No. 15-1495

In the Supreme Court of the United States

SOUTHEAST ARKANSAS HOSPICE, INC., PETITIONER

v.

SYLVIA BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES

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

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

Medicare imposes an annual aggregate cap, for hospice providers that choose to participate in the program, on the total amount paid in reimbursements for hospice patient care. The question presented is whether the aggregate cap effects a taking under the Fifth Amendment's Just Compensation Clause.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-4a) is reported at 815 F.3d 448. The opinion of the district court (Pet. App. 5a-32a) is reported at 1 F. Supp. 3d 915.

JURISDICTION

The judgment of the court of appeals was entered on March 10, 2016. A petition for a writ of certiorari was filed on June 8, 2016. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.*, commonly known as Medicare, established a federally subsidized health insurance program for the aged and persons with disabilities. In addition to providing insurance and reimbursement

for the costs of hospital and other medical care for participants, the Medicare program provides for reimbursement for hospice care for terminally ill patients. See 42 U.S.C. 1395c to 1395i-4; 42 U.S.C. 1395x(dd)(1) (hospice benefit). By electing to participate in Medicare, a hospice provider agrees to comply with an array of conditions, including those governing the process for obtaining payment, limits on reimbursement, and restrictions on discharging patients. See 42 U.S.C. 1395f(a)(1); 42 U.S.C. 1395x(dd)(2)(D); 42 U.S.C. 1395f(i)(2)(C); see also 42 C.F.R. 418.309(c). A provider of hospice services may voluntarily terminate its agreement with the Medicare program after providing proper notice. See 42 U.S.C. 1395cc(b)(1).

The Medicare program pays a daily rate to hospice care providers for each Medicare patient treated. See 42 C.F.R. 418.302. To receive benefits for hospice care, a patient must elect hospice care, and two physicians must certify that the patient is suffering from a terminal illness. See 42 U.S.C. 1395d(d)(2)(A); 42 U.S.C. 1395f(a)(7). After the initial election and certification, a patient must continue to elect hospice benefits and be certified at the beginning of each benefit period. See 42 U.S.C. 1395d(d)(1). There is no limit on the number of benefit periods. See 42 U.S.C. 1395d(a)(4).

As a condition of participating in and receiving payments from Medicare, a hospice must provide hospice services to eligible Medicare patients without regard to any patient's ability to pay and may not discharge a patient for inability to pay. See 42 U.S.C. 1395x(dd)(2)(D). A hospice provider may discharge a patient for one of three reasons: The patient has moved or transferred to another hospice facility; the

hospice provider has determined that the patient is no longer terminally ill; or the patient has been determined to be disruptive to the activities of the hospice. See 42 C.F.R. 418.26.

To ensure that payments for hospice care do not exceed the costs of care in a conventional setting, see H.R. Rep. No. 333, 98th Cong., 1st Sess. 1 (1983), Congress established a cap on the aggregate amount that Medicare will reimburse hospice providers each year. See 42 U.S.C. 1395f(i)(2)(C); see also 42 C.F.R. 418.309(c) (setting out a proportional method for calculating the aggregate cap). The cap applies to aggregate payments made to a hospice provider across all the Medicare patients served by the hospice during the cap year. See 42 U.S.C. 1395f(i)(2)(A) and (B) (setting cap at $6500 per patient, adjusted for inflation, multiplied by the total number of patients served per year and adjusted for the portion of the year served). Payments made in excess of the statutory cap are considered overpayments and must be refunded to the Medicare program by the hospice care provider. See 42 C.F.R. 418.308. The cap for each year is calculated after the hospice provider has received some reimbursements; the cap is used to determine the amount, if any, that the hospice must repay to the agency for reimbursements that have exceeded the cap. See 42 C.F.R. 405.371 (procedures for addressing overpayments to providers).

When a hospice provider exceeds its aggregate cap for an accounting year, the Medicare administrative contractor—a private contractor authorized to process provider claims for Medicare payment, see 42 U.S.C. 1395h(a)—issues a demand for the overpayment. See 42 C.F.R. 418.308(d). If a provider is dissatisfied with

the Medicare administrative contractor's decision as to the amount, it may appeal the decision to the Provider Reimbursement Review Board. See 42 U.S.C. 1395*oo*(a). A provider that is dissatisfied with the Board's ruling may obtain judicial review by filing a civil action within 60 days of the Board's final determination. See 42 U.S.C. 1395*oo*(f)(1).

2. Petitioner operated two hospice care facilities in Arkansas and voluntarily agreed to provide hospice services to Medicare patients. As a Medicare provider, petitioner received reimbursements for hospice care that it provided to Medicare beneficiaries and was required to repay any overpayments that exceeded the aggregate cap. Pet. App. 6a, 8a.

a. Petitioner filed suit challenging the requirement to make repayment of overpayments. Petitioner contended that the government should pay more for the hospice care that petitioner provides to Medicare beneficiaries, and also alleged that the current payment system effects a taking under the Fifth Amendment's Just Compensation Clause. The district court rejected petitioner's takings claim, relying on "the voluntary nature of [petitioner's] participation in the Medicare hospice program." Pet. App. 22a; see *id.* at 21a-26a. The court noted petitioner's "conce[ssion] that it voluntarily chose to become a hospice provider and participate in the Medicare hospice program." *Id.* at 25a. That concession, and petitioner's failure to "establish[] legal compulsion to continue to participate in the regulated industry," the court found, was fatal to petitioner's claim. *Id.* at 25a-26a.

b. The court of appeals affirmed. Pet. App. 1a-4a. The court noted that petitioner voluntarily chose to participate in the Medicare hospice program. "This

voluntariness forecloses the possibility that the statute could result in an imposed taking of private property which would give rise to the constitutional right of just compensation." *Id.* at 4a (quoting *Minnesota Ass'n of Health Care Facilities, Inc.* v. *Minnesota Dep't of Pub. Welfare*, 742 F.2d 442, 446 (8th Cir. 1984), cert. denied, 469 U.S. 1215 (1985)). The court also rejected petitioner's contention that the aggregate cap on reimbursement made it impossible to profitably engage in its business, or that petitioner's participation in Medicare was otherwise involuntary. *Id.* at 3a. Finally, the court contrasted the voluntary nature of petitioner's participation in the Medicare program with the regulatory scheme at issue in *Horne* v. *Department of Agriculture*, 135 S. Ct. 2419 (2015). See Pet. App. 4a.

ARGUMENT

The decision below is correct and does not conflict with any decision of this Court or of any other court of appeals. The petition should be denied.

1. The court of appeals correctly held that a hospice provider's voluntary participation in Medicare precludes its takings claim. It is settled that a challenged governmental action must create legal compulsion in order to require just compensation under the Fifth Amendment. See *Lingle* v. *Chevron U.S.A. Inc.*, 544 U.S. 528, 539 (2005); *Yee* v. *City of Escondido*, 503 U.S. 519, 532 (1992); *Bowles* v. *Willingham*, 321 U.S. 503, 517-518 (1944). Accordingly, the courts of appeals have uniformly rejected takings challenges to reimbursement rates and other conditions established under the Medicare and Medicaid programs. See *Burditt* v. *United States Dep't of Health & Human Servs.*, 934 F.2d 1362, 1376 (5th Cir. 1991) (rejecting takings

challenge to reimbursement under Medicare because "[o]nly hospitals that voluntarily participate in the federal government's Medicare program must comply"); see also *Franklin Mem'l Hosp.* v. *Harvey*, 575 F.3d 121, 129-130 (1st Cir. 2009); *Garelick* v. *Sullivan*, 987 F.2d 913, 916-917 (2d Cir.), cert. denied, 510 U.S. 821 (1993); *Baptist Hosp. East* v. *Secretary of Health & Human Servs.*, 802 F.2d 860, 869-870 (6th Cir. 1986); *Whitney* v. *Heckler*, 780 F.2d 963, 972 (11th Cir.), cert. denied, 479 U.S. 813 (1986); *Minnesota Ass'n of Health Care Facilities, Inc.* v. *Minnesota Dep't of Pub. Welfare*, 742 F.2d 442, 446 (8th Cir. 1984), cert. denied, 469 U.S. 1215 (1985) (*Minnesota Ass'n*); *St. Francis Hosp. Ctr.* v. *Heckler*, 714 F.2d 872, 875-876 (7th Cir. 1983) (per curiam), cert. denied, 465 U.S. 1022 (1984).

In this case, the court of appeals correctly rejected petitioner's takings claim because petitioner was not legally compelled to participate in Medicare. There is no requirement that a hospice enter into a Medicare provider agreement; businesses may choose to provide hospice services outside the Medicare program. Nor, once it has chosen to participate, must a hospice remain in the program after providing appropriate notice. See 42 U.S.C. 1395cc(b)(1). And even if petitioner could establish that its participation in the program was based upon economic circumstances, the "fact that practicalities may in some cases dictate participation does not make participation involuntary." *St. Francis Hosp. Ctr.*, 714 F.2d at 875; see *Garelick*, 987 F.2d at 917 ("economic hardship is not equivalent to legal compulsion for purposes of takings analysis"); *Minnesota Ass'n*, 742 F.2d at 446 ("Despite the strong financial inducement to participate in Med-

icaid, a nursing home's decision to do so is nonetheless voluntary.").

2. Petitioner does not contend that any court of appeals has agreed with its takings argument. To the contrary, petitioner acknowledges (Pet. 13) that "[a] long line of cases show[s] that generally no taking occurs when a person or entity voluntarily participates in a regulated program or activity, like Medicare hospice." Instead, petitioner asserts (Pet. 14) that "all the above cases are in direct opposit[ion] to" this Court's decision in *Horne* v. *Department of Agriculture*, 135 S. Ct. 2419 (2015).

Petitioner's reliance on *Horne* is misplaced. There, the government required raisin growers, as a condition of their participation in the market, to reserve from sale a percentage of their crop. Because the reserved raisins were held in an account for the government, which acquired control over and title to the account, the Court determined that the reserve requirement was "a clear physical taking." 135 S. Ct. at 2428. The Court relied for its conclusion on the fact that the reserve requirement "cannot reasonably be characterized as part of a * * * voluntary exchange." *Id.* at 2430.

Unlike the reserve requirement in *Horne*, the Medicare payment system did not impose a physical taking of petitioner's property. Nor did it restrict petitioner's right to participate in private transactions in interstate commerce. Rather, as the court of appeals correctly held, the system merely establishes the terms under which a hospice provider may receive payment under the Medicare program in the event that the provider chooses to participate. See Pet. App. 4a. Petitioner thus "voluntar[ily]" agreed to

abide by the conditions of the Medicare program "in exchange for the economic advantages" of participation, which "can hardly be called a taking." *Ruckelshaus* v. *Monsanto Co.*, 467 U.S. 986, 1007 (1984); see *Horne*, 135 S. Ct. at 2430 (requirement in *Ruckelshaus* that manufacturers disclose trade secrets in exchange for a "valuable Government benefit" was not a taking) (citation omitted).

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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