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D.C. Appeals Court Reverses Favorable Decision on Charity Care Days in *Adena Regional Medical Center v. Leavitt*

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In a brief but significant Medicare reimbursement decision, on May 30, 2008, the United States Court of Appeals for the District of Columbia Circuit ruled that Ohio's "Charity Care" days should not be included in the count of a provider's "Medicaid Days" used in the Medicare disproportionate share hospital (DSH) calculation. *Adena Regional Medical Center v. Leavitt*, D.C. Cir., No. 07-5273, 5/30/08.

As many providers are aware, Medicare DSH reimbursement is calculated based on a formula that is heavily dependent on the number of patient care days that are attributable to patients who are "eligible for medical assistance under a State plan approved under Title XIX." Each state provides this medical assistance through its own, unique, state Medical Assistance Program. Whether a patient is counted for Medicare DSH, therefore, would seem to depend on whether or not he or she is receiving "medical assistance" according to the state's approved "State plan." A state's Medical Assistance Program (that is, "traditional" Medicaid) must be part of its State plan, but it is usually not the only part; many states have other so-called "safety-net" programs that are detailed in their State plans but that are not part of their Medical Assistance Programs. These additional, State-plan-approved programs typically are payors of last resort. In other words, patients are only eligible for the state's limited "safety-net" funds where they are not already receiving funds under the state's primary payor Medical Assistance Program.

Given the fact that states often include as part of their "medical assistance" these additional "safety net" programs and given that the federal government not only approves these programs as part of the Title XIX state plan but also provides matching funds for these programs, providers have argued that the Medicare DSH calculation must include days attributable to these assistance days as well as to days covered by traditional Medicaid. The *Adena* court, however, rejected this position, at least in context of the Ohio plan.

The Court, in the very first sentence of its analysis, simply substituted the word

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"Medicaid" for the original statutory text "medical assistance under a State plan approved under subchapter XIX…" and then found it a simple matter to conclude that Ohio's Charity Care (HCAP) provisions were not part of a Medicaid approved plan. The Court reached this conclusion by noting, first, that under HCAP the hospitals are required to care for indigent patients without payment and, second, that HCAP was unavailable to patients already receiving aid through the state's Medicaid Plan.

The fact that Ohio's HCAP program actually is a part of its State Medicaid plan, reviewed and approved by CMS, did not alter the Court's analysis. As the Court explained, the inclusion of the HCAP provisions in the State plan related to Medicaid DSH and did not suggest in any way that HCAP patients were receiving care pursuant to the Ohio Medicaid Plan. The Court stated that, in order to prevail, the hospitals would need to demonstrate that HCAP patients were "'eligible for medical assistance under a State plan approved under [Medicaid]' within the meaning of that phrase in the Medicare statute." The Court then ruled that the term "medical assistance" must have the same meaning in Title XVIII [i.e. Medicare] as it does in Title XIX, which defines "medical assistance" as "payment of part or all of the cost" of medical "'care and services' for a defined set of individuals." Using this definition, the Court concluded that HCAP patients were not eligible for medical assistance under Medicaid.

Ober|Kaler's Comments: This decision is of particular importance to providers, because it was rendered by the United States Court of Appeals for the D.C. Circuit. All providers that are dissatisfied with a final decision of the Provider Reimbursement Review Board or the CMS administrator are permitted to appeal the decision either to the federal district court where the provider is located, or to the federal district court in the District of Columbia, with further appeal rights to the D.C. Circuit Court of Appeals. Providers that choose to appeal to the D.C. District Court are thus controlled by the decisions of the D.C. Circuit Court of Appeals.

Whether other circuits will follow the D.C. Circuit's analysis of the Medicare DSH/ Charity Care question remains to be seen, but this decision certainly does not bode well for the future of the other cases making their way through Medicare's administrative and judicial appeal systems.