The Act requires hospitals to provide written and oral notice to patients under observation for more than 24 hours of their observation status within 36 hours of being placed under observation but does not provide clear parameters about the observation status timeline. The treating physician controls when observation status begins and ends. In a hospital with a separate observation unit, a patient’s observation status may begin while the patient is still in emergency care, which may result in confusion to the nursing staff and other clinical personnel. Additionally, it is unclear whether observation services are continuous. This lack of clarity is illustrated by the following case study from Duane Abbey, Ph.D., a health care management consultant:

An elderly patient presents at 3 p.m. with complaints of chest pain and shortness of breath. After an emergency department workup, at 4:30 p.m. the patient is placed in observation through the hospital’s chest pain protocol. The patient is scheduled to have a cardiac catheterization the next morning. The patient is hydrated during the night to help reduce possible toxicity from the LOCMs (low osmolar contrast media) that will be used during the procedure. At 9 a.m. the patient undergoes cardiac catheterization, during which angioplasty is performed on a coronary artery and a stent is placed in a different coronary artery. The patient goes to recovery and then returns to the observation bed at 2 p.m. At 6 p.m., the patient is discharged home.

If the patient’s observation services had been continuous, the patient was entitled to notice because the services spanned more than 24 hours (between 4:30 p.m. on Day One and 6:00 p.m. the next day).
day). However, Dr. Abbey explains that the time spent during the catheterization procedure would not be considered observation for billing purposes; thus, notice was not technically required under the Act. Imagine a scenario in which the patient had been moved to inpatient care rather than being discharged home. Now the lack of notice has dire consequences. If the patient spent 2 additional days as an inpatient, she may erroneously believe that her 3-day stay triggered skilled nursing facility benefits.

In addition to these implementation issues, enforcement may also prove to be problematic based on administration of similar statutes enacted in various states. Before Congress’ nationwide implementation of the NOTICE Act, several states, including Virginia, Connecticut, Pennsylvania, New York, and Maryland, passed statutes requiring patients under observation to be notified of their status pursuant to state law. These statutes, though well-intentioned, ultimately lack teeth. Pennsylvania’s statute, for example, does not outline penalties for noncompliance. The Pennsylvania statute also expressly alleviates hospitals’ responsibility for coverage implications and notice requirements if a patient’s inpatient stay is later re-categorized. The MOON likewise does not designate penalties for noncompliance.

Since 2015, Virginia has required hospitals to provide oral and written notice to patients of their observation status within 24 hours of being placed under observation. In Cherrie v. Virginia Health Services, Inc., the Supreme Court of Virginia found no private right of action existed for individuals seeking to enforce the Virginia Board of Health’s nursing home and hospital regulations. The estates of two decedents who were residents in nursing homes prior to their deaths were the plaintiffs in Cherrie. The executors of the estates asked the nursing homes to provide copies of all written policies and procedures that were in effect during the decedents’ stays. State law requires all medical facilities, including nursing homes, to make these documents available for review to residents and their representatives upon request. When the nursing homes declined to produce the documents, the executors sought declaratory judgments to force the nursing homes to comply with the statute. The Supreme Court of Virginia ultimately affirmed the lower court’s dismissal of the declaratory judgment complaints because the plaintiffs lacked a private right of action under both Title 32.1, Chapter 5, of the Virginia Code and the Declaratory Judgment Act, Virginia Code § 8.01-184 et seq.

By finding no implied private right of action in Section 32.1, Chapter 5, of the Virginia code, Cherrie takes away any bite that Virginia’s notice requirement other-

97 Id.
98 Id.
101 Id. at § 3054.
104 Id. at 857.
105 Id.
106 Id. (citing 12 Va. Admin. Code 5-371-140 (West 2016)).
107 Id.
108 Id. at 868.
wise has when a hospital fails to notify patients of their observation status. The practical effect of the holding is that Medicare beneficiaries who do not receive proper notice are unable to assert their own rights by pursuing or even threatening litigation against hospitals. Patients can do nothing more than file administrative complaints against hospitals that do not comply with notice requirements, after which they must rely on the administrative process to issue sanctions or the state health commissioner to file suit. It is unclear whether Congress contemplated providing a private right of action for Medicare beneficiaries to enforce the NOTICE Act and allow for recovery of damages for medical bills accrued by patients unknowingly placed under observation. Regardless, the proposed MOON does not appear to possess any language that a court would interpret as expressly or impliedly recognizing such a right.

V. Beyond the NOTICE Act: What More Can Be Done to Avoid the Problems Surrounding the Increased Use of Observation Status?

Although notifying patients of their observation status has not been deemed constitutionally required by the courts, providing notice is virtually cost free. In terms of protecting older patients from the adverse consequences of hospitals’ increased use of observation stays, the NOTICE Act is a minimalist solution. More can be done. To resolve the issues caused by hospitals’ cost shifting and risk aversion, some doctors have proposed capping out-of-pocket expenses for patients under observation status at the inpatient’s deductible amount.\(^\text{109}\) Currently, no single charge to a patient under observation can exceed the cost of an inpatient deductible, but there is no limit on the total cost of an observation stay.\(^\text{110}\) In addition to capping the observation bill, Medicare could cover the costs of medications during an observation stay that are covered during an inpatient stay.\(^\text{111}\) Finally, Medicare could count days spent under observation toward the 2-midnight stay necessary to trigger skilled nursing facility benefits.\(^\text{112}\)

The combination of the three solutions listed previously — capping the cost of an observation stay, covering the same medications during an observation stay that are covered during an inpatient stay, and tolling time spent under observation — puts the Medicare patient under observation on virtually equal footing with the inpatient. In that case, perhaps the solution should be to eliminate observation status altogether, which is what some proponents of the NOTICE Act have suggested.\(^\text{113}\) Rep. Joseph Courtney (D-Conn.) has acknowledged that the notification requirement gives patients a fair chance to challenge the coding of their status before incurring thousands of dollars in observation charges; however, a better solution would be to restore the traditional 2-midnight rule to all Medicare patients, regardless of their classification as inpatient or under observation.\(^\text{114}\) According to Rep. Courtney, “We should build on this legislation and again restore Medicare’s promise, which … from day one, has said that medically prescribed care will be covered by the system at time of discharge from a hospital for longer than [three] days.”\(^\text{115}\)

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\(^\text{109}\) Baugh & Schuur, supra n. 51, at 305.
\(^\text{110}\) Id. at 304.
\(^\text{111}\) Id.
\(^\text{112}\) Id.
\(^\text{114}\) Id.
\(^\text{115}\) Id.
A. Proposed Solutions

1. A 24-Hour Cap on Observation Stays

Although Rep. Courtney’s vision is admirable, total elimination of observation status unnecessarily strips Medicare, hospitals, and patients of the benefits stemming from the original use of observation. Situations still arise in which a patient is not infirm to the degree requiring immediate hospital admission but is not well enough to be discharged to home; thus, observation is necessary. Capping observation stays at 24 hours strikes an appropriate balance among lowering patients’ hospital bills, improving Medicare beneficiaries’ ability to tap into skilled nursing facility benefits, and cutting costs for hospitals and Medicare. One study, which focused on observation stays with a mean length of 15 hours and maximum length of 24 hours, concluded that these short observation stays could save hospitals across the country $3.1 billion annually by avoiding 2.4 million inpatient admissions.

Proponents of the 2-midnight rule may resist a 24-hour cap for two reasons. First, the timing of this proposal is inopportune. Advocates for the elderly achieved a relative victory with the implementation of the NOTICE Act and may be unwilling to put the issue up for debate again, risking repeal of their progress. Second, hospitals and Medicare representatives may be equally unwilling to further reduce the length of observation stays at the risk of losing more of the financial benefits stemming from increased use of these stays.

Implementation of a 24-hour cap on observation stays requires eventual repeal of the 2-midnight rule as well as changes to the NOTICE Act. The NOTICE Act now requires notification not later than 36 hours after a patient receives observation services or “if sooner, upon release.” If observation stays were capped at 24 hours, notification not later than 12 hours after receiving observation services is likely a reasonable time frame to provide notice. The New York, Connecticut, and Virginia statutes all require notice not later than or within 24 hours; therefore, this proposed timeline is feasible. At what point notification could reasonably be given within 24 hours depends on hospitals’ patient volume and staff and other factors requiring careful consideration by Congress.

2. Right to Appeal/Right to Seek Damages for Hospital Noncompliance

Medicare beneficiaries need the ability to begin the appeals process once they receive notice of their observation status. This requires change to the MOON, which, as discussed previously, does not provide appeal rights. Allowing the right to appeal under the NOTICE Act would likely result in an increase in administrative appeals from patients. As a result, hospitals might respond to this new administrative burden by aiming to correctly admit patients when necessary and shorten the length of observation stays. Additionally, patients should be able to seek compensatory damages for hospital bills


117 Baugh et al., supra n. 72, at 2320.


unknowingly accumulated while under observation as a result of hospitals’ failure to provide notice in compliance with the Act. These two mechanisms, the right to appeal and the right to seek damages for hospitals’ noncompliance, are the teeth that the Act currently lacks.

VI. Conclusion

The changes proposed in this article could take years to implement by statute. In the meantime, elder advocates must continue to lobby Congress to provide appeal rights and encourage hospitals to cap observation stays at 24 hours. The NOTICE Act neither unlocks the full extent of Medicare benefits nor ferociously protects older patients’ rights; however, its passage signifies that Congress is mindful of and responsive to concerns surrounding protection of the elderly. Until changes are made, elderly patients such as Caroline Giada will continue to be unknowingly placed under prolonged observation and unfairly surprised by sky-high hospital bills.