No. 20-1114

IN THE

Supreme Court of the United States

AMERICAN HOSPITAL ASSOCIATION, ET AL.,
Petitioners,

v.

XAVIER BECERRA, SECRETARY OF HEALTH & HUMAN SERVICES, ET AL.
Respondents.

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

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

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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 United States.[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.

The Medicare Part B reimbursement adjustment at issue generated large savings within the Medicare program, and the redistribution of these savings has helped RHC and other hospitals continue to provide services to their patients. *Amicus* has a strong interest in ensuring that the current policy will continue to preserve and protect all hospitals paid under the OPPS framework and their patients, even

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[1] Pursuant to Supreme Court Rule 37.6, RHC states that no counsel for a party authored this brief in whole or in part; and that no person or entity, other than RHC and its counsel, made a monetary contribution intended to fund the preparation and submission of this brief. All parties have consented to the filing.

as rural hospitals struggle nationwide to keep their doors open. RHC writes again as *amicus curiae*, in alignment with the Federation of American Hospitals, and in support of Respondents.

SUMMARY OF ARGUMENT

RHC hereby respectfully submits the following reasons why the Court should uphold the Department of Health and Human Services' (HHS) interpretation in this case, which authorized the Secretary to adjust certain Medicare Part B payment amounts for all hospitals paid under the Medicare Outpatient Prospective Payment System ("OPPS").

Reversing the Secretary's authority to finalize this rule, let alone disrupting the implementation of an adjustment made effective nearly four years ago, is unusually burdensome, especially during an ongoing public health emergency. Indeed, the 2018 OPPS payment policy at issue did not eliminate any federal programs or support, but instead implemented adjustments to the OPPS payment rates. These adjustments at issue picked no winners and no losers; instead, they modified a payment calculation that affected *all* hospitals paid under the OPPS.

For the reasons described in greater detail below, RHC believes that these adjustments amount to an equitable approach towards OPPS payments, and respectfully urges this Court to uphold the decision of the Court of Appeals

ARGUMENT

I. Hospitals Expect and Rely Upon Annual Rulemaking that Updates Medicare Payment Rates

Section 1833(t)(9)(A) of the Social Security Act requires the annual rulemaking Congress established in enacting the Medicare Part B OPPS, which ensures the efficient delivery of outpatient services, makes Part B outpatient payments equitable for hospitals, and provides appropriate copayments for beneficiaries.[2] Accordingly, on July 20, 2017, CMS published a proposed a rule describing changes to certain payment rates under the OPPS and applying a budget neutrality factor. Following a period for public comment, the final rule issued on November 13, 2017, and hospitals began their processes to financially plan for subsequent cost years.

There is no dispute that the procedural aspects of this regular, annual rulemaking exercise took place without incident. Hospitals, including RHC members, rely on such routine updates to OPPS payment rates in order to ascertain the financial, logistical, and operational adjustments necessary to adapt to upcoming cost years.

The current policy, however, has existed in its final form for nearly four years now, and continuity is

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[2] *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).

essential. The Secretary's adjustment to the OPPS payment calculation with a budget neutrality adjustment applied and redistributed across *all* hospitals nationwide has remained continuously in effect since 2018. RHC's member hospitals are among the 89% of rural OPPS hospitals in the U.S. now sharing these redistributed savings under the current policy.[3] Undermining the Secretary's current policy as affirmed by the D.C. Circuit Court of Appeals is unnecessary, and at this point in time, regulatory continuity affecting Medicare payment rates is essential to rural hospital operations.[4]

II. Preserving the Secretary's Current Payment Policy Ensures Stability for All Hospitals and Will Not Disturb Those Hospitals Receiving Discounted Prices for Prescription Drugs.

Supporting rural hospitals, addressing troubling patterns of rural hospital closures, and making adjustments to the OPPS payment rates in annual rulemaking is complex, but not incompatible with the interests of the 340B drug discount program. Hospitals that receive drug discounts under the 340B program serve important roles in their communities – just as all rural hospitals do – particularly because

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[3] AVALERE HEALTH PRESENTATION, *OPPS Medicare Part B Payment Impact Analysis* ("AVALERE") at 9 (2021), https://www.fah.org/wp-content/uploads/2021/04/20210326_OPPS_Analysis_for_FAH.pdf

[4] *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).

low-income and indigent patients do not receive 340B drug discounts themselves directly.

However, the focus in this matter under review is the OPPS payment rate. The number of rural hospital closures merits consideration, and so too do the 57 million Americans living in rural communities that disproportionately represent our nation's most poverty-stricken and vulnerable populations. Great numbers of rural residents are military veterans[5] and minorities[6] and children[7]. Modifying the OPPS payment calculation in a budget neutral manner does not eliminate the 340B program, diminish the drug discounts that 340B hospitals receive, or limit the benefits the 340B program creates. The current policy simply preserves the efficient delivery of outpatient services under the OPPS and ensures stability for all hospitals, including those that participate in the 340B program.

III. The Current Payment Methodology for Outpatient Hospital Services Is More Equitable

The Secretary's adjustments created Medicare savings that are equitably distributed to all hospitals paid under the OPPS. As hospitals that feature

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[5] *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.

[6] *Id.*

[7] *Id.*

disproportionate numbers of lower-income patients, seniors, and minorities compared to their urban counterparts, rural hospitals depend on visibility, continuity, and equitable consideration by the federal government. That is especially true as the COVID-19 public health pandemic menaces all corners of the healthcare system, which only adds additional financial and operational stress.

Rural hospitals across the country need to be financially stable while approximately sixty million rural patients and their families receive services from rural hospitals. Although the Medicare and Medicaid programs fund approximately 56% of rural hospitals' net revenue overall,[8] Medicare and Medicaid payment rates are not only significantly lower than commercial rates, but fall far below the actual cost of care – reversing the current policy would make a bad situation worse for 89% of America's rural hospitals.[9] A recent study indicates that private health plans in the U.S. pay hospitals 247% of what Medicare would pay.[10] Perhaps unsurprisingly, since 2010, 138 rural hospitals have closed their doors, with more closures on the horizon.

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

[9] *See infra* note 3.

[10] Whaley, C. Briscombe, B., Kerber, R. O'Neill, B., Kofner, *A. Nationwide Evaluation of Helath Care Prices Paid by Private Health Plans*, RAND CORPORATION, https://www.rand.org/pubs/research_reports/RR4394.html

The current policy does not solve every problem that rural hospitals face, but taken in context, it favors the interests of equity. The Secretary has discretion to balance and protect the interests of a wide variety of hospitals and other stakeholder interests under the payment methodologies established in the Medicare OPPS. To this end, hospitals, rural hospitals in particular, have relied upon the Secretary's exercise of his authority since the current policy took effect in 2018, and therefore the RHC urges the Court to uphold these important payment adjustments for all hospitals paid under the OPPS.

CONCLUSION

For reasons explained above, the Court should uphold the decision of the Court of Appeals, which preserves the Secretary's current policy.

Respectfully submitted,

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