No. 13-4179

United States Court of Appeals
for the
Second Circuit

LEE BARROWS, MICHAEL SAVAGE, GEORGE RENSHAW, SARAH MULCAHY, SHIRLEY BURTON, AND **DENISE RUGMAN,**
ON BEHALF OF THEMSELVES AND ALL OTHERS SIMILARLY SITUATED, AND
ANN PELOW, EXECUTOR OF ESTATE OF **RICHARD BAGNALL,**

Plaintiffs- Appellants,

(ADDITIONAL APPELLANTS AND PLAINTIFFS LISTED ON THE INSIDE OF COVER)
v.
KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendant-Appellee.

On Appeal from the United States District Court
for the District of Connecticut, No. 3:11-cv-1703

BRIEF *AMICI CURIAE* OF AMERICAN MEDICAL ASSOCIATION AND OTHER MEDICAL ASSOCIATIONS IN SUPPORT OF PLAINTIFFS-APPELLANTS AND URGING REVERSAL OF THE DISTRICT COURT'S JUDGMENT

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ADDITIONAL APPELLANTS AND PLAINTIFFS:

LOUIS DZIADZIA, LORETTA JACKSON, MARTHA LEYANNA, AND **CHARLES HOLT,** ON BEHALF OF THEMSELVES AND ALL OTHERS SIMILARLY SITUATED**, IRMA BECKER, JESSIE RUSCHMANN,** REPRESENTATIVE OF THE ESTATE OF **FREDERICK RUSCHMANN,** AND **CHRISTINA ALEXANDER,** REPRESENTATIVE OF ESTATE OF **BERNICE MORSE,**

Intervenor Plaintiffs-Appellants,

RICHARD BAGNALL, ON BEHALF OF HIMSELF AND ALL OTHERS SIMILARLY SITUATED**, BERNICE MORSE, FREDERICK RUSCHMANN,**

Plaintiffs.

Corporate Disclosure Statement and FRAP 29(c)(5) Disclosure

Pursuant to FRAP 26.1, *amici*, American Medical Association ("AMA"), Connecticut State Medical Society ("CSMS"), American Academy of Home Care Medicine, American Association of Neurological Surgeons, American College of Emergency Physicians, American Urological Association, Congress of Neurological Surgeons, and Society of Hospital Medicine, state that they are not-for-profit corporations and no publicly held corporation owns 10% or more of the stock of any *amicus*.[1]

[1] Pursuant to FRAP 26(c)(5), *amici* state that no party or party's counsel authored this brief in whole or in part or contributed money intended to fund preparing or submitting this brief. *Amici* further state that no other person contributed money intended to fund preparing or submitting this brief.

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Identification and Interest of *Amici* and Source of Authority

The AMA is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in the AMA's House of Delegates, substantially all U.S. physicians, residents and medical students are represented in the AMA policy making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in all states and in all areas of medical specialization.

CSMS is comprised of physicians and medical students who practice in the State of Connecticut.[2] The remaining *amici*, the American Academy of Home Care Medicine, American Association of Neurological Surgeons, American College of Emergency Physicians, American Urological Association, Congress of Neurological Surgeons, and Society of Hospital Medicine, are associations of physicians and medical students who specialize in those areas of medical practice identified in their respective names. CSMS and the specialty medical associations are represented in the AMA House of Delegates and share the objectives of the

[2] The AMA and CSMS join this brief on their own behalves and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state, plus the District of Columbia, whose purpose is to represent the viewpoint of organized medicine in the courts.

AMA to promote the science and art of medicine and the betterment of public health.

Together, *amici* represent tens of thousands of physicians in Connecticut and across the country. *Amici* are concerned that those patients covered under the Medicare Program should receive the benefits to which they are legally entitled and that those patients do not suffer financial hardship on account of arbitrary administrative decisions.

The source of authority to file this brief is the consent of all parties.

Issue Addressed in this *Amici Curiae* Brief

The issue addressed in this brief is whether at least one of the Plaintiffs alleged sufficient facts to establish a property interest in his or her classification as a hospital inpatient under the Medicare Program.

Statement of the Case

Background

Because the District Court decided this case under a Rule 12(b)(6) motion to dismiss, the background statements are derived from the allegations in plaintiffs' complaint, Joint Appendix ("JA") [Doc. No. 38], pp. 19-49, and complaint in

intervention, JA, pp. 194-226,[3] plus relevant statutes, regulations, and administrative guidelines.

Under the Medicare Program, patients may be classified as hospital "inpatients," a word used but not defined in the Medicare Act. Special Appendix ("SPA") [Doc. No. 37-2], p. 1. If they are inpatients, they are entitled to Part A Medicare benefits and, if they have been inpatients for at least three consecutive days, they are entitled to coverage for post-hospitalization care at skilled nursing facilities ("SNFs"). 42 U.S.C. §§ 1395d (a) & 1395x(i); 42 C.F.R. § 409.30. The Medicare Act specifically characterizes these benefits as "entitlements:"

> The benefits provided to an individual by the insurance program under this part [42 USCS §§ 1395c et seq.] shall consist of entitlement to have payment made on his behalf or … to him. 42 U.S.C. §§ 1395d (a).

If they are not hospital inpatients, however, these benefits are unavailable. Even for those patients covered under Medicare Part B (and not all Medicare patients are so covered), Part B benefits in this situation are generally less than Part A benefits.

All of the plaintiffs were Medicare beneficiaries at the time of the alleged events.[4] JA, pp. 21-23, 197-198. Further, all of the plaintiffs were alleged to have

[3] Hereinafter, references in the text to the "complaint" also refer to the complaint in intervention.

[4] Some of the Medicare beneficiaries who are the subject of this suit died before the filing of the complaint. In such instances, the beneficiaries are represented by their estates. For ease of reference, the body of this brief will not distinguish

been hospitalized overnight, and most of the plaintiffs were alleged to have been hospitalized for several days and nights. All of the plaintiffs received medical services and treatment on regular hospital floors and received a level of care that required that they remain physically in the hospital. At least when they first received this treatment, they had no reason to think they would be deemed anything other than routinely admitted inpatients. JA, pp. 21, 33-43, 196, 208-218.

Nevertheless, the defendant Department of Health and Human Services (HHS), which administers the Medicare Program, did not deem any of the plaintiffs to have been inpatients. Rather, HHS deemed these patients to have been on "observation status," JA, pp. 33-43, 208-218, a term undefined under the Medicare Act and, at the time of the events, undefined under the Medicare regulations (but defined under the less formal Medicare Benefit Policy Manual ("Medicare Manual")).

According to the Medicare Manual,

> An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight. SPA, p. 62.

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between those beneficiaries who represent themselves and those who are represented by their estates, and will simply designate all of them as "plaintiffs."

The Medicare Manual further specifies that observation status "commonly" applies to patients "who present to the [hospital] emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge." SPA, p. 64. According to the Medicare Manual, observation status is generally supposed to last no longer than 24 hours and occasionally up to 48 hours, but only in "rare and exceptional cases" should observation status last longer than 48 hours. SPA, p. 64.

Initially, physicians determine whether a patient is to be admitted to a hospital or is to be deemed on observation status. JA, pp. 28, 203. However, hospitals may be financially penalized for admissions later deemed improper. Such penalties can arise in either of the following fashions:

- If a beneficiary is admitted but that admission is later found improper, the hospital must refund the Part A payment to Medicare. JA, pp. 30, 205.
- Under § 3025 of the Patient Protection and Affordable Care Act of 2010, a hospital can be penalized for an inpatient readmission. *See* 42 C.F.R. §§ 412.152 & 412.154. However, if the patient was deemed an outpatient during his first visit, he cannot, by definition, be readmitted and so the hospital could not be penalized. JA, pp. 30, 205.

Accordingly, hospitals are incentivized to label patients as outpatients on so-called "observation status," even if they receive the same treatment as beneficiaries who have been formally admitted. JA, pp. 20, 195. As a result of these incentives, some hospitals steer patients, who may physically stay in the hospital on an overnight basis, into observation status for Medicare payment purposes.

To facilitate such steerage, the complaint alleges --

> The physicians … sign proposed orders provided by the hospitals, which follow commercially available screening tools, such as those from the McKesson Corporation (Interqual) and Milliman, to determine if an admission is appropriate. These are proprietary systems that are not publicly available. JA, pp. 28, 203.

Furthermore, hospitals, through utilization review committees (URCs), may overrule the judgment of treating physicians and retroactively reclassify patients who were previously admitted as inpatients as having been on observation status.[5] JA, pp. 28-29, 203.

Since 2003, HHS has enforced these policies through increasingly aggressive audits, including audits undertaken by Recovery Audit Contractors. As a result, the number of Medicare claims for observation status has increased dramatically over the last several years, and the average period of time in

[5] Medicare regulations require hospitals to establish URCs to review the medical necessity of admissions and to promote "the most efficient use of available health facilities and services." 42 C.F.R. § 482.30 (f).

observation status, including observation status lasting more than two days, has been increasing. JA, pp. 30-31, 204-206.

Most of the plaintiffs in this case were never "formally admitted" to their respective hospitals. Notably, though, the plaintiff Lawrence Barrows, who had been hospitalized from July 3 to July 10, 2009, had been formally admitted before July 8. On that date the hospital retroactively changed his status to observation status. JA, p. 36. Similarly, the plaintiff Martha LeYanna was formally admitted to a hospital as an inpatient and remained in the hospital from November 16 through November 22, 2011. On November 20, 2011, she was advised that the hospital had changed her status to observation status, retroactive to the beginning of her hospital stay. JA, pp. 214-215.

Some of the other plaintiffs were informed that they were eligible for Part A benefits. The plaintiffs Richard Bagnall, Bernice Morse, and Loretta Jackson each received a written notice, identified as an "Important Message from Medicare," while in the hospital, listing their rights as hospital *inpatients.*

None of the plaintiffs except Martha LeYanna, who had been formally admitted and had received the Important Message from Medicare, was notified during his or her time in the hospital that he or she was on observation status. JA, pp. 214-215. None of the plaintiffs was afforded an opportunity, while in the hospital when their patient status was determined, to participate in that

determination at the time it was made. And, none of the plaintiffs was afforded a means, while in the hospital, to contest the outpatient determination after it was made. JA, pp. 21, 216.

The refusal by HHS to afford the plaintiffs the benefits that come with inpatient status led many of them to substantial medical and financial hardships. The plaintiffs Loretta Jackson, Martha LeYanna, and Frederich Ruschmann had to pay large sums of money up front in order to be admitted to SNFs for post-hospital care. JA, pp. 211, 213, 215. The plaintiffs Irma Becker, JA, p. 216, and Lawrence Barrows JA, p. 36, had to negotiate payment plans with their respective SNFs to manage their bills. The plaintiff Nettie Sapp was unable to afford necessary care and was forced to leave her SNF after two months. She moved to an assisted living facility, where she later died. JA, p. 40. The financial losses for each of the plaintiffs ranged from $4,000 to $30,000.

Procedural Posture

The complaint raised nine causes of action. The sixth and seventh causes of action alleged that characterization of the plaintiffs as on "observation status," without providing appropriate notification or other procedural protections, violated the Fifth Amendment Due Process Clause. JA, pp. 45-46, 221-222. HHS moved

to dismiss the entire complaint, under Fed. R. Civ. P. 12(b)(1)[6] and 12(b)(6). JA, p. 89.

In deciding the Due Process claims, the lower court observed that, while public welfare benefits could sometimes be deemed protectable property rights, SPA, p. 40, hospital admission decisions fall within the medical discretion of physicians. SPA, pp. 43-44. Thus, the court held, the plaintiffs had "failed to establish a property right in formal hospital admission … inpatient status" and the benefits ensuing therefrom. It therefore dismissed these Due Process claims, without addressing the other aspects of Due Process analysis.[7] SPA, p. 46.

Argument

This brief addresses only the Due Process claims, as raised in the sixth and seventh causes of action, with a focus on the "property" aspect of the plaintiffs' inpatient status.

I. Plaintiffs Barrows and LeYanna, at Least, Have a Property Right in Their Designation as Inpatients.

Barrows and LeYanna were initially admitted to their respective hospitals as formal inpatients. At the moment of their admission, they had well-founded

[6] The trial court denied the Rule 12(b)(1) motion, so this brief does not discuss it further.

[7] The lower court dismissed the remainder of the complaint as well and entered judgment for HHS. SPA, p. 51.

expectations of receiving Medicare Part A benefits. At that moment, there was nothing further to be done by a physician, a hospital, or anyone else to qualify them for such benefits. At that moment, there was zero discretion available to HHS to deprive them of their benefits. At that moment, they had a vested property right.

As to Barrows and LeYanna, the issue was not whether some future contingency had to occur in order to give them a vested interest. Rather, the issue was whether the occurrence of subsequent events – the actions of URCs acting under pressure from HHS – could divest them of their interests without impacting their right of Due Process. On that issue, the rule is well established: the termination of statutorily established welfare benefits must comply with constitutional Due Process. *Goldberg v. Kelly*, 397 U.S. 254 (1970) (welfare benefits, being a constitutionally protected right, could not be terminated without following due process). Accordingly, Barrows and LeYanna were owed Due Process protections in their inpatient status.

The district court found that inpatient status arises from discretionary determinations of physicians and hospitals. Quoting from *Kapps v. Wing*, 404 F.3d 105 (2nd Cir. 2005), it concluded that inpatient status is therefore too ephemeral to reach a "legitimate claim of entitlement." SPA, p. 40. While couched in terms of whether plaintiffs had a protectable property interest in inpatient status, the district

court's decision actually turned on the premise that it was providers, and not HHS, that made the determinations of inpatient or outpatient status. *Kraemer v. Heckler*, 737 F.2d 214 (2nd Cir. 1984), however, effectively repudiates that position.

Kraemer, a putative class action, challenged on procedural due process grounds the policies and procedures relative to the termination of Medicare Part A coverage. The plaintiffs claimed that a determination by a URC that a hospital or skilled nursing facility (SNF) admission (or continued stay) was medically unnecessary is, in effect, a termination of Medicare coverage and must be accorded due process protections. The district court entered summary judgment for HHS.

On appeal, HHS argued it was the medical providers that made URC determinations. HHS asserted that it merely accepted those determinations, and so it was private parties, not HHS, which caused the terminations of the plaintiffs' Part A benefits. However, the *Kraemer* court saw the matter differently. It found that the plaintiffs had raised sufficient facts to suggest that HHS had influenced the URC medical necessity determinations, and so those determinations could be attributed to HHS. The facts which created this inference included the following:

- The URC decision making process was governed largely by statute, regulation, HHS manuals, and HHS transmittal letters;
- HHS policy created financial incentives to health care providers to terminate services covered under Part A;

- Several providers had testified to a Congressional subcommittee that, because of such incentives, they felt pressured to make decisions based on cost-cutting, rather than purely medical considerations. A *New England Journal of Medicine* article had reached a similar conclusion.

The *Kraemer* court therefore reversed the summary judgment, concluding that "the plaintiff class may well be able to demonstrate the Secretary's directives serve to pressure intermediaries and providers to cut back on benefits." 737 F.2d, at 221.

While the *Kraemer* court's analysis primarily addressed the "state action" element of the Due Process requirement, that analysis is directly relevant to this case. Particularly, the facts in *Kraemer* are strikingly similar to the facts at bar. In both cases, Part A coverage terminations were made by the hospital's URC, which *should* have been making decisions based on objective medical considerations, but were, *in fact*, reacting to financial pressures and incentives from HHS to recommend a lower level of care. In both cases, there is evidence that the URCs were effectively the agents of HHS, rather than unbiased instrumentalities of health care institutions.

The district court here found that inpatient status depended on medical decisions of health care providers, rather than a determination by government officials. Quoting *Furlong v. Shalala*, 156 F.3d 384, 394 (2nd Cir. 1998), the court

held that "entitlement to the benefit occurs only when official discretion is so narrowly confined as to virtually guarantee conferral of the benefits." SPA, pp. 40-41.

In fact, Barrows and LeYanna met that standard. The Medicare Manual states: "The physician or other practitioner responsible for a patient's care at the hospital is … responsible for deciding whether the patient should be admitted as an inpatient." SPA, p. 62. The physicians for Barrows and LeYanna determined that they should be admitted as inpatients, thereby solidifying their entitlement to the benefits that come with inpatient status. For Barrows and LeYanna, then, their right to receive benefits did not depend on discretionary decisions of medical providers or of government officials. The discretionary decision had already been made. It was only the grounds for termination of their rights that depended on discretionary decisions.

Furthermore, Barrows and LeYanna alleged that the retroactive termination of their inpatient status was made by a *de facto* government authority, and those terminations were not made in accordance with objective medical discretion. *Kraemer* mandates that the facts asserted in support of such claim be deemed

sufficient to merit further development and, if appropriate, a trial.[8] At least as to Barrows and LeYanna, therefore, the district court judgment should be reversed.

II. Those Plaintiffs Who Were Informed That They Were Being Treated As Inpatients Have a Property Right in Their Designation as Inpatients.

Although Bagnall, Morse, and Jackson may not have been formally admitted to the hospital, they were affirmatively led to believe that they had inpatient status. They were, of course, physically present in the hospital on an overnight basis, and the Important Message from Medicare notification strongly suggested they were inpatients. No reasonable person in their position could have understood anything other than that they were inpatients.

Theoretically at least, if these plaintiffs had been informed that they were ineligible for Medicare Part A benefits, they could have left the hospital or taken other steps to reduce their potential expense. *See Kraemer*, 737 F.2d, at 222 ("Astronomical nature" of medical costs could cause patients to forego necessary care). Based on the record as it exists so far, HHS led these plaintiffs to incur

[8] *Estate of Landers v. Leavitt*, 545 F.3d 98 (2nd Cir. 2008), *cert. denied*, 557 U.S. 937 (2009), on which the district court heavily relied, is not to the contrary. *Landers* held that the HHS rule that a patient cannot be deemed an inpatient unless he or she has been formally admitted to a hospital was consistent with Equal Protection. However, *Landers* did not consider the Due Process requirement of the Fifth Amendment, it did not consider factual challenges to the integrity of the HHS decisional process, and it did not consider application of the inpatient rule to the retroactive termination of Medicare benefits.

additional expenses, under the reasonable assumption that Medicare would pay those expenses. The protectable property rights of these plaintiffs arose no later than when they received their "Important Message from Medicare."[9] From that point on, these plaintiffs reasonably believed – and relied on the belief – that no further action was required for them to be accorded Part A inpatient status. For HHS to deny that these plaintiffs had a protectable property right at that point is unconscionable.

III. The Remaining Plaintiffs also Have a Property Right in Their Designation as Inpatients.

While the evidence that Barrows, LeYanna, Bagnall, Morse, and Jackson had a protectable property interest in their Part A status may be the strongest, in fact all of the plaintiffs have such an interest. In this case, based on HHS policy as reflected in the Medicare Manual, the property right should be deemed to vest at such time as the physicians of the remaining plaintiffs determined that their medical conditions required that they stay in the hospital on an overnight basis and receive a level of hospital care consistent with inpatient status. At that point, the plaintiffs enjoyed *de facto* inpatient status. Whether the hospitals' formal admission decision confirming such status were acts of medical significance involving the legitimate discretion of medical professionals or whether the

[9] If HHS maintains that the Important Message from Medicare notifications were not attributable to HHS, this should be addressed at trial.

admission decisions were technical gestures taken in response to HHS compulsion is a question of fact.

As to the general right of Medicare beneficiaries to due process, *Goldberg v. Kelly*, 397 U.S. 254 (1970), *Mathews v. Eldridge*, 424 U.S. 319 (1976), and *Gray Panthers v. Schweiker*, 652 F.2d 146 (D.C. Cir. 1981), are informative. *Goldberg* found that, for constitutional purposes, characterization of welfare benefits as a "gratuity," rather than as "property" was anachronistic. The designation of such interests as "entitlements" is indicative of a vested right. Moreover, as a practical matter, aid recipients are frequently in desperate need of those benefits. A deprivation of benefits is likely to cause great and irreparable harm.

> Since [the aid recipient] lacks independent resources, his situation becomes immediately desperate. His need to concentrate upon finding the means for daily subsistence, in turn, adversely affects his ability to seek redress from the welfare bureaucracy. 397 U.S., at 262.

The *Goldberg* rationale certainly applies to Medicare beneficiaries. In most cases, these beneficiaries are elderly; by definition, they are in need of medical care. Their ability to navigate the Medicare bureaucracy is typically at best constrained. Most importantly, they are qualified to receive at least some benefits, and Congress has specifically designated these benefits as an "entitlement." 42 U.S.C. § 1395d (a)(1). Their deprivation, therefore, qualifies for constitutional due process protections.

Mathews v. Eldridge held that Social Security disability benefits, being a statutorily created right, constitute a property interest protected under the Fifth Amendment. Thus, the federal government cannot deprive a beneficiary of a claim without a reasonable opportunity to be heard at a meaningful time and in a meaningful manner.

Gray Panthers v. Schweiker specifically held that applications for Medicare benefits are entitled to constitutional due process protections, even if those claims fall below the statutory minimum ($100) Congress had established for a full evidentiary hearing. The *Gray Panthers* claims were for discrete services (unlike continuing payments based on need (as in *Goldberg*) or disability (as in *Mathews*)). As in the case at bar, the *Gray Panthers* suit arose in the context of a denial of anticipated benefits. The determining factor behind the due process right was the statutorily created entitlement.

These general considerations were made applicable to a situation comparable to the one at bar in *Kapps v. Wing*, 404 F.3d 105 (2nd Cir. 2005), a case involving claims under New York's Home Energy Assistance Program. The court there held that, while a merely "unilateral expectation" of receiving a welfare benefit would be insufficient to create a property right, a protectable interest would be created if there is "a very strong likelihood" that the benefit should be granted.

This would be true even if the granting of the benefit might be subject to various contingencies. 404 F.3d, at 115-116.

Here, such a strong likelihood does exist. The Medicare Manual, which HHS itself publishes, states that observation status should usually last no longer than 24 hours, and only in rare cases should that status extend beyond 48 hours. Moreover, the consensus position of the medical profession on acceptable medical practice in this situation is set forth in AMA Policy H-320.965, which states that "the determination of the medical necessity for hospital admission should be made only by a doctor of medicine or a doctor of osteopathy."[10] Here, however, medical necessity was determined by URCs, which may have had non-physician members. 42 C.F.R. § 482.30.

Even further evidence of the likelihood of inpatient status is found in the Important Message from Medicare notices that Bagnall, Morse, and Jackson received. Clearly, hospital personnel understand that if a patient has received hospital services on a multi-night basis, then the patient has been admitted (or at least is very likely to be deemed admitted) to the hospital as an inpatient. Based on these considerations, the probability of inpatient status for all of the plaintiffs was

[10] AMA policies can be found at http://www.ama-assn.org/ama/pub/about-ama/our-people/house-delegates/policyfinder.page.

much more than a unilateral expectation. It was, in fact, a very strong likelihood, and the *Kapps* holding should apply.

HHS argues that, notwithstanding these factors, the plaintiffs' inpatient status should be deemed unvested, as it depended on medical discretion. This argument, however, rings hollow in light of *Kraemer v. Heckler*, 737 F.2d 214 (2nd Cir. 1984). As *Kraemer* held, if HHS unduly influenced URC medical necessity determinations, those determinations could be attributed to HHS. In other words, the probability of hospital admissions did not depend so much on the uncertainties of complex medical judgments as it depended on the degree to which HHS stacked the odds.

There is another problem with the HHS argument as well. That argument would give the plaintiffs no constitutional right to challenge a UCR decision to deny hospital admission status, no matter how far that decision might diverge from accepted medical practice or other considerations. That simply cannot be right – at some point, the plaintiffs' entitlement must depend on something other than unfettered whim or caprice. *Cf. Kraemer*, 737 F.2d at 215 (assuming the existence of a property right to Medicare Part A coverage, giving rise to a due process analysis).

All of the plaintiffs, therefore, should have the opportunity to prove that the formal admission determinations by their hospitals were unduly influenced by the

HHS payment scheme and by the format of the intake forms. They should also be allowed to demonstrate that they were not mere statistical outliers and their supposedly exceptional patient status reflected systematic HHS policy, rather than extraordinary medical facts. Plaintiffs should have the right to prove that, as to themselves, inpatient status was not dependent on a complex medical judgment, but, if the law had been applied in unbiased fashion, would have been a "virtual guarantee."[11]

CONCLUSION

If circumstances give rise to a legally reasonable claim for Medicare benefits, based on only a slight element of contingency, those claims should be deemed a form of property. As such, those claims should be afforded Fifth Amendment Due Process protections. These require, at minimum, a reasonable opportunity to be heard at a meaningful time and in a meaningful manner.

The instant plaintiffs have alleged sufficient facts to show that their specific Part A Medicare benefits were virtually guaranteed. That virtual guarantee arose when they were hospitalized on an overnight basis and received a level of care consistent with inpatient status. The supposed discretion of health care professionals to determine patient status was, for these patients, a charade. It was

[11] If this case is remanded, it would be for the trial court to determine whether class certification is warranted.

HHS that decided on observation status, not medical facts and not the judgment of their treating physicians.

As to whether the plaintiffs were in fact accorded the process they were constitutionally due, an issue the trial court did not resolve, *amici* refer to the plaintiffs' brief. *See* Plaintiffs' Brief [Doc. 37-1] at pp. 55-62.

For the foregoing reasons, *amici* American Medical Association, Connecticut State Medical Society, American Academy of Home Care Medicine, American Association of Neurological Surgeons, American College of Emergency Physicians, American Urological Association, Congress of Neurological Surgeons, and Society of Hospital Medicine, urge this Court to reverse the trial court judgment, at least insofar as it dismissed the constitutional Due Process claims in the sixth and seventh causes of action.

Dated: February 20, 2014

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 29(d) because it contains 4,596 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in Times New Roman 14 point font.

By: /s/ Ilze C. Thielmann

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CERTIFICATE OF SERVICE

I certify that on February 20, 2014, a copy of this document was filed through the Court's CM/ECF system. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system or by mail to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing. Parties may access this filing through the Court's CM/ECF System.

/s/ Ilze C. Thielmann

Ilze C. Thielmann