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 CHILDREN'S HOSPITAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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INTERESTS OF *AMICUS CURIAE*[1]

Amicus Curiae Children's Hospital Association ("CHA") is a national non-profit organization representing the interests of 220 children's hospitals across the country. CHA members provide specialized care to children, covering complex conditions such as heart ailments, cancer, and low birth weight. Medicaid covers more than half of the patients served by the average children's hospital, but Medicaid reimbursement rates are typically too low to pay fully for those patients' care. As a result, CHA members rely substantially on supplemental Medicaid payments through the federal Disproportionate Share Hospital ("DSH") program. DSH payments allow CHA members to provide comprehensive care, advance pediatric medicine, and keep pace with cutting-edge developments in medicine and technology.

The DSH rule challenged in this case will fundamentally harm CHA's member hospitals by denying them tens of millions of dollars in supplemental Medicaid payments each year. The rule directly undermines a major purpose of the DSH program, which is to assist these hospitals financially and preserve access to specialized

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[1] No counsel for a party authored this brief in whole or in part. No party, counsel for a party, or person other than *amicus curiae*, its members, or its counsel, made any monetary contribution intended to fund the preparation or submission of this brief. Counsel of record for all parties have received timely notice, under Sup. Ct. R. 37.2(a), of the intent to file this brief. Counsel of record for all parties have provided written consent to the filing of this brief.

services for all children. CHA submits this brief to illustrate for the Court the far-reaching harm the rule will inflict upon children's hospitals and the pediatric communities that they support.

SUMMARY OF ARGUMENT

The DSH rule challenged here will devastate children's hospitals, undermining essential healthcare for pediatric patients throughout the country. Therefore the question whether the agency exceeded its statutory authority in issuing the rule is an important question of federal law. This Court should grant the petition to address it.

The statute's text expressly requires the DSH program to support children's hospitals, because they treat disproportionate numbers of Medicaid-eligible patients. Nearly half of all Medicaid beneficiaries are children. The reason is that children's hospitals provide care to children with serious illnesses and complex chronic conditions across large geographic areas, without regard to a family's ability to pay.

DSH payments to children's hospitals are critical, because standard Medicaid payments do not come close to covering the cost of services for the hospitals' substantial populations of Medicaid-eligible patients. Children's hospitals are financially vulnerable even when DSH payments are taken into account. The rule would make matters much worse by imposing multi-million dollar cuts in DSH payments for typical children's hospitals.

The harms from the rule already have begun, with cuts to DSH payments implemented for hospital services since the time of the court of appeals' mandate. In addition, if the agency's assertions are correct, the rule will even be implemented retroactively, requiring children's

hospitals to pay multi-million dollar refunds to the government.

The current pandemic is causing massive economic harm to children's hospitals even without considering the adverse impact of the challenged rule. The harmful effects of the challenged rule would justify this Court's intervention at any time. But at this particular time, given the public health emergency, there is a heightened need for intervention. The Court should grant the petition.

ARGUMENT

Unless this Court intervenes, the DSH rule challenged here will devastate children's hospitals throughout the nation and directly harm the millions of children whom they serve. The question whether the agency exceeded its statutory authority in issuing the rule therefore is an important question of federal law. That question has not been, but should be, settled by this Court.

I. THE RULE WILL DEVASTATE CHILDREN'S HOSPITALS THAT CONGRESS INTENDED THE DSH PROGRAM TO SUPPORT

A. The Statute's Text Requires the DSH Program to Support Children's Hospitals, Because They Treat Disproportionate Numbers of Medicaid-Eligible Patients

In 1981, Congress amended the Medicaid Act to create the DSH program, which requires states to ensure that Medicaid payments to hospitals "take into account . . . the situation of hospitals which

serve a disproportionate number of low-income patients with special needs." 42 U.S.C. § 1396a(a)(13)(A)(iv) (2018). The DSH program supports hospitals that admit patients regardless of "source of payment" or "ability to pay" and therefore "serve a large number of Medicaid-eligible and uninsured patients who other providers view as financially undesirable." H.R. Rep. No. 100-391(I), at 524 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1, 2313-344. Through the DSH program, these hospitals receive supplemental Medicaid payments, to ensure that they are financially viable and can continue providing vital healthcare services to Medicaid-eligible patients.

Children's hospitals are the quintessential example of the hospitals entitled to these supplemental payments. The statute expressly refers to "disproportionate share hospitals, *including children's hospitals*" in describing the providers that should receive DSH payments, given "the proportion of low-income and Medicaid patients . . . served by such hospitals." 42 U.S.C. § 1396r-4(a)(2)(D) (2018) (emphasis added).

Congress focused on children's hospitals because their Medicaid patient populations are exceedingly large. Medicaid is the biggest source of insurance coverage for children.[2] The reason is that children's hospitals provide care to children with

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[2] Children's Hospital Association, *Covering America's Kids* (2020), https://www.childrenshospitals.org/-/media/Files/CHA/Main/Issues_and_Advocacy/Key_Issues/Medicaid/Fact_Sheets/2020/kids_coverage_fact_sheet_020720.pdf.

serious illnesses and complex chronic conditions across large geographic areas, without regard to a family's ability to pay. In 2018, Medicaid insured 38 percent of children in the United States (a total of 29.1 million children).[3] Nearly half of all Medicaid beneficiaries are children.[4] Children's hospitals devote more than one half of their inpatient care (59 percent of inpatient days) to the treatment of children covered by Medicaid.[5] In addition, although they account for less than five percent of hospitals in the U.S., children's hospitals provide 35 percent of the hospital care required by children covered by Medicaid.[6]

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[3] *See* Henry J. Kaiser Family Foundation, *Health Insurance Coverage of Children 0-18*, http://kff.org/other/state-indicator/children-0-18/; *see also* U.S. Department of Health and Human Services, *2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP* (Feb. 2016) at 1, https://www.medicaid.gov/medicaid/quality-of-care/downloads/2015-child-sec-rept.pdf.

[4] Centers for Medicare and Medicaid Services, *Medicaid and CHIP Enrollment Data Highlights* (Jan. 2020), https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

[5] Children's Hospital Association, *Annual Benchmark Report* (2015).

[6] Children's Hospital Association, *Analysis of American Hospital Association Database* (2014).

B. The Rule Will Cripple Children's Hospitals

1. Children's Hospitals Depend Fundamentally Upon the DSH Program to Offset Huge Financial Losses Caused by Their Substantial Medicaid-Eligible Patient Populations

It is expensive to meet the unique medical needs of children. Children's hospitals provide age-specific, technology-enriched care focused on the pediatric subspecialties. Children's hospitals also provide specialized equipment and supplies not available in other hospitals. Accordingly, children's hospitals need substantial revenues to be financially viable. Yet traditional Medicaid payments do not fully cover the care that they provide.

The complexity and severity of children's illnesses compel CHA's member hospitals to provide services that Medicaid does not even cover, such as extra social and public health programs and services. When Medicaid does provide coverage, it typically reimburses providers far less than what Medicare would pay for the same services.[7] Because Medicaid is the primary insurer for the majority of children, CHA's member hospitals incur significant losses that cannot be offset by other limited revenue streams. Supplemental DSH payments therefore are vital to

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[7] Stephen Zuckerman, Laura Skopec, and Marni Epstein, *Medicaid Physician Fees after the ACA Primary Care Fee Bump*, Urban Institute (Mar. 2017).

ensure that children's hospitals are financially stable, so that they can continue to provide comprehensive care, advanced pediatric medicine, and a wide range of subspecialty services and equipment.

A recent peer-reviewed study published in the *Journal of the American Medical Association, Pediatrics* documents the substantial losses that children's hospitals incur treating Medicaid-eligible children and the extent to which the DSH program mitigates those losses.[8] The study examined more than 800,000 pediatric hospitalizations across 1,485 hospitals located in 23 states, to identify which hospitals incurred the highest aggregate Medicaid financial losses from pediatric hospitalizations. The study used a subset of freestanding children's hospitals for comparison to other hospitals. These children's hospitals incurred a median Medicaid loss of approximately $10 million, while median Medicaid losses at other hospitals were less than $50,000.[9] There are several reasons for the huge disparity in losses between children's hospitals and other hospitals.

First, Medicaid provides benefits to children with certain serious illnesses without regard to family income. *See, e.g.*, 42 U.S.C. § 1396a(a)(10)(A)(i)(II) (2018) (children are eligible

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[8] J.D. Colvin, *et al.*, *Financial Loss for Inpatient Care of Medicaid-Insured Children*, 170 JAMA Pediatrics 1055 (Nov. 2016).

[9] *Id.* at 1058.

for Medicaid if they are eligible for Supplemental Security Income); 20 C.F.R. §§ 416.934(j), (k) (2019) (children born weighing less than 1,200 grams are eligible for Supplemental Security Income). That helps explain why Medicaid covers more than one third of children in the United States.

Second, children's hospitals are uniquely dependent upon Medicaid reimbursement as a major revenue source, devoting more than one half of their inpatient care to the treatment of children covered by Medicaid.[10]

Third, Medicaid reimburses children's hospitals on average only 69 percent of their costs for providing care, resulting in an immediate loss of 31 cents for every dollar spent providing vital preventive and critical care for children.[11] Even when DSH payments are included, the total Medicaid reimbursement is only 80 percent of the actual costs incurred.[12] Multiplying these revenue shortfalls by millions of patients, these losses are substantial. For example, for the subset of ten freestanding children's hospitals examined in the *JAMA Pediatrics* study, the aggregate median costs

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[10] Children's Hospital Association, *Annual Benchmark Report* (2015).

[11] Children's Hospital Association, *Annual Benchmark Report* (2018).

[12] Children's Hospital Association, *Kids Rely on Medicaid* (Feb. 2020), https://www.childrenshospitals.org/-/media/Files/CHA/Main/Issues_and_Advocacy/Key_Issues/Medicaid/Fact_Sheets/2020/Medicaid_101_Fact_Sheet_020720.pdf.

attributed to pediatric Medicaid patients was $143 million, for which the median Medicaid reimbursement was only $99 million. The result was a median Medicaid financial loss per hospital of $42 million, with each hospital losing more than $30 million.[13]

Finally, children's hospitals have limited revenue sources that cannot offset millions of dollars in Medicaid losses and still allow the hospitals the funds necessary to re-invest in equipment, technology and clinical programs that enhance the lives of all patients and provide life-saving treatment, including for Medicaid pediatric patients. A large majority of children's hospitals are major academic centers responsible for leading pediatric research and training the next generation of pediatric specialists. Unlike adult hospitals, children's hospitals do not receive meaningful revenue from the Medicare program, which pays higher rates than Medicaid and provides supplemental funds through the Medicare DSH program.

For these reasons, children's hospitals rely fundamentally on supplemental Medicaid payments through the DSH program. The *JAMA Pediatrics* study demonstrated that factoring in DSH payments reduced by one half the Medicaid losses at ten free-standing children's hospitals.[14]

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[13] 170 JAMA Pediatrics at 1058-59.

[14] 170 JAMA Pediatrics at 1059.

The *JAMA Pediatrics* study confirms that for children's hospitals, the DSH program performs exactly as Congress intended. The DSH program assures that these hospitals can continue to serve a large number of Medicaid-eligible patients, whom "other providers view as financially undesirable," yet still "surviv[e] the financial consequences of competition in the health care marketplace." H.R. Rep. No. 100-391(I), at 524.

2. The Rule Conflicts With Congressional Intent by Substantially Cutting Essential DSH Payments to Children's Hospitals

The challenged rule substantially reduces a qualifying hospital's DSH payments—by an amount equal to the revenues the hospital receives from private insurers, and other third parties, for Medicaid-eligible patients. In so doing, the rule conflicts with Congress's intent to support the financial viability of children's hospitals.

In *Children's Hospital of the King's Daughters, Inc. v. Price*, 258 F. Supp. 3d 672 (E.D. Va. 2017), *aff'd in part and vacated in part by*, *Children's Hospital of the King's Daughters, Inc. v. Azar*, 896 F.3d 615 (4th Cir. 2018), the U.S. District Court for the Eastern District of Virginia illustrated the impact on a specific children's hospital—the petitioner Children's Hospital of the King's Daughters—if such private insurance payments were subtracted from DSH payments. This hospital's cost data showed an actual loss of $28.3 million under those circumstances—a result fully consistent with the *JAMA Pediatrics* study.

In 2013, Children's Hospital of the King's Daughters treated 108,347 children for whom Medicaid was the primary source of insurance. The hospital sustained an actual loss of $38.4 million to treat those children, because as discussed above, Medicaid pays on average only 69 percent of a hospital's actual costs. The hospital also treated 2,199 children who were eligible to receive Medicaid benefits (such as children with disabilities who receive Supplemental Security Income) but were covered by private insurance, so that Medicaid did not actually pay for their care. 258 F. Supp. 3d at 680 n.3. (Because hospitals negotiate contracts with private insurance companies, those policies often pay a premium above a hospital's actual costs, to support the higher costs related to the specialized care provided, such as pediatric research and advanced technologies.)

To help address this sizeable loss, the DSH program paid the hospital $16.4 million in supplemental Medicaid payments. These funds reduced this actual loss, to treat Medicaid children, to a somewhat more manageable level ($38.4 million - $16.4 million = $22.0 million). *Id*. at 680 n.3, 681.

Under the challenged rule, this DSH payment would be eliminated entirely, because the total amount paid by private insurance (that would need to be subtracted from the DSH payment) far exceeded the amount of the DSH payment itself. That would boost the actual loss back to $38.4 million.

To offset these substantial losses and remain solvent, children's hospitals will have to reduce costs

dramatically under the challenged rule. Children's hospitals will be faced with unpalatable choices between such actions as cutting staff, defunding programs, foregoing facility updates, and delaying technological improvements. However the hospitals resolve this dilemma to stay financially viable under the challenged rule, one thing is certain. The level of care for children with serious medical issues will deteriorate substantially.[15]

3. The Harms from the Rule Already Have Begun, and Possible Retroactive Application of the Rule Will Exacerbate Those Harms

The harms from the challenged rule already have begun. The court of appeals issued its mandate (effectuating the rule) on November 19, 2019, and there is no stay in place while this Court considers the petition for a writ of certiorari. The agency also has not decided informally to delay implementing the rule while this Court considers the petition. Therefore the rule has been in effect ever since November 19, 2019. DSH payments for hospital

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[15] The challenged rule creates a healthcare problem with a nationwide impact. Because there are a relatively small number of children's hospitals, they have a much broader geographic reach than most adult hospitals. Pediatric patients often need to travel to get care at a children's hospital, and for many children that means crossing state lines. In addition, national shortages of pediatric specialists cause many children, particularly those with complex medical conditions, to travel long distances to other states to get access to appropriate specialty care. This interstate problem calls out for a uniform federal resolution by this Court.

services provided since that date have been subject to the rule, immediately short-changing children's hospitals that have received those payments. This harm will continue indefinitely unless the Court intervenes.[16]

Other harms flow from the agency's assertion that the (previously-vacated) rule applies retroactively now that the court of appeals has reinstated it. The agency asserts that the rule applies to hospital services rendered after June 2, 2017 (which was the rule's original effective date).[17] Petitioners object to that retroactive application, and the matter is now pending before the district court on remand. But unless this Court intervenes, children's hospitals will be harmed—regardless of which party's view prevails.

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[16] The states (which are responsible for implementing the DSH program) make interim payments to a hospital during the course of a calendar year, based upon the hospital's cost data from the prior year. After the end of the calendar year, the state "trues up" the payments based on an audit of the actual cost data for the year. To date, it is these interim payments (based on the challenged rule) that have fallen short, imposing immediate revenue shortfalls harming the affected hospitals.

[17] Centers for Medicare and Medicaid Services, *Medicaid Disproportionate Share Hospital (DSH) Payments*, https://www.medicaid.gov/medicaid/financial-management/medicaid-disproportionate-share-hospital-dsh-payments/index.html (last visited May 6, 2020) ("In the absence of an operative judicial ruling vacating or enjoining the 2017 rule, the 2017 rule applies with respect to all hospital services furnished on or after June 2, 2017, and CMS intends to enforce it accordingly.").

If the agency prevails, and the rule is applied retroactively, children's hospitals will have to *pay back* substantial payments received in the past (under the prior DSH rule's methodology). These refunds would substantially compound the current and prospective harms from revenue shortfalls caused by the rule. Petitioners have documented that a June 2, 2017 effective date would require just two children's hospitals to pay back more than $110 million collectively.[18]

Furthermore, children's hospitals are currently suffering immediate harm from the *risk* that the agency *could* prevail on the retroactivity issue, even if the agency ultimately does not *actually* prevail. Faced with the risk of potential multi-million dollar payback obligations, children's hospitals must now consider booking multi-million dollar reserves to cover that risk. The funds set aside for reserves will need to be diverted from investment in research, facilities, technology, staff, and other important hospital improvements. Undermining those investments will undercut the hospitals' ability to provide quality care for their pediatric patients.

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[18] *Children's Hospital Association of Texas v. Azar*, D.D.C. No. 1:17-cv-844-EGS, Plaintiff's Motion and Memorandum to Clarify the Effective Date of the Final Rule (Dkt. #44) (filed January 13, 2020), at 7 (citing Declaration of Dennis Ryan ¶9 and Declaration of Robert E. Simon ¶10).

4. Implementing the Challenged Rule During the Current Public Health Emergency Will Have a Catastrophic Effect on Children's Hospitals

The harmful effects of the challenged rule would justify this Court's intervention at any time. But at this particular time, there is a heightened need for intervention, to prevent massive near-term irreparable harm to children's hospitals. Implementing the challenged rule during the current public health crisis will have a catastrophic effect on children's hospitals. This is the worst conceivable time to cut federal support for these hospitals; the pandemic already is causing each hospital multi-million dollar financial harm, for two major reasons.

First, the pandemic is decimating children's hospital revenues. In mid-March 2020, the U.S. Surgeon General and a number of state governors requested the hospital industry to cancel all deferrable care, to create surge capacity that will accommodate growing volumes of novel-coronavirus patients. Rallying to support the public interest, children's hospitals fully participated in these state and national efforts to confront the pandemic. But the revenue losses from cancelling or postponing this care already have been, and will continue to be, substantial.[19]

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[19] Recent federal legislation (providing public money to reduce the financial impact of the pandemic on hospitals) has substantially bypassed children's hospitals. Many of these financial relief measures have overlooked hospitals with high Medicaid populations. For example, the Department of Health

The nation's largest children's hospitals have reported financial data to CHA, documenting the pandemic's initial impact and projecting the future impact over the next few months. These hospitals are the leading providers of the most complex pediatric cancer, cardiovascular, trauma, and lifelong chronic care in their regions and across the nation. All are academic teaching and research hospitals, governed as charitable community benefit organizations. Their experience illustrates the real challenges that the broader children's hospital community faces. Patient care revenues declined in the range of 20–40% at the beginning of the pandemic, and as of the date of this brief the revenue losses have grown to nearly 50%.[20]

Second, the revenue drop has accompanied a large increase in children's hospital costs. Some costs, such as those for capital expenses and labor, are fixed, regardless of the hospital's revenue-generating activity. Fixed costs are problematic enough at a time of falling revenues. But other costs have skyrocketed because of the pandemic. Screening and testing costs have gone up as emergency rooms must assess whether symptomatic

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and Human Services distributed $30 billion in funding to eligible health care providers based on a provider's Medicare fee-for-service reimbursement in 2019. This program only minimally benefited children's hospitals.

[20] Letter to Hon. Alex Azar from Mark Wietecha (May 1, 2020), https://www.childrenshospitals.org/-/media/Files/CHA/Main/Issues_and_Advocacy/Key_Issues/General/COVID19/PHSSEF_Letter_to_Sec_Azar_050120.pdf.

pediatric patients have routine influenza or COVID-19. Mandatory protective measures have increased the cost for personal protective equipment needed to shield health care workers, patients, and their families from the novel coronavirus. There are also increased costs to establish isolation zones; create higher levels of sterilization and infection control across entire institutions; implement new telehealth strategies to care for children and families on a remote basis; support increased in-home care to keep medically fragile children out of the hospital; and support housing needs of personnel confronting self-quarantines.

The cost impact already has been huge. A sample of the largest children's hospitals noted above report a 5–10% increase in operating expenses connected to the pandemic, with a projected collective quarterly expense increase of more than $200 million.

The perfect storm of revenue shortfalls and cost increases threatens children's hospitals with financial ruin. Based on the data from children's hospitals noted above, the typical net negative impact is $10–30 million per hospital each month, with larger hospitals incurring monthly losses of up to $100 million. According to these data, the children's hospital sector is currently facing losses of nearly $2 billion per month.

What children's hospitals desperately need is substantially more federal support, not less. Instead, the challenged rule makes matters much worse, inflicting substantially more financial harm on children's hospitals, through multi-million dollar

cuts in their DHS revenues. It is essential for this Court to intervene to protect these hospitals, thereby furthering the congressional goal to support the essential healthcare needs of thousands of children nationwide.

CONCLUSION

The court of appeals decided an important question of federal law that has not been, but for the foregoing reasons should be, settled by this Court. The Court therefore should grant the petition for a writ of certiorari.

Respectfully submitted,

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