No. 08-818

In the Supreme Court of the United States

ADENA REGIONAL MEDICAL CENTER, ET AL.,
PETITIONERS

v.

CHARLES E. JOHNSON, ACTING SECRETARY OF
HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

In calculating the Medicare disproportionate share hospital adjustment, the Secretary must count patient days attributable to "patients who * * * were eligible for medical assistance under a State plan approved under [the Medicaid statute]." 42 U.S.C. 1395ww(d)(5)(F)(vi)(II).

The question presented is whether the Secretary must count days attributable to patients who were *not* eligible for Medicaid but who were given charity care by hospitals under a state program.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases:

Statutes:

Statutes—Continued: Page

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-9a) is reported at 527 F.3d 176. The opinion of the district court (Pet. App. 10a-18a) is reported at 524 F. Supp. 2d 1.

JURISDICTION

The judgment of the court of appeals was entered on May 30, 2008. A petition for rehearing was denied on July 31, 2008 (Pet. App. 21a). On October 21, 2008, the Chief Justice extended the time within which to file a petition for a writ of certiorari to and including November 28, 2008. On November 18, 2008, Justice Stevens further extended the time to December 28, 2008, and the

petition was filed on December 26, 2008. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. This case involves both the Medicaid and Medicare programs. Medicare provides payments for medical services for the elderly and disabled. 42 U.S.C. 1395c *et seq.* The Secretary of Health and Human Services (Secretary) pays hospitals serving Medicare recipients for covered inpatient services. 42 U.S.C. 1395ww(d). However, for those hospitals that serve a "significantly disproportionate number of low-income patients," 42 U.S.C. 1395ww(d)(5)(F)(i)(I), the Secretary provides an increased payment. The measuring stick for this extra payment is an equation called the Medicare disproportionate share hospital adjustment (Medicare DSH). The part of that equation at issue in this case is the "Medicaid fraction," which is defined as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of *patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter* [*i.e.*, the Medicaid program], but who were not entitled to benefits under part A of this subchapter [*i.e.*, the Medicare program], and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. 1395ww(d)(5)(F)(vi)(II) (emphasis added). In other words, the Medicaid fraction is a ratio comparing a hospital's provision of services to patients eligible for Medicaid but not entitled to Medicare, with the hospital's total provision of services. At issue in this case is

the first portion (the numerator) of the Medicaid fraction.[1]

Medicaid is a cooperative federal-state program which provides medical assistance to certain limited categories of low-income persons and other individuals who face serious financial burdens in paying for needed medical care. 42 U.S.C. 1396 *et seq.* To participate in Medicaid, a State develops a plan that specifies the categories of eligible individuals who will receive medical assistance and the specific kinds of medical care and services that will be covered. See 42 U.S.C. 1396a.

2. The State of Ohio has developed a Medicaid plan pursuant to the federal Medicaid requirements. See Ohio Rev. Code Ann. §§ 5111.01 *et seq.* (LexisNexis 2004). Additionally, Ohio has enacted a separate Hospital Care Assurance Program (HCAP), *id.* §§ 5112.01 *et seq.*, under which participating hospitals must "provide, without charge * * *, basic, medically necessary hospital-level services to" low-income Ohio residents who do not qualify for the State's Medicaid program, *id.* § 5112.17(B). HCAP does not reimburse hospitals for the charity care they are obligated to provide under the program.[2]

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[1] Subsequent references to the "Medicaid fraction" or the "Medicare DSH" are thus references to the numerator of the Medicaid fraction.

[2] However, *Medicaid* has its own disproportionate share hospital adjustment (Medicaid DSH) that gives States broad leeway in implementing the adjustment. 42 U.S.C. 1396r-4. In calculating the adjustment, States may consider, among other things, the "costs, volume, or proportion of services provided * * * to low-income patients," including charity care patients. 42 U.S.C. 1396r-4(c)(3)(B). In calculating Medicaid DSH payments, Ohio includes charity care provided under HCAP. Ohio Rev. Code Ann. § 5112.08(B)(2) (LexisNexis 2004).

3. Petitioners are 25 Ohio hospitals that participate in HCAP. They requested the Secretary to include, in the Medicaid fraction of the Medicare DSH, patient days attributable to patients who receive charity care under HCAP. Pet. App. 13a. The Secretary declined, and after an unsuccessful administrative appeal, petitioners filed suit in the District Court for the District of Columbia, alleging that the Medicare DSH "should include HCAP patients." *Id.* at 13a-15a. The district court granted petitioners' motion for summary judgment, *id.* at 10a-18a, reasoning that the Medicare DSH was "unambiguous" and required the inclusion of charity-care patients, *id.* at 16a.

4. The court of appeals reversed, concluding for two separate reasons that the Medicare DSH does not include HCAP patients. First, the court observed that HCAP is not part of Ohio's Medicaid program and that accordingly "HCAP patients are not eligible for care 'under a State plan approved under [Medicaid]' within the meaning of the Medicare statute." Pet. App. 4a. Second, the court explained that HCAP charity-care patients "are not 'eligible for medical assistance' within the meaning of that term in the Medicare DSH provision." *Id.* at 3a. The term "medical assistance," the court explained, is "defined * * * in the federal Medicaid statute" as "'payment for part or all of the cost' of medical 'care and services,'" whereas "the HCAP does not entail any [such] payment." *Id.* at 7a.

ARGUMENT

The court of appeals' decision is correct, and contrary to petitioners' contention (Pet. 14-26), it does not conflict with any other court of appeals decision. Further review is therefore unwarranted.

1. The Medicare DSH accounts for care given to patients "eligible for medical assistance under a State plan approved under [the federal Medicaid program]." 42 U.S.C. 1395ww(d)(5)(F)(vi)(II). The court of appeals correctly concluded that patient days attributable to charity care provided under HCAP should not be counted in the Medicare DSH calculation.

a. As the court of appeals correctly held, the Medicare DSH cannot account for services provided under HCAP because HCAP "is not part of the Ohio 'State plan approved under [Medicaid].'" Pet. App. 3a (brackets in original). Whereas state Medicaid plans must "provide for financial participation by the State," 42 U.S.C. 1396a(a)(2), HCAP "requires [petitioners] to care for indigent patients without payment," Pet. App. 4a. Moreover, HCAP itself recognizes that it applies only to low-income Ohio residents who "are not recipients of [the State's Medicaid assistance]." Ohio Rev. Code Ann. § 5112.17(B) (LexisNexis 2004). Thus, HCAP is separate from Ohio's Medicaid plan and cannot be factored into the Medicare DSH.

b. As the court of appeals also correctly held, charity care provided under HCAP would not qualify for inclusion in the Medicare DSH calculation for the additional reason that HCAP patients are not "eligible for medical assistance" under Medicaid. Although the Medicare statute does not define "medical assistance," the Medicaid statute defines it as "payment of part or all of the cost" of medical "care and services" to certain categories of individuals who lack the resources to pay for their care. 42 U.S.C. 1396d(a). "The substantial relation between [Medicare and Medicaid] presents a classic case for application of the normal rule of statutory construction that identical words used in different parts of the

[Social Security Act] are intended to have the same meaning." *Sullivan* v. *Stroop*, 496 U.S. 478, 484 (1990) (internal quotation marks and citation omitted). That conclusion is bolstered by the Medicare DSH's explicit reference to the Medicaid statute. See *Cabell Huntington Hosp., Inc.* v. *Shalala*, 101 F.3d 984, 987 n.1 (4th Cir. 1996) (*Cabell*) (looking "to the Medicaid statute for guidance on the meaning of ['medical assistance'] in the [Medicare DSH]"). Accordingly, the Medicare DSH's reference to "medical assistance" carries the same meaning as it does in the Medicaid statute.

The Medicare DSH therefore accounts only for medical care and services provided to individuals eligible for Medicaid. Care under HCAP, however, is not provided to patients eligible for Medicaid. HCAP care is thus immaterial for purposes of the Medicare DSH computation at issue in this case.

2. Petitioners contend (Pet. 14-26) that the decision below conflicts with decisions from the Fourth, Sixth, Eighth, and Ninth Circuits. That contention is incorrect.

The decision below does not conflict with any of the four decisions cited by petitioners because those cases concerned a different question than the one at issue here. In those cases, hospitals had provided care pursuant to state Medicaid plans, but the plans imposed certain limits on payment. The hospitals argued that unreimbursed services should nonetheless be counted in the Medicare DSH. In *Cabell*, for instance, West Virginia's Medicaid plan "provide[d] for a maximum of twenty-five paid hospital days," 101 F.3d at 987, and the question for the court was whether the Medicare DSH "should take account of only those inpatient hospital days which are actually paid by West Virginia's Medicaid program," or

"should include all the days of patients who otherwise qualify for Medicaid but who may have exceeded the number of days covered under the state Medicaid plan," *id.* at 986-987.[3]

All four decisions concluded that the Medicare DSH included patient days attributable to patients who were eligible for Medicaid, regardless whether Medicaid actually paid for those days. See *Cabell*, 101 F.3d at 989 ("It is apparent that 'eligible for medical assistance under a State plan' refers to patients who meet the * * * qualifications specified by a particular state's Medicaid plan, whether or not they are actually receiving payment."); *Legacy Emanuel Hosp. & Health Ctr.* v. *Shalala*, 97 F.3d 1261, 1265 (9th Cir. 1996) ("[T]he [Medicare DSH] includes all patient days for which a person was eligible for Medicaid benefits, whether or not Medicaid actually paid for those days of service."); *Jewish Hosp., Inc.* v. *Secretary of HHS*, 19 F.3d 270, 274 (6th Cir. 1994) ("Thus, it appears that all days for which an individual is capable of receiving Medicaid should be figured into the [Medicare DSH]."); *Deaconess Health Servs. Corp.* v. *Shalala*, 912 F. Supp. 438, 447 (D. Mo. 1995) (mem.) ("If a person generally is eligible for medical assistance under a state plan approved by Medicaid * * *, then

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[3] See *Legacy Emanuel Hosp. & Health Ctr.* v. *Shalala*, 97 F.3d 1261, 1263 (9th Cir. 1996) (noting that Oregon "limit[s] the number of days that the state plan provides for inpatient care"); *Jewish Hosp., Inc.* v. *Secretary, Dep't of HHS*, 791 F. Supp. 168, 169 (W.D. Ky. 1992) (mem.) (noting that the plaintiff hospital argued that "it [was] entitled to reimbursement * * * for the hospital stay of all Medicaid patients, even though these patients were not reimbursed for Medicaid for all of their stay"), rev'd, 19 F.3d 270 (6th Cir. 1994); *Deaconess Health Servs. Corp.* v. *Shalala*, 912 F. Supp. 438, 443 (D. Mo. 1995) (mem.) (noting that certain hospitals in Missouri "are subject to specified length-of-stay payment limits"), aff'd, 83 F.3d 1041 (8th Cir. 1996) (per curiam).

all of the days during which such services were received during such eligibility should be included in the [Medicare DSH], whether or not the state Medicaid plan pays for all such days."), aff'd, 83 F.3d 1041 (8th Cir. 1996) (per curiam).

Importantly, there was no dispute in those cases that the hospitals were providing services to patients who were eligible for the "medical assistance" provided by the Medicaid program, even though limits had been reached for particular services. By contrast, patients covered by HCAP are not eligible under Medicaid. As the court of appeals concluded, HCAP is not part of Ohio's Medicaid plan, and HCAP patients do not receive "medical assistance." No court of appeals has ruled to the contrary on either of those questions. The court of appeals thus had no need to reach the question presented in *Cabell*, *Legacy Emanuel*, *Jewish Hospital*, or *Deaconess Health*—*i.e.*, whether the Medicare DSH includes all services that a hospital provides to Medicaid-eligible individuals, or only those services that are paid for.[4] Accordingly, there is no conflict warranting this Court's review.

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[4] Petitioners are thus incorrect in asserting (Pet. 13) that had this case "been decided in the Fourth, Sixth, Eighth, or Ninth Circuits, * * * those circuit courts would not have excluded HCAP patient days from the calculation of Petitioners' Medicare DSH adjustments." As stated, those decisions relied on the fact that the patients at issue were Medicaid-eligible. That circumstance is not present here.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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