Nos. 19-840, 19-1019

IN THE

Supreme Court of the United States

STATE OF CALIFORNIA, *et al.*,

Petitioners,

v.

STATE OF TEXAS, *et al.*,

Respondents.

STATE OF TEXAS, *et al.*,

Cross-Petitioners,

v.

STATE OF CALIFORNIA, *et al.*,

Cross-Respondents.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF *AMICUS CURIAE* NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS IN SUPPORT OF PETITIONERS AND CROSS-RESPONDENTS

EDWARD T. WATERS
Counsel of Record
PHILLIP A. ESCORIAZA
FELDESMAN TUCKER LEIFER FIDELL LLP
1129 20th Street, N.W., 4th Floor
Washington, D.C. 20036
(202) 466-8960
ewaters@ftlf.com

Counsel for Amicus Curiae

296065

TABLE OF CONTENTS

Page

TABLE OF CONTENTS. i

TABLE OF CITED AUTHORITIES iii

INTEREST OF *AMICUS CURIAE* 1

INTRODUCTION. 3

SUMMARY OF THE ARGUMENT. 7

ARGUMENT. 10

I. Health Centers are the Main Source of Accessible Primary Care for Over 28 Million Low-Income Individuals and Medically Underserved Communities 10

II. The Patient Protection and Affordable Care Act Expanded and Strengthened the Health Center Program. 13

III. Health Centers Deliver Quality, Cost-Effective Services While Serving More At-Risk Patients than Other Ambulatory Primary Care Providers 18

Table of Contents

Page

IV. Completely Repealing the ACA, Including Invalidating Key Health Center Program Provisions such as the CHC Fund, Teaching and NHSC Funding, and Health Center Medicare PPS, and Critical Sources of Revenue that Support Operations such as the Medicaid Expansion and the Subsidized Health Insurance Marketplace Would Severely Jeopardize Health Centers' Ability to Deliver the Primary Care Services Upon Which Over 28 Million Low-Income Individuals and Thousands of Medically Underserved Communities Depend 21

CONCLUSION 26

TABLE OF CITED AUTHORITIES

Page

CASES

Arizona Christian Sch. Tuition Org. v. Winn,
563 U.S. 125 (2011) 24

Ayotte v. Planned Parenthood,
546 U.S. 320 (2006) 24

King v. Burwell,
135 S. Ct. 2480 (2015). 18

Maine Community Health Options v. United States,
590 U.S. ___ (2020) 7, 18, 25

National Federation of Independent Business v. Sebelius,
567 U.S. 519 (2012) 17

United States v. Booker,
543 U.S. 220 (2005) 7, 24

STATUTES

26 U.S.C. § 36B 18

42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) 16

42 U.S.C. § 1396d(y)(1) 17

Cited Authorities

Page

Bipartisan Budget Act of 2018, Pub. L. 115-123
§ 50901(a) 3

§ 50901(c) 3, 15

§ 50901(d) 3, 16

Coronavirus Aid Relief and Economic Security Act ("CARES Act"), Pub. L. 116-136 (Mar. 27, 2020)
§ 3211 5

§ 3831 3

§ 3831(a) 14

§ 3831(b) 15

§ 3831(c) 16

Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Pub. L. 116-123 (Mar. 6, 2020), Div. A, Tit. III, 134 Stat. 149 4

Further Consolidated Appropriations Act, 2020, Pub. L. 116-94, Div. N, Title I, §§ 401(a), 401(c) 4

Further Continuing Appropriations Act, 2020 and Further Health Extenders Act of 2019, Pub. L. 116-69, §§ 1101(a), 1101(c) 3-4

Page

Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. 114-10, § 221 . . . . .3, 15, 16

Patient Protection and Affordable Care Act (ACA), Pub. L. 111-148 (Mar. 23, 2010) § 5601(a)(1). 3, 13

§ 5508. . . . . .3, 15

§ 5602. 11

§ 10501 . . . . .3, 17

§ 10503(b)(1) 7

§ 10503. . . . . .3, 14, 15

§ 10503(b)(2)(F) 15

Paycheck Protection Program and Healthcare Enhancement Act, Pub. L. 116-139, H.R. 266, Div. B, Tit. I (Apr. 24, 2020) 5

Public Health Service Act, § 319, 42 U.S.C. § 247d. 5

Public Health Service Act, 42 U.S.C. § 254b § 254b(a)(1) 11, 12

§ 254b(b)(1)(A) 10

§ 254b(b)(3)(A) 11

Page

§ 254b(c). 11

§ 254b(e). 11

§ 254b(k)(3)(G)(iii) 12

Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§ 5121-5207 5

Special Health Revenue Sharing Act of 1975, Pub. L. 94-63, § 501, 89 Stat. 342-346 3

Third Continuing Appropriations for Fiscal Year 2018, Pub. L. 115-96, Div. C, § 3101 3

OTHER AUTHORITIES

American Academy of Family Physicians, *AAFP to Congress: Reauthorize the THCGME Program Now* (Sept. 17, 2019), *available at*: https://www.aafp.org/news/government-medicine/20190917thcgmespeakout.html (last visited May 11, 2020). 16

Linda J. Blumberg *et al.*, *State by State Estimates of the Coverage and Funding Consequences of Full Repeal of the ACA*, Urban Institute (Mar. 26, 2019), *available at*: https://www.urban.org/sites/default/files/publication/100000/repeal_of_the_aca_by_state_2.pdf (last visited Apr. 25, 2020) 22

Page

Letter from President Donald J. Trump on Emergency Determination Under the Stafford Act (Mar. 13, 2020), *available at*: https://www.whitehouse.gov/briefings-statements/letter-president-donald-j-trump-emergency-determination-stafford-act/ (last visited Mar. 24, 2020) 5

NACHC, *Community Health Center Chartbook 2020* (Jan. 2020), *available at*: https://www.nachc.org/wp-content/uploads/2020/01/Chartbook-2020-Final.pdf (last visited Apr. 25, 2020) . . . *passim*

Proclamation by President Donald J. Trump on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak (Mar. 13, 2020), *available at:* https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/ (last visited Apr. 3, 2020). 5

Sara Rosenbaum *et al.*, *Community Health Centers Ten Years After the Affordable Care Act: A Decade of Progress and the Challenges Ahead*, Geiger Gibson RCHN Community Health Foundation Research Collaborative (Mar. 2020), *available at*: https://www.rchnfoundation.org/wp-content/uploads/2020/03/FINAL-GG-IB-61-ACA-CHC-3.4.20.pdf (last visited Apr. 20, 2020) . . *passim*

Page

Peter Shin *et al.*, *A Profile of Community Health Center Patients: Implications for Policy*, Kaiser Family Foundation (Dec. 23, 2013), *available at*: https://www.kff.org/medicaid/issue-brief/a-profile-of-community-health-center-patients-implications-for-policy/ (last visited Apr. 25, 2020) 19

Peter Shin, Jessica Sharac & Sara Rosenbaum, *If the Affordable Care Act is Repealed, What Would Be the Impact on Community Health Centers and the Communities They Serve?* GW Health Policy and Management Matters (May 1, 2020), *available at*: http://gwhpmmatters.com/if-affordable-care-act-repealed-what-would-be-impact-community-health-centers-and-communities-they (last visited May 1, 2020) . . 23, 24

U.S. Department of Health and Human Services, Determination that a Public Health Emergency Exists (Jan. 31, 2020), *available at:* https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx, (last visited Mar. 24, 2020) 5

Page

U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Bureau of Health Workforce, National Center for Health Workforce Analysis, *National Regional Projections of Supply and Demand for Primary Care Practitioners 2013-2025* (Nov. 2016), *available at*: https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/primary-care-national-projections2013-2025.pdf (last visited Apr. 26, 2020) 6

U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Bureau of Primary Health Care, 2018 Health Center Data: National Data, Other Data Elements (2019), *available at*: https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2018&state (last visited Apr. 25, 2020). 19

U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Bureau of Primary Health Care, 2018 Health Center Data: National Data, Table 5: Staffing and Utilization (2019), *available at*: https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2018&state (last visited Apr. 25, 2020). 15

U.S. Dep't of Health & Human Servs., Centers for Medicare & Medicaid Servs., *FQHC PPS Overview* (Nov. 13, 2019), *available at*: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS (last visited May 8, 2020) 17

Page

U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Bureau of Primary Health Care, *Notice of Funding Opportunity Service Area Competition HRSA-20-100* (Jan. 7, 2020), *available at*: https://bphc.hrsa.gov/program-opportunities/sac (last visited May 7, 2020) 11

U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., *NHSC Builds Healthy Communities* (2019), *available at*: https://bhw.hrsa.gov/sites/default/files/bhw/loans-scholarships/bhw-nhsc-infographic.pdf (last visited Apr. 25, 2020). 15

U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., *Notice of Funding Opportunity HRSA-20-011: Teaching Health Centers Graduate Medical Education (THCGME) Program* (Jun. 13, 2019), *available at*: https://www.hrsa.gov/grants/find-funding/HRSA-20-011 (last visited Apr. 25, 2020) 15-16

U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Press Release: *HHS Awards $1.32 Billion to Health Centers in Historic U.S. Response to COVID-19* (Apr. 8, 2020), *available at*: https://www.hhs.gov/about/news/2020/04/08/hhs-awards-billion-to-health-centers-in-historic-covid19-response.html (last visited Apr. 27, 2020) 5

Page

U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Press Release: *HHS Awards $100 Million to Health Centers for COVID-19 Response* (Mar. 24, 2020), *available at*: https://www.hhs.gov/about/news/2020/03/24/hhs-awards-100-million-to-health-centers-for-covid-19-response.html (last visited Apr. 27, 2020) 4-5

U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Press Release: *HHS Awards More Than Half Billion Dollars Across the Nation to Expand COVID-19 Testing* (May 7, 2020), *available at*: https://www.hhs.gov/about/news/2020/05/07/hhs-awards-more-than-half-billion-across-the-nation-to-expand-covid19-testing.html (last visited May 7, 2020) 4, 13, 25

U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., *Requesting a Change in Scope to Add Temporary Service Sites in Response to Emergency Events, Program Assistance Letter 2020-05* (Apr. 15, 2020), *available at*: https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/pdf/pal202005.pdf (last visited Apr. 27, 2020) 25

U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., *Teaching Health Centers Graduate Medical Education (THCGME) Program: Who do we serve?* (Dec. 2019), *available at*: https://bhw.hrsa.gov/grants/medicine/thcgme (last visited May 10, 2020) 16

Page

U.S. Government Accountability Office, *Health Centers: Trends in Revenue and Grants Supported by the Community Health Center Fund*, Report 19-496 (May 2019), *available at*: https://www.gao.gov/assets/700/699394.pdf (last visited Apr. 24, 2020). 12

U.S. Government Accountability Office, *Medicare Payments to Federally Qualified Health Centers*, Report 10-576R (Jul. 30, 2010), *available at*: https://www.gao.gov/products/GAO-10-576R (last visited May 8, 2020) 17

INTEREST OF *AMICUS CURIAE*

The National Association of Community Health Centers (NACHC), a Section 501(c)(3) tax-exempt organization, is the national membership organization for health centers, which provide comprehensive, primary care services to one in twelve Americans.[1] The origins of the health center program date back to the 1960's and the grant program that establishes the base funding for these community-based organizations is found under Section 330 of the Public Health Service Act. Over the past 50 years, Congress has passed numerous pieces of legislation to ensure health centers grow and thrive in order to provide needed primary and preventive care services to medically underserved individuals without regard to income level or insurance status. Nearly 1,400 health centers serve as the source of primary health care for over 28 million individuals in more than 11,700 rural and urban communities; clinical, administrative and support staff surpass 236,000 full-time equivalents (FTEs).

NACHC files this brief to provide to the Court appropriate insight into how the Patient Protection and Affordable Care Act (ACA), Pub. L. 111-148 (Mar. 23, 2010), significantly furthered the purpose and reach of the health center program through substantial direct funding, including creation of the Community Health Center Fund.

---

1. Pursuant to Supreme Court Rule 37.6, *amicus* certifies that no party or counsel for a party authored this brief in whole or in part, and no party other than amicus, its members, or its counsel contributed money intended to fund the preparation or submission of the brief. All parties have filed blanket consents to the filing of *amicus* briefs or provided written consent to the filing of this brief.

Congress has reauthorized this funding three times in the ten years since passage of the ACA. This health center specific funding combined with the ACA's expansion of insurance coverage to millions of new patients nationwide and resulted in dramatic improvements in access to quality, cost-effective health care services for residents of low income and medically underserved rural and urban communities across the United States.

Further expansion and, indeed, the continued viability of many health centers that exist today, would be severely damaged should the Court follow the logic of the lower court by finding that, by setting the shared responsibility payment in 26 U.S.C. § 5000A(c) to zero, Congress rendered the ACA unconstitutional in its entirety. Such a ruling obliterating the ACA would nullify the reforms that have been essential to the success of the modern health center program, including the Medicaid expansion, special payment rates for health centers under Medicare, the Community Health Center Fund, and specific programs such as the Teaching Health Centers Graduate Medical Education program, which has trained more than 1,000 health care professionals to address highly trained medical workforce shortages.

Today, tens of thousands of health center staff, working in the poorest communities, serve on the front lines of the fight against the coronavirus (COVID-19) pandemic in all 50 states, the District of Columbia, Puerto Rico and other territories, as Congress intended. Now, more than ever, consistent with this Court's precedents, the ACA provisions that support the health center program must be upheld.

INTRODUCTION

Congress first authorized the health center program in Section 501 of the Special Health Revenue Sharing Act of 1975, Pub. L. 94-63, 89 Stat. 342-346. Since then, Congress has ensured the program's continued growth as an independent, key component of the nation's health care landscape. Congress launched a dramatic expansion of the health center program through the ACA. Key health center program provisions in the ACA include: (i) establishing the program's permanent funding formula; (ii) creating a dedicated multi-billion dollar fund to add new health center sites, expand and support operations and increase service capacity; (iii) implementing a health center prospective payment system for Medicare services; (iv) authorizing grants to support primary care physician training through health center residency programs; and (v) strengthening the health center workforce through special funding for the National Health Service Corps. ACA, §§ 5508, 5601(a)(1), 10501, 10503.

Moreover, Congress has appropriated extensive direct support to health centers by amending the ACA funding provisions specific to health centers three times since 2010. *See* Coronavirus Aid Relief and Economic Security Act (CARES Act), Pub. L. 116-136, § 3831 (Mar. 27, 2020) (health center program funding extension through Nov. 30, 2020). *See also* Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Pub. L. 114-10, § 221; Third Continuing Appropriations for Fiscal Year 2018, Pub. L. 115-96, Div. C, § 3101; Bipartisan Budget Act of 2018 (BBA), Pub. L. 115-123, §§ 50901(a), 50901(c), 50901(d); Further Continuing Appropriations Act, 2020 and Further Health Extenders Act of 2019, Pub. L. 116-69,

§§ 1101(a), 1101(c); Further Consolidated Appropriations Act, 2020, Pub. L. 116-94, Div. N, Title I, §§ 401(a), 401(c).

Unprecedented growth since enactment of the ACA has positioned health centers to improve community health and to deliver crucial services where they are needed most to prevent, treat and contain public health threats such as HIV infection, opioid addiction and Zika infection. Indeed, without the ACA's direct funding of health centers, Medicaid expansion and other critical reforms, 4.5 million patients would lose insurance coverage and health centers would lose more than $4 billion in funding annually, curtailing their ability to maintain the scale of services they provide in communities across the nation today.

Now health centers are confronting, on their communities' behalf, the greatest public health threat this nation has experienced in a century. "'Health centers are a first line of defense, as they are testing for coronavirus and delivering high-quality primary care to our nation's most vulnerable populations.'" U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Press Release: *HHS Awards More than Half Billion Dollars Across the Nation to Expand COVID-19 Testing* (May 7, 2020). So important are their efforts that Congress has authorized additional appropriations totaling $2.02 billion in emergency federal funding to support health centers' work on the COVID-19 front-line. *Id. See also* Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, Pub. L. 116-123 (Mar. 6, 2020), Div. A, Tit. III, 134 Stat. 149 (appropriating $100,000,000 for health center program grants to prevent, prepare for, and respond to coronavirus); U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Press Release: *HHS*

Awards $100 Million to Health Centers for COVID-19 Response (Mar. 24, 2020); CARES Act, *supra*, § 3211 (Mar. 27, 2020) (appropriating $1,320,000,000 for Fiscal Year 2020 supplemental awards to health centers for the detection of SARS-CoV-2 or the prevention, diagnosis and treatment of COVID-19); U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Press Release: *HHS Awards $1.32 Billion to Health Centers in Historic U.S. Response to COVID-19* (Apr. 8, 2020); Paycheck Protection Program and Healthcare Enhancement Act, Pub. L. 116-139, H.R. 266, Div. B, Tit. I (Apr. 24, 2020) at 7 (appropriating $600,000,000 for section 330 grants to health centers).[2]

The achievements of health centers over the past decade would have been impossible without the ACA reforms. Before the ACA, the health center program was highly effective but limited by staff, funding and facilities.

---

2. On January 31, 2020, the Secretary of the Department of Health and Human Services declared a public health emergency for the coronavirus pandemic, pursuant to Section 319 of the Public Health Service Act, 42 U.S.C. § 247d. U.S. Department of Health and Human Services, Determination that a Public Health Emergency Exists. The PHE is retroactive to January 27, 2020. In turn, in response to the coronavirus pandemic, on March 13, 2020, the President issued a proclamation under the National Emergencies Act. Proclamation by President Donald J. Trump on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak. Likewise, on March 13, 2020, the President declared a national emergency under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§ 5121-5207, in response to the coronavirus pandemic. Letter from President Donald J. Trump on Emergency Determination Under the Stafford Act. These three national emergency declarations remain in effect at the time of filing this brief.

The ACA transformed health centers into a mainstay of the nation's primary health care system and they have become the single most important source of primary care for low-income and medically underserved populations.

This growth was necessary to solve gaps in health care delivery particularly in primary care. Prior to 2014, 62 million people in our country had inadequate access to primary health care. NACHC, *Community Health Center Chartbook 2020* (Jan. 2020), Fig. 6-8. In addition to the need for access to sites and services, primary care staffing was and is a growing problem. Primary care physician shortages are expected to reach 23,640 FTEs by 2025. U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Bureau of Health Workforce, National Center for Health Workforce Analysis, *National Regional Projections of Supply and Demand for Primary Care Practitioners 2013-2025* (Nov. 2016) at 4. In response to these problems, Congress strengthened health centers through numerous provisions of the ACA that are discussed in detail throughout this brief; provisions designed to mitigate the growing workforce shortage, add new facilities and stabilize health center funding. The goal of these provisions is clear -- to increase access to primary care for needy populations. By striking the ACA in its entirety, including all of the specific health center provisions, a program that has grown to serve over 28 million individuals in medically underserved areas would face cutting hours, laying off staff, and even shutting down facilities, all in the middle of a pandemic.

The ACA health center program sections are completely unrelated to the minimum coverage provision at issue. In fact, many of the health center provisions

went into effect before 2014, when the minimum coverage provision became effective. *See, e.g.*, ACA, § 10503(b)(1) (appropriating billions in health center program funds from Fiscal Year 2011 to the present). With or without the minimum coverage provision, the sections in the ACA that support the health center program would independently remain "'consistent with Congress' basic objectives in enacting the statute," *United States v. Booker*, 543 U.S. 200, 258-59 (2005), and would continue to further "Congress' basic statutory goal," *id*. at 250, to support health centers so that individuals in medically underserved areas obtain the health care they need. Clearly, to invalidate the ACA health center program provisions would not effectuate the intent of Congress.[3] These provisions stand on their own and are severable from the minimum coverage provision should the Court find it unconstitutional.

SUMMARY OF THE ARGUMENT

I. Health centers are vital to Congress's healthcare safety net design. Section 330 of the Public Health Service Act authorizes the Secretary of Health and Human Services to make grants to public and nonprofit private entities to plan and develop health centers and to make grants to reimburse the costs of health center operations. As recipients of these grants, health centers must provide health care to all residents of their service area,

3. This Court has held that "…Congress passed the Patient Protection and Affordable Care Act… seeking to improve national health-insurance markets and extend coverage to millions of people without adequate (or any) health insurance." *Me. Cmty. Health Options v. United States*, 590 U.S. ___, slip op. at 2 (Apr. 27, 2020).

regardless of ability to pay. Health centers may be the only source of primary care services for vulnerable populations in certain communities. Overall, health centers provide services to 1 in every 12 people in the United States at substantial costs savings per patient when compared to non-health center users.

II. Growing community health centers was a key goal of the ACA, with dramatic results. By permanently authorizing the program, the ACA eliminated the need for periodic reauthorization. The ACA also launched policy reforms to provide health centers with additional sources of funding to meet the costs of caring for patients. First, the ACA created the Community Health Center Fund ("CHC Fund"), a long-term funding source that permitted health centers to increase capacity, add new sites, widen the scope of preventive and primary care services (including oral health, behavioral health, and pharmaceutical assistance), and train, hire, and retain clinical, administrative, and patient support staff. Second, the ACA expanded eligibility for Medicaid program benefits to adults with incomes up to 138 percent of the FPL and increased federal financial participation ("match") for Medicaid services to the expansion population. Third, the ACA added preventive services payments to the Medicare payment rate, eliminated a cap on Medicare payments to health centers and implemented a prospective payment system to align payments for Medicare services better with actual health center costs. Fourth, the ACA established a new pathway to health insurance coverage through subsidized marketplace plans.

III. The ACA has enabled health centers to expand so that they can meet growing demand and care for more complex patient needs. Despite serving more at-

risk patients and patients who suffer from chronic health conditions at higher rates than the general population, health centers continue to maintain top quality and efficiency standards. For instance, health centers achieve higher rates of hypertension control and diabetes control than the national average. In meeting these healthcare needs, health centers deliver a wide range of services with remarkably cost-effective, quality care.

IV. Health centers experienced a substantial influx of new patients as the ACA health center provisions supported program expansion and hiring additional staff, established a health center Medicare prospective payment system and increased health coverage through expanded Medicaid and the private subsidized marketplace. Complete ACA repeal would profoundly harm health centers and the populations they serve. Researchers from the George Washington University Milken Institute of Public Health estimate conservatively that repealing the ACA's Medicaid expansion and Marketplace subsidies would lead to an increase of 4.5 million uninsured health center patients and a 12 percent reduction in total revenue ($3.5 billion in a single year), which would in turn trigger a reduction in capacity of 3.4 million patients, nearly 29,000 FTE staff members, over 14.2 million patient visits, and 1,432 sites from 2018 levels. Congress has supported the health center program as a proven, quality care, patient-focused and cost-efficient solution to primary care shortages and other barriers to access to care. The COVID-19 pandemic has particularly highlighted the critical role of health centers. Health centers are serving the primary care needs of their patients throughout the ongoing coronavirus public health emergency. At the time of filing this brief, almost 90 percent of health centers

report an aggregate of over 100,000 patients tested for coronavirus weekly and more than 65 percent offer walk-up or drive-up testing. This Court extends deference to the policy choices of the coordinate, political branches of government and accordingly should not override Congress's policy judgment here.

ARGUMENT

I. Health Centers are the Main Source of Accessible Primary Care for Over 28 Million Low-Income Individuals and Medically Underserved Communities.

Health centers are a lynchpin of Congress's healthcare safety net design. Section 330 of the Public Health Service Act (PHSA), 42 U.S.C. § 254b, provides federal grants to health centers to operate in medically underserved areas. The Act requires health centers to provide a comprehensive array of services that includes family medicine, internal medicine, pediatrics, obstetrics and gynecological services; diagnostic laboratory and radiologic services; prenatal and perinatal services; well-child care and immunizations against vaccine-preventable diseases; preventive health services such as screenings for cancer, blood lead levels, communicable diseases and cholesterol; voluntary family planning services; preventive dental services; emergency medical services; and pharmaceutical services, among other services. 42 U.S.C. § 254b(b)(1)(A) (defining "required primary health services").

Section 330 of the PHSA authorizes the Secretary of Health and Human Services to make grants to public

and nonprofit private entities to plan and develop health centers and to make grants to reimburse the costs of health center operations. *Id.* §§ 254b(c) (planning grants), 254b(e) (operating grants). Health centers must provide services to medically underserved populations. *Id.* The term "medically underserved population" means "the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services." *Id.* § 254b(b)(3)(A). In fact, a health center program provision in the ACA required the Secretary to open a process of negotiated rulemaking to develop the methodology and criteria for designating medically underserved populations and health profession shortage areas in consultation with health centers and other entities and stakeholders. ACA, § 5602 (negotiated rulemaking requirement).

Organizations compete for program support to provide comprehensive primary health care services to defined service areas and patient populations. *See* U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Bureau of Primary Health Care, *Notice of Funding Opportunity Service Area Competition HRSA-20-100* (Jan. 7, 2020) at 1. Health centers fall into four general categories: (1) centers serving medically underserved areas; (2) centers serving homeless populations in a specific community or geographic area; (3) centers serving migrant and seasonal farmworker populations in a geographical area; and (4) centers serving public housing residents. 42 U.S.C. § 254b(a)(1).

The PHSA requires health centers to provide health care to all residents of their service area, regardless

of ability to pay. 42 U.S.C. §§ 254b(a)(1), 254b(k)(3)(G)(iii) ("no patient will be denied health care services due to an individual's inability to pay for such services"). Consequently, for half a century community health centers have been the main source of community-based, cost-effective and accessible health services to underserved, low-income persons. Most health center patients (82 percent) are publicly insured or uninsured. *See* NACHC, *supra,* at Fig. 1-5. Health center patients are disproportionately poor: 91 percent of health center patients are under 200 percent of the Federal Poverty Line ("FPL"); 69 percent of patients are at or below 100 percent FPL; 48 percent of patients are Medicaid beneficiaries; and 23 percent are uninsured. *Id*. Figs. 1-8, 2-9 and 2-11. Health centers serve 1 in 3 people living in poverty, 1 in 5 residents of rural areas, 1 in every 9 children in the United States, 1 in 8 people of a racial or ethnic minority, and 1 in every 6 Medicaid beneficiaries. *Id.* Fig. 1-1. Health centers provide services to more than 385,000 veterans and may be the only primary care providers to vulnerable populations in certain communities. U.S. Government Accountability Office, *Health Centers: Trends in Revenue and Grants Supported by the Community Health Center Fund, Report 19-496* (May 2019) at 1; NACHC, *supra*, Fig. 1-2. Overall, health centers provide services to 1 in every 12 people in the United States at an estimated annual costs savings of $1,263 (24 percent less) per patient when compared to non-health center users. *See* NACHC, *supra,* Fig. 4-2.

II. The Patient Protection and Affordable Care Act Expanded and Strengthened the Health Center Program.

Growing community health centers was a key goal of the ACA, with dramatic results. The number of health centers reached 1,362 by 2018, the most recent year for which data from the Department of Health and Human Services Uniform Data System ("UDS") are available. This represents a 21 percent increase from 2010, the year the ACA passed. Likewise, in that period, the number of health center service sites grew by 69 percent from 6,949 to 11,744 and patient visits rose to 116 million visits annually, a 50 percent increase from 77 million visits in 2010. *See* S. Rosenbaum *et al.*, *Community Health Centers Ten Years After the Affordable Care Act: A Decade of Progress and the Challenges Ahead*, Geiger Gibson RCHN Community Health Foundation Research Collaborative (Mar. 2020) at 6. The latest funding information from HHS places the total number of health centers at 1,385. U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Press Release: *HHS Awards More than Half Billion Dollars Across the Nation to Expand COVID-19 Testing* (May 7, 2020).

Underscoring that health centers have become an essential component of the health care safety net, the ACA permanently authorized the program, eliminating the need for periodic reauthorization. ACA, § 5601(a)(1), 124 Stat. 677 (authorizing health center program appropriations for Fiscal Years 2010 through 2016 and adopting permanent funding formula for subsequent fiscal years). The ACA also launched policy reforms to provide health centers with additional sources of funding to meet the costs of caring for patients, which we review in turn.

First, the ACA created the Community Health Center Fund ("CHC Fund"), a long-term funding source that permitted health centers to increase capacity by adding new sites and expanding operations. ACA, § 10503. For Fiscal Years 2011 through 2017, health centers received $15.8 billion in section 330 grants funded by the CHC Fund, of which $12.6 billion (more than 70 percent) primarily supported health center operations and services nationwide. GAO, *supra,* at 12. Another $1.1 billion (7 percent) helped establish new health centers or new sites at existing health centers. *Id.* at 13. Congress has replenished the CHC Fund through periodic amendments to Section 10503 of the ACA, including the latest funding extension in the CARES Act. Pub. L. 116-136, 3831(a) (setting Fiscal Year 2020 funding at $4 billion and providing funding through the end of November of 2020). Without the CHC Fund, health centers would incur substantial losses as these funds "fill the gap" between operations costs and revenues, particularly with respect to services to uninsured patients, services not typically covered by other payors such as adult dental care, services for low-income patients who qualify for sliding fee assistance, to support services to patients who carry insurance yet face substantial deductibles and cost-sharing or to make care accessible to vulnerable populations through translation, transportation, care management, and other patient supports. GAO, *supra*, at 13; Rosenbaum *et al.*, *supra*, at 12. Congress understands these financial and operational challenges and has appropriated funds accordingly.

Health center expansion through ACA program reforms resulted in substantial staff increases in the last ten years. The number of nurses increased 62 percent, from 11,365 FTEs in 2010 to 18,445 FTEs in 2018. Dental

staff nearly doubled, from 9,452 in 2010 to 18,715 in 2018. Behavioral health staff increased 165 percent, from 5,095 FTEs in 2010 to 13,518 FTEs in 2018. Likewise, the number of health center physicians grew 40 percent from 9,592 in 2010 to 13,394 in 2018. Rosenbaum *et al.*, *supra*, at 6, 7. In all, more than 236,000 dedicated health professionals and support staff ensure health center patients receive quality, effective medical care. U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Bureau of Primary Health Care, *2018 Health Center Data: National Data, Table 5: Staffing and Utilization* (2019).

CHC Fund awards and ACA provisions that created special funding for the National Health Service Corps and the Teaching Health Centers Graduate Medical Education (THCGME) program facilitated these dramatic health center staff increases. ACA, §§ 5508, 10503(b)(2)(F). Close to 60 percent of the National Health Service Corps's 13,000 primary care clinicians, mental and behavioral health providers, and dental clinicians serve patients at health centers, making the Corps "a major source of health center clinical staffing." Rosenbaum *et al., supra*, at 4; *see also* U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., *NHSC Builds Healthy Communities* (2019). As with the CHC Fund, Congress amended Section 10503 of the ACA to replenish funding for the National Health Service Corps in the MACRA, § 221, the BBA, § 50901(c), and most recently in the CARES Act, § 3831(b) (allocating close to $362 million through the end of November of 2020).

Furthermore, the Teaching Health Centers program supports primary care medical and dental residency programs in health centers. U.S. Dep't of Health & Human

Servs., Health Res. & Servs. Admin., *Notice of Funding Opportunity HRSA-20-011: Teaching Health Centers Graduate Medical Education (THCGME) Program* (Jun. 13, 2019) at 4. Since 2011, the program, "whose purpose was to strengthen the ties between health centers and health professions and medical residency training programs," Rosenbaum *et al.*, *supra*, at 4, has prepared over 1,000 new primary care physicians and dentists to provide high quality care in rural and urban underserved communities and develop competencies to serve these diverse populations and communities. American Academy of Family Physicians, *AAFP to Congress: Reauthorize the THCGME Program Now* (Sept. 17, 2019). *See also Notice of Funding*, *supra*, at 4. With over half of training sites based in health centers and rural clinics that serve medically underserved communities, U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., *Teaching Health Centers Graduate Medical Education (THCGME) Program: Who do we serve?* (Dec. 2019), the THCGME program has facilitated health centers' efforts to train, recruit and retain professional clinical staff. Congress has consistently funded the Teaching Health Centers program since passage of the ACA, also through MACRA, § 221, and BBA, § 50901(d), and most recently in response to the coronavirus public health emergency, through the CARES Act, § 3831(c) (appropriating over $21 million in additional funds through the end of November of 2020).

Second, the ACA expanded eligibility for Medicaid program benefits to adults with incomes up to 138 percent of the FPL and increased federal financial participation ("match") for Medicaid services to the expansion population. 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII) (creation

of "expansion" population eligibility), 1396d(y)(1) (federal cost-share of services to "expansion" population); *see also National Federation of Independent Business v. Sebelius*, 567 U.S. 519, 583 (2012) ("the federal government's share of the costs of medical services provided to this group… started at 100% through 2016 and will gradually decline until it reaches 90% for 2020 and years thereafter."). Before the ACA, 38.5 percent of health center patients were insured through Medicaid. NACHC, *supra*, Fig. 2-6. With Medicaid expansion, that share increased to 49 percent providing health centers with a newly-insured population with the attendant increase in revenue.

Third, the ACA added preventive services payments to the Medicare payment rate and eliminated a cap on Medicare payments to health centers. ACA, § 10501, 42 U.S.C. § 1395m(o) (development and implementation of a health center prospective payment system for Medicare services). A GAO analysis of 2007 health center Medicare cost reports found that about 72 percent of health centers had costs per visit that exceeded Medicare upper payment limits, which added to nearly $60 million in underpayments. U.S. Government Accountability Office, *Medicare Payments to Federally Qualified Health Centers*, Report 10-576R (Jul. 30, 2010). To align payments for Medicare services better with actual health center costs, Congress enacted a Medicare Prospective Payment System for health centers in Section 10501 of the ACA. Health centers began transitioning to this new Medicare payment methodology on October 1, 2014. *See* U.S. Dep't of Health & Human Servs., Centers for Medicare & Medicaid Servs., *FQHC PPS Overview* (Nov. 13, 2019).

Fourth, the ACA established a new pathway to health insurance coverage through subsidized marketplace plans. 26 U.S.C. § 36B (providing refundable tax credits to purchase coverage to eligible individuals with household incomes between 100 percent and 400 percent of the FPL); *King v. Burwell*, 135 S. Ct. 2480, 2487 (2015); *Me. Cmty. Health Options v. United States*, 590 U.S. ___, slip op., at 1-2 (Apr. 27, 2020). Subsidized marketplace insurance generated a new funding stream to pay for covered services and resulting revenue has spurred health center growth. Rosenbaum *et al.*, *supra*, at 4.

Overall, the CHC Fund made it possible for health centers to build, expand, add new sites, widen the scope of preventive and primary care services (including oral health, behavioral health, and pharmaceutical assistance), and train, hire, and retain clinical, administrative, and patient support staff. The permanent funding formula, substantial funding through the CHC Fund, Medicaid expansion and subsidized marketplace coverage have provided vital revenue to support health center operations and permitted health centers to deliver services to more individuals who lack insurance or other means of paying for necessary medical care. In fact, health centers outrank other ambulatory care providers in new patient acceptance rates, NACHC, *supra*, Fig. 2-5, and experienced a remarkable 46 percent growth in service capacity, from 19.5 million patients in 2010 to 28.4 million patients in 2018.

III. Health Centers Deliver Quality, Cost-Effective Services While Serving More At-Risk Patients than Other Ambulatory Primary Care Providers.

The dramatic expansion of the health center program after enactment of the ACA has enabled health centers to

meet growing demand and care for more complex patient needs. By 2018, health centers had broadened services so that 95 percent offered behavioral care; 57 percent had on site staff authorized to provide medication-assisted opioid use disorder treatment; 77 percent could provide continuous care for physical and behavioral health conditions as recognized patient centered medical homes; 60 percent were using telehealth for specialist provider consultations and 54 percent were using telehealth for patient interaction. U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Bureau of Primary Health Care, *2018 Health Center Data: National Data, Other Data Elements* (2019); Rosenbaum *et al.*, *supra*, at 8.

Health centers care for patients who suffer from chronic health conditions at higher rates than the general population. Where health center patients report a hypertension prevalence rate of 45 percent, it stands at 32 percent in the general population; 42 percent of health center patients show high cholesterol, compared to 36 percent in the general population; 21 percent of health center patients suffer from asthma, compared to 14 percent nationally; and 21 percent of health center patients have diabetes, more than doubling the national rate of 11 percent. NACHC, *supra*, Fig. 1-10. Health center patients are also more likely to present known health risks such as smoking and obesity than the general population. Peter Shin *et al.*, *A Profile of Community Health Center Patients: Implications for Policy*, Kaiser Family Foundation (Dec. 23, 2013). Moreover, health centers have experienced an increasing demand in care from people presenting serious health problems or risks to health. UDS data for the period 2013-2018 demonstrates the number of health center patients with HIV diagnosis has increased 66 percent from 115,421 to 191,717; alcohol and

other substance abuse disorder patients increased from 506,279 to 908,984 (80 percent); patients with obesity, "a health condition that leads to major complications," grew by 193 percent (from 2,228,089 to 6,520,928); and patients with depression, mood and anxiety disorders increased by 72 percent, from 2,740,638 to 4,724,691. Rosenbaum *et al.*, *supra*, at 9. In sum, the number of health center patients diagnosed with a chronic health condition grew 25 percent from 2013 to 2017. NACHC, *supra*, Fig. 1-11.

Despite serving more at-risk patients, health centers continue to maintain top quality and efficiency standards. Health centers achieve higher rates of hypertension control (63 percent of the population) and diabetes control (67 percent) than the national average (57 percent and 60 percent respectively). NACHC, Fig. 3-1. Likewise, health center patients present slightly lower rates of low birth weight (8 percent) than the prevailing national average (8.3 percent). Health center patients are more likely to receive mammograms, PAP smears, and colorectal cancer screenings than individuals nationwide. NACHC, Figs. 3-8, 3-9, 3-10. Health center patients have access to more preventive services than with other primary care providers, such as asthma education, tobacco cessation education, health education, and immunizations for 65 years and older. NACHC, Fig. 3-7. In all, 98 percent of all health center patients report being satisfied with care, higher than low-income patients nationally (87 percent). Clearly, health centers meet the special needs and widening demand for services of the populations they serve.

Health centers deliver a wide range of services with remarkably cost-effective, quality care. The average daily

cost per health center patient, $2.09, is almost one third lower than office-based physician settings ($3.06). NACHC, Fig. 4-9. Compared to other providers, health centers save 24 percent in total spending per Medicaid patient and 35 percent per child. NACHC, Figs. 4-2, 4-7. Likewise, areas with high health center penetration show 10 percent lower Medicare spending per beneficiary ($926) than low-health-center penetration areas. NACHC, Fig. 4-6. On a per patient per year basis, health center expenditures add up to $4,043 or 24 percent lower than $5,306 in annual expenditures per patient among non-health center users. NACHC, Fig. 4-8. Finally, while health centers generate substantial care delivery savings, they are key economic drivers in the communities they serve, accounting for $54.6 billion in total economic activity nationally through payroll outlays, capital investments, and procurements. NACHC, Fig. 4-10.

IV. Completely Repealing the ACA, Including Invalidating Key Health Center Program Provisions such as the CHC Fund, Teaching and NHSC Funding, and Health Center Medicare PPS, and Critical Sources of Revenue that Support Operations such as the Medicaid Expansion and the Subsidized Health Insurance Marketplace Would Severely Jeopardize Health Centers' Ability to Deliver the Primary Care Services Upon Which Over 28 Million Low-Income Individuals and Thousands of Medically Underserved Communities Depend.

Health centers experienced an influx of new patients as ACA provisions led to expanded facilities, permitted hiring additional staff, established a health center

Medicare prospective payment system and more individuals gained health coverage through expanded Medicaid and the private subsidized marketplace. As noted, the number of health center patients currently exceeds 28 million, a 46 percent increase from patient levels prior to enactment of the ACA. While 59 percent (almost 17 million) of health center patients are covered through Medicaid or other forms of public insurance, 23 percent of patients are uninsured. NACHC, *supra*, Figs. 1-5, 1-8, 2-9 and 2-11.

Complete ACA repeal would profoundly harm health centers. Without the ACA, federal spending on health care would fall by at least $134.7 billion, a 35 percent loss, and state spending on health care would in turn fall by at least $9.6 billion (a 6 percent drop when compared to current ACA spending). Repeal would cause an additional 19.9 million people to become uninsured, a 65 percent increase in the number of uninsured people in the United States, which would then exceed 50 million people. Linda J. Blumberg *et al.*, *State by State Estimates of the Coverage and Funding Consequences of Full Repeal of the ACA*, Urban Institute (Mar. 26, 2019) at 22. Demand for uncompensated care would increase by at least $50.2 billion, an increase of 82 percent compared with ACA levels. *Id.* at 2. This sudden increase in uninsured individuals will make it impossible nationwide for health centers to meet the needs of their communities and will surely jeopardize program viability.

Health centers are required to provide services to patients regardless of ability to pay and they use their Section 330 basic grant to cover some of the costs of treating uninsured patients. Repeal of the ACA would

trigger an explosion in the numbers of uninsured patients who seek primary care, placing an impossible financial burden on health centers. Termination of the CHC Fund would mean health centers would lose more than 70 percent of federal funding. *See* Peter Shin, Jessica Sharac & Sara Rosenbaum, *If the Affordable Care Act is Repealed, What Would Be the Impact on Community Health Centers and the Communities They Serve?* GW Health Policy and Management Matters (May 1, 2020) at 5. Stripping away the ACA Medicaid expansion, repealing subsidized marketplace plans, and eliminating the health center Medicare reforms would leave health centers with severely diminished access to insurance revenue; remaining grants would provide health centers with funding vastly below the cost of caring for their patients. Even today, total revenue falls well below the cost of care; in 2018, for example, health centers cared for over 6.4 million uninsured individuals, leaving a cost gap in excess of $1.5 billion. NACHC, *supra*, Fig. 6-4. The expected influx of uninsured patients due to ACA repeal would saddle health centers with an unsustainable balance of unpaid services, threatening their ability to serve their communities.

Researchers from the George Washington University Milken Institute of Public Health estimate conservatively that repealing the ACA's Medicaid expansion and Marketplace subsidies would lead to an increase of 4.5 million uninsured health center patients and a 12 percent reduction in total revenue ($3.5 billion in a single year), which would in turn trigger a reduction in capacity of 3.4 million patients, nearly 29,000 FTE staff members, over 14.2 million patient visits, and 1,432 sites from 2018 levels. That analysis does not include the impact of a decrease in

Medicare patient revenue if the ACA's Medicare patient payment reforms were repealed, or repeal of the CHC Fund, which would eliminate over 70 percent of health center operational funding, a catastrophe only a relatively few centers could survive. Peter Shin, Jessica Sharac & Sara Rosenbaum, *supra*, at 5.

Congress has supported the health center program as a proven, quality care, patient-focused and cost-efficient solution to primary care shortages and other barriers to access to care. If this Court were to hold the ACA stricken in its entirety, including provisions Congress intended to ensure health centers have the resources to fulfill their mission, the consequences would be catastrophic for over 28 million people in close to 12,000 rural and urban communities who rely on health centers for their primary health care needs. This result would be contrary to the intent of Congress and this Court's precedents against facial or implied invalidation of statutes.

This Court extends deference to the policy choices of the coordinate, political branches of government, and refuses to act "in the role of a Council of Revision, conferring on itself the power to invalidate laws at the behest of anyone who disagrees with them." *Arizona Christian Sch. Tuition Org. v. Winn*, 563 U.S. 125, 145-46 (2011); *see also United States v. Booker*, 543 U.S. 220, 258-259 (2005) (noting that "[m]ost of the statute [the Sentencing Act] is perfectly valid," and retaining statute's portions that are constitutionally valid, capable of functioning independently, and consistent with Congress' basic objectives in enacting the statute); *Ayotte v. Planned Parenthood*, 546 U.S. 320, 329 (2006) (disfavoring facial challenges and acknowledging caution not to frustrate

the intent of the elected representatives of the people); *Me. Cmty. Health Options*, 590 U.S. ___ (restating that "repeals by implication are generally disfavored").

Health centers are serving the primary care needs of their patients throughout the ongoing coronavirus public health emergency. At the time of filing this brief, almost 90 percent of health centers report an aggregate of over 100,000 patients tested for coronavirus weekly and more than 65 percent offer walk-up or drive-up testing. U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Press Release: *HHS Awards More than Half Billion Dollars Across the Nation to Expand COVID-19 Testing, supra.* Proving that, "[a]s a vital component of the nation's health care safety net, health centers are uniquely positioned to deliver needed primary care services during an emergency," U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., *Requesting a Change in Scope to Add Temporary Service Sites in Response to Emergency Events, Program Assistance Letter 2020-05* (Apr. 15, 2020) at 2, Congress allocated $2.02 billion of federal money to ensure health centers continue to provide critical triage, diagnosis, treatment and other indispensable patient supports in response to the pandemic. The health center program is fulfilling its mission as Congress directed; it must be protected and fully supported.

CONCLUSION

For the foregoing reasons, this Court should hold that the minimum coverage provision, if unlawful, is severable, and reverse the judgment of the Court of Appeals.

May 13, 2020

Respectfully submitted,

Edward T. Waters
Counsel of Record
Phillip A. Escoriaza
Feldesman Tucker Leifer Fidell LLP
1129 20th Street, N.W., 4th Floor
Washington, D.C. 20036
(202) 466-8960
ewaters@ftlf.com

Counsel for Amicus Curiae