No. 23-715

In the Supreme Court of the United States

ADVOCATE CHRIST MEDICAL CENTER, et al.,

v.

XAVIER BECERRA, SECRETARY OF HEALTH AND HUMAN SERVICES

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

BRIEF FOR AMERICAN HOSPITAL ASSOCIATION, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, AMERICA'S ESSENTIAL HOSPITALS, CATHOLIC HEALTH ASSOCIATION, FEDERATION OF AMERICAN HOSPITALS, AND NATIONAL RURAL HEALTH ASSOCIATION AS AMICI CURIAE SUPPORTING PETITIONERS

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INTEREST OF AMICI CURIAE[1]

The American Hospital Association represents nearly 5,000 hospitals, healthcare systems, and other healthcare organizations. Its members are committed to improving the health of the communities that they serve, and to helping ensure that care is available and affordable for all Americans.

The Association of American Medical Colleges is a nonprofit association dedicated to improving the health of people everywhere through medical education, healthcare, medical research, and community collaborations. Its members include all 158 U.S. medical schools accredited by the Liaison Committee on Medical Education; approximately 400 academic health systems and teaching hospitals; and more than 70 academic societies.

America's Essential Hospitals is dedicated to equitable, high-quality care for all people, including those who face social and financial barriers to care. Consistent with this safety-net mission, the association's more than 300 members provide a disproportionate share of the nation's uncompensated care, with three-quarters of their patients uninsured or covered by Medicare or Medicaid.

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[1] No counsel for any party authored this brief in whole or in part, and no party or counsel made a monetary contribution to the preparation or submission of this brief. No person other than amici, their members, or their counsel made a monetary contribution to the preparation or submission of this brief. Consistent with Rule 37.2, all counsel of record received timely notice of amici's intent to file this brief.

The Catholic Health Association of the United States is the national leadership organization of the Catholic health ministry, representing the nation's largest group of not-for-profit healthcare providers. CHA's Vision for U.S. Health Care calls for healthcare to be available and accessible to everyone, paying special attention to underserved populations. CHA works to advance the ministry's commitment to a just, compassionate healthcare system that protects life.

The Federation of American Hospitals is the national representative of more than 1,000 leading taxpaying hospitals and health systems throughout the United States. FAH members provide patients in urban and rural communities with access to high-quality, affordable healthcare. Its members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals. They provide a wide range of acute, post-acute, emergency, children's, cancer care, and ambulatory services.

The National Rural Health Association is a national nonprofit organization whose 21,000 members represent nearly every component of rural America's healthcare. This includes rural hospitals, critical access hospitals, doctors, nurses, and patients. NRHA provides leadership on rural health issues through advocacy, communication, education, and research.

Amici's member hospitals treat patients enrolled in public-assistance programs such as Medicare, Medicaid, and the Supplemental Security Income program. Many of those hospitals receive or, under an appropriate construction of the Medicare statute, would receive "disproportionate share hospital" (DSH) payments to offset their costs so that the hospitals are not disadvantaged by treating a large number of low-income pa-

tients. Amici have an interest in ensuring that the Department of Health and Human Services complies with its statutory mandate to fully fund DSH payments. When HHS systemically undercounts those payments—as it has by more than $1 billion per year for the relevant years—it puts hospitals and their patients at risk.

INTRODUCTION AND SUMMARY OF ARGUMENT

Medicare reimburses hospitals for the care that they provide to elderly and disabled Americans. But ordinary Medicare reimbursement rates are not always enough to cover the hospitals' true costs. In particular, hospitals often incur significant uncompensated costs when treating the neediest patients. Those costs burden hospitals in poorer communities, and can force hospitals to terminate important programs or even shutter for good. Congress mandated "disproportionate share hospital" (DSH) payments to solve that problem. By offsetting a portion of hospitals' otherwise-uncompensated costs, DSH payments help hospitals stay afloat and allow them to continue offering 24/7 care to America's neediest populations.

Under a formula set by Congress, a hospital's DSH payments are pegged to the size of its needy-patient population. To measure that population, the DSH formula focuses on three public-assistance programs: Medicare, Medicaid, and Supplemental Security Income (SSI). For patients who are over 65 or disabled, the formula calculates a fraction (called the "Medicare fraction"), with the SSI-entitled Medicare population in the numerator, and the total Medicare population in the denominator. See 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). This case concerns a question that is critical to calculating the Medicare fraction:

When are patients "entitled to" SSI benefits and so counted in the numerator? Is it when they are *eligible for* SSI benefits, or when they are *actually receiving cash* SSI benefits?

After this Court's decision two Terms ago in *Becerra* v. *Empire Health Foundation*, 597 U.S. 424 (2022), that question should be straightforward. *Empire Health* held that patients are "'entitled to [Medicare Part A] benefits'" for purposes of the DSH formula if they are "qualifie[d] for the Medicare program," even if "Medicare is not paying" for their hospital stay. *Id.* at 428 (citation omitted). That reasoning applies with full force here. The statute uses the phrase "entitled to" twice in the same sentence, once to refer to Medicare benefits and once to refer to SSI benefits. See 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). In each case, the meaning should be the same: a patient is "entitled to" benefits if she qualifies for the relevant category of public assistance.

HHS has refused to adopt that straightforward reading of "entitled to" for the SSI category. A focus on eligibility for Medicare helps the agency inflate the *denominator* in the Medicare fraction, but a focus on eligibility for SSI would increase the *numerator*, too. So the agency has adopted the view—and persuaded the court of appeals to uphold it—that a patient is "entitled to" SSI benefits only if the patient actually received cash SSI payments during a hospital stay. See Pet. App. 9-14.

HHS's interpretation is inconsistent with the logic of *Empire Health*. But more than that, the agency's approach to SSI eligibility continues a long history of undermining the DSH program. Although Congress established DSH payments to address the critical needs of hospitals serving poor communities, HHS has

repeatedly interpreted the statute in the most restrictive manner possible. The agency's approach has led to protracted litigation over the DSH formula, with HHS contorting its position from one case to the next to drive down payments. This case is just the latest—and hopefully last—iteration of "an agency, hostile from the start to the very idea of making the payments at issue," attempting "to rewrite the will of Congress." *Cabell Huntington Hosp., Inc.* v. *Shalala*, 101 F.3d 984, 990 (4th Cir. 1996); see *Northeast Hosp. Corp.* v. *Sebelius*, 657 F.3d 1, 20 n.1 (D.C. Cir. 2011) (Kavanaugh, J., concurring in the judgment) ("The only thing that unifies the Government's inconsistent definitions . . . is its apparent policy of paying out as little money as possible.").

The correct interpretation of the DSH formula is vitally important to America's hospitals. Although HHS has refused to share the data that would allow hospitals to accurately count the SSI-eligible patients whom the agency's approach excludes, the available estimates suggest that hospitals will lose more than a billion dollars each year in DSH funds. What's more, a hospital's eligibility for DSH payments affects its entitlement to other federal benefits designed to help hospitals "provide a wide range of medical services" to vulnerable populations. *American Hosp. Ass'n* v. *Becerra*, 596 U.S. 724, 730 (2022). HHS's error thus has far-reaching implications for hospitals, patients, and the American healthcare system.

Those harms will fall hardest on America's rural and safety-net hospitals, many of which are already in extreme financial distress. In the last 20 years, hundreds of hospitals in rural and low-income communities have closed their doors. Those closures have harmed patients, denying them access to care and forcing

already-vulnerable populations to travel long distances to receive essential services. Closures have likewise harmed local communities, eliminating thousands of good-paying jobs and pushing healthcare providers to move elsewhere. And they have harmed the healthcare system more broadly, causing overcrowding at nearby hospitals and discouraging hospitals from investing in programs to benefit low-income patients.

These are real harms, felt today. They result from four decades of the agency's heads-I-win-tails-you-lose interpretation of a single statutory sentence. In light of HHS's troubling history of curtailing DSH payments and the serious consequences of its statutory gymnastics, this Court should intervene now and reverse the judgment below. There is nothing to be gained from further percolation, and there are quite literally lives to be lost.

ARGUMENT

In *Empire Health*, HHS successfully argued that a patient is "entitled to" Medicare under the DSH formula so long as she is qualified for the program. But despite that victory, HHS has refused to apply the same logic to determine whether a patient is "entitled to" SSI benefits—even though Congress used the same words in the same sentence. That inconsistent approach to statutory interpretation would be wrong in any context. But this is not just an isolated error of statutory interpretation; it is the latest turn in a decades-long saga of agency resistance to the DSH program, to the detriment of the neediest hospitals and patients. This Court's immediate review is warranted.

I. HHS'S APPROACH TO SSI ELIGIBILITY CONFLICTS WITH *EMPIRE HEALTH*.

A. The decision below is wrong, as this Court's recent decision in *Empire Health* makes clear. *Empire Health* held that a patient must be counted in the Medicare fraction when she is "qualifie[d] for the Medicare program." 597 U.S. at 428. The Court reached that result by looking to the plain text of the Medicare statute, which consistently uses the phrase "entitled to benefits" to "mean qualifying . . . for benefits." *Id.* at 435.

That should make this case straightforward. Although *Empire Health* declined to address SSI entitlement, 597 U.S. at 434 n.2, the DSH formula uses the same language to describe Medicare-entitled and SSI-entitled patients. See 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) (stating that the "numerator" of the Medicare fraction is "made up of patients who . . . were *entitled to* benefits under part A of [Medicare] and were *entitled to* supplementary security income benefits") (emphases added). Given the "normal presumption that, when Congress uses a term in multiple places within a single statute, the term bears a consistent meaning throughout," *Azar* v. *Allina Health Servs.*, 139 S. Ct. 1804, 1812 (2019), a patient should be "entitled to" SSI benefits if she is "qualified for" the SSI program.

B. HHS does not construe the statute that way. Instead, it includes in the numerator of the Medicare fraction only those patients who actually "receive [cash] SSI benefits for a particular month." 75 Fed. Reg. 50,042, 50,280 (2010). That interpretation excludes both patients who are eligible for cash SSI payments but (for a variety of reasons) do not receive them, and those who are not eligible for cash SSI pay-

ments but are eligible for other SSI benefits. The consequences of HHS's statutory construction can be best illustrated by describing three sets of patients who are *not* covered:

1. Some beneficiaries are enrolled in the SSI program and eligible for cash payments but cannot receive a check for a given month because of SSI program rules. For example, beneficiaries may not receive a check because they are in their first month of eligibility or are living in a nursing home. See Social Sec. Admin., *State Verification & Exchange System and State Online Query Manual* 178 (2013) (SSI Manual); see also 75 Fed. Reg. at 50,280 (first-full-month rule); 20 C.F.R. § 416.414 (nursing-home rule). Those beneficiaries are "qualified for" SSI cash benefits and will receive a check as soon as other circumstances change—another month passes or they leave the nursing home.

2. Some beneficiaries qualify for cash benefits but do not receive them because of a technical issue—for instance, because the Social Security Administration has the wrong mailing address or because the beneficiary cannot accept a direct deposit. See SSI Manual 181. As the SSI Manual makes clear, those beneficiaries "may still be eligible." *Id.* at 178. Here again, the beneficiary is qualified for cash payments; he just does not receive them for administrative reasons unrelated to SSI-eligibility rules.

3. Some beneficiaries do not meet the criteria for cash payments in a given month but remain entitled to the many non-cash benefits of the SSI program, such as vocational rehabilitation services or Medicare Part D subsidies. See 42 U.S.C. § 1382d (rehabilitation services); *id.* § 1395w-114(a)(3)(B)(v) (Medicare). Those beneficiaries are qualified for and actually receiving SSI benefits, but not SSI cash benefits.

C. Under a straightforward reading of *Empire Health*, all three sets of those beneficiaries are qualified for SSI and should be included in the DSH formula. The court of appeals nonetheless affirmed the agency's statutory construction—which excludes all three of those groups—for two reasons. Both were misguided.

First, the court of appeals focused not on the question of eligibility-versus-receipt but on the separate question of whether the DSH formula's reference to SSI benefits captures only "cash payments for needy individuals." Pet. App. 9. Its focus on the type of benefits, though, misses half the picture. Of the three categories described above, only the third relates to SSI benefits other than cash payments. The first two categories, by contrast, comprise patients who are indisputably *eligible for cash SSI payments* but who do not receive checks during their hospital stay. HHS's interpretation leaves out those patients, too. So regardless of the court's view that "subchapter XVI is about [only] cash payments," Pet. App. 9, the court could not avoid the square conflict between HHS's interpretation and *Empire Health*.

In any event, the court of appeals' cash-only reading of the statute is wrong, too. The DSH formula refers to "supplemental security income benefits . . . under Subchapter XVI." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). As petitioners explain, non-cash SSI benefits, such as "rehabilitation services for blind and disabled individuals," are provided to beneficiaries "under Subchapter XVI," see 42 U.S.C. § 1382d, and "have been part of the SSI program . . . since the program's inception in 1972." Pet. 34. Because cash and non-cash benefits are both provided "under Subchapter XVI," the DSH for-

mula should treat them the same. And again, after *Empire Health*, the key question should be whether a patient is eligible for those SSI benefits at the time of her hospital stay.

Second, when the court of appeals finally grappled with *Empire Health*, it dismissed the relevance of this Court's decision in a single paragraph. See Pet. App. 13. The court of appeals pointed to two "key distinctions between the [Medicare] Part A and SSI schemes." *Ibid.* One is that a patient may be entitled to Medicare even if Medicare does not pay for his current medical needs, whereas the court believed "[t]here is no comparable parallel in the SSI context." *Ibid.* That is incorrect. As described above, petitioners have identified several parallels in the SSI context, including patients who are in nursing homes or who cannot receive Social Security checks for administrative reasons. See p. 8, *supra*. The court next worried that SSI beneficiaries, unlike Medicare beneficiaries, will "ping-pong in and out of 'eligibility' depending on fluctuations in their income or wealth from one month to the other." Pet. App. 13. But even if SSI eligibility is more variable than Medicare eligibility, that does not change the bottom line: what matters is *eligibility*, not receipt of a check.

Finally, to the extent the court of appeals departed from *Empire Health*'s reasoning because of administrability concerns about "ping-pong[ing]," Pet. App. 13, those concerns are overblown. HHS has available to it all of the data it needs to count SSI-eligible beneficiaries—including all three categories of excluded beneficiaries discussed above—and could readily include those beneficiaries if it wanted to. And even if fluctuations in SSI enrollment pose a practical chal-

lenge, that challenge applies no less to the agency's approach, which pulls SSI-eligible patients in and out of the Medicare fraction based on monthly changes in their payment status.

II. HHS'S LONGSTANDING HOSTILITY TO THE DSH PROGRAM REQUIRES IMMEDIATE REVIEW.

This is not the first time that American hospitals have been forced to ask courts to correct HHS's errors in its DSH payments. For over four decades, hospitals and the agency have fought over the DSH program. In the beginning, the dispute centered on HHS's refusal to disburse payments altogether. But after Congress and the Judiciary stepped in, the ground has shifted to the agency's stingy DSH calculations.

Time and again, HHS has adopted interpretations of the DSH formula that drive payments lower. When HHS interprets a category in the numerator, it counts patients as "entitled to" or "eligible for" public assistance only if the government actually paid for the patient's hospital stay. But when it interprets a category in the denominator, it takes the opposite approach, counting every patient who meets the criteria for public assistance, even if the government did not ultimately pay for the patient's care. One can "appreciate the desire for frugality, but not in derogation of law." *Northeast Hosp. Corp.*, 657 F.3d at 20 n.1 (Kavanaugh, J., concurring in the judgment).

A. HHS Initially Resisted Its Obligation To Make DSH Payments.

HHS has resisted DSH payments from the start. In 1983, Congress directed HHS to "adjust[] payments" for the Medicare program "to take into account the special needs of . . . hospitals that serve a significantly

disproportionate number of patients who have low income." Pub. L. 98-21, §601(e). But HHS simply "chose not to formulate the DSH adjustment." *Cabell Huntington Hosp.*, 101 F.3d at 986. So the following year Congress passed a law *requiring* HHS to identify hospitals eligible for DSH funds, and set a firm deadline of December 31, 1984, for the agency to complete its work. See Pub. L. 98-369, § 2315(h). When HHS blew through that deadline, a group of hospitals went to court to force the agency to act. *See Samaritan Health Ctr.* v. *Heckler*, 636 F. Supp. 503, 517 (D.D.C. 1985) ("There is no dispute that the Secretary has failed to perform this mandatory duty within the time required."). Only after losing that litigation did HHS publish its first DSH regulations. See 50 Fed. Reg. 53,398 (1985). And those regulations merely established a definition of "disproportionate share hospitals"; the agency still refused to "mak[e] adjustments to the prospective payment rates for disproportionate share hospitals." *Id.* at 53,400.

The next year, Congress responded to HHS's footdragging by replacing the agency's discretion over DSH payments with a detailed statutory formula—similar to the formula found in the Medicare Act today. See Pub. L. 99-272, § 9105; see also S. Rep. 146, 99th Cong. 258 (1986) (explaining that Congress created the DSH formula because the Secretary failed to carry out its obligations under the 1983 statute). Under the new legislation, HHS was no longer empowered to develop its own method for measuring a hospital's low-income population and disbursing funds. Instead, it was tasked with implementing the formula prescribed by Congress.

B. HHS Has Repeatedly Interpreted The DSH Formula To Drive Down Payments.

Since Congress intervened, HHS has carried out its statutory duty in a way that repeatedly minimizes DSH payments.

1. An early dispute concerned the Medicaid fraction, which is the other half of the DSH formula. The Medicaid fraction measures a hospital's needy-patient population under the age of 65 by dividing the number of patients "eligible for" Medicaid by the "total number" of patients treated in the hospital. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Starting in 1986, HHS counted patients as "eligible for" Medicaid assistance—which, like SSI, appears in the numerator of its respective fraction—only if a state Medicaid program actually paid for the patient's care in the hospital, even if the patient was enrolled in Medicaid. See 51 Fed. Reg. 16,772, 16,777 (1986) ("Any day of a Medicaid patient's hospital stay that is not payable by the Medicaid program will not be counted as a Medicaid patient day.").

Hospitals challenged HHS's cramped reading of the statute, leading to a string of court of appeals decisions rejecting HHS's interpretation. See *Legacy Emanuel Hosp. & Health Ctr.* v. *Shalala*, 97 F.3d 1261, 1265 (9th Cir. 1996) ("T]he Medicaid proxy includes all patient days for which a person was eligible for Medicaid benefits, whether or not Medicaid actually paid for those days of service."); see also *Cabell Huntington Hosp.*, 101 F.3d at 991; *Deaconess Health Servs. Corp.* v. *Shalala*, 83 F.3d 1041, 1041 (8th Cir. 1996) (per curiam); *Jewish Hosp., Inc.* v. *Secretary of HHS*, 19 F.3d 270, 274 (6th Cir. 1994).

2. After losing on the Medicaid fraction, HHS turned its attention to the denominator of the Medicare fraction. In 2004, HHS published a rule stating that

the agency would consider patients "entitled to" Medicare Part A so long as they were enrolled in the program, even if Medicare did not pay for their hospital stay. See 69 Fed. Reg. 48,916, 49,099 (2004). That position directly contradicted HHS's approach in the Medicaid litigation—where it had defined eligibility by looking only to whether Medicaid had *actually paid* for a patient's care. But the agency was content extending courts' rulings about Medicaid to the Medicare context. After all, a broader interpretation of Medicare eligibility had the effect of driving down DSH payments by expanding the number of patients counted in the Medicare fraction's denominator.

This Court agreed with HHS's revised approach to Medicare payments in *Empire Health*. According to the Court, reading "entitled to" to cover all patients enrolled in Medicare aligned with the meaning of those words "throughout the Medicare statute." 597 U.S. at 434. The Court also acknowledged the similarities between the Medicare and Medicaid fractions, *id.* at 436 n.3, and explained that HHS had adopted its interpretation of "entitled to" to "bring its reading of the . . . Medicare fraction into line" with the earlier court of appeals decisions about the Medicaid fraction, *id.* at 441 n.4.

3. HHS's desire for consistency stopped there. Once this Court affirmed the agency's construction of Medicare eligibility, the agency made no effort to "bring its reading of" SSI eligibility "into line" as well. *Empire Health*, 597 U.S. at 441 n.4. Hospitals have thus again been forced to rely on the courts to hold HHS to a consistent administration of the DSH formula.

The upshot is that, across 30 years of litigation, this Court and courts of appeals have uniformly agreed that

patients should be included in the DSH formula whenever they qualify for the relevant public-assistance program, regardless of whether that program actually paid for the patient's hospital care. That approach led to higher payments when applied to Medicaid eligibility, see *Cabell Huntington Hosp.*, 101 F.3d at 987, and lower payments when applied to Medicare eligibility, *Empire Health*, 597 U.S. at 433. It would lead to higher payments when applied to SSI eligibility, too. So rather than adhere to the logic of those decisions, HHS has taken one last swing at constraining DSH payments. This Court should step in to impose consistency—finally—across a single statutory formula.

III. UNDERFUNDING DSH PAYMENTS HARMS HOSPITALS AND PATIENTS.

The decision below will have serious repercussions for healthcare in the United States. Many hospitals around the country are operating on thin margins and teetering on the edge of survival. And many of those hospitals are concentrated in rural America and other communities with a high number of low-income patients. They are the reason Congress created DSH payments to supplement Medicare reimbursement rates, which are often well below the actual cost of care. See Alison Binkowski et al., *Assessing Payment Adequacy and Updating Payments: Hospital Inpatient and Outpatient Services*, MedPAC 7 (Jan. 11, 2024) (reporting that 2022 reimbursement rates were more than 12% below the cost of care). DSH payments are a vital lifeline for those hospitals, and can mean the difference between expanding services and shutting down. But DSH payments have steadily declined for years, with payments to DSH hospitals falling by more than $950 million from fiscal year 2023 to fiscal year

2024. See 88 Fed. Reg. 58,640, 59,409 (2023).[2] HHS's flawed interpretation of the DSH formula is speeding that decline, with the costs of its policy falling hardest on the hospitals and communities that can least afford it.

A. HHS's Interpretation Of SSI Eligibility Has Serious Financial Consequences For Hospitals.

HHS's undercounting of SSI-eligible patients in the numerator of the Medicare formula results in significant cuts to hospitals' DSH payments. Those cuts deprive hospitals of billions of dollars in federal assistance and may cause some hospitals to lose access to other federal programs.

HHS has never given hospitals the data needed to accurately count the patients it has excluded from the Medicare fraction and to calculate the difference in DSH payouts under its view and petitioners'. To calculate DSH payments, HHS compares hospital records with data it receives from the Social Security Administration (SSA), which assigns a particular code to each SSI beneficiary to indicate whether the patient received a cash benefit and why or why not. Pet. App. 7. Although Congress requires HHS to give hospitals "the data necessary" to check its work, see 42 U.S.C. § 1395ww note, the agency does not give hospitals the full data available from the SSA.

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[2] The Affordable Care Act amended the DSH formula to account for costs incurred by hospitals when treating uninsured patients. See Pub. L. 111-148, § 3133 (2010) (codified at 42 U.S.C. § 1395ww(r)). Under the revised formula, which went into effect in fiscal year 2015, 25% of the payments to DSH hospitals are based on the pre-existing DSH formula, while the remaining 75% are based on a new formula that measures the cost of "uncompensated care." *Ibid.*

Instead, HHS provides hospitals with a patient list that includes only a "binary yes-or-no marker indicating whether the patient . . . was counted as being entitled to SSI benefits" under HHS's approach. Pet. App. 7. Hospitals do not receive any information indicating which patients would be included if HHS had focused on eligibility rather than payment status, nor can hospitals otherwise get that information from the SSA. *Id.* at 6-7. It is thus impossible for hospitals to measure their SSI-eligible population precisely.

That said, hospitals have estimated that HHS's interpretation of SSI eligibility is costing them more than a billion dollars each year, at least for the years under review here. To calculate that shortfall, petitioners sampled hospitals and identified patients who should have been included in the DSH formula but were not. Based on that population, petitioners estimate that HHS's interpretation lowered DSH payments to the sample hospitals by 15%, which they have extrapolated to hospitals nationwide for a total of approximately $1.5 billion annually. Pet. 18. And that rough estimate may be conservative, as it captures just the effect on hospitals that *still receive* DSH payments. Because hospitals must treat a certain percentage of needy patients to qualify for DSH payments, HHS's undercounting also means that hospitals close to the cut-off may become ineligible for DSH payments altogether. See 42 U.S.C. § 1395ww(d).

The financial consequences ripple outward from there because the DSH formula affects hospitals' eligibility for other federal programs and resources. Perhaps most significantly, a hospital's DSH percentage may establish its eligibility for the 340B Drug Pricing Program, which gives hospital access to discounted pharmaceutical drugs to treat their patients.

See Health Resources & Services Admin., 340B Eligibility (June 2022), https://www.hrsa.gov/opa/eligibility-and-registration. The 340B Program both helps control hospitals' drug costs and enables hospitals to "provide a wide range of medical services in low-income and rural communities." *American Hosp. Ass'n*, 596 U.S. at 730-731. When a hospital loses its DSH qualification for the 340B Program, and must qualify through a different path or not at all, the repercussions can be staggering. For example, one of amici's member hospitals, a Northeastern academic medical center, reports that it is very close to the cut-off for DSH payments and that it stands to lose more than $100 million in 340B Program benefits if it falls short of the DSH threshold. Another member hospital, located in a rural county in the mid-Atlantic, has cycled in and out of eligibility for the 340B Program, causing it to lose millions of dollars and threatening its ability to support indigent care, free drug programs, and other services for vulnerable patients. That member estimates that even a modest 1% increase in the qualifying SSI days in the DSH formula would push it over the threshold for 340B Program eligibility.

Similarly, under the Affordable Care Act, hospitals can receive funds to offset uncompensated care—*i.e.*, care for "patients who have no means to pay"—only if they also receive DSH payments. *Florida Health Sci. Ctr., Inc.* v. *Secretary of HHS*, 830 F.3d 515, 517 (D.C. Cir. 2016) (citing 42 U.S.C. § 1395ww(r)). As a result, hospitals that miss out under HHS's stingy view of the DSH formula miss out on other funding programs as well.

B. HHS's Interpretation Of SSI Eligibility Harms Patients, Communities, And The Healthcare System.

1. These financial losses will have severe consequences for hospitals that treat the most vulnerable patients, including rural and safety-net hospitals that are already confronting serious financial challenges. "[R]ural hospitals often treat patient populations that are older, sicker and poorer compared to the national average." American Hosp. Ass'n, *Rural Hospital Closures Threaten Patient Access to Care* 5 (2022). Those hospitals came under intense pressure during the Covid-19 pandemic, "which hit rural areas especially hard." *Id.* at 3. Since 2010, more than 130 rural hospitals have closed or discontinued inpatient services, with a record 19 closures in 2020 alone. *Id.* at 4.

Outside of rural America, safety-net hospitals located in major urban areas are also struggling to stay afloat. Those facilities face "financial headwinds" caused by low reimbursement rates, uncompensated care for patients who lack adequate health insurance, and "high labor costs from worker shortages." David Kendall et al., *Revitalizing Safety Net Hospitals: Protecting Low-Income Americans From Losing Access to Care*, Third Way 2 (2023). These forces have led many safety-net hospitals to close in recent years, leaving some communities without access to essential services. *Ibid.* To give a few examples, Hahnemann Hospital in downtown Philadelphia closed its doors in 2019, depriving the community of "500 [hospital] beds" and "600 medical professionals." *Ibid.* And last year, the Kingsbrook Jewish Medical Center in Brooklyn, which "predominantly serves low-income patients," announced that it was halting emergency services. See

Maya Kaufman, *Brooklyn Safety-Net Hospital Slated For More Cuts*, Politico (Aug. 7, 2023).

Short of closure, the loss of DSH funding can also make it difficult for hospitals to maintain or expand needed services—particularly those like behavioral health that tend to lose significant amounts of money—and to make long-term capital investments. This is especially true for hospitals that serve low-income communities, including large populations of unhoused individuals, and that are already operating at thin or negative margins. Members of amicus America's Essential Hospitals, for example, had an average aggregate margin of -8.6% in 2021, and provide close to $9 billion in uncompensated care annually. For these and other safety-net hospitals, every dollar matters.

Congress designed DSH payments to help hospitals like these survive the distinct challenges they face. But HHS's failure to fully fund the DSH program puts these hospitals at risk and makes it more likely that the trend of closures or service cuts will accelerate.

2. The most obvious victims of hospital closures or cuts are patients, who may have to travel long distances or forgo necessary treatment after losing access to a hospital in their community. See Melissa Gomez & Hannah Fry, *This Rural County Lost Its Only Hospital, Leaving Residents With Dire Healthcare Choices*, LA Times (June 6, 2023) (reporting that hospital closure in rural county forced residents to drive more than 45 minutes to reach another facility); Jane Wishner et al., *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies*, Kaiser Family Foundation 7 (July 7, 2016) (finding that hospital closures prevented patients from accessing emergency care and made it more challenging to "transport[] patients back home after they are taken

by ambulance to another community for care"). The risk of closures also drives talented healthcare professionals to seek jobs elsewhere, which both deprives patients of care now and makes it more difficult to open a new hospital in the future. See Wishner et al., *A Look at Rural Hospital Closures*, at 7-8.

Closures also put significant pressure on the broader healthcare system. Patients who can no longer access their local hospital may seek care from the nearest alternative. See Shayann Ramedani et al., *The Bystander Effect: Impact of Rural Hospital Closures on the Operations and Financial Well-being of Surrounding Healthcare Institutions,* 17 J. Hosp. Med. 901, 902 (2022). That can lead to significant overcrowding and a deterioration in the quality of care, even if the neighboring hospital is on strong financial footing and does not rely on DSH payments. For example, one recent study found that hospital closures had spillover effects for emergency care in nearby hospitals, leading to a significant increase in mortality rates. See Renee Y. Hsia & Yu-Chu Shen, *Emergency Department Closures and Openings: Spillover Effects on Patient Outcomes in Bystander Hospitals*, 38 Health Affairs 1496, 1499 (2019).

The loss of a hospital can also cripple a local economy. "A hospital closure can eliminate a hundred or more jobs immediately," and "can make it more challenging for rural communities to attract employers." Wishner et al., *supra*, at 9. And those impacts are felt for years, with "annual county income and county population size . . . decreas[ing] steadily several years after the closures." Richard Payerchin, *Rural Hospital Closures Affect More Than Health Outcomes*, Med. Econ. (Mar. 22, 2022), https://www.medicaleconomics.com/view/rural-hospital-closures-affect-more-

than-health-outcomes. The economic harms for communities affected by hospital closures may be difficult to reverse, as worsening economic conditions make it challenging to attract new hospitals and medical professionals.

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Congress created the DSH program because it recognized the unique burdens faced by hospitals that treat the most vulnerable patients. Yet HHS has settled on an interpretation of the DSH formula that excludes significant swaths of low-income, SSI-eligible patients. If allowed to stand, the decision below will have lasting consequences throughout the healthcare system and will exacerbate the very problem that Congress has long tried to solve.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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