NO. 19-1203

IN THE
SUPREME COURT OF THE UNITED STATES

CHILDREN'S HOSPITAL ASSOCIATION OF TEXAS, et al.,

Petitioners,

v.

ALEX M. AZAR II, SECRETARY OF HEALTH AND HUMAN SERVICES, et al.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court of Appeals For The District of Columbia Circuit

BRIEF OF NEW HAMPSHIRE HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONERS AS *AMICUS CURIAE*

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May 11, 2020

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STATEMENT OF INTEREST OF *AMICUS CURIAE*

A*micus curiae*, the New Hampshire Hospital Association ("NHHA"), submits this brief in support of Petitioners' petition for a writ of certiorari.[1]

The interests at stake in this case are interests that NHHA has successfully championed on behalf of its members for years. NHHA's mission is to provide leadership through advocacy, education, and information in support of its members which include twenty-six acute care hospitals that deliver high quality health care to the patients and communities they serve in the State of New Hampshire. NHHA has been at the forefront of advocating on behalf of its members for Medicaid reimbursement that is consistent with the Medicaid Act, its regulations, the New Hampshire State Medicaid Plan, and other applicable federal and state laws, including issues related to disproportionate share hospital ("DSH") funding. All hospitals that qualify for DSH funding under the

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[1] No counsel for a party authored this brief in whole or in part. No party or counsel for a party made any monetary contribution intended to fund the preparation or submission of this brief. No person or entity, other than *amicus curiae*, its members, or its counsel, made any such monetary contribution to the preparation or submission of this brief. All counsel of record received timely notice of the intention of counsel for *amicus curiae* to file this brief and granted consent to file this brief in accordance with Rule 37 of the Rules of the Supreme Court of the United States.

New Hampshire State Medicaid Plan are members of NHHA. They include critical access hospitals and acute inpatient prospective payment system hospitals. Nearly all of NHHA's DSH qualifying acute care hospitals are nonprofit organizations. Thirteen of them qualify as small rural hospitals under the Social Security Act. All of these hospitals treat large numbers of Medicaid patients. In turn, Medicaid reimburses them, but only at a fraction of the actual costs the hospitals incur to treat these patients. Accordingly, the hospitals rely heavily on DSH payments in order to recapture a portion of the financial shortfalls they suffer in treating disproportionately high numbers of Medicaid-eligible patients.

The 2017 rule at issue in this case fundamentally affects NHHA's members, because it reduces the hospital-specific DSH payment limit for each DSH-qualified member hospital by the amount of payments the hospital has received from Medicare and private insurers for patients with dual eligibility.[2] NHHA, on behalf of its member

[2] In June 2018, due to the uncertainty presented by the pending DSH litigation in various federal courts and a history of challenges in New Hampshire state courts to the State's assessment of its Medicaid Enhancement Tax ("MET") on hospitals, NHHA's member hospitals reached an agreement with the State of New Hampshire regarding DSH payments and MET assessments. The parties entered into a court-approved consent decree and order which temporarily sidelines the problem of DSH payment reductions based on dual eligibility for a term of seven years, ending in 2024, and guarantees minimum DSH payments to hospitals pursuant to an agreed-upon formula. As soon as the agreement terminates,

hospitals, successfully challenged the unlawful policy now codified in the 2017 rule as an unreasonable exercise of statutory authority, which was inconsistent with prior agency practice. *N.H. Hosp. Ass'n v. Azar*, 887 F.3d 62 (1st Cir. 2018).

SUMMARY OF ARGUMENT

This Court's review is warranted because Petitioners' challenge to the Centers for Medicare & Medicaid Services' ("CMS") 2017 rule will materially impact not only children's hospitals, but all DSH-qualified acute care hospitals under the various State Medicaid Plans around the country. The impact has always been an important one, but it is felt now, more than ever, as revenue-starved hospitals must persist in their fundamental mission of caring for patients in the midst of the COVID-19 pandemic.

Freestanding children's hospitals, like those represented by Petitioners, experience losses resulting from the 2017 rule due to the volume of Medicaid-eligible children they serve. Other acute-care hospitals serving more diverse patient populations, such as those who are members of NHHA, also endure losses from the inclusion of third-party payments in the calculation of "costs incurred."

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if the 2017 rule remains in effect, the dual-eligibility DSH payment reductions will resume, and NHHA's qualifying hospitals will face material reductions in funding.

The 2017 rule requires that the hospital-specific DSH payment limit for DSH-qualified acute care hospitals throughout the country be reduced by payments received from Medicare and private insurers for patients with dual eligibility. CMS's unlawful change to the calculation has the effect of substantially and materially reducing DSH payments to each qualifying NHHA member, and to similarly-situated hospitals throughout the country. Subtracting third-party payments from hospitals' DSH payments has far-reaching, harmful effects on DSH-qualified acute care hospitals and is contrary to congressional intent in enacting the Medicaid DSH program.

NHHA has previously successfully challenged the enforcement of new policies announced by CMS through "frequently-asked questions" ("FAQs") posted on its website as FAQs 33 and 34. *N.H. Hosp. Ass'n v. Burwell*, No. 15-cv-460-LM, 2017 WL 822094 (D.N.H. Mar. 2, 2017) (enjoining the policies of CMS's FAQs 33 & 34 to deduct Medicare and third party payments as "costs incurred" from the DSH limit), *aff'd sub nom N.H. Hosp. Ass'n v. Azar*, 887 F.3d 62 (1st Cir. 2018). While *Burwell* was pending, the Secretary published the 2017 rule entitled "Medicaid Program: Disproportionate Share Hospital Payments—Treatment of Third Party Payers in Calculating Uncompensated Care Costs," promulgated pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq*. (the "Medicaid Act") with an effective date of June 2, 2017. 87 Fed. Reg. 16,114 (April 3, 2017). The 2017 rule includes the unlawful, enjoined, and ultimately withdrawn

policies referenced for the first time in FAQs 33 and 34.

CMS promulgated the 2017 rule in an attempt to rectify the various procedural infirmities identified by numerous federal district courts, and affirmed, in relevant part, by four courts of appeals. Those courts found that CMS's effort to make substantive changes to federal law through FAQs, rather than through notice and comment procedure established by the Administrative Procedures Act, was unlawful.[3] The 2017 rule, just like FAQs 33 and 34, is substantively infirm, and contrary to the purpose of the Medicaid Act. This Court's review of the 2017 rule is necessary because the D.C. Circuit's opinion inflicts widespread harm to all DSH-qualifying acute care hospitals, and potentially impacts those hospitals' ability to continue to prioritize care to vulnerable patient populations. In many instances, the reduction of DSH funding may directly correspond to the loss or decreased provision of certain patient services.

[3] *See Burwell*, 2017 WL 822094, at *16, *aff'd*, 887 F.3d 62 (1st Cir. 2018); *Children's Hosp. of the King's Daughter's, Inc. v. Price*, 258 F. Supp. 3d 672, 689 (E.D. Va. 2017), *aff'd* in part, vacated in part, 896 F.3d 615 (4th Cir. 2018); *Tenn. Hosp. Ass'n v. Price*, No. 16-cv-3263, 2017 WL 2703540, at *8 (M.D. Tenn. June 21, 2017), *aff'd* and remanded, 908 F.3d 1029 (6th Cir. 2018); *Children's Health Care v. CMS*, No. 16-cv-4064, 2017 WL 3668758, at *8 (D. Minn. June 26, 2017), *aff'd*, 900 F.3d 1022 (8th Cir. 2018).

ARGUMENT

This Court should accept the petition for review, reverse the court of appeals' rejection of Petitioner's arguments, and should instead follow the reasoning of the district court, which vacated the 2017 rule codifying CMS's unlawful policy.

I. The 2017 Rule's Impact is Widespread, Adversely Affecting All Acute Care Hospitals Serving High Levels of Medicaid-Eligible and Uninsured Patients, and Represents a Material Issue Deserving of This Court's Attention.

Hospitals in New Hampshire and across the nation find themselves in unprecedented and precarious times. They operate on the front lines in the war against the coronavirus pandemic. They provide technically complex, life-saving, and often expensive care to all patients who need it, regardless of income or ability to pay, including those with COVID-19 who require hospitalization. In their efforts to fight the pandemic, hospitals have suspended non-urgent and elective surgeries, losing their main drivers of revenue in the process. Still, hospitals must navigate these uncertain financial times while assuring the safety of their patients and the quality of the care they provide.

Even before the pandemic, hospitals serving vulnerable patient populations with high levels of Medicaid-eligible and uninsured individuals

operated under challenging financial circumstances. Whether located in rural or more densely populated areas, whether a small critical access hospital or part of a larger health system, low-income and uninsured individuals rely upon these hospitals for their basic care needs. The costs associated with providing the necessary care for these individuals significantly impacts hospital finances. Medicaid reimbursement, while an important source of funds flowing into these hospitals, falls far short of covering hospitals' actual costs to care for these patients. Recognizing that Medicaid does not reimburse for all hospital services provided to Medicaid patients, and does not even wholly reimburse hospitals for costs of covered services, Congress established the DSH program to provide supplemental payments to hospitals serving a disproportionately high level of Medicaid-eligible patients. 42 U.S.C. § 1396a(a)(13)(A)(iv); 42 U.S.C. § 1396r-4.

The DSH program's payment adjustments to qualifying hospitals are important to sustaining Petitioner hospitals, who specialize in caring for children, and to acute-care hospitals providing care to high numbers of Medicaid-eligible patients of all ages, some of whom are also covered by private health insurance and Medicare. Supplemental DSH payments are crucial to offsetting these hospitals' costs of providing uncompensated care. Without them, hospitals may be forced to decrease or eliminate certain services, or to raise rates in order to continue providing governmental-payor-dependent essential health services. This, in turn,

would work a hardship on at-risk patients who may be compelled to seek care elsewhere, pay more for care, or forego seeking care all together due to higher costs.

Reduction of supplemental DSH payments would also require hospitals to work even harder than they already do to negotiate the highest possible contract rates from private health insurers to help offset losses incurred due to comparatively low, and artificially depressed, reimbursement rates by governmental payors. Private payors typically pay higher rates than Medicaid-allowable costs, Medicaid-covered services, or Medicaid reimbursement rates. The 2017 rule requires that the hospital-specific DSH payment limit be further decreased by the amount of payments received from Medicare and private health insurers for patients with dual eligibility. Essentially, the 2017 rule artificially counts private health insurance and Medicare payments as Medicaid payments in its hospital-specific DSH payment limit calculation. Private health insurance and Medicare payments had never been applied or used in determining the hospital-specific limit prior to CMS's issuance of the unlawful FAQs 33 and 34. Rather, the Medicaid Act unambiguously required only that actual Medicaid payments be subtracted from a hospital's Medicaid-eligible costs.

II. The 2017 Rule Is Contrary to Statutory Authority and Undermines the Medicaid Act's Purpose by Harming Acute Care Hospitals that Treat Disproportionate Numbers of Medicaid-Eligible Patients.

The 2017 rule is contrary to the Medicaid Act's express language and frustrates the purpose of the DSH program. States participating in the Medicaid program are required to take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs when setting reimbursement rates. 42 U.S.C. § 1396a(a)(13)(A)(iv). This is the source of the DSH program and its payment adjustments to qualifying hospitals. 42 U.S.C. § 1396r-4(c). With Medicaid reimbursement rates historically and consistently lower than what it actually costs a hospital to provide care, Congress enacted the DSH program intending to close that gap and thereby relieve the financial burden on hospitals to continue treating large numbers of Medicaid patients. *See* 42 U.S.C. § 1396r-4. The DSH program helps to partially reimburse such hospitals for the treatment they provide to high levels of uninsured and Medicaid patients through "payment adjustment[s]". 42 U.S.C. § 1396r-4(c). Federal DSH funding is calculated for each state pursuant to 42 U.S.C. § 1396r-4(f)(3), and this fixed pool of funds is allocated among DSH-qualifying hospitals in each state.

The Medicaid Act, in a provision entitled "Amount of adjustment subject to uncompensated costs," sets the method for calculating the cap on the

amount of DSH funding any particular hospital can receive in a year (or the hospital-specific DSH limit) as:

> [T]he costs incurred during the year of furnishing hospital services (as determined by the Secretary and *net of payments under this subchapter*, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year.

42 U.S.C. § 1396r-4(g)(1)(A) (emphasis added). This subchapter does not reference payments from private health insurers, Medicare, or other third party payments.

Put another way, the Medicaid Act's hospital-specific DSH limit is calculated to be the hospital's net costs of care it provides to Medicaid-eligible and uninsured individuals. Net costs are determined by an offset of payments the hospital receives under the Medicaid program. If a hospital must also offset payments it has received from Medicare and third-party payors, as the 2017 rule requires, the hospital-specific limit is lowered, sometimes substantially, and so is the amount of Medicaid DSH funds the hospital can receive.

The Petitioners have outlined the impact of the 2017 rule's codification of FAQ 33 relating to private health insurance payments on their ability to provide children's health care. FAQ 34, which was not directly at issue in the proceedings below, but which was similarly codified by the 2017 rule, relates to inclusion of Medicare payments in the calculation of the hospital-specific limit. It presents another important aspect of Medicaid reimbursement that complicates the provision of health care by all DSH-qualified acute care hospitals that provide care to the population at large, including children and adults. After four appellate court decisions found in favor of hospitals, FAQs 33 and 34 were withdrawn by CMS, and audits undertaken pursuant to those FAQs are now subject to revision. *See Tenn. Hosp. Ass'n v. Azar*, 908 F.3d 1029 (6th Cir. 2018); *Children's Health Care v. CMS*, 900 F.3d 1022 (8th Cir. 2018); *Children's Hosp. of the King's Daughters, Inc. v. Azar*, 896 F.3d 615 (4th Cir. 2018); *N.H. Hosp. Ass'n v. Azar*, 887 F.3d at 62.

FAQs 33 and 34, now codified in the 2017 rule, introduced for the first time a material change to the DSH calculation by requiring the deduction of payments received from Medicare and third-party payors for Medicaid patients with dual eligibility. While the FAQs themselves have been vacated, their unlawful calculation change survived in CMS's 2017 rule. DSH payments may not exceed "costs incurred" in furnishing hospital services to eligible individuals "(as determined by the Secretary and net of [Medicaid] payments)." 42 U.S.C. § 1396r-4(g)(1)(A). In the 2017 rule, the Secretary defined "costs

incurred" as "costs net of third-party payments, including, but not limited to, payments by Medicare and private insurance." 42 C.F.R. § 447.299(c)(10)(i) (effective June 2, 2017).

The effect of the 2017 rule's calculation is to markedly reduce the resulting DSH payments to all qualifying acute care hospitals. As noted *supra*, in challenges to the FAQs, federal courts of appeals and district courts soundly rejected CMS's contention that the changes contained in FAQs 33 and 34 represented longstanding policy or permissible interpretations under the Medicaid Act. On the contrary, the FAQ policies were never consistently, if ever, applied at all prior to the FAQs' issuance. *N.H. Hosp. Ass'n v. Azar*, 887 F.3d at 72 (stating that the policy articulated in FAQs 33 and 34 "looks to us more as if the Secretary is using delegated power to announce a new policy out of whole cloth, rather than engaging in an interpretive exercise.").

Accordingly, by denying acute care hospitals their statutory right to receive the full amount of DSH payments they are due, the 2017 rule frustrates the purpose of the Medicaid Act and the fundamental intent of the DSH program.

CONCLUSION

This Court should grant the petition for a writ of certioriari and reverse the court of appeals.

May 8, 2020

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