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REFORMING HEALTHCARE REFORM

Jacqueline Fox *

INTRODUCTION

Healthcare reform is not a singular event, but instead is a constant process that will continue into the foreseeable future. This article proposes a creative solution to the acrimonious and debilitating method we currently use in assessing and implementing healthcare reform proposals.

Current scholarship has not addressed the systemic problems that occur in the process of implementing healthcare reform, tending instead to focus on proposing single reform measures to cure specific problems or on constitutional problems related to the Affordable Care Act.¹ To address that gap, this article carefully analyzes a case study of Medicare's efforts to control unnecessary hospital admissions over the course of thirty years—efforts that have been subjected to almost universal criticism—and uses this case study to illustrate perennial problems with reform more generally. This article then explores other cultural and regulatory processes that function better than healthcare reform in similar circumstances, specifically the tax regulatory system, and proposes a series of changes to healthcare related regulatory processes.

This article's thesis is simple: assuming healthcare reform is a constant and enduring aspect of the healthcare system, and, in light of the problems healthcare reform causes, the system needs

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1. For an early scholarly treatment of the roots of these issues, see Rand E. Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 *YALE L.J.* 243 (1978).

to be reformed so that it progresses in a manner that is less adversarial, more tolerant of unintended consequences, and better able to manage the concerns of risk-averse participants.

In any given year, there are more than 136 million visits to the emergency department, with 16.2 million of those visits resulting in hospitalization.² Including those patients admitted from the emergency department, there are more than 35 million overnight stays every year in United States hospitals.³ Anything that has a substantial impact on those visits matters tremendously for vast swaths of people, obviously for the patients and their families, but also for the healthcare system.

The Centers for Medicare and Medicaid Services (“CMS”)⁴ has long believed that many patients are unnecessarily admitted to the hospital and for decades it has sought to find a method to reduce these admissions.⁵ As discussed in Parts I and II of this article, observation status has gradually emerged as an unhappy middle ground, a status of coverage for hospital stays that reduces third-party payer costs but consistently creates turmoil. When a patient who is a member of Medicare is admitted to the hospital as a regular admission, their care is covered under Medicare Part A.⁶ The benefits are fairly generous and the patient has limited out-of-pocket expenses based on the entire admission as one event with one copayment.⁷ If the hospital stay is considered observation (commonly referred to as observation status), it is billed through Medicare Part B as an outpatient service, even though the patient is staying in the hospital, perhaps in a bed right next to a patient who is an admission.⁸ Under Part B, the hospital and physician are paid less than under Part A, and the patients have

2. *Hospital Utilization (in Non-Federal Short-Stay Hospitals)*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <http://www.cdc.gov/nchs/fastats/hospital.htm> (last visited Dec. 1, 2015).

3. *See id.*

4. For continuity purposes, the title CMS will be used in this article to refer to CMS and previous federal agencies that had responsibility for the Medicare program.

5. *See* Press Release, Ctrs. for Medicare & Medicaid Servs., Better Care, Smarter Spending, Healthier People: Improving Our Health Care Delivery System (Jan. 26, 2015), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26.html>.

6. 42 U.S.C. § 1395c (2012).

7. *See id.* § 1395d.

8. *See id.* § 1395k; *see also* DEP'T HEALTH & HUMAN SERVS., ARE YOU A HOSPITAL INPATIENT OR OUTPATIENT? (2014), <https://www.medicare.gov/Pubs/pdf/11435.pdf>.

far higher out-of-pocket costs.⁹ Further complicating the matter, when hospitalized under Part B, patients are not entitled to coverage for rehabilitative nursing home care once they leave the hospital.¹⁰ So, if care is required, patients can end up paying tens of thousands of dollars in unexpected costs, costs that would have been fully reimbursed under Part A.¹¹

The origins of observation have nothing to do with insurance coverage. Starting before the Medicare program was created in 1965, emergency departments kept patients in the hospital to watch them when doctors were unsure of the correct diagnosis but they seemed too ill to send home.¹² For short-term observation, a patient would stay in the emergency department itself.¹³ For longer stays, the patient would be admitted.¹⁴

During the 1980s, hyperinflation in healthcare, coupled with unprecedented growth in patient use of hospitals, led CMS to focus on cost¹⁵ and, in particular, on unnecessary hospital admissions.¹⁶ CMS began to scrutinize hospital admissions to determine if they were appropriate and gradually became more willing to refuse coverage after the fact.¹⁷ Patients were increasingly kept in observation in the emergency department, with hospitals unwill-

9. See DEPT OF HEALTH & HUMAN SERVS., ARE YOU A HOSPITAL INPATIENT OR OUTPATIENT? (2014), <https://www.medicare.gov/Pubs/pdf/11435.pdf>; cf. 42 U.S.C. § 1395k (2012).

10. See *What Part B Covers*, MEDICARE.GOV, <http://www.medicare.gov/what-medicare-covers/part-b/what-medicare-part-b-covers.html> (last visited Dec. 1, 2015).

11. Compare *id.*, with *What Part A Covers*, MEDICARE.GOV, <https://www.medicare.gov/what-medicare-covers/part-a/what-part-a-covers.html> (last visited Dec. 1, 2015).

12. SOC'Y OF HOSP. MED., PUB. POLICY COMM., THE OBSERVATION STATUS PROBLEM: IMPACT AND RECOMMENDATIONS FOR CHANGE 2,4 (2014), http://webcache.googleusercontent.com/search?q=cache:UE9vtBZ_zVoJ:www.hospitalmedicine.org/observation+&cd=2&hl=en&ct=clnk&gl=us [hereinafter THE OBSERVATION STATUS PROBLEM].

13. Zhanlian Feng, Brad Wright & Vincent Mor, *Sharp Rise in Medicare Enrollees Being Held in Hospitals for Observation Raises Concerns About Causes and Consequences*, 31 HEALTH AFF. 1251, 1252 (2012).

14. THE OBSERVATION STATUS PROBLEM, *supra* note 12, at 4.

15. See Gregory Acs & John Sabelhaus, *Trends in Out-of-Pocket Spending on Health Care, 1980-92*, MONTHLY LAB. REV. 35, 37, 43 (1995), <http://bls.gov/mlr/1995/12/art4full.pdf>; see also *Rising Health Care Costs: What Factors Are Driving Increases?*, ASS'N OF WASH. HEALTHCARE PLANS 2-4, http://www.awhp-online.com/issues/AWHP_RisingHealthCareCosts_7-26-04.pdf (last visited Dec. 1, 2015).

16. Carel T. Hedlund & Thomas W. Coons, *CMS Revises Part B Billing Policy for Unnecessary Inpatient Admissions*, PAYMENT MATTERS (Mar. 21, 2013), <http://www.ober.com/publications/2159-cms-revises-part-b-billing-policy-unnecessary-inpatient-admissions> (discussing CMS Ruling 1455-R).

17. *Id.*

ing to risk admitting them until a formal diagnosis was made that could be used to justify admission to CMS.¹⁸ For a few of these years, up to the mid-1990s, CMS was unwilling to pay for observation as a separate charge, allowing doctors to bill for their treatment and for diagnostic services but not for the use of a bed.¹⁹

By 2010, hospitals and CMS were in an entrenched battle over patient status in the hospital. Starting with a pilot program in 2003,²⁰ which expanded nationally by 2008, CMS entered into contracts with Recovery Audit Contractors (“RAC”) who were paid for their services with a percentage of hospital charges they overturned and collected back for the government.²¹ The CMS regulations governing observation and admission status were extremely unclear, making the admission status of the patient a soft target for the auditors who could then collect a bounty for each admission they overturned.²² The turmoil led to extensive complaints and, eventually, congressional hearings.²³

In 2013, CMS, in an attempt to clarify how hospitals and doctors should bill Medicare for patient admissions, promulgated a regulation that quickly came to be known as the “Two Midnight Rule.”²⁴ This regulation, in turn, unleashed a high volume of criti-

18. Nathan R. Hoot & Dominik Aronsky, *Systematic Review of Emergency Department Crowding: Causes, Effects, and Solutions*, 52 ANNALS OF EMERGENCY MED. 126, 129 (2008), <http://www.sciencedirect.com/science/article/pii/S0196064408006069>.

19. Concurrently, and entirely unconnected to CMS concerns, studies began to show that patients with certain conditions, particularly chest pain, did extremely well if treated for short stays in a dedicated observation unit that was attached to the emergency department. This promising data has been completely pushed aside, lost in the appropriation of observation as a billing concept, rather than a treatment concept.

20. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified at 42 C.F.R. § 423.150 (2005)).

21. Press Release, Ctrs. for Medicare & Medicaid Servs., New Report Shows CMS Pilot Program Saving Nearly \$700 Million in Improper Medicare Payments (July 11, 2008), <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2008-Press-releases-items/2008-07-11.html>.

22. See 42 C.F.R. § 455.500 (2014).

23. Erica Stocker, *House Lawmakers Introduce RAC Reform Legislation*, WASH. HEALTH CARE WEEK (May 7, 2015), <http://www.anad.org/wp-content/uploads/2012/04/Health-Care-Update-May-7-2015.pdf>.

24. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status, 78 Fed. Reg. 50,496 (Aug. 19, 2013) (to be codified at 42 C.F.R. pts. 412–14, 419, 424, 482, 485, 489); Amanda Cassidy, *The Two-Midnight Rule*, HEALTH AFF. (Jan. 22, 2015), <http://www.healthaf>

cism, building on the already existing anger among divergent stakeholders about how Medicare policies in this area were already causing turmoil and financial strain for the healthcare system and for the elderly.²⁵ Federal legislation was quickly passed that delayed the regulation's implementation.²⁶ It appears that the Two Midnight Rule has now been supplanted, as of July 1, 2015, by another CMS proposal that seeks to ameliorate some of the more egregious problems that have arisen.²⁷

Much has been written about the Two Midnight Rule and the problems that CMS decisions about observation status have caused patients.²⁸ The problem, however, extends beyond the current regulatory complexities. Observation status as it is used now is a creature of cost containment²⁹ and has lost much of its prior connection to patient care. The entire concept has become questionable and needs to be re-examined.

As discussed in Part IV of this article, an examination of observation status opens the door to the extraordinarily complex interweaving of problems and challenges that occur throughout the healthcare system and have done so for decades: increasingly sick patient populations;³⁰ growing patient populations generally;³¹

fairs.org/healthpolicybriefs/brief.php?brief_id=133.

25. See, e.g., Stephanie Masaba, *Diagnosed with Time Is Money: Arbitrary Medicare Provisions Differentiating Observation Services from Inpatient Admissions Violate Beneficiaries' Due Process Rights*, 23 WM. & MARY BILL RTS. J. 1185 (2015); J.D. Thomas, *What's Past Is Prologue: Health Care Fraud Enforcement and What's Ahead for 2015*, 17 J. HEALTH CARE COMPLIANCE 9 (2015); Rachel A. Polzin, Comment, *Short-Stay, Under Observation, or Inpatient Admission?—How CMS' Two Midnight Rule Creates More Confusion & Concern*, 8 ST. LOUIS U. J. HEALTH L. & POL'Y 147 (2014).

26. Extension of Two-Midnight Rule, Pub. L. No. 113-93, § 111, 128 Stat. 1044 (Apr. 1, 2014).

27. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Short Inpatient Hospital Stays; Transition for Certain Medicare-Dependent, Small Rural Hospitals Under the Hospital Inpatient Prospective Payment System, 80 Fed. Reg. 39,200 (July 8, 2015) (to be codified at 42 C.F.R. pts. 410, 412, 416, 419).

28. See, e.g., Jonathan W. Padish, *Distinction Without A Difference: Reforming the Medicare Three-Day Qualifying Stay Rule for SNF Care*, 21 ELDER L.J. 465, 466 (2013); Lori J. Parker, *Observing Observational Status – Auditors and Inequities*, 16 MARQ. ELDER'S ADVISOR 83, 83 (2014).

29. Zack Budryk, *Complex Observation-Status Rules Complicate Patient Care*, FIERCEHEALTHFINANCE (Apr. 21, 2015), <http://www.fiercehealthfinance.com/story/complex-observation-status-rules-complicate-patient-care/2015-04-21>.

30. Deepak Asudani & Vaishal Tolia, *Pros and Cons of Clinical Observation Units*, THE HOSPITALIST (Nov. 1, 2013), <http://www.the-hospitalist.org/article/pros-and-cons-of-clinical-observation-units/>.

struggles with scarce resources;³² rampant inflation in medical care and health insurance;³³ the use of financial incentives to motivate healthcare providers and the unpredictability of how those incentives will actually play out in the market place;³⁴ deep distrust and lack of effective communication between payers and healthcare providers;³⁵ unintended consequences of legislative and regulatory actions;³⁶ and the extreme risk aversion of both physicians and hospitals, leading to provider behavior that can frustrate the intent of regulators.³⁷

The conflicts and limitations of the healthcare system are not going away. The human condition, whereby people are both frail and ultimately mortal, makes it impossible for a healthcare system to do more than imperfectly delay death. Against this grim set of background conditions, the societal desire to heal injury and illness leads to constant innovation,³⁸ making it impossible to determine the resources necessary to provide health care to a population. Further adding to the shifting sands, new diseases consistently emerge.³⁹ Both innovation and newly emerging dis-

31. Robert W. Derlet & John R. Richards, *Overcrowding in the Nation's Emergency Departments: Complex Causes and Disturbing Effects*, 35 ANNALS OF EMERGENCY MED. 63, 64 (2000).

32. *See id.* at 65 (noting that some hospitals around the country suffer from overcrowding due to lack of beds for admitted patients and a shortage of nurses, administrative staff, and clerical support).

33. *See id.* at 67 (explaining that hospitals "cost shift" expenses incurred from nonpaying patients to paying and insured patients because healthcare providers are unwilling to cover emergency departments' increased expenses).

34. *See id.*; Tiana Mayere Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement*, 13 ANNALS HEALTH L. 145, 170 (2004) (assessing the possible use of government subsidies to reimburse physicians at primary care facilities above the cost of treatment so that emergency healthcare centers are used as a last resort).

35. *See Derlet & Richards, supra* note 31, at 65–67 (discussing the dissatisfaction of patients due to faulty communication channels with hospitals and third-party payers).

36. *See id.* at 67 (noting that the federal government contributes to the problem by requiring emergency departments to pay for all patients with medical emergencies without compensating physicians or hospitals).

37. *See id.* at 66 (describing how the increase of paperwork that physicians are required to complete at the request of insurance providers and the Health Care Financing Administration ("HCFA") shortens the amount of hands-on time physicians can spend with patients).

38. For an excellent description of the challenges presented by medical innovation for Medicare, see Sean R. Tunis & Steven D. Pearson, *Coverage Options For Promising Technologies: Medicare's 'Coverage With Evidence Development'*, 25 HEALTH AFFAIRS 1218 (2006), <http://content.healthaffairs.org/content/25/5/1218.full.pdf+html>.

39. Tracking and identifying the emergence of new infectious diseases is a significant

eases add scope to what health care is tasked with accomplishing. Finally, societal norms and values continue to shift, leading to ever-changing notions of wellness, personal responsibility, governmental responsibility, and what health care ought to encompass.⁴⁰

Given the constant complexities and conflicts within health care, healthcare reform also needs to be recognized as “a constant,” a term used to describe the apparently endless grappling with shifting sands in an effort to direct an unruly system towards greater quality, lower cost, and greater access. Healthcare reform is not a single undertaking that will somehow emerge victorious with all problems solved. Unless something truly radical changes about the nature of being human, the problems will never be solved and society will continually seek better answers.

This article proposes that it is time for all stakeholders in the healthcare system to recognize that incremental change will be the norm (even if a single increment may have breathtaking scope) and adapt to it. Attempts to regulate a shifting system will always generate unintended consequences, and many of those, in turn, will not be optimal.⁴¹ Some may even be horrible. Financial and other incentives will always be unruly, as autonomous human actors and marketplaces will conceive of responses that were never imagined by those who sought to create the incentive structure in the first place.

In the face of the problems that reform will always generate, the system needs to take constant change into account, much as the tax system does. The regulators (a term used broadly here) need to become more nimble in order to respond effectively to shifting conditions and unintended consequences. The effectiveness of the response will depend on information from providers. The goal should be constant, open, and honest communication

part of the role of public health organizations. See, e.g., *Pandemic and Epidemic Diseases*, WORLD HEALTH ORG., <http://www.who.int/csr/disease/en/> (last visited Dec. 1, 2015) (noting that the World Health Organization’s Twelfth Programme of Work aims to reduce the mortality and societal disruption caused by epidemics). For a current example of emerging diseases, see *Disease Outbreak News (DONs)*, WORLD HEALTH ORG., <http://www.who.int/csr/don/en/> (last visited Dec. 1, 2015).

40. For examples of these shifting norms, see *infra* notes 271–72.

41. Rob Norton, *Unintended Consequences*, THE CONCISE ENCYCLOPEDIA OF ECONOMICS, <http://www.econlib.org/library/Enc/UnintendedConsequences.html> (last visited Dec. 1, 2015).

among stakeholders. Attorneys need to take a more active role in healthcare planning, acting as constant advisors to healthcare providers, identifying and communicating client concerns to regulators, and working to devise increasingly effective methods for doing so. These communications can help rationalize the system by reducing inappropriate reactions by risk-averse healthcare providers, which, in turn, can help reduce the gap between what a regulation permits and what the regulated are actually doing.

The changes described above also require a less adversarial stance among participants. When it is counterproductive to be adversarial, stakeholders in health care need to quickly identify and step back from condemnatory postures that undermine the communication that is necessary to continually nudge health care in the right direction. While actual criminals do seek to exploit the healthcare system for financial gain, they are rare. Not every mistake is fraud,⁴² and not everything that costs an unprecedented amount of money is caused by greed. Most people involved in the healthcare system do care about people, and this needs to stay uppermost in people's minds and expectations.

This article suggests that the United States tax regime is a useful model for accomplishing many of the changes suggested here. While the tax regime is not perfect, it does many things right. Its culture accepts complexity and constant change as a norm.⁴³ Many aspects of this system—such as opinion letters issued by attorneys,⁴⁴ private letter rulings issued by the IRS,⁴⁵ and

42. This statement is intuitively true, but the author realizes that determining the causes of errors in billing is exceedingly difficult. See, e.g., Letter from Shaun Donovan, Dir., Exec. Office of the President, to The Honorable Sylvia Mathews Burwell, Sec'y of Health & Human Servs. (Feb. 26, 2015), <https://www.documentcloud.org/documents/2322973-pages-from-r-combined-sixth-interim-response.html>.

43. The federal tax code changes hundreds of times per year, while regulatory structures must grapple with both code changes and taxpayer changes. See TAXPAYER ADVOCATE SERV., ANNUAL REPORT TO CONG. (VOLUME 1), THE COMPLEXITY OF THE TAX CODE 3–4 (2008), https://www.irs.gov/pub/tas/08_tas_arc_msp_1.pdf.

44. Patricia B. Hsue, Comment, *Lessons from United States v. Stein: Is the Line Between Criminal and Civil Sanctions for Illegal Tax Shelters A Dot?*, 102 NW. U. L. REV. 903, 911 (2008).

45. Judy S. Kwok, *The Perils of Bright Lines: Section 6110(k)(3) and the Ambiguous Precedential Status of Written Determinations*, 24 VA. TAX REV. 863, 868 (2005) (“A P[ri]vate L[etter] R[uling] is a written statement by the National Office, prepared in response to a written request from a taxpayer that states how it will treat a prospective or completed transaction for federal tax purposes. A taxpayer may generally rely, if doing so in good faith, on a PLR received from the Service. A ruling may be modified or revoked under certain circumstances.”).

revenue rulings issued by the IRS,⁴⁶ which allow participants to proceed with some assurances of legality—can be adapted by the healthcare system. These tools would help achieve the changes described above by allowing for a less adversarial and less punitive system.⁴⁷

This article consists of five components: the introduction, which gives a brief description of the case study and theory of reform; Parts I and II contain a case study about observation status; Part I is about the evolution of hospital-based patient observation in the face of scarce resources, particularly the time between 1965 and 2000; Part II examines what occurred after the introduction of bounty-incentivized claims auditing; Part III contains the author's proposal for a theoretical framework for achieving more effective incremental healthcare reform; and the conclusion.

I. THE FIRST EVOLUTION OF HOSPITAL-BASED PATIENT OBSERVATION IN THE FACE OF SCARCE RESOURCES, 1965–2000

Observation status has proven to be an effective method of providing care,⁴⁸ but it has also been, for some time, highly problematic from a policy perspective. It is helpful to look at the evolution of the practice to more fully understand its current complexity.

A. *What Is Observation?*

Observation occurs when a physician in a hospital emergency department lacks sufficient information to recommend a course of treatment for a patient and wishes to engage in watchful waiting for a period of time in order to make a more informed determination as to the illness or injury, see what other symptoms emerge, and judge if the patient is medically stable and therefore able to be released.⁴⁹ Throughout most of the twentieth century, patients

46. 26 C.F.R. § 601.601(d)(2)(i)(a) (2015).

47. See, e.g., Hsue, *supra* note 44, at 912 (discussing how the use of opinion letters allows tax attorneys to avoid liability and tax advisors to reasonably disagree on what type of treatment a transaction should receive under the tax code).

48. See Asudani & Tolia, *supra* note 30.

49. See Christopher W. Baugh, Arjun K. Venkatesh & Stephen J. Bohan, *Emergency Department Observation Units: A Clinical and Financial Benefit for Hospitals*, 36 HEALTH CARE MGMT. REV. 28 (2011), http://www.nursingcenter.com/journalarticle?Article_ID=110

under observation would often be admitted to an acute care hospital if a room were available. The hospital stay would be covered by the patient's insurance under the theory that monitoring the development of the diagnosis, once it reaches a certain level of acuity, is an insurable event.⁵⁰ Historically, health insurance plans provided care on a fee-for-service basis, meaning that doctors determined the care the patients required and the insurance companies would reimburse the doctors for providing "reasonably necessary" care.⁵¹ Courts, reluctant to intrude in the doctor/patient relationship, generally interpreted this language so that a treating physician's order that a patient be hospitalized for observation was sufficient evidence that the care was "reasonably necessary," thus satisfying contractual terms.⁵²

B. *Rapid Change in Healthcare Dynamics from the 1970s to the 1980s*

The medical and payment dynamic for hospital-based observation is radically different now. Beginning in the 1970s, health care experienced a steady and worrisome increase in cost.⁵³ This increase, combined with an equally steady increase in treatments, began to seem like a crisis by the mid-1980s.⁵⁴ By that point, the number of insured people was dropping due to the increased cost of care,⁵⁵ even as the cost borne by the Medicare program and employers who provided health insurance was growing. While there have been numerous times in American history when governments and private parties attempted to both increase quality of care and make care more accessible,⁵⁶ the flurry of activity

1967.

50. See *A Patient's Guide to Observation Care*, ILL. HOSP. ASS'N, <http://www.ihatoday.org/uploaddocs/1/observationstayguidelines.pdf> (last visited Dec. 1, 2015).

51. See Jacqueline Fox, *The Hidden Role of Cost: Medicare Decisions, Transparency and Public Trust*, 79 U. CIN. L. REV. 1, 12 (2011).

52. See *id.*

53. *Id.* at 12–13.

54. HENRY J. KAISER FAMILY FOUND., HEALTH CARE COSTS: A PRIMER, fig.1 (2012), <http://kff.org/report-section/health-care-costs-a-primer-2012-report/> (stating that the rate of medical spending, per capita, increased from \$1110 in 1980 to \$2854 in 1990, and up to \$4878 in 2000, but has not had a similar percentage hike since then.)

55. Robin A. Cohen et al., *Health Insurance Coverage Trends, 1959–2007: Estimates from the National Health Interview Survey*, 17 NAT'L HEALTH STAT. REP. 1, 5 (2009), <http://www.cdc.gov/nchs/data/nhsr/nhsr017.pdf>.

56. Examples of this would include such disparate activities as the founding of the

in private markets, state and federal legislatures, and federal agencies that occurred during the late 1980s in response to rapid healthcare inflation can arguably be seen as the beginning of the modern era of healthcare reform.⁵⁷ It is here that one can see the roots of the challenges the current healthcare system faces with regards to observation.

Because of both the market and legal changes, the late 1980s and early 1990s was a time of extraordinary turmoil in the American healthcare system, particularly for emergency departments and hospitals more generally.⁵⁸ During this time, there was a rapid increase in patients choosing emergency departments for treatment.⁵⁹ Within the medical field, the possible causes for the increase and the appropriate responses were fiercely debated, but no consensus was ever reached.⁶⁰ The number of hospital beds for admitted patients had been steadily decreasing up to this point,⁶¹

Rockefeller Institute for Medical Research in 1901, see JOHN M. BARRY, *THE GREAT INFLUENZA: THE EPIC STORY OF THE DEADLIEST PLAGUE IN HISTORY* 72, 79, 82 (2005); the creation of the first Blue Cross health insurance plan in 1929, see Melissa A. Thomasson, *From Sickness to Health: The Twentieth Century Development of U.S. Health Insurance*, 39 *EXPLORATIONS IN ECON. HIST.* 233, 237 (2002); and the creation of Medicare and Medicaid in 1965, see 42 U.S.C. § 1395 (2012).

57. See *Timeline: History of Health Reform in the U.S.*, HENRY J. KAISER FAMILY FOUND. (May 2, 2013), <https://kaiserfamilyfoundation.files.wordpress.com/2011/03/5-02-13-history-of-health-reform.pdf/>; see also William D. White, *Market Forces, Competitive Strategies, and Health Care Regulation*, 2004 U. ILL. L. REV. 137, 146 (2004).

58. For a contemporary and detailed discussion of these problems, see Erik J. Olson, *No Room at the Inn: A Snapshot of an American Emergency Room*, 46 *STAN. L. REV.* 449, 451, 453–55 (1994).

59. According to an article published in 1990, the increase in patient use of emergency departments was extraordinarily high, with the authors stating that “although inpatient-care volume has declined 5 to 10 percent since 1984, the E[mergency] D[epartment] volume has increased 40 to 60 percent in the typical inner-city hospital.” Steven R. Eastaugh & Janet A. Eastaugh, *Putting the Squeeze on Emergency Medicine: The Many Pressures on Today’s ED*, 68 *HOSP. TOPICS* 21, 21 (1990). Volume across the country increased by an additional 14% from 1992 to 1999, “mainly due to an increase in visits for illness-related as opposed to injury-related conditions.” Linda F. McCaig & Catharine W. Burt, *Trends in Hospital Emergency Department Utilization: United States, 1992–99*, 13 *VITAL & HEALTH STAT.* 1, 1 (2001), http://www.cdc.gov/nchs/data/series/sr_13/sr13_150.pdf.

60. In retrospect, it was a very complex situation that resulted from numerous changes in the healthcare delivery system. One interesting statistic is that the number of people visiting emergency departments because of injury was actually dropping over this period of time, even as the number of people who needed medical management of illness steadily increased. This may have been one of the first signals alerting us to the system’s continuing problems with managing chronic conditions. See McCaig & Burt, *supra* note 59, at 1.

61. CTR. FOR DISEASE CONTROL, HOSPITALS, BEDS, AND OCCUPANCY RATES, BY TYPE OF OWNERSHIP AND SIZE OF HOSPITAL: UNITED STATES, SELECTED YEARS 1975–2009, (2011), <http://www.cdc.gov/nchs/data/hus/2011/116.pdf>.

even as emergency department utilization increased.⁶² By 1990, it had become a common occurrence for all hospital beds to be filled and for patients to be left on stretchers in the emergency department until beds were available for them, further increasing crowding and taxing resources.⁶³ As further evidence of overcrowding, it was also common for these departments to contact ambulance services and ask to have no more patients brought in until the crowding decreased, a process known as diversion.⁶⁴

C. *The Changing Environment for Emergency Departments: Prospective Payment Systems, Managed Care, and EMTALA*

The 1980s saw high levels of medical inflation and a sharp reduction in the percentage of Americans who had access to healthcare due to a drop in both the percentage of Americans with health insurance and the increasing inability of people to pay, by themselves, for the medical care they received.⁶⁵ The emergency department was becoming the last option for those seeking care.⁶⁶ Against the backdrop of crowded and stressed emergency departments, three changes in the healthcare system are key to understanding the complexities surrounding observation care: Prospective Payment System ("PPS");⁶⁷ the rapid ex-

62. See D.P. Andrulis et al., *Emergency Departments and Crowding in United States Teaching Hospitals*, 20 ANNALS EMERGENCY MED. 980, 982 (1991). The federal government did not begin tracking emergency department utilization until 1992, when the numbers show a continual growth in utilization since then, with, for example, a 20% increase between 1992 and 2000. A.B. BERNSTEIN, HEALTH CARE IN AMERICA: TRENDS IN UTILIZATION 32 (2003), <http://www.cdc.gov/nchs/data/misc/healthcare.pdf>.

63. Andrulis, *supra* note 62, at 982.

64. See R.J. Lague & M.S. Jastremski, *Relieving Overcrowded Emergency Departments Through Ambulance Diversion*, 68 HOSP. TOPICS 23, 23, 24–26 (1990).

65. Cohen et al., *supra* note 55, at 6; see also Cynthia G. Tudor, *Medicaid Expenditures and State Responses*, 16 HEALTH CARE FINANCING REV. 1, 1 (1995), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193516/>; Kevin Drum, *A Longer Look at Medical Inflation*, MOTHER JONES (June 18, 2013), <http://www.motherjones.com/kevin-drum/2013/06/longer-look-medical-inflation>.

66. Sean McNeeley, *Urgent Care Centers: An Overview*, 9 AM. J. CLINICAL MED. 80, 80 (2012), <http://www.aapsus.org/wp-content/uploads/ucc80.pdf>.

67. The Prospective Payment System was developed, passed into law, and then implemented by regulation extraordinarily quickly, with perhaps one year between the first law and the final regulation being put into place. The Payment System was first introduced in a tax law passed in 1982 requiring the HCFA to develop a prospective payment system. Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324. After HCFA drafted a proposal, it was passed into law on April 20, 1983. Social Security Amendments of 1983, Pub. L. No. 98-21, tit. VI, 97 Stat. 65, 149. An interim final regulation was published in the Federal Register on September 1, 1983, "Medicare Program;

pansion of managed care plans; and the passage of the Emergency Medical Treatment and Active Labor Act (“EMTALA”).⁶⁸

The PPS system was created in an effort to control the rapidly increasing costs of hospital care for Medicare.⁶⁹ These costs had been increasing by roughly 19% a year for the three years prior to the introduction of the new payment system.⁷⁰ PPS is a payment system that determines hospital charges at the time a patient is discharged by using flat fees based on the Diagnostic Related Groups (“DRG”), codes that describe the condition(s) a patient was treated for, which in turn have reimbursement rates associated with them.⁷¹ This system created a set of financial incentives meant to counterbalance those within the fee-for-service system.⁷² In fee-for-service, a care provider is paid for every medical interaction with a patient.⁷³ Under PPS, the care provider retains more profit by having fewer, shorter, and less intense interactions if those interactions are sufficient to treat the underlying medical condition.⁷⁴ The hope is that a reasonable amount of care is provided and, absent financial incentives to unnecessarily complicate treatment, that the cost is controlled. The new payment system was gradually rolled out across the country and became a national system for Medicare reimbursement to hospitals by 1988.⁷⁵

Prospective Payments for Medicare Inpatient Hospital Services.” 48 Fed. Reg. 39,752–39,890 (Sept. 1, 1983). The final rule was published in the Federal Register in January 1984. 49 Fed. Reg. 234 (Jan. 3, 1984).

68. 42 U.S.C. § 1395dd (2012).

69. *Learning from Medicare: Prospective Payment*, HEALTH CARE FINANCING & ORG. (May 2011), <http://www.hcfo.org/publications/learning-medicare-prospective-payment>.

70. Judith Mistichelli, *Diagnosis Related Groups (DRGs) and the Prospective Payment System: Forecasting Social Implications*, SCOPE NOTE 4, at 1 (1984), <https://repository.library.georgetown.edu/bitstream/handle/10822/556896/sn4.pdf>.

71. *Id.*

72. ELIAS N. MATSAKIS, ROD ST. CLAIR & JOHN L. BENDER, AM. MED. ASS’N., CHAPTER 14: EVOLVING COMPENSATION METHODOLOGIES FOR EMPLOYED PHYSICIANS IN AN ERA OF CHANGING CLINICAL PRACTICE, REIMBURSEMENT AND HEALTH REFORM 1 (2012), <http://www.hklaw.com/files/Publication/b6de2ca8-4a8e-407f-b7cb-75ba11ee555/Presentation/PublicationAttachment/9240414b-3dfc-4164-936a-882c833dbbd4/chapter-14-payment-options.pdf>.

73. *Fee-for-Service*, MEDICAID.GOV, <http://www.medicare.gov/medicaid-chip-program-information/by-topics/delivery-systems/fee-for-service.html> (last visited Dec. 1, 2015).

74. Mistichelli, *supra* note 70, at 6.

75. *Id.* at 2.

In response to patient overcrowding coupled with patient inability to pay, hospitals resorted to refusing to treat or transferring unwanted patients, a practice commonly referred to as patient dumping.⁷⁶ EMTALA is the federal law that requires all emergency departments to stabilize all people who show up at their doors, without regard for the patient's ability to pay.⁷⁷ The financial penalties for failing to do so could be severe for both doctors and hospitals, making EMTALA a key tool to prevent patient dumping.⁷⁸ Once patients presented themselves to an emergency department, the hospital had to provide appropriate treatment within EMTALA parameters or risk violating federal law.⁷⁹ Significantly, EMTALA did not require that an acute care hospital have an emergency department at all.⁸⁰ The rising number of facilities either never operating an emergency department or closing them escalated,⁸¹ while the financial and compliance burden on those covered by EMTALA also escalated.⁸²

The advent of managed care combined with EMTALA created a complex scenario for physician and hospital decision making regarding observation of patients. The advent of managed care is relevant because the health insurance contracts for managed care plans reserve far greater rights to the third-party payer—the insurance company—to determine medical necessity than the earlier fee-for-service contracts did.⁸³ This power is considered an es-

76. Lynn Healey Scaduto, *The Emergency Medical Treatment and Active Labor Act Gone Astray: A Proposal to Reclaim EMTALA for Its Intended Beneficiaries*, 46 UCLA L. REV. 943, 943, 945 (1999).

77. *Id.* at 946 n.8 (quoting KEVIN F. O'MALLEY, 3 FEDERAL JURY PRACTICE & INSTRUCTIONS § 110.08 (4th ed. 1997)). Congress enacted EMTALA in the face of "the increasing number of reports that hospital emergency rooms are refusing to accept to treat patients with emergency condition if the patient does not have medical insurance." *Reynolds v. MaineGeneral Health*, 218 F.3d 78, 83 (1st Cir. 2000) (quoting 1986 U.S.C.C.A.N. 42, 605).

78. Scaduto, *supra* note 76, at 951–52.

79. 42 U.S.C. § 1395dd(a) (2012).

80. *Id.*

81. The number of emergency departments has steadily declined since then, from 4998 in 1993 to 4440 in 2013. See AM. HOSP. ASS'N, CHARTBOOK: TRENDS AFFECTING HOSPITALS AND HEALTH SYSTEMS tbl.3.3 (2015), <http://www.aha.org/research/reports/tw/chartbook/index.shtml>.

82. Jeffrey Rowes, *EMTALA: OIG/HCFR Special Advisory Bulletin Clarifies EMTALA, American College of Emergency Physicians Criticizes It*, 28 J. L. MED. & ETHICS 90, 91 (2000) (estimating that, as of 2000, the cost of compliance with EMTALA was already between \$10 billion and \$27 billion).

83. See John K. Iglehart, *Health Policy Report: Physicians and the Growth of Managed Care*, 331 NEW ENG. J. MED. 1167, 1167 (1994).

stantial part of managed care.⁸⁴ Supporters of managed care argue that traditional fee-for-service plans encourage doctors to over-utilize care because the doctors are financially incentivized to do so, given that they are paid for all medical care they provide.⁸⁵ Managed care gatekeeping is meant to counterbalance this incentive by having the payer assess whether the proposed treatment is truly necessary for the patient's care.⁸⁶

While managed care concepts were gathering steam in the United States during the 1970s and 1980s, the percentage of people enrolled in some form of a managed care plan rather than a fee-for-service plan exploded between 1987 and 1991, and it has only increased since then.⁸⁷ For example, currently, less than 1% of people with employer-sponsored health insurance have plans that are not managed care plans.⁸⁸ Contemporary managed care plans come in a variety of formats, and managed care is best understood as an umbrella term that covers most modern insurance plans, all of which have cost containment mechanisms. The increased market share of managed care plans coupled with these plans' ability to refuse to pay for care that was ordered by a treating physician inserted third-party payers firmly in the middle of hospital decision making.⁸⁹

As managed care rapidly spread across the country, it began to suffer from a significant image problem. Much was written in academic literature and the popular press about problems with managed care during this time period, particularly Health

84. *See id.*

85. Gerald B. Hickson, William A. Altemeier & James M. Perrin, *Physician Reimbursement by Salary or Fee-for-Service: Effect on Physician Practice Behavior in a Randomized Prospective Study*, 80 *PEDIATRICS* 344, 344 (1987).

86. Douglas A. Mains, Alberto Coutasse & Kristine Lykens, *Physician Incentives: Managed Care and Ethics*, 2 *INTERNET J. OF L., HEALTHCARE & ETHICS* 1, 1–2 (2003), <http://ispub.com/IJLHE/2/1/12416> (describing managed care utilization of primary care physician gatekeepers to determine appropriateness of proposed care for patient).

87. For example, “[1987 to 1993] witnessed a 100% increase in HMO enrollment, with 2.2 million having been added in 1991 alone.” LES SEPLAKI, *COST AND COMPETITION IN AMERICAN MEDICINE: THEORY, POLICY AND INSTITUTIONS* 180 (1994). For a chart showing the change in types of enrollment for people who receive health insurance through their employers, see HENRY J. KAISER FAMILY FOUND., 2014 EMPLOYER HEALTH BENEFITS SURVEY, Exhibit E (2014), <http://kff.org/report-section/ehbs-2014-summary-of-findings/>.

88. HENRY J. KAISER FAMILY FOUND., 2014 EMPLOYER HEALTH BENEFITS SURVEY, Exhibit E (2014), <http://kff.org/report-section/ehbs-2014-summary-of-findings/>.

89. *Id.*; Rowes, *supra* note 82, at 90, 91.

Maintenance Organizations (“HMO”).⁹⁰ These companies became renowned in the 1990s for controlling costs and protecting profits by aggressively preventing patients from accessing medical care.⁹¹ One of the tools for doing this was the prior authorization requirement: patients were required to have all interactions with the medical establishment pre-approved by the payer before the patient could receive covered care.⁹² This requirement originally included emergency treatment and all hospital admissions.⁹³ Requiring pre-authorization for emergency treatment was a deeply unpopular part of managed care.⁹⁴ As the 1990s progressed, the managed care industry was threatened with federal legislation that would specifically prohibit requiring pre-authorization for

90. For an example in popular culture, the movie *As Good As It Gets* (TriStar Pictures 1997) contains a scene where the heroine decries horrible HMOs. This scene was reported at the time to have generated widespread applause from audiences. David S. Hilzenrath, *Art Imitates Life When It Comes to Frustration with HMOs*, WASH. POST (Feb. 10, 1998), <https://www.washingtonpost.com/archive/business/1998/02/10/art-imitates-life-when-it-comes-to-frustration-with-hmos/86c2f39b-b1aa-47ba-b7e0-77651424f6b8/>; see also Samuel H. Zuvekas & Joel W. Cohen, *Paying Physicians by Capitation: Is the Past Now Prologue?*, 29 HEALTH AFF. 1661, 1661 (2010), <http://content.healthaffairs.org/content/29/9/1661.full> (“[In the 1990s,] HMOs’ use of prior authorization, gatekeepers, and other managed care techniques produced a backlash among consumers and providers.”).

91. Zuvekas & Cohen, *supra* note 90, at 1661, 1663.

92. Rowes, *supra* note 82, at 91; Zuvekas & Cohen, *supra* note 90, at 1661.

93. It is helpful to recall how profoundly ugly the emergency pre-authorization requirement could get. See, e.g., Tiana Mayere Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement*, 13 ANNALS HEALTH L. 145, 147 (2004) (describing gruesome media accounts of “patient dumping” resulting in great harm to patients, including a pregnant woman). For example, many HMOs would not allow a patient to receive emergency care of any kind without prior precertification, and would also, once contacted by the person having an active medical emergency, attempt to direct patients to hospitals that were in the HMO’s network (thus controlling costs), even if there was an emergency department that was closer to the patient. *Id.* at 147–48. Not surprisingly, many of these situations resulted in damage to patients who were delayed care due to these conditions. *Id.* at 148. If an employer provided the insurance coverage, the Employee Retirement Income Security Act (“ERISA”) would prevent the patient from suing for damages due to the ERISA preemption. See 29 U.S.C. § 1144 (2012). However, a notable case from this time period, brought by a family that had individual coverage, highlights what was known at the time as “telephone triage” and the damages it caused. See Thomas William Malone, *Changes in Medicine—An Overview of Handling Medical Negligence Cases for the Past 30 Years*, 1 ANN. 2001 ATLA-CLE 1177 (2001). See generally Rob Rosenbaum, *End H.M.O. ‘Telephone Triage’: Pass the Patients’ Rights Bill*, OBSERVER (June 25, 2001), <http://observer.com/2001/06/end-hmo-telephone-triage-pass-the-patients-rights-bill/> (discussing “telephone triage” as a euphemism for HMO abuse).

94. Managed care suffered from a terrible reputation by the end of the 1990s. See generally George J. Church, *Backlash Against HMOs: Doctors, Patients, Unions, Legislators Are Fed Up and Say They Won’t Take It Anymore*, CNN (Apr. 7, 1997), <http://www.cnn.com/ALLPOLITICS/1997/04/07/time/hmo.html> (describing the various political and popular responses at that time).

emergencies.⁹⁵ In the face of this widespread disapproval, the managed care industry generally began to remove the requirement for pre-authorization of emergency department visits from its contracts and also allowed members to seek care at the closest hospital, rather than continuing to require patients to find an emergency department that had a contract with their particular insurer.⁹⁶ However, the insurers retained the right to find the emergency department visit medically unnecessary and thus not reimburse the insured, resulting in a financially catastrophic problem for patients. In response to this problem, many states enacted “prudent layperson” laws.⁹⁷ While the details of these laws varied, they all generally required managed care plans to be subject to state regulation requiring insurers to judge the medical necessity of emergency department visits from the perspective of a prudent layperson viewing the situation prior to the provision of any medical care.⁹⁸ Given the complexity of these laws and the financial incentives for managed care organizations to deny coverage, hospitals were often left uncertain about managed care reimbursement for emergency care and always left unclear about reimbursement for *post-stabilization* hospital stays that occurred when a patient was admitted after the stabilization that is required under EMTALA.⁹⁹

From a hospital’s perspective, unreimbursed care was a complex and frightening problem with financial consequences as worrisome as those attached to EMTALA violations. Particularly during this first phase of managed care, many in-network doctors and facilities had contracts with managed care companies that financially penalized healthcare providers for giving patients care that cost more than a fairly low contractually stipulated cost

95. A proposed federal Patient’s Bill of Rights introduced in both the Senate and the House of Representatives included this prohibition. S. 1890, 105th Cong. § 101(a)(1)(A) (1980); H.R. 3605, 105th Cong. § 101(a)(1)(A) (1998).

96. Interesting and frank discussions of this dynamic can be found in managed care trade journals from that time. See, e.g., Steve Heimoff, *Will Prudent Layperson Please Report to the ER*, MANAGED CARE (1999), <http://www.managedcaremag.com/archives/9905/9905.prudent.html>.

97. Lee, *supra* note 93, at 164 & nn.136 & 137. With the passage of the Affordable Care Act in 2010, this general standard now applies to all health plans in the United States. 42 U.S.C. § 300gg-19a(b) (2012).

98. Lee, *supra* note 93, at 164 & nn.136 & 137.

99. *Id.*

point.¹⁰⁰ Furthermore, as is true today, care that was already provided and was then denied coverage by a third-party payer was far less likely to be paid for, since most people could not afford the out-of-pocket costs of the care they were receiving.¹⁰¹

Hospitals were rapidly thrust into a position of being forced to justify decisions to admit patients, even as they were also compelled by EMTALA to stabilize all patients presented to their emergency departments.¹⁰² If a patient seemed too ill to send home but had no clear diagnosis of a quality or certainty that would satisfy a cost-conscious third-party payer in terms of justi-

100. The most common form of financial penalty was through capitation agreements, which was a method of shifting insurable risk from the insurance company to the healthcare provider. Zuvekas & Cohen, *supra* note 90, at 1661. For example, a primary care provider might be paid a fixed amount per month for each patient who chooses them as the primary care doctor. *Id.* In exchange for this payment, the physician contracts to provide all of the primary care and, perhaps, to bear financial responsibility for a subset of all specialty care that the patient requires. *Id.* at 1662. Currently, most states limit these contracts so that physicians are limited in the risk they can take on in these contracts. *Id.* In the 1990s, however, it was not unusual for a physician to take on the risk for all possible care a patient required, including hospitalization and oncology treatments. *Id.* Not surprisingly, many doctors were quickly facing bankruptcy under these contracts and patient care became fragmented. *See, e.g.*, Ed Egger, *System Losses, Poor Capitation Profitability, Bankruptcy Warnings Signal Distress for Docs*, 17 HEALTH CARE STRATEGIC MGMT. 10, 10 (1999) (describing the increasing financial burden on doctors and hospitals and how capitation agreements were becoming non-profitable). State insurance commissioners eventually responded to this with regulation because, by entering into these contracts, insurance companies were contractually shifting their actuarial risk to undercapitalized and unprepared physicians, thus evading the careful regulations of insurance companies that the states had devised. *See Lee, supra* note 93, at 146.

101. It is difficult to track the precise impact of managed care reimbursement denials on hospitals, but evidence showing a connection between managed care reimbursement rates and hospital closings from that time make it clear that hospitals would be rational in being concerned about the problem. *See* Renee Y. Hsia, Arthur L. Kellermann & Yu-Chu Shen, *Factors Associated with Closures of Emergency Departments in the United States*, 305 J. AM. MED. ASS'N 1978, 1978 (2011). From 1990 to 2009, 27% of all emergency departments in the United States closed and a careful analysis of those that closed versus those that remained open show that a low profit margin is associated with a significant increased risk of closure. *Id.* at 1984. Furthermore, a study of hospital closings in California from 1995 to 2000 found that “[m]anaged care, technological developments, capitation and competition combine to push some hospitals out of business.” NICHOLAS C. PETRIS CTR. ON HEALTH CARE MKTS. AND CONSUMER WELFARE, CALIFORNIA’S CLOSED HOSPITALS, 1995–2000 13, (2001) <http://oag.ca.gov/sites/all/files/agweb/pdfs/charities/publications/nonprofitosp/report.pdf>. There is a clear connection between managed care reimbursements and hospital survival. Anecdotal evidence from that time period seems to show, if not actual hospital failures due to managed care reimbursement denials, a belief that this can occur. *See, e.g.*, Maureen Glabman, *Managed Care Makes It Tough for Some Hospitals to Stay Afloat*, MANAGED CARE (June 2003), <http://www.managedcaremag.com/archives/0306/0306.er.html>.

102. *See* Glabman, *supra* note 101.

fyng a hospital admission, the emergency department was left in a complicated position.¹⁰³ One possible response would be to leave the patient in the emergency department for as long as it took to determine if admission was medically required. But at the same time, emergency departments were grappling with crowding due to the steady increase of patients seeking care, making it difficult to simply warehouse patients for any extensive period of time.¹⁰⁴

In an effort to handle these problems, some emergency departments began to set aside beds in designated observation units.¹⁰⁵ These fairly small units, called Emergency Department Observation Units (“EDOU”), were located within the emergency department but somewhat separated, and the patients were primarily cared for by emergency department nurses.¹⁰⁶ Academic physicians quickly noticed that patients did extremely well in these observation units, and there has been a steady stream of literature showing their benefits, particularly for patients exhibiting cardiac problems such as chest pain.¹⁰⁷ These observation units are often thrust into the discussion of observation status as though they were the same thing, but they are distinct creatures. Observation status does not require a patient to be in an observation unit but is, instead, a payment status that simply reimburses a hospital at a lesser rate than would occur were the patient to be

103. See OFFICE OF INSPECTOR GEN., DEPT OF HEALTH & HUMAN SERVS., THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT: SURVEY OF HOSPITAL EMERGENCY DEPARTMENTS 3 (2001), <http://www.oig.hhs.gov/oei/reports/oei-09-98-00220.pdf> (reporting that managed care reimbursement policies “leave many hospitals with a tough choice: risk an EMTALA violation or forgo reimbursement”); Baugh, Venkatesh & Bohan, *supra* note 49, at 30 (“The growth of EDOUTs over the past four decades has been fueled by the acknowledgement that emergency physicians should no longer be forced into a dichotomous discharge to home or inpatient admission decision . . .”).

104. Olson, *supra* note 58, at 465.

105. See Hoot & Aronsky, *supra* note 18, at 131 (identifying observation units as a commonly studied solution to crowding in emergency departments).

106. Baugh, Venkatesh & Bohan, *supra* note 49, at 29 (“Logistically, the EDOUT is usually a discrete unit with 4 to 20 beds contained within or adjacent to the ED.”); Mark G. Moseley, Miles P. Hawley & Jeffrey M. Caterino, *Emergency Department Observation Units and the Older Patient*, 29 CLINICAL GERIATRIC MED. 1, 2 (2013), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3810312/> (“In the majority of cases observation units are under the discretion and clinical responsibility of the ED.”).

107. See Michael E. Farkouh et al., *A Clinical Trial of a Chest-Pain Observation Unit for Patients with Unstable Angina*, 339 NEW ENG. J. MED. 1882, 1882 (1998). But see Edward O. McFalls, Letter to the Editor, *Chest-Pain Observation Units*, 340 NEW ENG. J. MED. 1596, 1596 (1999) (arguing that chest-pain observation units are not the safest approach for patients).

classified as a hospital admission.¹⁰⁸ One cannot credit observation status with having the same proven benefit to patients as observation units. A patient in observation status can be in any bed in the hospital.¹⁰⁹ The promise of these units may have been overlooked due to the distraction caused by the continual problems that observation status has presented to both hospitals and Medicare. Indeed, rarely do patients in observation status see the inside of a dedicated observation unit. While the data is unclear, available reports show that between 19%¹¹⁰ and 33%¹¹¹ of hospitals currently have a designated observation unit in the emergency department.

D. *The Development of Physician and Hospital Reimbursement for Observation Status*

When Medicare was first created in 1965, coverage was divided into two types: Part A for hospital care¹¹² and Part B for physician services provided outside of hospitals.¹¹³ At that time, there was no concept of observation care with regards to hospital reimbursement.¹¹⁴ If a patient went to the hospital and was admitted, even if it were for some form of observation, the hospital was reimbursed under Part A.¹¹⁵ At the same time, emergency departments did use observation unit beds to monitor patients who were

108. See Michelle Andrews, *Observation Units May Ease Burdens of ER Care, but Benefits to Patients Come at a Price*, WASH. POST (Feb. 11, 2013), https://www.washingtonpost.com/national/health-science/observation-units-may-ease-burdens-of-er-care-but-benefits-to-patients-come-at-a-price/2013/02/08/84ddf37e-706d-11e2-a050-b83a7b35c4b5_story.html (noting that insurers treat observation services as outpatient care, and highlighting the discrepancies between coverage for outpatient and inpatient care).

109. *Id.*

110. Moseley, Hawley & Caterino, *supra* note 106, at 2 (identifying “34% of hospitals have an observation unit, 56% of which are classified as EDOUs”).

111. Jennifer L. Wiler, Michael A. Ross & Adit A. Ginde, *National Study of Emergency Department Observation Services*, 18 ACAD. EMERGENCY MED. 959, 960 (2011), <http://onlinelibrary.wiley.com/doi/10.1111/j.1553-2712.2011.01151.x/epdf>; see also Andrews, *supra* note 108.

112. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1811, 79 Stat. 286, 291 (codified as amended at 42 U.S.C. § 1395c (2012)).

113. See *id.* § 1831, 79 Stat. at 301 (codified as amended at 42 U.S.C. § 1395j (2012)).

114. Letter from Elise Smith, Senior Vice President, Fin. Policy and Legal Affairs, Am. Health Care Ass'n, to Marilyn Tavenner, Acting Adm'r, Ctrs. for Medicare and Medicaid Servs. (Sept. 4, 2012), http://www.ahcancal.org/facility_operations/medicare/Documents/AHCA%20Comment%20Letter%20on%20Observation%20Stays.pdf.

115. See *id.* (noting that the term “inpatient,” as applied in 1965, included every patient not receiving emergency care).

likely to be in the emergency department for longer than four to six hours, usually for conditions such as suspected appendicitis.¹¹⁶ If the patient was not subsequently admitted, this would be covered under Part B, as an outpatient service.¹¹⁷ The payment method in both cases was a traditional fee-for-service model.¹¹⁸

By the late 1980s, the dynamics within emergency departments was rapidly changing, but observation of unstable patients was still required in many cases. Studies consistently showed that the best place for observation was in the emergency department using an observation unit.¹¹⁹ In fact, in 1988, as numerous studies continued to show the efficacy of observation units attached to emergency departments, the American College of Emergency Physicians recognized and formalized the role of observation units connected to emergency departments by publishing Observation Unit Guidelines.¹²⁰

Changes to reimbursement methods that did not take into account the need to observe unstable patients led to some chaos. After the implementation of PPS and the increased role of managed care gatekeeping, it was an increasingly complex undertaking to admit patients to the hospital for observation since these patients did not usually have a diagnosis that would justify the admission. The need to prospectively justify the admission could make the whole method of differential diagnosis difficult to complete.

The warehousing of patients in emergency department hallways was caused not only by third-party payer reluctance to approve hospital admissions, but also by EMTALA. For patients who came to the emergency department, EMTALA required a certain level of care to be provided, that is, that the patient be stabilized.¹²¹ Observation status floats in a precarious limbo in relation to EMTALA precisely because observation is often called for when it is unclear whether the patient is stable. In other words, observation is sometimes necessary in order to identify whether a hospital would be violating EMTALA by releasing or

116. Baugh, Venkatesh & Bohan, *supra* note 49, at 29.

117. See Polzin, *supra* note 25, at 156 (“At first, observational stays were included generally as a type of outpatient service.”).

118. See *id.* at 151.

119. See Baugh, Venkatesh & Bohan, *supra* note 49, at 29.

120. *Id.* at 29–30.

121. Scaduto, *supra* note 76, at 950.

transferring a particular patient. Adding these patients to an already over-crowded department added to emergency department gridlock.

E. *Increased CMS Focus on Unnecessary Hospital Admissions*

Leaving aside managed care payers and focusing on Medicare, patients who had DRGs that would allow payment for hospital admissions were, of course, admitted to the hospital. Given the bundled nature of the payment, the hospital had a financial incentive to treat and release those patients as quickly as possible. After the introduction of PPS in the mid-1980s, the number of very short hospital stays began to increase. While a certain percentage of patients have always had short hospital stays, between 1990 and 1997, the number who were in the hospital for only one day prior to discharge increased by 57%.¹²² In August 2000, Medicare implemented a bundled payment system for outpatient care called Hospital Outpatient Prospective Payment System ("HOPPS").¹²³ This payment system, using Ambulatory Payment Classifications ("APC"), was similar to PPS. It initially folded observation care into a more general emergency department payment.¹²⁴ This created a strong financial incentive for hospitals to admit patients who were covered by Medicare and needed observation because there was no other way for hospitals to be paid for the observation care they were providing.¹²⁵ By 2002, 10% of all Medicare patients admitted to the hospital were released the next day.¹²⁶ This incentive structure was, in turn, quickly rectified at least partly by a new rule allowing (or restoring) emergency department billing for observation status for patients who had chest pain, asthma, and congestive heart failure.¹²⁷

122. Linda A. Baumann, *One Day Stays: The OIG's Next National Project?*, AHLA SEMINAR MATERIALS (2002), http://archive.healthlawyers.org/google/health_law_archive/program_papers/2002_MM/%5B2002_MM%5D%20ONE%20DAY%20STAYS-%20THE%20OIG's%20NEXT%20NATIONAL%20PROJECT.pdf ("[T]he number of one-day inpatient hospital discharges, as a percentage of total discharges increased 57% from 1990 to 1997; from 6.8 to 10.7 percent.")

123. See Medicare Program; Prospective Payment System for Hospital Outpatient Services; Delay of Effective Date, 65 Fed. Reg. 40,535 (June 30, 2000).

124. Baumann, *supra* note 122.

125. *Id.*

126. *Id.*

127. Medicare Program; Changes to the Hospital Outpatient Prospective Payment Sys-

Interestingly, while the 2002 CMS regulation that allowed payment for observation care is evidence of CMS recognizing the usefulness of observation, the new coverage policy did not require that patients be kept in observation units connected to emergency departments, which is what the research had focused on.¹²⁸ Instead, CMS created observation status, a strange middle reimbursement level for hospitals, where patients could be treated in any area of the hospital while being covered under Medicare Part B as outpatients.¹²⁹

The initial CMS coverage for observation care was limited to three conditions: chest pain, asthma, and congestive heart failure. This is particularly interesting because, although the three conditions chosen for coverage had been repeatedly shown to do well in EDOUs, there was no specific evidence as to patients with these conditions gaining any benefit from being under observation in traditional hospital wards. This was a missed opportunity for CMS to more pointedly encourage the development of observation units. Under the current rules, two Medicare beneficiaries could lie side by side in hospital beds, treated by the same nurses and doctors, and one would be covered under Medicare Part A and the other under Medicare Part B, with very different financial results for the hospital, the patients, and Medicare.

II. THE RAC: WHAT HAPPENS WHEN YOU INTRODUCE BOUNTY- INCENTIVIZED CLAIMS AUDITING TO HOSPITAL ADMISSIONS?

It is fair to say that, beginning in 2002, the specter of unnecessary hospital admissions caused great concern for CMS.¹³⁰ The sudden and large increase in patients with short-term admissions following CMS's attempt to create incentive structures to reduce hospital costs in turn caused CMS to have grave suspicions of the veracity of hospital billing processes. This suspicion appears to have led to CMS accepting more confrontational methods for reducing admissions while at the same time seeking to ensure, by the language in the regulations, that patients who needed to be admitted would receive the necessary care.

tem for Calendar Year 2002, 66 Fed. Reg. 59,856, 59,879 (Nov. 30, 2001).

128. *See id.*

129. *Id.*

130. *See* Baumann, *supra* note 122.

CMS's suspicions may not have been based on a clear picture of the dynamics within hospitals at that time. A more reasoned assessment, with the benefits of hindsight, shows hospitals and emergency departments to be somewhat less blameworthy. Consider again the hospital and emergency department from the early 1980s up to 2002. While the healthcare system played a significant role in creating and sustaining out-of-control inflation of healthcare spending, other changes were probably equally as responsible.¹³¹ Throughout this time, the system saw an increase in people living with chronic conditions that led to more patients with far more complex problems than had been seen in emergency departments before, a shift that is accepted as commonplace today but was straining resources at the time.¹³² Many of these people, in turn, had Medicare coverage.¹³³ The cost of employer-sponsored health insurance skyrocketed in the 1980s. For example, when costs of employer insurance increased by 23.5% between March 1982 and March 1983,¹³⁴ this led to a steady reduction in individuals with health insurance so that, as a study on this issue conducted by the Center for Disease Control in 2009 concluded, "[t]he percentage of persons under age 65 years with private coverage remained stable from 1968 to 1980 and then declined from 1980 to 2007."¹³⁵ People who did not have access to health care because they did not have health insurance turned to the emergency departments, which had to stabilize them under EMTALA.

131. Albert E. Schwenk, *Trends in Health Insurance Costs*, COMPENSATION & WORKING CONDITIONS 31, 32 (1996), <http://www.bls.gov/opub/mlr/cwc/trends-in-health-insurance-costs.pdf>.

132. Kenneth E. Thorpe & David H. Howard, *The Rise in Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity*, 25 HEALTH AFF. 378, 385–86 (2006), <http://content.healthaffairs.org/content/25/5/w378.full.html>.

133. *Id.* at 385.

134. Schwenk, *supra* note 131, at 31.

135. Cohen et al., *supra* note 55, at 4. The discussion that follows this statement is illuminating and worth including here:

During 1968–1980, the percentage of persons under age 65 years who had private coverage remained stable at about 79%, while the number with private coverage increased from 140.5 million to 154.1 million persons During 1980–2007, the percentage with private coverage declined steadily . . . [f]rom 1999 to 2007, the percentage of persons under age 65 with any private coverage declined at an average rate of more than 1% per year, to 67% in 2007 The downward trend in private coverage was driven in large part by a decline in employer-sponsored coverage. In 2007, 62% of persons reported employer-sponsored coverage, down from 71% in 1980.

Id.

At the same time, the methods available to control costs under the Medicare program are distinctly limited by its enabling act, thus limiting its ability to respond to complex scenarios as imaginatively as it might in an ideal scenario. First, Medicare is bound by the terms of the Medicare Act, which puts strict limits on its capacity to bargain.¹³⁶ Second, it is merely a payer, as opposed to either a healthcare provider or an owner of organizations that provide health care. Third, Medicare is an entitlement, meaning all beneficiaries have a legal right to have the Medicare system pay for Medicare's share of the health care to which they are entitled. It cannot simply go broke or cut back on what is promised.¹³⁷ The shift to bundled payments based on diagnosis codes could only be accomplished through an act of Congress amending the Medicare Act.

The introduction of both DRG-based payment and APC-based payment was for the purpose of creating a financial incentive structure for physicians and hospitals, in an effort by CMS to drive providers' decision making in specific directions.¹³⁸ It should not have been a surprise to the federal government that the responses to the incentive structures distorted behavior in ways that were neither foreseen nor beneficial to Medicare. However, the shift in payment methods and CMS's subsequent struggle to prevent healthcare providers from increasing the severity of patient diagnosis (upcoding) and ordering unnecessary hospital admissions has led to a strange, chaotic exercise in legislative and regulatory whack-a-mole resulting in the federal government seemingly ignoring the truly difficult challenge of running a modern emergency department and viewing doctors and hospitals as, if not the enemy, certainly not colleagues in the same undertaking.

136. Fox, *supra* note 51, at 5.

137. This is not meant to imply that Medicare is not a creature of statute. Were Congress and the President to amend or repeal Medicare, it would, of course, be changed. Absent this type of activity, CMS and its predecessor agencies have limited avenues for achieving cost control.

138. See Baumann, *supra* note 122.

A. *Modern Regulatory Efforts to Differentiate Between Observation and Admission Status*

Before 2002, CMS recognized that there was a problem with overuse of hospital admissions.¹³⁹ The CMS manuals, which governed both when admission and outpatient care—including observation—were appropriate, were vague.¹⁴⁰ The language was extremely circular.¹⁴¹ Much was left to the doctor's discretion, though it was important that she chart the appropriate analytic steps in her decision-making process.¹⁴² A particular area of confusion was the effect of the length of stay on Medicare coverage. In general, observation care was meant to be short, somewhere between eight and twenty-four hours, whereas admissions could be contemplated for hospital stays that were anticipated to be longer than twenty-four hours. However, while this was implied in coverage manuals, there was also language clarifying that these were not binding rules governing the appropriate level of care.¹⁴³

In 2000, the Health and Human Services (“HHS”) Office of the Inspector General (“OIG”) began to formally identify and investigate hospitals with a pattern of billing Medicare for admissions of less than one day.¹⁴⁴ The OIG believed that hospitals were manipulating the billing process and sought to prove that many of the

139. See generally *id.* (discussing the OIG's investigation of “one-day hospital stays” and the abuse of hospital admissions).

140. For inpatient admissions, see Medicare Intermediary Manual, HCFA-Pub. 13 ((MIM)) § 3101; Hospital Manual, HCFA-Pub. 10 ((HM)) § 210. For outpatient observation care, see MIM, § 3112.8; HM § 230.6.

141. “Th[e] definition of ‘inpatient’ is maddeningly circular—it provides that an ‘inpatient’ is one who has been admitted for purposes of receiving ‘inpatient hospital services’ and provides further that a person is ‘generally’ ‘considered an inpatient’ if he has been ‘formally admitted as an inpatient.’” Health Care Compliance Adviser, *OIG Focus on One-Day Inpatients and Combined Admissions*, JONES DAY 1, 1 [hereinafter Healthcare Compliance Adviser], <http://www.jonesday.com/oig-fo-cus-on-one-day-inpatients-and-combined-admissions-11-11-2002/> (last visited Dec. 1, 2015).

142. See Baumann, *supra* note 122.

143. See *id.*

144. JUNE GIBBS BROWN, DEPT OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GEN., WORK PLAN: FISCAL YEAR 2000 1 (2000), <http://oig.hhs.gov/publications/docs/workplan/2000/workpl.pdf>. For a discussion of this process, see Healthcare Compliance Adviser, *supra* note 141, at 1–2. The OIG did not designate this as a “national project” but included it in its work plan. *Id.* at 1. Contemporary discussions about this development seem to have occurred primarily in health law practitioner journals of that time.

short admissions were, in effect, Medicare fraud.¹⁴⁵ Working with the Justice Department, the OIG was successful in reaching a settlement under the False Claims Act against a handful of hospitals in New Jersey.¹⁴⁶ The OIG was also investigating hospitals in a number of other states and sought to spread the investigations across the country.¹⁴⁷ The focus on short hospital stays was arguably a sensible one since those short stays were often retroactively found to have not required hospital admission. But many hospital administrators felt it was unfairly punitive since it was often difficult to know prior to admission what the patient prognosis was.

To further complicate matters, Medicare had a system whereby it reviewed claims, often retrospectively, using private insurance companies known as Medicare Administrative Contractors (“MACs”) to process claims.¹⁴⁸ These companies imposed bright-line rules regarding length of hospital stays so that, even though the Medicare manuals specifically did not commit to requiring hospital admissions to be for longer than twenty-four hours, claims were being denied in some areas of the country based on this reasoning.¹⁴⁹ At first, HHS OIG audits involved a statistical approach.¹⁵⁰ If the rough numbers of a hospital’s admissions history implied a pattern, fines were applied with limited or no appeals process to seek recourse for errors.¹⁵¹ It was eventually widely recognized as an imprecise process that often led to unfair and incorrect results.¹⁵² In the rare cases where actual audits were conducted, they were paper-based, took an extraordinary amount of time, and were cumbersome for the providers.¹⁵³ These audits often showed how imprecise the statistical assumptions were. The main focus of the statistical audits was on admissions that lasted less than twenty-four hours, even though CMS rules

145. Healthcare Compliance Adviser, *supra* note 141, at 1–2.

146. *Id.* at 2.

147. *Id.*

148. 42 U.S.C. § 1395kk-1 (2012).

149. Healthcare Compliance Adviser, *supra* note 141, at 2.

150. *Id.* at 1–2.

151. *See id.* at 2 (discussing recommended actions hospitals can take to defend themselves during an OIG fraud investigation).

152. *Id.* at 4.

153. *Id.*

did not in fact prohibit them.¹⁵⁴ Other admissions were only subject to scrutiny in the paper-based audits.¹⁵⁵

B. *The RAC: A CMS Program That Exacerbated Problems with Observation Status*

In 2003, CMS found that the limited auditing it was doing revealed errors in Medicare billing at a rate between 6% and 10% and that the program was inappropriately paying out billions of dollars a year.¹⁵⁶ In the same year, in an effort to control this problem, Congress directed CMS to begin a three-year pilot program of auditing all Medicare billing.¹⁵⁷ In an effort to have precise and accurate determinations about whether admissions complied with the rules governing coverage, this pilot program planned to utilize private contractors whose audits would be financed through a bounty system.¹⁵⁸ The audits would cover all actual claims submitted for Medicare reimbursement in two states.¹⁵⁹ Given the sheer number of claims, the system promised to be highly labor intensive.

The idea to use private contractors who worked for bounties was highly attractive for a number of reasons. First, under the terms of the agreements with the private companies, the auditors would be tasked with finding over- and under-billing problems,¹⁶⁰ a pleasantly neutral sounding proposition. In truth, however, the incentive structure tilted towards finding overpayments as the auditors would only be “compensat[ed] . . . through retention of a percentage of the overpayment recoveries.”¹⁶¹ The auditors would be empowered to directly recover the overpayments,¹⁶² but could

154. *Id.* at 1–2.

155. *See id.* at 2–3.

156. Medicare Learning Network, *MMA—The Centers for Medicare & Medicaid Services (CMS) Recovery Audit Contract (RAC) Initiative*, MLN MATTERS 1 (Mar. 29, 2013) [hereinafter MLN MATTERS], <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0469.pdf>.

157. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 306, 117 Stat. 2066, 2256.

158. *Id.* § 306(a)(1), 117 Stat. at 2256.

159. *Id.* § 306(b), 117 Stat. at 2256.

160. *Id.* § 306(a), 117 Stat. at 2256.

161. MLN MATTERS, *supra* note 156, at 2.

162. Including having the ability to charge interest to hospitals for any overpayments not refunded within thirty days of notification. *Id.*

only refer underpayment problems to the original Medicare claims processor.¹⁶³ Second, at that time, it was politically attractive to use non-government private contractors to handle historically governmental tasks.¹⁶⁴ This was not limited to health care. For example, the ongoing war in Iraq at the time utilized private contractors to an unprecedented degree.¹⁶⁵ Third, the use of what are in effect bounty payments as the sole source of funding allowed for the creation of a labor-intensive audit process without significant federal spending.¹⁶⁶ This third reason is premised on the auditors finding significantly more over-billing than under-billing, which has been the pattern.¹⁶⁷

Through the pilot program, CMS selected the RACs.¹⁶⁸ The RAC demonstration was designed to perform audits of billing after all other CMS cost-control provisions had been applied.¹⁶⁹ To do that, the RACs had to wait a minimum of one year after all regular payment processes had been completed.¹⁷⁰ When the program initially began, RACs could audit claims up to four years old, but this was subsequently changed to three years midway through the pilot program.¹⁷¹ In order to thoroughly audit hospital claims, the RACs were given the power to request all claims information from MACs, the regional companies that handled the claims processing for the Medicare program.¹⁷² RACs could also

163. *Id.*

164. See Marsha Gold, *Private Plans in Medicare: Another Look*, MKT. WATCH 1302, 1302 (2005).

165. For a contemporary study of the use of private contractors during the United States war in Iraq during this time, see Peter W. Singer, *Outsourcing War*, BROOKINGS INST. (2005), <http://www.brookings.edu/research/articles/2005/03/01usdepartmentofdefense-singer>.

166. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 306(a)(1), 117 Stat. 2066, 2256.

167. This article uses the phrase “bounty” purposefully. Recent scholarship by Nicholas R. Parrillo examines the rejection of government-sanctioned bounty hunting in the United States due to negative experiences with it. In his book, *Against the Profit Motive*, he gives numerous examples of these problems in a time spanning 1780 to 1940. The book effectively savages the use of such programs, and the RAC fits squarely within his definition. See NICHOLAS R. PARRILLO, *AGAINST THE PROFIT MOTIVE: THE SALARY REVOLUTION IN AMERICAN GOVERNMENT, 1780-1940* (2013).

168. THE MEDICARE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM: AN EVALUATION OF THE 3-YEAR DEMONSTRATION 7 (2008) [hereinafter RAC DEMONSTRATION], <http://yalepress.yale.edu/book.asp?isbn=9780300176582>.

169. See *id.* at 11.

170. MLN MATTERS, *supra* note 156, at 2.

171. See RAC DEMONSTRATION, *supra* note 168, at 3.

172. See *id.* at 1; CTRS. FOR MEDICARE & MEDICAID, RECOVERY AUDITING IN MEDICARE

request patient files from the providers.¹⁷³ In the pilot program, if overpayments were found, healthcare providers were entitled to appeal the finding to the MACs.¹⁷⁴

The multi-year window for reviewing claims created substantial financial risk for healthcare providers in the pilot program.¹⁷⁵ Prior to the implementation of the RAC program, Medicare had a legal obligation to pay claims in a timely manner.¹⁷⁶ While fraud investigations could result in those payments being recovered, generally, Medicare could assure hospitals of payment within thirty days of patient care being provided.¹⁷⁷ After RAC program implementation, these payments could be recovered years after they had been paid.¹⁷⁸

The pilot program quickly made money for CMS.¹⁷⁹ Over the two-and-one-half year pilot, RACs recovered over \$1 billion.¹⁸⁰ Most impressively, after a relatively slow start during the months after implementation, with only 4% of the final reimbursement dollars being collected in 2006, 62% of the money was collected in the first six months of 2008.¹⁸¹ During this pilot program, 14% of RAC determinations of overbilling were appealed to the MACs and one-third of those appeals were successful.¹⁸² The RACs were required to reimburse CMS for any bounties that had been paid on the determinations that were overturned on the first level of appeal.¹⁸³ Finally, CMS found that the RACs earned one dollar for

FOR FISCAL YEAR 2013, at v (2014), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY-2013-Report-To-Congress.pdf>.

173. See RAC DEMONSTRATION, *supra* note 168, at 12.

174. See MLN MATTERS, *supra* note 156, at 2.

175. See RAC DEMONSTRATION, *supra* note 168, at 20, 25.

176. See CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE CLAIMS PROCESSING MANUAL § 30.3.12 (2015), <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf>.

177. See *id.* at § 80.2.1.1.

178. 42 U.S.C. § 1395ddd(f)(1)(A) (2012).

179. See RAC DEMONSTRATION, *supra* note 168, at 2.

180. See *id.* at 2, 15.

181. See *id.* at 2, 34.

182. See *id.* at 2, 20.

183. See *id.* at 20.

CMS for every twenty cents that was spent, making it extremely cost-effective.¹⁸⁴

C. *The National Expansion of the RAC Program*

In light of the cost savings that the federal government almost immediately realized, coupled with the revenue-neutral financing mechanism for the program (i.e., the contractors were paid through bounties rather than tax revenue), the pilot program did not go for the full three years before it was expanded nationally.¹⁸⁵ Congress passed a law expanding the RAC program in 2006 for implementation by 2010.¹⁸⁶ Since the beginning of the pilot program, the RAC concept has not been substantially altered in terms of its goals or financing mechanism.¹⁸⁷ The pilot program and expansion were created during a Republican presidential administration and a Democrat-controlled Congress, and maintained and expanded during a Democrat presidential administration and a Republican-controlled Congress.¹⁸⁸ It is fair to say that this program is not a partisan political issue, making it an ideal pilot program to examine. In 2013, the RAC program recovered almost \$4 billion, resulting in returns of over \$3 billion to the Medicare program.¹⁸⁹ From a financial perspective, the expansion of the program has been a success for CMS.

184. *See id.* at 3.

185. *See id.* at 54; *see also* 42 U.S.C. § 1395ddd(h)(1)(B)(3) (2012).

186. Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 302, 120 Stat. 2922, 2991–92 (codified at 42 U.S.C. § 1395ddd (2012)).

187. *Compare* 42 U.S.C. § 1395ddd (2012) (explaining the Medicare Integrity Program, and in order to recover overpayments, the Secretary shall enter into a plan with the provider for the purposes of repayment), *and* MLN MATTERS, *supra* note 156, at 2 (providing details about the RACs pilot program and mentioning that the collection policies to be applied will be the same as those currently in effect), *with* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 306, 117 Stat. 2256 (explaining a demonstration project to explore the use of RACs to recoup overpayments under the Medicare Integrity Program).

188. *Presidents and Vice-Presidents of the United States*, ABOUT.COM AMERICAN HISTORY, <http://americanhistory.about.com/library/charts/blchartpresidents.htm> (last visited Dec. 1, 2015); *Visual Guide: The Balance of Power Between Congress and the Presidency (1945–2015)*, WIREDPEN, <http://wiredpen.com/resources/political-commentary-and-analysis/a-visual-guide-balance-of-power-congress-presidency/> (last visited Dec. 1, 2015).

189. CTRS. FOR MEDICARE & MEDICAID SERVS., RECOVERING AUDITING IN MEDICARE FOR FISCAL YEAR 2013, at iv, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY-2013-Report-To-Congress.pdf>.

This article focuses primarily on Medicare Parts A and B, particularly the auditing of hospitals' admissions and observation stays, which have been particularly problematic. However, the problems with the RAC program are far more widespread than this one example. Currently, including the expansion of the program that was included in the Affordable Care Act,¹⁹⁰ the bounty-based audit program covers all Medicare components, including Medicare Parts A, B, C, and D.¹⁹¹ Furthermore, the states must use RACs for Medicaid.¹⁹² The current audit program has considerable breadth.¹⁹³

During the initial phase of the expansion and up until very recently, the RACs have been fairly similar to what they were in the initial pilot program. The RACs audit Medicare admission claims to determine if incorrect coding was used for patient care.¹⁹⁴ If they find an incorrect coding, the amount paid to the hospital or physician is corrected according to the RAC finding.¹⁹⁵ The RAC auditors are still paid by a bounty system.¹⁹⁶ They are

190. Expansion of the Recovery Audit Contractor (RAC) Program, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6411, 124 Stat. 119 (2010).

191. Ctrs. for Medicare & Medicaid Servs., *Parts C and D Recovery Audit Program*, CMS.GOV (May 22, 2012), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/> (discussing the RAC program's implementation for Medicare parts A, B, C, and D).

192. *Id.*

193. CTRS. FOR MEDICARE & MEDICAID SERVS., IMPLEMENTATION OF RECOVERY AUDITING AT THE CENTERS FOR MEDICARE & MEDICAID SERVICES: FY 2010 REPORT TO CONGRESS AS REQUIRED BY SECTION 6411 OF AFFORDABLE CARE ACT, at iii, v (2011), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/downloads/fy2010reportcongress.pdf>. The CMS proposed regulations of July 1, 2015 do alter the program's reach, in that it would no longer perform audits of observation of admission claims. Ctrs. for Medicare & Medicaid Servs., *Fact Sheet: Two-Midnight Rule*, CMS.GOV (July 1, 2015) [hereinafter *Fact Sheet: Two-Midnight Rule*], <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-07-01-2.html>.

194. RAC DEMONSTRATION, *supra* note 168, at 1.

195. See CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE FEE-FOR-SERVICE RECOVERY AUDIT PROGRAM MYTHS 1-3 (2012), <https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/recovery-audit-program/downloads/rac-program-myths-12-18-12.pdf>; *Frequently Asked Questions about Medicare Recovery Audit Contractors (RACs)*, MED. GRP. MGMT. ASS'N, <http://www.mgma.com/government-affairs/issues-overview/compliance/racs-recovery-audit-contractors/faqs-about-racs> (last visited Dec. 1, 2015).

196. AM. HOSP. ASS'N, FACTS ABOUT THE MEDICARE AUDIT IMPROVEMENT ACT OF 2013 (H.R. 1250/S. 1012) (2014).

also meant to identify common errors in billing to facilitate system improvement and communicate the common errors to both the provider and CMS.¹⁹⁷

There are now two levels of appeal conducted through the supervision of the MAC for medical service providers who have been found to be in error by a RAC. After these appeals have been exhausted, an appellant has recourse to a hearing before an Administrative Law Judge (“ALJ”).¹⁹⁸ This decision can, in turn, be appealed to a Medicare panel and, finally, to a federal district court.¹⁹⁹

Even though the appeals process is cumbersome and time consuming for appellants, enough appeals have proceeded to expose significant rates of error in the RAC system. According to data released by CMS, on average, since the program became national in 2010, a minimum of 50% of third-level appeals before an ALJ from hospitals challenging a denial have been found entirely in favor of the hospital.²⁰⁰ The American Hospital Association collects data regarding RAC audits from their members. According to their statistics, hospitals appeal 44% of all RAC denials.²⁰¹ Of appeals that have been through the process, 73% have been overturned at some level.²⁰² However, due to the backlog of appeals, which have yet to be heard and have quickly accumulated since the RAC program was expanded in 2010, 44% of all appeals are still awaiting resolution.²⁰³ Looked at in the light most favorable for RACs, given the extraordinary number of claims audited by RACs, some error is likely, and appeals allow for a process where legitimate concerns can be heard and responded to. However, the

197. *See Recovery Audit Program*, CMS.GOV, <https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/> (last visited Dec. 1, 2015).

198. DEP’T OF HEALTH & HUMAN SERVS., MEDICARE PARTS A & B APPEALS PROCESS 1 (2015), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsprocess.pdf>.

199. *Id.*

200. DANIEL R. LEVINSON, DEP’T OF HEALTH & HUM. SERVS., IMPROVEMENTS ARE NEEDED AT THE ADMINISTRATIVE LAW JUDGE LEVEL OF MEDICARE APPEALS 9 (2012), <http://oig.hhs.gov/oei/reports/oei-02-10-00340.pdf>.

201. AM. HOSP. ASS’N, EXPLORING THE IMPACT OF THE RAC PROGRAM ON HOSPITALS NATIONWIDE 4 (2015) [hereinafter EXPLORING THE IMPACT], <http://www.aha.org/content/15/15q1ractracresults..pdf>.

202. *Id.*

203. *Id.*

true success rates of appeals are unclear. The backlog of appeals before ALJs has reached over one million, with wait times estimated at 541 days for appeals filed in 2015.²⁰⁴

D. *The Medical Community and the RAC*

The perspective from the medical community is quite different from that of CMS. It is fair to generalize that, from the hospital perspective, RACs have been a mess. For hospitals, the program has been extremely costly, time consuming, and frightening. According to American Hospital Association data, a majority of hospitals spend at least \$40,000 a year on managing RAC processes, with a third of hospitals spending at least \$100,000.²⁰⁵ The RAC program's success has encouraged other third-party payers to become increasingly aggressive with regards to challenging physician decisions to admit patients, which also adds to hospital administrative burdens.²⁰⁶ Finally, the wrangling about observation status has intruded deeply into the physician-patient relationship, influencing treatment decisions in ways that can have a negative impact on patient outcomes and patient financial status.²⁰⁷

The reason admission and observation status is a particularly difficult area for RAC audits goes back to the continual problem of the medical complexity inherent in determining whether a patient should be in observation status or admitted. These decisions cannot be reduced to a simple rubric when one is faced with situations involving sick patients who do not have a clear, obviously admission-worthy illness. The Medicare program has found it impossible to define these statuses with any clarity, leaving the fi-

204. *Medicare Appellant Forum Recap: OMHA Overwhelmed with Appeals Backlog, Providers Will Wait Close to 3 Years for a Hearing*, HANCOCK, DANIEL, JOHNSON & NAGLE, P.C. (Feb. 21, 2014), http://www.hdjn.com/pdfs/advisories/2014/ClientAdvisory-MedicareAppellantForumRecap_OMHAOverwhelmedWithAppealsBacklog2.21.14.pdf; *Adjudication Timeframes*, HHS.GOV (Apr. 29, 2015), http://www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html.

205. Mark Taylor, *Whacked by RAC*, HH&N DAILY (Jan. 14, 2014), <http://www.hhnmag.com/articles/5303-whacked-by-rac>.

206. See AM. HOSP. ASS'N, HOSPITAL SURVEY REPORT: THE REAL COST OF THE INEFFICIENT MEDICARE RAC PROGRAM, <http://www.aha.org/content/15/hospurveyreport.pdf> (last visited Dec. 1, 2015).

207. KEITH D. LIND ET AL., OBSERVATION STATUS: FINANCIAL IMPLICATIONS FOR MEDICARE BENEFICIARIES 1 (2015), <http://www.aarp.org/content/dam/aarp/ppi/2015/Hosp%20Obs%20Financial%20Impact%20Paper.pdf>.

nal decision up to the treating physician. After the fact, it can be relatively easy to see whether admission was necessary, but the initial decision has to be made with imperfect knowledge.

The absence of clarity while the decision is being made, the relative obviousness of the outcome after the fact, and the lack of clear safe harbors in Medicare rules make short-term hospital admissions a soft target, attracting attacks by auditors who are paid by commission or bounty. Add to this the burdensome appeals process faced by healthcare providers and one can see that the incentives are in place for RACs to focus on challenging short hospital admissions. The number of denials for these types of cases is significant. According to data collected by the American Hospital Association, in the third quarter of 2014, 23% of all RAC denials were related to admission status for hospital stays of less than forty-eight hours.²⁰⁸

There are numerous examples of problems that have arisen in this area. Claims for hospital admissions must be submitted to Medicare within 120 days of the patient's treatment.²⁰⁹ The RACs audit claims long after this window has closed. For a number of years, if the RAC determined that a patient should have been placed in observation status rather than admission, the hospital would be forced to return the admission payment but would be precluded from collecting any payment for the observation care that was provided because the claim was not properly filed within the initial time frame.²¹⁰ CMS is currently seeking to fix this problem, but the initial result was to put more pressure on hospitals to shift patients from admission to observation status.²¹¹

Risk-averse hospitals have been shifting patients from admission to observation status²¹² in order to avoid audit problems, and this, in turn, has had negative financial and health outcome ef-

208. EXPLORING THE IMPACT, *supra* note 201, at 19.

209. DEP'T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE APPEALS 10 (2015).

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

211. Susan Jaffe, *FAQ: Hospital Observation Care Can Be Costly for Medicare Patients*, KAISER HEALTH NEWS (June 18, 2014), <http://khn.org/news/observation-care/faq/>.

212. For a discussion of the increase in Medicare patients in observation, see Feng, Wright & Mor, *supra* note 13.

fects on patients.²¹³ In a 2013 testimony before the Senate Committee on Finance, the Center for Medicare Advocacy presented detailed data about this problem.²¹⁴ In brief, if a patient receives care under observation, the care is covered under Medicare Part B, which provides for outpatient care.²¹⁵ For an admission, the care is covered under Medicare Part A, which has much more generous benefits.²¹⁶ Under Part B, the patient must make co-payments for every service billed, resulting in far higher out-of-pocket payments than would be required for the exact same care under Part A.²¹⁷

Perhaps more important than reimbursement rates, many Medicare beneficiaries require lengthy acute-skilled nursing home treatment when they are released from the hospital, and coverage for this depends on the patient's hospital status.²¹⁸ If a patient is an admission and stays for at least three days, Medicare Part A covers skilled nursing home care.²¹⁹ On the other hand, if the patient is in observation status, there is no coverage under Medicare Part B for skilled nursing home care.²²⁰ The costs for skilled nursing home care can be many thousands of dollars a month.²²¹ Many patients do not find out about these financial issues until after their release to the skilled nursing home, leading to numerous instances of significant financial strain.²²²

213. Debra Wood, *Admit or Observe: Where Do We Go from Here?*, AMN HEALTHCARE (Mar. 15, 2014), <https://www.amnhealthcare.com/latest-healthcare-news/admit-or-observe-where-do-we-go-from-here/>.

214. *Program Integrity: Oversight of Recovery Audit Contractors: Hearing Before the S. Comm. on Fin.*, 113th Cong. 69–71 (2013) (statement of the Center for Medicare Advocacy, Inc.). The challenges for patients in observation status have been discussed at length in scholarly articles. This article recognizes that this is a significant facet of the problem with the distinction between admission and observation status. For an in-depth examination of this, see Parker, *supra* note 28.

215. DEPT OF HEALTH & HUM. SERVS., ARE YOU A HOSPITAL INPATIENT OR OUTPATIENT? (2014), <http://www.medicare.gov/Pubs/pdf/11435.pdf>.

216. *Id.*

217. *Id.*

218. Parker, *supra* note 28, at 94.

219. *Id.*

220. *Id.* at 94–95.

221. METLIFE, MARKET SURVEY OF LONG-TERM CARE COSTS: THE 2012 METLIFE MARKET SURVEY OF NURSING HOME, ASSISTED LIVING, ADULT DAY SERVICES, AND HOME CARE COSTS 5 (2012), <https://www.metlife.com/assets/cao/mmi/publications/studies/2012/studies/mmi-2012-market-survey-long-term-care-costs.pdf>.

222. CMS has made efforts to explain this situation to patients. The explanations are extremely complex and unclear, reflecting the general inability of the healthcare system to

In a comment letter sent to CMS in 2012, the American Healthcare Association did an excellent job of pointing out that the three-day in-patient stay trigger for skilled nursing home coverage is part of the original Medicare Act of 1965, drafted when observation status did not exist.²²³ The letter asked CMS to allow all stays in the hospital to count towards the three-day requirement for skilled nursing care coverage.²²⁴ The Medicare Act, as originally drafted, does not envision this problem, and the current financial penalty for patients appears to have developed by happenstance rather than coherent legislative intent. The lack of governmental process in the development of this significant financial burden makes it appear terribly unfair. The problem still remains unresolved.

E. Change, Yet Again: Abandoning the RAC for Observation and Admission Review

In 2013, CMS proposed a new regulation in an effort to clarify observational status.²²⁵ This regulation, the Two Midnight Rule, did not calm the situation, but rather seemed to have created a flash point for the frustration experienced by various stakeholders who grapple with RAC audits, patient costs, and hospital administrative burdens.²²⁶ The rule created a presumption that patients who needed to stay in the hospital for more than forty-eight hours should have admission status, though a physician was required to certify the medical necessity of that stay.²²⁷ The rule also implied that stays that were shorter than forty-eight hours would presumptively be observation stays.²²⁸ It did not sufficiently clarify how hours in the hospital were to be counted. For example, would time spent in the emergency department prior to admis-

clearly delineate when observation or admission status is appropriate. *See, e.g., Find out if You're an Inpatient or an Outpatient—It Affects What You Pay*, MEDICARE.GOV, <https://www.medicare.gov/what-medicare-covers/part-a/inpatient-or-outpatient.html> (explaining the different scenarios that could affect patients' benefits).

223. Letter from Elise Smith to Marilyn Tavener, *supra* note 114.

224. *Id.*

225. Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System, 78 Fed. Reg. 50,496, 50,506 (Aug. 19, 2013) (to be codified at 42 C.F.R. pt. 412, 413, 414, 419, 424, 482, 485 & 489).

226. *See* Wood, *supra* note 213.

227. Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System, 78 Fed. Reg. at 50,506.

228. *Id.* at 50,746.

sion count towards forty-eight hours? The rule appeared to create the possibility that a patient could be charged for observation status, including responsibility for skilled nursing care, while the hospital could be reimbursed for an admission.

The uproar over the Two Midnight Rule eventually resulted in Congress passing a law to delay its implementation.²²⁹ After passing this legislation, Congress sent a letter to CMS expressing its concern about observation status.²³⁰ In it, more than one hundred members of Congress state “[W]e are concerned that Medicare beneficiaries could assume a higher financial burden for their care under the new policy. Additionally, we are concerned that hospitals in our districts could be undercompensated for providing medically necessary services that do not meet the new criteria spelled out by CMS”²³¹

In July 2015, CMS shifted its position. First, it made a clear statement that it intended to allow admission status when a physician believes that a patient requires a hospital stay of longer than forty-eight hours, even if subsequent events such as patient death, clinical improvement, or a patient leaving against medical advice, reduce the time a patient actually spends in the hospital.²³²

Second, it announced that RACs, would no longer conduct the majority of reviews of admission and observation statuses, but rather Quality Improvement Organizations would assume this role.²³³ These organizations are radically different from RACs. They are groups made up of consumer representatives, healthcare provider representatives, and related people.²³⁴ While they are paid for their work, they do not receive any financial incentive to deny claims or to achieve any other outcome.²³⁵

229. Extension of Two-Midnight Rule, Pub. L. No. 113-93, § 111, 128 Stat. 1040, 1044 (2014).

230. Letter from 109 Members of Congress Representing Both Parties, to Marilyn Tavenner, Adm’r, Ctrs. for Medicare & Medicaid Servs. (Sept. 24, 2013).

231. *Id.*

232. *Fact Sheet: Two-Midnight Rule*, *supra* note 193.

233. *Id.*

234. *Quality Improvement Organizations*, CMS.GOV (Aug. 3, 2015), <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityimprovementorgs/index.html>.

235. See Letter from Robert McLean, Chair, Med. Practice and Quality Comm., Am. Coll. of Physicians, to Andy Slavitt, Acting Adm’r, Ctrs. for Medicare & Medicaid Servs.

Finally, it clarified how it would handle patient stays that are less than forty-eight hours and thus are not subject to a rule presumptively allowing admission.²³⁶ The primary determination will be the opinion of the treating physician as to whether admission is necessary.²³⁷ However, the determinations will be considered on a case-by-case basis, subject to a medical necessity review (presumably conducted by the Quality Improvement Organizations).²³⁸ In particular, the rule seems to imply that stays of less than twenty-four hours will be examined closely to see if the admission is justified.²³⁹

CMS's new policy may calm the waters troubled by the Two Midnight Rule and—by removing RAC auditors from this area—may lessen the adversarial tension between caregivers and Medicare. However, if the new regime develops its own problematic enforcement culture, the same problems that have plagued observation status will continue. Furthermore, the proposal does not fix the financial problems that patients face as a result of what must appear to them to be an arbitrary decision-making process. From a patient perspective, two patients in beds in the same ward with the exact same nurses and doctors can be treated very differently from a financial perspective.

This case study began in emergency departments, and it seems fitting to return to them in its conclusion. In 2016, how does an emergency department respond to patients in light of the confusion regarding observation status, the high stakes hospitals face, and the need to provide a high level of care to ever increasing numbers of increasingly sick patients?

The Pope Francis Emergency Department of Providence Hospital in Washington, D.C., graciously allowed the author of this article to spend a shift there in the summer of 2015.²⁴⁰ In order to ensure that all patient claims are properly given observation or admission status, the Emergency Department has two nurses whose full-time job is to review all claims before they are submit-

(Aug. 6, 2015).

236. *Fact Sheet: Two-Midnight Rule*, *supra* note 193.

237. *Id.*

238. *See id.*

239. *See id.*

240. Interview with Various Emergency Room Doctors, Providence Hosp. in Washington, D.C. (May 11, 2015) (interview notes on file with author).

ted in order to ensure that the status is proper.²⁴¹ To do this, the nurses use a series of computer programs—some provided by the government, some provided by national organizations, and some licensed to the hospital—that allow them to analyze the medical records of the patients to determine which status is appropriate.²⁴² The hospital also contracts with a review organization that gives a second read to any claims that the nurses are unsure about.²⁴³

What was most interesting about the process for internally reviewing claims was how the nurses view it as an opportunity to ensure high levels of quality in patient care. If a patient appears to have a condition that would justify admission but the doctor has not ordered it, the nurse will go over the medical records, check the diagnostic procedures that were recorded in the notes, and seek out the doctor to clarify the orders.²⁴⁴ The nurses also consult quality checklists to see if any appropriate steps have been skipped in a patient's care.²⁴⁵ The nurses were comfortable asking doctors to change admission to observation status if it seemed necessary for reimbursement.²⁴⁶ If the doctor agreed with the nurse who approached her, the orders would be changed.²⁴⁷ It was surprisingly serene when experienced against the backdrop of the systemic tension surrounding these issues.

It is odd, when one considers the historical antecedents to the current situation, to see how it is currently playing out. In 1965, observation was used in emergency departments to assess patients whose prognosis was unclear.²⁴⁸ Currently, third-party payers use observation status to reduce the costs of medical care, and the concept has become increasingly detached from its clinical roots.²⁴⁹ Hospitals, in turn, are trying to manage the current pay-

241. *Id.*

242. *Id.*

243. *Id.*

244. *Id.*

245. *Id.*

246. *Id.*

247. *Id.*

248. Robbin Dick, *Medicare Rule Requiring 3-Day Inpatient Stay as Condition for Skilled Nursing Care Dates to 1965*, MEP HEALTH (Mar. 27, 2014), <http://www.mephealth.com/the-shift/the-shift/hospital-partnership/medicare-rule-requiring-3-day-inpatient-stay-condition-skilled-nursing-care-dates-1965/>.

249. *Id.*

ment system in a manner that protects their financial well-being and improves patient care.

III. A THEORETICAL FRAMEWORK FOR EFFECTIVE INCREMENTAL HEALTHCARE REFORM

It would be helpful at this stage in healthcare reform to clarify societal goals ground expectations within a framework that acknowledges immutable characteristics of the system, and plan in such a way that the developing system anticipates and nimbly responds to the problems that will continuously arise. This is not an impossible task, but it does require a certain degree of modesty in expectations and a willingness to refrain from blame.

A. *Avoiding Heightened Rhetoric, Moving Towards Reflective Equilibrium*

Currently, public discussions about healthcare reform commonly take two paths, neither of which is especially useful. The first, and most colorful, is fraught with apocalyptic accusations. For example, those opposed to healthcare reform claim that current laws or proposals empower untrained shadow figures who, motivated by nothing but evil, seek to slay the elderly and vulnerable.²⁵⁰ This is often contrasted with a description of the current system where loving, happy families generally enjoy health and the best healthcare system the world has to offer.²⁵¹ The rhetoric against those who oppose healthcare reform is also extremely heightened, often containing accusations of a cold-blooded absence of concern for those who suffer illness or pain.²⁵²

250. See, e.g., Sarah Palin, *Statement on the Current Health Care Debate*, FACEBOOK (Aug. 7, 2009, 4:26 PM), <https://www.facebook.com/notes/sarah-palin/statement-on-the-current-health-care-debate/113851103434> (“[W]ho will suffer the most when they ration care? The sick, the elderly, and the disabled of course . . . [s]uch a system is downright evil.”).

251. See, e.g., Leigh Ann Caldwell, *Boehner Defends Romney’s Critique of Individual Mandate*, CBS NEWS (July 1, 2012), <http://www.cbsnews.com/news/boehner-defends-romneys-critique-of-individual-mandate/> (stating that healthcare reform “will bankrupt our country and ruin the best healthcare delivery system in the world”).

252. For an excellent discussion of the heightened rhetoric in healthcare reform, see Elizabeth Weeks Leonard, *Death Panels and the Rhetoric of Rationing*, 13 NEV. L. J. 872 (2013).

The second, less rhetorically vehement approach is still problematic. Perhaps in an effort to persuade the political system to move in a positive direction, policy makers and politicians often present a proposed healthcare system reform as though it will solve once and for all serious and intractable problems.²⁵³ Counter-proposals are presented in a similar manner. The language focuses on what will be fixed, leaving out compromises, burdens, and difficult choices that remain.²⁵⁴ In seeking to simplify political decisions, this form of debate avoids the serious moral and structural challenges that the healthcare system is actively grappling with on any given day and will continue to grapple with into the foreseeable future.²⁵⁵

It appears that the politics of healthcare reform often devolve into a ludicrous display, leaving those who work in healthcare policy torn between irritation and despair. The heightened rhetoric used by many of those who speak about reform seems to promise perfection and destruction in equal parts.²⁵⁶ In response to these promises and threats, one can imagine that those who must interact with the healthcare system (almost everyone) grapple with confusion, elation, and terror. These emotions are closely followed by vague disappointment as neither their greatest hopes

253. Laxmaiah Manchikanti et al., *Patient Protection and Affordable Care Act of 2010: Reforming the Health Care Reform for the New Decade*, 14 PAIN PHYSICIAN E35, E36 (2011).

254. *See id.*

255. For example, proponents who supported the expanded availability of health insurance under the Affordable Care Act focused on access to insurance, but did not directly address the increase in cost that would be borne by those who had previously been less expensive to insure. *See* Douglas A. Kahn & Jeffrey H. Kahn, *The Unaffordable Health Act—A Response to Professors Bagely and Horwitz* 6 (Social Science Research Network, 2011), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1900964###. Young adult men with high incomes who purchased individual insurance would see costs rise because they would be included in a pool with young adult women, who are generally more expensive to insure due to the cost associated with pregnancy. *See* Jeffrey Dorfman, *The High Costs of Obamacare Hit Home for the Middle Class*, FORBES (Oct. 31, 2013), <http://www.forbes.com/sites/jeffreydorfman/2013/10/31/the-high-costs-of-obamacare-hit-home-for-the-middle-class/>.

256. *See, e.g.*, Thomas C. Feeney, *Preserving Freedom and Federalism: What's at Stake for Americans in the Health Care Debate*, HERITAGE FOUNDATION (Oct. 13, 2009), <http://www.heritage.org/research/reports/2009/10/preserving-freedom-and-federalism-whats-at-stake-for-americans-in-the-health-care-debate> (highlighting the pursuit of perfection in America's healthcare system); *Will Obamacare Destroy Jobs?*, THE ECONOMIST (Aug. 21, 2013), <http://www.economist.com/blogs/democracyinamerica/2013/08/health-reform-and-employment> (noting that one argument against healthcare reform is the destruction of jobs).

nor fears are realized. For example, the oft-cited “miracles of modern medicine in the United States” cannot absolutely prevent mortality. At the same time, caregivers of the elderly quickly realize that they are not fending off murderous panels of federal bureaucrats, as some portended would occur with the passage of the Affordable Care Act.²⁵⁷ Rather, the experience of illness in the elderly is often a sad one, tinged with inevitability. Caregivers are a mix of committed and distracted, resources are a mix of scarce and plentiful, and insurance coverage is, in turn, irrational, burdensome, and a godsend. The high promises and grave threats of much recent political rhetoric are detached from these struggles. And this detachment and distance is itself the strongest possible condemnation of the rhetoric. If our political debates about health care do not resonate with those who are ill or those caring for the ill, we are not talking about what matters.

In clinical bioethics, the practice of reflective equilibrium teaches us first to clarify areas of agreement, then to define terminology carefully, and eventually focus the discussion on the remaining areas of disagreement.²⁵⁸ Often what remains to disagree about is somewhat small and, because the participants in the debate recognize that they all, in truth, agree about many ethical norms and goals, the ensuing negotiations can take place with mutual respect and trust. This is not happening with regard to many current political discussion about healthcare reform.

Stepping back from rhetoric, overarching societal goals about health care are fairly easy to determine. It is likely true that the vast majority of people would agree that the goals of the public health system are to reduce morbidity and mortality.²⁵⁹ Methods for achieving these goals can be in conflict with other goals and values such as those related to the proper scope of government, allocation of scarce resources, and autonomy. But it does not seem

257. See, e.g., *Obamacare's Penalties on Hospital Readmissions Will Kill off the Sick and Elderly*, PATRIOT UPDATE (May 18, 2014), <http://patriotupdate.com/obamacares-penalties-hospital-readmissions-will-kill-sick-elderly/> (arguing that the Affordable Care Act will result in elderly deaths).

258. For a more philosophical discussion of reflective equilibrium, see Norman Daniels, *Reflective Equilibrium*, STAN. ENCYCLOPEDIA PHIL. (Jan. 12, 2011), <http://seop.illc.uva.nl/entries/reflective-equilibrium/>.

259. See *What is the Public Health System?*, DEPT OF HEALTH & HUM. SERVS., <http://www.hhs.gov/ash/initiatives/quality/system/> (last visited Dec. 1, 2015) (stating the mission of the public health system is to “ensure conditions in which people can be healthy”).

extreme to assume that people generally would prefer, in the absence of other issues, for there to be less illness and injury, and for those who suffer to be healed.

B. *The Background Conditions of the Healthcare System:
Constant Incremental Reform*

There is no perfect outcome in health care, and there are no perfect systems for providing health care. Healthcare systems seek the least bad outcome, defining success against background conditions that are both not ideal and constantly shifting. There are two primary characteristics of these background conditions that lead to these conclusions: (1) human mortality and fragility²⁶⁰ and (2) the conflict among cost, access, and quality.²⁶¹ Given this tension, health care, the industries within it, and the myriad regulatory schemes that affect it, are all inherently imperfect and must struggle continuously to achieve the least bad outcomes.

Humans are fragile. Because humans are mortal, no healthcare system can ever be perfect. Any healthcare system exists against a backdrop of illness, injury, and disease striking most people at some time in their lives, and all lives end eventually in death. Healthcare systems seek to minimize the effects of injury, cure disease, treat symptoms when diseases cannot be cured, delay death, and provide comfort and pain relief as unavoidable death approaches.²⁶² But all health care eventually ends in mortality, and healthcare providers spend much of their time and resources making the best of very bad circumstances.²⁶³

Within societal schemes to reduce morbidity and mortality, there is inherent tension among quality, access, and cost, so that it is extremely difficult to achieve any great success in improving one (or perhaps two) without constraining another.²⁶⁴ A simple example of this tension is access and quality for primary care. If a

260. See Donald M. Berwick, Thomas W. Nolan & Josh Whittington, *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759, 759–60 (2008).

261. *Id.* at 760.

262. See Gary Cohen, *What Is the Purpose of Healthcare?*, THOMSON REUTERS FOUND. (Apr. 2, 2014), <http://www.trust.org/item/20140402123148-6vk7g/>.

263. Joanne Lynn & David M. Adamson, *Living Well at the End of Life: Adapting Health Care to Serious Chronic Illness in Old Age*, RAND HEALTH 4–8 (2003), https://www.rand.org/content/dam/rand/pubs/white_papers/2005/WP137.pdf.

264. Berwick, Nolan & Whittington, *supra* note 260, at 760.

system has insufficient primary care physicians to treat all patients quickly, it may consider licensing nurse practitioners to treat patients for fairly simple conditions.²⁶⁵ This will improve access (and most likely reduce costs) since it is easier, less expensive, and faster to train a nurse practitioner than to train a board-certified family practitioner or internist.²⁶⁶ It may reduce quality in circumstances where a physician will recognize a serious condition and a nurse practitioner will not. The hope, then, is to devise a system where this quality issue is minimized, while improvements to access are maximized.

Even with the inherent difficulties involved, we continually seek better outcomes, greater access, lower costs, and less waste. Further adding to the complexity of this endeavor to improve, we hope to achieve all of this while respecting values that are often in conflict with each other, such as autonomy and human dignity, distributive justice, and the ability of societies to protect public health more generally (societal self-defense, in effect).

The final layer of complexity results because all of these schemes rely on the behavior of people who are subject to various desires and incentives and these are extremely difficult to predict or control.²⁶⁷ While there are occasional bad actors, carried away by greed or criminal intent, most people involved in healthcare systems are there, at least in some part, to do good. These people not only include physicians, but also hospital administrators, fraud investigators for the government, and people who work for third-party payers or for-profit pharmaceutical manufacturers. Even as most of these people seek to do good for others, they are also vulnerable to altering their behaviors in the face of incentives.²⁶⁸ Any healthcare system is riddled with incentives for types of behavior. These incentives can be the result of purposeful introduction of financial or cultural incentives, or can be created by the system itself without purposeful action.²⁶⁹ What is absolutely

265. P. Venning et al., *Randomised Controlled Trial Comparing Cost Effectiveness of General Practitioners and Nurse Practitioners in Primary Care*, 320 *BMJ* 1048, 1049 (2000).

266. *Id.* at 1052.

267. Erich H. Loewy, *Healthcare Systems and Motivation*, MEDSCAPE, <http://www.medscape.com/viewarticle/551709> (last visited Dec. 1, 2015).

268. *See id.*

269. Int'l Council of Nurses et al, *Incentive Systems for Health Care Professionals*, WORLD HEALTH PROF. ALLIANCE 1-3 (2008), http://www.whpa.org/Incentive_systems_for_

certain is that it is far easier to assess the existence and effect of incentives in hindsight than it is to understand them with foresight.

If one accepts this description of the limitations and goals of a healthcare system and acknowledges that, in light of both of these absolute limitations and inherent conflicts, no solution can be devised, one must accept that change will be a constant in health care into the foreseeable future. Change comes, of course, from the desire to improve patient outcomes through research, experimentation, and eventual implementation of new approaches. It also comes from the need to address societal complexities that are fluid and value-laden. These complexities are sometimes visible on the horizon, such as the development of extremely expensive new medical treatments²⁷⁰ or are unpredictable and can range from insurance market fluctuations in the face of newly emerging diseases²⁷¹ to parental decisions about child immunizations.²⁷² The

health_care_professionals-ENG.pdf.

270. For example, consider the recent and continuing struggles with providing Medicaid coverage for new and extremely expensive drugs that treat Hepatitis C. For a discussion of this problem, see Soumitri Barua et al., *Restrictions for Medicaid Reimbursement of Sofosbuvir for the Treatment of Hepatitis C Virus Infection in the United States*, 163 ANNALS INTERNAL MED. 215, 215 (2015).

271. For example, the unexpected appearance of AIDS in the 1980s had a tumultuous effect on the private individual insurance markets in cities such as San Francisco and Washington, D.C. For an excellent article from that time analyzing the financial impact of AIDS, see Henry T. Greely, *Aids and the American Health Care Financing System*, 51 U. PITT. L. REV. 73, 74–76 (1989). The article discusses the numerous effects of the AIDS crisis on insurance companies, such as seeking to screen applicants for sexual orientation, *id.* at 126, attempting to exclude coverage for all sexually transmitted diseases, *id.* at 125, and trying to withdraw plans from areas with high levels of single gay men, *id.* These efforts were met, in turn, by various state insurance regulatory responses seeking to protect both public health and private access to health care. *Id.* at 108.

272. The complex political and personal choices within this issue have been discussed in both academic contexts and in the press. For a summary of this debate and the underlying evidentiary facts as of early 2015, see Lawrence O. Gostin, *Law, Ethics, and Public Health in the Vaccination Debates: Politics of the Measles Outbreak*, 313 J. AM. MED. ASS'N, 1099, 1099 (2015), <http://jama.jamanetwork.com/article.aspx?articleid=2119391>. For purposes of this article, the problem can be summarized as the following: Many states have historically allowed parents to avoid immunizing their children even though it is scientifically unjustified to do so because the actual numbers of parents who choose to do so have been quite small and thus have not interfered with the development of herd immunity. *Id.* In the last decade, immunization avoidance has begun to reach high levels in a number of small communities, leading to broad public health threats such as the recent outbreak of measles in a number of states. *Id.* The subsequent public reaction from parents who feel their own children are threatened by vaccine refusal has led to an emotion-laden debate regarding compulsory vaccination and parental rights and exposing, interestingly, widespread misunderstanding about the scope of state powers to protect the public health. *Id.*

interaction of these two dynamics adds a further level of complexity to the healthcare system as neither societal shifts nor purposeful reforms exist in a vacuum but must function in continual response to each other.²⁷³

This article does not seek to argue that we should privilege incremental reform above other possible approaches, but rather that we should recognize that incremental reform is what we do, and, structurally, what we will continue to do until there is truly seismic and unimaginable alteration in the human condition. This needs to be pointed out first because political discussions about healthcare reform are often misleading at best and can function as distractions from the significant policy decisions that continually need to be made. Second, and most importantly, the current system needs to be more coherently tailored to better support the reality of constant change.

As is well known, the United States healthcare system is currently seeking methods for reducing the cost of providing health care and for improving the quality of health care that is administered.²⁷⁴ No system in the world has a perfect method for achieving the best possible outcome in all circumstances. This is not due to a lack of good will or effort, since poor outcomes and high costs are significant drains on society and any country that can minimize these problems will benefit greatly. Rather, it is because of the inherent challenges described above. Systems constantly choose between trade-offs. Purposefully interjecting change into the complex arena that is health care in the United States, a task we continue to undertake, will assuredly lead to unanticipated consequences. Some of those, experience tells us, will not be optimal.

C. *A Proposal for Reforming Healthcare Reform*

The case study in this article is the process whereby CMS has attempted to reduce unnecessary hospital admissions. The ques-

273. See Beatrix Hoffman, *Health Care Reform and Social Movements in the United States*, 93 AM. J. PUB. HEALTH 75, 75 (2003) (describing the historical intersection between social movements and healthcare reform).

274. REDUCING COSTS AND IMPROVING THE QUALITY OF HEALTH CARE, ECONOMIC REPORT OF THE PRESIDENT 161 (2013), https://www.whitehouse.gov/sites/default/files/docs/erp2013/ERP2013_Chapter_5.pdf.

tions the article addresses are slightly different: mainly how, in light of continual changes in the healthcare system, can the United States handle unanticipated negative consequences that emerge from well-intentioned efforts to improve the nation's healthcare system? In particular, how can negative consequences be discovered relatively early and addressed in a nimble and productive manner?

A system that may offer some useful comparisons to health care is the tax system. There are distinct parallels. Like health care, paying taxes is unavoidable. Similar to healthcare compliance issues, calculating taxes can be extremely complex and there can be penalties for getting it wrong.²⁷⁵ Also, like health care, the tax system and payers must constantly grapple with unintended consequences that occur in response to both changes within the tax code, and changes in behavior that do not neatly fit within prior experience of taxation.²⁷⁶ Finally, the tax code itself undergoes constant tinkering in an effort to refine it and ameliorate the unintended effects, much as healthcare reform must do in order to respond to unanticipated problems.²⁷⁷

While there are parallels between complexities in health care and taxation, the tax system has developed methods for dealing with these complexities that the healthcare system can learn from. Lawyers who specialize in tax planning are available to advise people and companies who are risk-averse and seek to minimize tax consequences. The relationship between lawyers and clients is ongoing, rather than lawyers being hired when problems arise. While many lawyers currently advise clients on healthcare regulatory compliance, tax lawyers, who are intimately involved in both tax planning and tax preparation, know they can communicate with the Internal Revenue Service ("IRS") in a number of ways when there is substantial uncertainty.²⁷⁸ This is a signifi-

275. See *Avoiding Penalties and the Tax Gap*, IRS.GOV (Aug. 20, 2010), <https://www.irs.gov/uac/Avoiding-Penalties-and-the-Tax-Gap>.

276. See, e.g., Gerri B. Chanel, *The Kiddie Tax: Inequitable Consequences and the Need for Reform*, TAX ADVISER (Feb. 1, 2015), <http://www.thetaxadviser.com/issues/2015/feb/chanel-feb15.html> (describing the unintended consequences of the "Kiddie Tax" in application).

277. See, e.g., NATIONAL TAXPAYER ADVOCATE, ANNUAL REPORT TO CONGRESS 12 (2014), www.taxpayeradvocate.irs.gov/2014AnnualReport (reporting on the frequency of changes made to the tax code over the last decade).

278. See generally IRS, INTERNAL REVENUE BULLETIN 7-9 (2015) (describing letter rul-

cant difference from health law. For example, the IRS is willing to issue private letter rulings, where lawyers can submit the description of a proposed business structure or transaction and the IRS issues an analysis of the tax implications.²⁷⁹ The opinion letters are made public and bind the IRS for the client who requested it, unless there is a subsequent change in the law or a new letter is issued.²⁸⁰ The IRS also issues revenue rulings, where private letter rulings, with the names redacted, are published and binding on the IRS, unless a subsequent change occurs.²⁸¹ There are also numerous publications read by both the tax bar and the IRS, such as *Tax Notes*, which create a daily feedback loop about tax lawyer and IRS concerns.²⁸² Finally, the IRS reserves the right to prohibit tax avoidance, meaning that a highly effective structure that appears legal, and greatly reduces tax liability, can be prohibited.²⁸³ This, in turn, constrains excessive distortions caused by unanticipated incentive responses.

While the tax system is highly imperfect and sometimes unjust, the system itself functions in such a manner that people can generally go about their business without undue concern about unanticipated tax consequences springing from their actions.

Healthcare behavior, in contrast, is often regulated by the imposition of penalties after the activity has occurred. The penalties can come from many places. CMS and other government agencies concerned with fraud, cost, or quality are primary sources.²⁸⁴ Oth-

ings, closing agreements, determination letters, information letters, and oral advice as means of submitting questions to the IRS when uncertainty arises).

279. *See id.* at 7.

280. *See id.* at 59 (discussing the binding nature of letter rulings); Mitchell Rogovin & Donald L. Korb, *The Four R's Revisited: Regulations, Rulings, Reliance, and Retroactivity in the 21st Century: A View from Within*, 46 DUQ. L. REV. 323, 347 (2008) (noting the requirement that letter rulings are to be made public).

281. *See* IRS, INTERNAL REVENUE BULLETIN 1 (2015) (describing the privacy of revenue rulings); Rogovin & Korb, *supra* note 280, at 335 (discussing the idea that taxpayers may rely on revenue rulings published in the Internal Revenue Bulletin).

282. *See generally* TAXNOTES, <http://www.taxnotes.com/federal-tax-products> (showing the purpose and use of TaxNotes by tax experts).

283. *See, e.g.,* IRS, *EO Abusive Tax Avoidance Transactions*, IRS.GOV, <https://www.irs.gov/Charities-&-Non-Profits/EO-Abusive-Tax-Avoidance-Transactions> (last visited Dec. 1, 2015) (discussing how some tax-exempt organizations are directly involved in abusive tax avoidance transactions and providing a means of reporting these abuses).

284. *See generally* Bob Herman, *CMS Imposes Record Number of Medicare Advantage Fines in First Quarter*, MOD. HEALTHCARE (Apr. 13, 2015), <http://www.modernhealthcare.com/article/20150413/NEWS/150419982> (describing fines and penalties levied on several healthcare groups by CMS).

er sources of financial penalties include malpractice awards being used as a quality control mechanism and non-government third-party payers reducing reimbursement for poor-quality outcomes.²⁸⁵

In response to this dynamic where one learns one was wrong when the penalties are levied, it makes sense for the culture to be extremely risk-averse while at the same time unavoidably unsure as to what the actual risks are that it is seeking to avoid. The healthcare system tends to respond to perceived threats by seeking out safe harbors,²⁸⁶ but given the absence of formal methods for defining safe harbors in specific circumstances, the system has limited or no ability to ascertain if the safe harbor is in fact safe.²⁸⁷ Problems of miscommunication, unintended consequences, and inefficient use of resources for minimum or no improvement begin to snowball and can get structurally entrenched.

Medical malpractice is a well-known example of this problem. While it is not clear how common it truly is, most people are familiar with the concept of defensive medicine, where a doctor orders tests or performs procedures that she believes are medically unnecessary but are necessary for the purpose of avoiding a future lawsuit.²⁸⁸ The physician seeks a legally unnecessary safe harbor, at a cost to both the patient and the healthcare system more broadly. Within the culture of medicine, there are surveys showing a prevalence of a defensive mentality, with physicians reporting viewing patients as lawsuits waiting to happen.²⁸⁹

At the same time as state legislators reacted to a perceived malpractice crisis by capping damage awards and making it more

285. Robert S. Kaplan & Michael E. Porter, *The Big Idea: How to Solve the Cost Crisis in Health Care*, HARV. BUS. REV. (Sept. 2011), <https://hbr.org/2011/09/how-to-solve-the-cost-crisis-in-health-care>.

286. Cecilia Ong & Allen Kachalia, *Safe Harbors: Liability Reform for Patients and Physicians*, BULL. AM. C. SURGEONS (Mar. 2, 2013), <http://bulletin.facs.org/2013/03/safe-harbors/>.

287. See James F. Blumstein, *Medical Malpractice Standard-Setting: Developing Malpractice "Safe Harbors" as a New Role for QIOs?*, 59 VAND. L. REV. 1017, 1049 (2006).

288. Anthony Rivas, *Worried Doctors More Prone to Order Unnecessary Tests to Avoid Malpractice Lawsuits*, MED. DAILY (Aug. 14, 2013), <http://www.medicaldaily.com/worried-doctors-more-prone-order-unnecessary-tests-avoid-malpractice-lawsuits-251505>.

289. E.g., Dike Drummond, *Physician Burnout: Why It's Not a Fair Fight*, THE HAPPY MD, <http://www.thehappy.md.com/blog/bid/295048/Physician-Burnout-Why-its-not-a-Fair-Fight> (last visited Dec. 1, 2015) (describing how the hostile legal environment causes physicians to view patients as potential lawsuits).

difficult for patients to prevail in court, the Institute of Medicine reported that tens of thousands of people died every year because of preventable errors in the medical system.²⁹⁰ The malpractice system was not doing a good job of policing the quality of the healthcare system. It was both over- and under-inclusive. It was over-inclusive because lawsuits were filed against doctors when there was a legitimate argument that the doctor had followed the appropriate standard of care, as opposed to a clear-cut failure on the doctor's part.²⁹¹ It was under-inclusive because it failed to provide a mechanism for redress for tens of thousands, perhaps more, yearly cases where significant harm was done, but not harm that could be monetized in such a way as to make bringing a lawsuit worth it for the lawyers.²⁹²

Driven by increased awareness about the costs of medical error, the healthcare system has begun to recognize that medical errors need to be prevented by reforming structures and systems. Currently, HHS has a number of programs where it is trying to develop both carrots and sticks to decrease errors and improve outcomes.²⁹³ While this is a great improvement over relying almost entirely on malpractice and occasional licensing revocations to ensure quality of care, the same risk is inherent here as with malpractice. How can these programs best be utilized? If the system reacts by seeking out safe harbors, if the different parties view each other as antagonists, and if feedback loops are not built into the development of new procedures, it is unlikely that the best processes will be developed. Rather, if penalties are severe and confusing, defensive measures that are not tied to the best methods for improving quality of care are likely to develop.

290. Quality of Health Care in America Committee, *The Institute of Medicine Report on Medical Errors: Misunderstanding Can Do Harm*, MEDSCAPE GEN. MED. (Feb. 2, 2000), http://www.medscape.com/viewarticle/418841_2.

291. See Claire Bartholome, *Leveraging Our Strengths: Reinforcing Pay-for-Performance Programs as the Solution for Defensive Medicine*, 4 J. HEALTH & BIOMED. L. 333, 349–50 (2008).

292. *Id.*

293. John Wennberg & Shannon Brownlee, *Bending the Curve with Carrots and Sticks*, HEALTH AFF. BLOG (Nov. 12, 2009, 11:10 AM), <http://healthaffairs.org/blog/2009/11/12/bending-the-curve-with-carrots-and-sticks/>.

CONCLUSION

The healthcare system can be chaotic, irrational, counter-productive, wasteful, and riddled with suspicion and distrust. The healthcare system is also made up of a highly functioning, diverse group of people, organizations, and regulators who generally seek to care for those they are responsible for and often have great success in doing so. Health care itself is inherently imperfect, and those who spend their careers wedded to it must do so, at least partially, out of a deep desire to help other human beings who suffer from disease and injury, even as they realize they routinely confront systemic and personal failure.

Healthcare reform is inescapable. The system will always be subject to change and to resource allocation challenges, and so must exist in a constant state of alteration as society seeks to make each iteration accurately reflect the values of those for whom it provides. This article argues that it is essential to remain optimistic about the possibility of improvement, to remain confident in the innate humanity of those in the system, and to seek to improve the current system so that it can better grapple with the problems we know will continue to occur. The problems do not necessarily reflect blameworthiness, but rather the immutable characteristics of the challenge of providing health care in modern times.

The case study about observation status is meant to be illustrative of the need for constant reform. The story is a showcase of the pressures that have bedeviled health care for the last forty years, and how strange regulatory and market decisions can appear in hindsight. The case study also shows the pitfalls of some specific areas of healthcare reform and how to avoid them.

First, when any party seeks to create incentives for others, it must be assumed that the incentives will often lead to unanticipated outcomes. Incentives are potent, whether they are financial or cultural, and those who seek to use them should likely refrain from excessive blame when those who have been incentivized behave in unpredictable ways. CMS implemented PPS so that the healthcare system would be financially incentivized to provide efficient care. Doctors and hospitals attempted to utilize PPS to make money, in part by quickly moving patients out of hospitals. CMS then reacted by forcefully seeking to constrain short-term

hospital admissions, assuming they were not necessary. This area has been fraught with blame, fear, and worry for decades.

Second, punitive regulatory frameworks encourage those who are regulated to become extremely risk-averse. Risk aversion, in turn, leads people to seek safe harbors. In an effort to avoid as much risk as possible, attractive safe harbors often fall well short of regulatory requirements, and this, in turn, can frustrate the intentions of regulators who have sought to draft rules calculated to elicit optimal outcomes. Currently, it appears that patient quality of care and financial well-being are suffering as a result of physician and hospital reluctance to formally admit them to the hospital. Patients have been left on stretchers in the emergency department for days at a time or put in the hospital under observation status so that hospitals can avoid any punitive interactions with auditors over the decision to admit.

Third, adversarial relationships frustrate quality. Communication is far more complex when there is persistent distrust. Healthcare reform requires continual feedback loops so that it can effectively grapple with changing circumstances, and there are inadequate avenues for accomplishing this, even putting aside issues of suspicion. In the case study, CMS, often directed to do so by Congress, sought to constrain Medicare costs related to hospital admissions. The series of attempts it made, the reactions, and the counterreactions, became increasingly adversarial. The utilization of bounty hunters, a method of enforcement rejected by western culture more than one hundred years ago, was a culmination of this adversarial stance. There is much to be admired in the proper utilization of observation units, but this has been almost entirely lost in the battle over reimbursement. There is almost nothing about quality of care reflected in the current concept of observation and it seems to exist as a reluctant form of reimbursement at best. This does not have to continue.

Incremental, continual reform is not remotely exciting and is probably politically unattractive, but it is unavoidable. The system should respond to this in a more self-aware manner and shape itself to better grapple with the types of challenges it will always experience.
