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Medicare DSH Reimbursement for Charity Care Dealt Another Blow

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In the wake of the disappointing (and brief) decision in *Adena Regional Medical Center v. Leavitt* (527 F.3d 176 (D.C. Cir. 2008)), providers were left to wish for a court to thoroughly address the tangled knot of issues presented by Medicare Disproportionate Share Hospital (DSH) Reimbursement for "Charity Care" days. They should have been more careful what they wished for. In the recently released ***Cooper University Hospital v. Sebelius*** [PDF], (No. 08-3781, slip op. (D.N.J. Sept. 28, 2009)) the United States District Court for the District of New Jersey wrote a detailed and thorough opinion that rejected the provider's arguments at every turn.

Cooper discusses a New Jersey hospital's "Charity Care" days. In New Jersey, public hospitals are required to care for patients without regard for their ability to pay. Patients who are unable to pay, meet certain income qualifiers, and are not eligible to receive Medical Assistance through the joint Federal/State program known as Medicaid, may be eligible for the state's Charity Care program. They are provided care by the hospital, which in turn is compensated by the state from a fixed pool of money, determined on a year-to-year basis. One hundred percent of the state charity care fund is paid to New Jersey hospitals who participate in the program — the pool is divided between the hospitals based on the charity care they provide in the year. (A hospital that provided 10% of the state's charity care, for instance, would be entitled to 10% of the state's pool.) The Charity Care Program is described in New Jersey's approved state plan, as required under Title XIX of the Social Security Act, and is at least partially funded by matching funds received from the federal government (through the Medicaid DSH program). It is not, however, subject to the federal rules which govern medical assistance (often called "Medicaid" or "Traditional Medicaid").

As in *Adena*, where hospitals operated under Ohio's similar (but not precisely the same) program, the New Jersey hospital had always counted patients who receive Charity Care as "eligible for medical assistance" under Title XIX. Accordingly, until the 2000 fiscal year, the hospital received substantial DSH funding based on its high percentage of "medical assistance" patients. Following the release of Program Memorandum A-99-62, however, Cooper's fiscal intermediary struck 5,518 Charity Care patient days from the numerator of the Medicaid Fraction component of the Medicare DSH formula for fiscal year 2000. The net effect to the hospital was a loss of 1.145 million dollars.

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The hospital appealed to the Provider Reimbursement Review Board (PRRB), which agreed that patients receiving assistance with their medical needs as a result of a state program that is approved as a part of the state's Title XIX state plan are "eligible for medical assistance" under a state plan and the days should be included in the DSH Medicaid Fraction. The Administrator reversed, on the grounds that Charity Care patients are not, by definition, eligible for Medicaid, and the District Court upheld this decision.

The *Cooper* court began its analysis by determining that the operative statutory language, including the language that refers to all patients who are "eligible for medical assistance under a State plan approved under subchapter XIX," is ambiguous. As evidence of this ambiguity, the Court pointed to the fact that the PRRB and the Administrator read the statute differently. This, of course, raises the issue of whether the Administrator can effectively render *any* statutory language ambiguous simply by proposing a contrary reading.

Having found that the operative statutory language was ambiguous, the court turned to step two of the famous *Chevron* inquiry to determine whether the Secretary's interpretation of the statute was "reasonable."

For its part, CMS argued, as it has consistently in these matters, that the statutory language should be read much more narrowly than it first appears. Noting that "medical assistance" is not defined in the Medicare statute (Title XVIII), CMS pointed to a definition contained in Title XIX which defines "medical assistance" as payments made on behalf of patients that are either categorically needy or medically needy — in other words, patients who receive traditional Medicaid.

The *Cooper* court, citing heavily to the D.C. circuit court's *Adena* decision, agreed that this was a reasonable way to define the "ambiguous" language. In support of its decision that Congress meant to use "eligible for medical assistance" as "shorthand" for "eligible for Medicaid" the *Cooper* court noted that this is precisely how CMS's regulations use the two terms. Moreover, New Jersey's Charity Care program, as the similar Ohio program did in *Adena*, specifically excludes patients who are eligible for "Medicaid." Accordingly, the *Cooper* court found that New Jersey Charity Care patients are not Medicaid beneficiaries and may not be included in a DSH Medicaid Fraction calculation of patients "eligible for Medical Assistance."

Ober|Kaler's Comments: *Cooper* is not a Court of Appeals case, and will almost certainly be appealed. Nevertheless, the district court's clear reliance on the *Adena* decision does not bode well for hospitals pursuing DSH claims for similar "Charity Care" programs. The appeals court decision in *Adena* effectively forestalled any such litigation in the D.C. Circuit. An unsuccessful appeal by the provider in *Cooper* would do the same in the Third Circuit, which governs New Jersey, Delaware, and Pennsylvania. Providers that wish to pursue this issue can expect to lose at the CMS Administrator level and will therefore need to file appeal in federal court. As providers cannot successfully pursue this issue in the D.C. federal court, they will need to carefully examine the jurisprudence of their home federal district and circuit courts to determine the likelihood of success.

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