No. 20-1114

IN THE

# Supreme Court of the United States

AMERICAN HOSPITAL ASSOCIATION, et al.,
*Petitioners,*

v.

Norris Cochran, Acting Secretary of Health & Human Services, et al.
*Respondents.*

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**On Petition for a Writ of Certiorari to the United States Court of Appeals for the District of Columbia Circuit**

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## BRIEF OF AMICUS CURIAE RURAL HOSPITAL COALITION IN SUPPORT OF RESPONDENTS

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April 12, 2021

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## INTERESTS OF *AMICUS CURIAE*

The Rural Hospital Coalition ("RHC") is a national coalition of nearly 200 rural hospitals located in 33 states across the U.S.[1] Our members are among the nation's leading rural health hospitals and providers committed to serving the healthcare needs of the nearly one in five vulnerable Americans living in rural areas. RHC advocates on behalf of its members before the Congress, Senate, and federal agencies, and routinely submits public comments to the Centers for Medicare & Medicaid Services ("CMS") on Medicare and Medicaid coverage and reimbursement issues for rural hospitals. RHC also works closely with both governmental and non-governmental entities to expand rural access to telehealth and maternal health services, and offers guidance to courts on the complicated legal issues that affect RHC members.

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[1] Pursuant to Rule 37.2(a), counsel for both parties were timely notified and have consented in writing to the filing of this *amicus curiae* pleading. Pursuant to Rule 37.6, the *amicus curiae* affirms that no counsel for a party authored any part of this brief; no party or party's counsel made a monetary contribution intended to fund the preparation or submission of the brief, and no person other than the *amicus curiae*, its members, or its counsel, made any monetary contribution to the brief's preparation or submission.

## SUMMARY OF ARGUMENT

RHC hereby aligns its position with arguments set forth in the Federation of American Hospitals' Brief for *Amicus Curiae,* and hereby respectfully submits the following additional reasons why the Petition for Writ of Certiorari should be denied.

Rural hospitals anchor access to quality healthcare services for some 60 million rural patients and their families nationwide. In 2017, Medicare and Medicaid funded 56% of rural hospitals' net revenue overall.[2] Rural hospitals are typically the town's largest or second largest employer where they are located. They provide jobs, spur local development, and keep rural neighborhoods and towns secure.[3] Yet rural hospitals are closing at an alarming rate, shutting off access to millions who depend on them. Over the past ten years, 136 rural hospitals have closed, with 20 closing in 2020 alone. Despite the emergency posed by an ongoing global pandemic, current trends may see at least ten more close in 2021.

In 2018, the Secretary of Health and Human Services finalized a Medicare Part B reimbursement adjustment for hospitals paid under the Medicare Outpatient Prospective Payment System ("OPPS").

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[2] AMERICAN HOSPITAL ASSOCIATION RURAL REPORT ("AHA RURAL REPORT") at 4 (2019), https://www.aha.org/system/files/2019-02/rural-report-2019.pdf.

[3] *See* Thomas C. Ricketts & Paige E. Heaphy, *Hospitals in Rural America*, 173 W.J. MED. 418-422 (2000), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1071201/pdf/wjm17300418.pdf.

As explained in greater detail below, this payment policy reduced OPPS reimbursement rates to a limited class of hospitals thereby generating large savings within the Medicare program. Redistribution of these savings under the Secretary's policy has helped rural hospitals mitigate the serious financial stresses that have led to an alarming rate of rural hospital closures. Further, the current policy preserves and equitably protects all hospitals paid under the OPPS framework and their patients.

RHC's members rely heavily on OPPS payments made under the Medicare program to maintain rural-based operations and strongly oppose Petitioner's efforts here to reverse the Secretary's polic.

This Court should deny the Petition for a Writ of Certiorari.

## ARGUMENT

### I. Savings Realized Under the Secretary's Current Policy are Redistributed to All Hospitals Under the OPPS, and Thus Subject to Budget Neutrality.

Congress enacted the Medicare Part B Outpatient Prospective Payment System ("OPPS") to ensure the efficient delivery of outpatient services, to make Part B outpatient payments equitable for hospitals, and to provide appropriate copayments for beneficiaries.[4] Separately, however, certain hospitals (*i.e.*, "covered entities") may participate in a prescription drug discount program authorized by section 340B of the Public Health Service Act and administered by the Health Resources and Services Administration (HRSA), which allows such hospitals to acquire certain outpatient drugs at deeply discounted rates.[5]

Citing a number of serious policy concerns with the large payment gap between the Medicare OPPS reimbursement amount and the actual drug acquisition costs to these participating hospitals, the Secretary adjusted the OPPS payment calculation from average sales price (ASP) plus 6% to ASP minus

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[4] *See Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs*, 82 Fed. Reg. 52,356, 52,623 (Nov. 13, 2017); 42 U.S.C. §§ 1395*l*(t), 1395l(t)(14)(H) (2018). *See also* H.R. Rep. No. 105-149, at 1323 (1997).

[5] *See Veterans Health Care Act of 1992*, Pub. L. No. 102-585, § 602, 106 Stat. 4943, 4967-71 (1992); 42 U.S.C. § 256b(a)(4) (2018).

22.5%.[6] CMS estimates that the 2018 policy would effectively recapture and re-distribute approximately $1.6 billion in Medicare savings across *all* hospitals nationwide, thereby increasing by 3.2% non-drug services-related payments for all hospitals operating under the budget neutral OPPS system.[7]

This increased payment adjustment now benefiting all OPPS hospitals is critical to the survival of our nation's rural hospitals. RHC's member hospitals are among the 89% of rural OPPS hospitals in the U.S. now sharing these redistributed savings.[8] Reversing this policy as affirmed by the D.C. Circuit Court of Appeals would be devastating.[9]

### II. Preserving the Secretary's Payment Policy Will Continue to Protect Rural Hospitals and Their Communities from Further Harm.

Rural hospitals are indispensable to our nation's health care infrastructure, but the recent rate of rural hospital closures is seriously threatening patients

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[6] *See* 82 Fed. Reg. at 52,496.

[7] *Id*. at 52,509-10.

[8] AVALERE HEALTH PRESENTATION, *OPPS Medicare Part B Payment Impact Analysis* ("AVALERE") at 9 (2021), https://www.fah.org/fah-ee2-uploads/website/documents/20210326_OPPS_Analysis_for_FAH.pdf.

[9] *Id*. at 9, 12-13 (indicating that approximately 100% of rural OPPS hospitals in 21 states, 89% of rural OPPS hospitals, and 82% of OPPS hospitals overall, would be adversely impacted).

who rely on rural hospitals for meaningful healthcare access.[10] Indeed, this recent closure rate has increased the median distance to the most common health care services by 20 miles.[11] Barriers to viable transportation make matters even worse.

Some 57 million Americans living in rural communities disproportionately represent our nation's most poverty-stricken and hence vulnerable populations. Patients in rural counties consistently underperform in key sociodemographic and socio-economic indicators such as smoking, obesity, teen births, uninsured rates, preventable hospital stays, education, and more.[12] And unlike their urban counterparts, rural hospitals are located in counties with 20% lower income and where one-fifth of the population is elderly.[13] Rural residents also are more

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[10] *See* Amy Goldstein, *In the Tennessee Delta, a Poor Community Loses Its Hospital – and sense of security*, WASH. POST, Apr. 11, 2017, https://www.washingtonpost.com/national/health-science/in-the-tennessee-delta-a-poor-community-loses-its-hospital--and-sense-of-security/2017/04/10/6c550492-1941-11e7-855e-4824bbb5d748_story.html.

[11] U. S. Government Accountability Office, GAO-21-93, *Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services*, at 14 (2020), https://www.gao.gov/assets/gao-21-93.pdf.

[12] AHA RURAL REPORT at 5.

[13] NORTH CAROLINA RURAL HEALTH RESEARCH AND POLICY ANALYSIS CENTER REPORT, *The 21st Century Rural Hospital: A Chart Book* (2015), https://www.shepscenter.unc.edu/wp-content/uploads/2015/02/21stCenturyRuralHospitalsChartBook.pdf.

likely to be military veterans than urban residents.[14] In 2017, 10 million rural residents identified as Black, Hispanic, American Indian/Alaska Native, Asian American/Pacific Islander, or mixed race.[15] In 2016, 28.8% of the rural American Indian/Alaska Native population lived below the federal poverty line, while 75.1% of the rural Black population lived in high poverty counties.[16] In 2015, 95 of the 100 U.S. counties with the highest child poverty rates were rural counties.[17] All told, low patient volumes, geographic isolation, workforce shortages, and limited options for essential services like primary and dental care all contribute to a bleak picture of the existential threats facing our nation's rural hospitals that are delivering care to their communities.[18]

The adverse impact of upending the current payment policy cannot be overstated. As noted above, rural hospitals are closing at a breakneck pace, with 136 closures in the last ten years alone. Both "rural" patients and "rural" hospitals defy conventional stereotypes – these communities are not monolithic. Worse, the COVID-19 public health pandemic and the

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[14] *See* RURAL HEALTH RESEARCH GATEWAY ISSUE, *Rural Ethnic/Racial Disparities: Social and Systemic Inequities* (2020), https://www.ruralhealthresearch.org/assets/3974-16603/rural-ethnic-racial-disparities-inequities-recap.pdf.

[15] *Id.*

[16] *Id.*

[17] *Id.*

[18] AHA RURAL REPORT at 4-9.

opioid epidemic are exacerbating the existing financial stress rural hospitals are now experiencing, and threaten devastating adverse consequences for outpatient services.[19]

Equitably distributing savings consistent with the Secretary's current policy provides a desperately needed measure of support for the millions of our rural hospital patients. While the current policy was not initially designed to rescue these rural hospitals or their communities, equitably distributing the savings to *all* hospitals reimbursed under Medicare Part B is providing desperately needed relief for rural hospitals—hospitals fighting to keep their doors open and survive.

### III. The Current Payment Policy Equitably Protects All Hospitals and the Patients They Serve.

RHC has no desire to diminish the significance of the 340B Program or its participants, especially during a pandemic health emergency that has strained the healthcare community overall. Indeed, the merits of the 340B Program are not at issue here. More so than ever today *all* hospitals work tirelessly to provide healthcare access and services to their patient communities. The Secretary's current policy simply ensures an equitable approach to all hospitals paid under the OPPS.

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[19] *Id.* at 7. *See also* Khary K. Rigg, Shannon M. Monnat, & Melody N. Chavez, *Opioid-Related Mortality in Rural America: Geographic Heterogeneity and Intervention Strategies*, 57 INT'L J. DRUG POL'Y 119-129 (2018).

Maintaining an equitable approach to all hospitals also necessarily extends to the similar Medicare beneficiaries they serve. Out-of-pocket expenses (*i.e.*, cost-sharing) incurred by Medicare beneficiaries are a fixed percentage of a medical bill, which is tied to the OPPS payment level. However, as the D.C. Circuit Court of Appeals correctly observed, Medicare Part B beneficiaries paid a disproportionate copayment amount prior to the 2018 payment adjustment at issue. The Secretary's policy corrects that.[20] A recent study also concludes that reversing the Secretary's current policy would increase Medicare Part B beneficiary cost-sharing amounts for 340B drugs by 37%.[21] Here too, the Secretary's current policy favors the equity interests that limit the arbitrary increases in out-of-pocket expenses from one Medicare beneficiary population to another.

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[20] *See Am. Hosp. Ass'n v. Azar*, 967 F.3d 818, 822-23 (D.C. Cir. 2020).

[21] AVALERE at 6.

## CONCLUSION

For reasons explained above, the Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

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