No. 20-1312

In the Supreme Court of the United States

XAVIER BECERRA, SECRETARY
OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

EMPIRE HEALTH FOUNDATION,
FOR VALLEY HOSPITAL MEDICAL CENTER

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF FOR THE PETITIONER

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QUESTION PRESENTED

The Medicare statute, 42 U.S.C. 1395 *et seq.*, provides that a hospital that serves a "significantly disproportionate number of low-income patients" may receive an additional payment for treating Medicare patients, known as the disproportionate-share-hospital adjustment. 42 U.S.C. 1395ww(d)(5)(F)(i)(I) and (ii). The statute directs the Secretary of Health and Human Services to calculate a hospital's disproportionate-share-hospital adjustment (if any) using a formula that is based principally on the sum of two separate proxy measures of the proportion of low-income patients the hospital serves. The first proxy measure, known as the Medicare fraction, is the percentage of all patient days of "patients who (for such days) were entitled to benefits under [Medicare] part A" and who were also entitled to supplemental-security-income benefits. 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). The second proxy measure, known as the Medicaid fraction, is the percentage of all of a hospital's patient days that are attributable to individuals who were eligible for Medicaid coverage but who were not entitled to Medicare Part A benefits. 42 U.S.C. 1395ww(d)(5)(F)(vi)(II). The question presented is as follows:

Whether the Secretary has permissibly included in a hospital's Medicare fraction all of the hospital's patient days of individuals who satisfy the requirements to be entitled to Medicare Part A benefits, regardless of whether Medicare paid the hospital for those particular days.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-22a) is reported at 958 F.3d 873. The order of the district court (Pet. App. 23a-75a) is reported at 334 F. Supp. 3d 1134. The decision of the Provider Reimbursement Review Board (Pet. App. 76a-83a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on May 5, 2020. A petition for rehearing was denied on October 20, 2020 (Pet. App. 84a-85a). On March 19, 2020, the Court extended the time within which to file any petition for a writ of certiorari due on or after that date to 150 days from the date of the lower-court judgment, order denying discretionary review, or order denying a timely petition for rehearing. The effect of that order

was to extend the deadline for filing a petition for a writ of certiorari in this case to March 19, 2021. The petition for a writ of certiorari was filed on that date, and the petition was granted on July 2, 2021. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Pertinent statutory and regulatory provisions are reproduced in an appendix to this brief. App., *infra*, 1a-31a.

STATEMENT

A. Legal Background

1. The Medicare program, established in 1965 by Title XVIII of the Social Security Act (Medicare Act), 42 U.S.C. 1395 *et seq.*, provides health-insurance coverage to individuals who are at least 65 years old and are entitled to monthly Social Security benefits, and to disabled individuals who meet certain requirements. 42 U.S.C. 426(a) and (b). Such individuals are automatically "entitled to * * * benefits" under Medicare Part A, *ibid.*, which authorizes payments to providers for certain hospital and related services that they furnish to Medicare beneficiaries, see 42 U.S.C. 1395c *et seq.* The Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS) administers the Medicare program on behalf of the Secretary. See *Maine Med. Ctr.* v. *Burwell*, 841 F.3d 10, 13-14 (1st Cir. 2016).

a. Prior to 1983, with certain exceptions, "the federal government reimbursed hospitals for the 'reasonable cost' of treating Medicare patients." *Maine Med. Ctr.*, 841 F.3d at 14; see 42 U.S.C. 1395f(b)(1) (1982). A hospital's "'reasonable cost'" of treating a patient was

generally defined as "the cost the hospital 'actually incurred,' minus any portion of that cost" that Medicare "deemed 'unnecessary in the efficient delivery of needed health services.'" *Rhode Island Hosp.* v. *Leavitt*, 548 F.3d 29, 39 (1st Cir. 2008) (quoting 42 U.S.C. 1395x(v)(1)(A) (1982)). Although subject to various limitations, that approach to reimbursing hospitals based on actual costs as long as they were reasonable led to high Medicare expenditures. See *ibid.*; *Jewish Hosp., Inc.* v. *Secretary of HHS*, 19 F.3d 270, 280 (6th Cir. 1994) (Batchelder, J., dissenting).

In 1983, Congress replaced that retrospective, reasonable-actual-cost approach with "a prospective payment system." *Maine Med. Ctr.*, 841 F.3d at 14; see Social Security Amendments of 1983 (1983 Act), Pub. L. No. 98-21, Tit. VI, § 601(e), 97 Stat. 153-157 (42 U.S.C. 1395ww(d)(1)-(4) (Supp. I 1983)).[1] Under that prospective payment system, "Medicare does not reimburse healthcare providers according to the costs they actually incur in treating Medicare patients." *Rhode Island Hosp.*, 548 F.3d at 31 n.1. Instead, the government pays "a hospital a fixed dollar amount for each Medicare patient it discharges on the basis of the patient's diagnosis, regardless of the actual cost of the treatment provided." *Metropolitan Hosp.* v. *United States Dep't of HHS*, 712 F.3d 248, 250 (6th Cir. 2013) (citing *Good Samaritan Hosp.* v. *Shalala*, 508 U.S. 402, 406 n.3 (1993)). Those fixed rates are designed to "reflect the resources an efficiently run hospital, in the same region, would regularly expend in treating a patient with the same

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[1] This case specifically concerns the Medicare inpatient prospective payment system relevant to Medicare Part A benefits. A separate payment system addresses hospital outpatient benefits under the Medicare program. See 42 U.S.C. 1395*l*(t).

diagnosis at time of discharge." *Rhode Island Hosp.*, 548 F.3d at 31 n.1. That approach "provides a powerful incentive for providers to maximize the efficiency of their treatment programs": a hospital that "treats a given patient for less than that predetermined rate" earns a profit, while a hospital that incurs costs above that rate faces a shortfall. *Id.* at 32 n.1.

Congress also recognized, however, that the costs incurred by hospitals may vary for reasons unrelated to efficiency. In the 1983 Act and in the years since, Congress has established, or authorized HHS to adopt, various "adjustments" to a hospital's payment rates "based on various hospital-specific factors." *Northeast Hosp. Corp.* v. *Sebelius*, 657 F.3d 1, 3 (D.C. Cir. 2011); *e.g.*, 1983 Act § 601(e), 97 Stat. 157-158 (42 U.S.C. 1395ww(d)(5) (Supp. I 1983)); see *Edgewater Med. Ctr.* v. *Blue Cross & Blue Shield Ass'n*, HCFA Adm'r Dec. (PRRB Dec. Nos. 2000-D44 & 2000-D45), 2000 WL 1146601, at *2-*3 (June 19, 2000).

b. At issue here is one such adjustment that provides increased Medicare payments to "hospitals that serve a disproportionate share of low-income patients," *Sebelius* v. *Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 150 (2013); see 42 U.S.C. 1395ww(d)(5)(F), known as the "disproportionate share hospital" adjustment (colloquially, the "DSH adjustment" or "DSH payment[]"). *E.g.*, 42 U.S.C. 1395ww(r)(1); Pet. App. 3a, 54a (citation omitted). When Congress enacted the prospective payment system, it recognized that "low-income patients are often in poorer health, and therefore costlier for hospitals to treat." *Catholic Health Initiatives Iowa Corp.* v. *Sebelius*, 718 F.3d 914, 916 (D.C. Cir. 2013); see *Samaritan Health Ctr.* v. *Heckler*, 636 F. Supp. 503, 508 (D.D.C. 1985). And "because hospitals with an unusually high

percentage of low-income patients generally have higher per-patient costs," Congress determined that "such hospitals * * * should receive higher reimbursement rates." *Auburn Reg'l Med. Ctr.*, 568 U.S. at 150.

In the 1983 Act and in subsequent legislation, Congress initially directed HHS to develop adjustments to account for those higher costs of treating lower-income Medicare patients. See *Cabell Huntington Hosp., Inc.* v. *Shalala*, 101 F.3d 984, 985-986 (4th Cir. 1996) (citing, *inter alia*, Deficit Reduction Act of 1984, Pub. L. No. 98-369, Tit. III, Subtit. A, Pt. 1, § 2315(h), 98 Stat. 1080-1081, and 1983 Act § 601(e), 97 Stat. 157 (42 U.S.C. 1395ww(d)(5)(C)(i) (Supp. I 1983)). When after several years those efforts had not come to fruition, Congress "established its own measure for assessing whether a hospital 'serves a significantly disproportionate number of low income patients.'" *Metropolitan Hosp.*, 712 F.3d at 250 (quoting 42 U.S.C. 1395ww(d)(5)(F)(v)); see Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, Tit. IX, Subtit. A, Pt. 1, Subpt. A, § 9105(a), 100 Stat. 159 (42 U.S.C. 1395ww(d)(5)(F)(vi)); *Cabell Huntington Hosp.*, 101 F.3d at 986.

The centerpiece of the disproportionate-share-hospital adjustment that Congress enacted is the "disproportionate patient percentage," 42 U.S.C. 1395ww(d)(5)(F)(v) and (vi), which is a "'proxy measure' for the number of low-income patients a hospital serves," *Northeast Hosp.*, 657 F.3d at 3 (quoting H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 1, at 17 (1985)). That percentage is used to determine whether a hospital will receive any disproportionate-share-hospital payment and, if so, the amount. See 42 U.S.C. 1395ww(d)(5)(F)(i)-(v) and (vii)-(xiv); *Metropolitan Hosp.*, 712 F.3d at 250-251. A "higher [disproportionate-patient percentage] means

greater reimbursements" for a hospital, reflecting that "the hospital is serving more low-income patients." *Catholic Health Initiatives*, 718 F.3d at 916. The disproportionate-patient percentage, however, "is not the *actual* percentage of low-income patients served"; it is instead merely "an indirect, proxy measure." *Ibid.*

The disproportionate-patient percentage "is statutorily defined as the sum of two fractions, often called the 'Medicare fraction' and the 'Medicaid fraction.'" *Catholic Health Initiatives*, 718 F.3d at 916. Those two component fractions "represent two distinct and separate measures of low income" that are focused on two different populations: a hospital's low-income patients who *are* insured by Medicare Part A, and its low-income patients who are *not* insured by Medicare Part A, respectively. *Ibid.*; see 42 U.S.C. 1395ww(d)(5)(F)(vi). That two-pronged approach embodies a compromise reached in Congress between competing proposals favored by the Senate and House of Representatives, respectively. H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. 459-461 (1985) (Conference Report); *Jewish Hosp.*, 19 F.3d at 280-283 (Batchelder, J., dissenting).

The Senate's preferred "proxy measure for low income patients" would have focused only on the proportion of patients with low incomes among a hospital's Medicare Part A patients. Conference Report 460. The Senate would have used entitlement to Supplemental Security Income (SSI) benefits under Title XVI of the Social Security Act, 42 U.S.C. 1381 *et seq.*—which provides financial assistance to certain "financially needy individuals," *Bowen* v. *Galbreath*, 485 U.S. 74, 75 (1988)—to identify low-income Medicare patients. Conference Report 460. The House's version, by contrast, would have considered the proportion of low-income patients in a

hospital's entire patient population and would have employed a different metric—eligibility for medical assistance under a State's Medicaid plan under Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq*—to identify low-income patients. Conference Report 459. The final legislation that Congress crafted combined elements of both of those approaches. *Id.* at 461; *Jewish Hosp.*, 19 F.3d at 282-283 (Batchelder, J., dissenting) (observing that the final version was "hashed out in conference," but also tracked an earlier Senate proposal).

The first component of the disproportionate-patient percentage—the Medicare fraction, also "commonly called the SSI fraction," *Auburn Reg'l Med. Ctr.*, 568 U.S. at 150—focuses on the patient days of low-income patients treated by a hospital "who (for such days) were entitled to benefits under [Medicare] part A" when treated. 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). To identify patients in that pool of Medicare Part A beneficiaries who also have low incomes, the Medicare fraction uses a patient's entitlement to SSI benefits. Specifically, the Medicare fraction is defined as a

> fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter [*i.e.*, Medicare Part A] and were entitled to supplementary security income benefits (excluding any State supplementation) under [Title XVI], and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under [Medicare] part A.

Ibid. The Medicare fraction thus "effectively asks, out of all patient days *from Medicare beneficiaries*, what

percentage of those days came from Medicare beneficiaries who *also*" were entitled to SSI benefits. *Catholic Health Initiatives*, 718 F.3d at 917; see *Auburn Reg'l Med. Ctr.*, 568 U.S. at 150.

The second component of the disproportionate-patient percentage—the Medicaid fraction—focuses on the patient days of low-income patients within a hospital's overall patient population "who were *not* entitled to benefits under [Medicare] part A." 42 U.S.C. 1395ww(d)(5)(F)(vi)(II) (emphasis added). To calculate the number of low-income non-Medicare patients a hospital serves relative to its total patient population, the Medicaid fraction uses a patient's eligibility for medical assistance under Medicaid, rather than entitlement to SSI benefits. Specifically, the Medicaid fraction is defined as a

> fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under [Title] XIX, but who were not entitled to benefits under part A of this subchapter [*i.e.*, Medicare Part A], and the denominator of which is the total number of the hospital's patient days for such period.

Ibid. The Medicaid fraction thus calculates the percentage of a hospital's total patient days that were attributable to patients who were *not* entitled to Medicare Part A benefits but who *were* eligible for Medicaid benefits. *Catholic Health Initiatives*, 718 F.3d at 917.

The Medicare and Medicaid fractions thus provide separate but complementary proxies for the percentage of low-income patients a hospital serves, each focused on a different subset of its low-income patients: those

entitled to benefits under Medicare Part A, and those not entitled to benefits under Medicare Part A, respectively. The D.C. Circuit has depicted the Medicare and Medicaid fractions as follows:

	Medicare fraction	Medicaid fraction
Numerator	Patient days for patients "entitled to benefits under [Medicare] part A" *and* "entitled to SSI benefits"	Patient days for patients "eligible for [Medicaid]" but *not* "entitled to benefits under [Medicare] part A"
Denominator	Patient days for patients "entitled to benefits under part A"	Total number of patient days

Catholic Health Initiatives, 718 F.3d at 917 (citation omitted) (emphases added). "[W]hen summed together," those two measures collectively "provide a proxy for the [hospital's] total low-income patient percentage." *Id.* at 916.

2. This case concerns the calculation of the Medicare fraction—and, in particular, the phrase "patients who (for such days) were entitled to benefits under [Medicare] part A" in the Medicare fraction's numerator and denominator. 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). The central dispute is whether that phrase encompasses individuals who satisfied the statutory criteria to be "entitled" to Medicare Part A benefits, 42 U.S.C. 426(a) and (b), at the time a hospital treated them, but for whose treatment the Medicare program was not required to pay

for other reasons. In the final rule at issue here, promulgated in 2004 in HHS's annual rulemaking addressing the inpatient prospective payment system, the Secretary determined that such individuals should be counted in the Medicare fraction. 69 Fed. Reg. 48,916, 49,098-49,099, 49,246 (Aug. 11, 2004) (J.A. 169-174).

a. The Secretary has long interpreted the term "entitled" in the Medicare context to refer to an individual's status under the Medicare program—*i.e.*, that the individual satisfies the statutory requirements for entitlement to benefits under the program. For example, a regulation first promulgated in 1983, and still in force today, provides that, "[a]s used in connection with the Medicare program, unless the context indicates otherwise," the term "'*[e]ntitled*' means that an individual meets all the requirements for Medicare benefits." 48 Fed. Reg. 12,526, 12,535 (Mar. 25, 1983) (42 C.F.R. 400.202).

Prior to 2004, however, when HHS calculated a hospital's disproportionate-share-hospital adjustment, it nevertheless included in the Medicare fraction only "covered" Medicare patient days, 42 C.F.R. 412.106(b)(2)(i) (2003)—*i.e.*, days for which payment from the Medicare program was actually available to the hospital. See 69 Fed. Reg. at 49,098 (J.A. 170); cf. 42 C.F.R. 409.3 (2003) (the term "*[c]overed*" in regulations addressing inpatient hospital services "refers to services for which the law and the regulations authorize Medicare payment"). The Medicare program may not be responsible to pay for particular care for a person who meets the requirements for Medicare Part A benefits for various reasons. For example, Medicare Part A generally will pay only for a limited number of successive hospital inpatient days (typically 90) during a single "spell of illness." 42 U.S.C.

1395d(b); see 42 U.S.C. 1395x(a); 42 C.F.R. 409.61(a)(1). With certain exceptions, if a patient's stay exceeds that limit, his or her Medicare coverage of hospital inpatient days for that period is "exhausted," and Medicare does not pay for the days in excess of the limit. Pet. App. 7a n.8; see 42 C.F.R. 409.61(a)(1) and (2). Such patient days are known as "exhausted coverage days." 69 Fed. Reg. at 49,098 (J.A. 171). In addition, under the Medicare Act's "secondary payer" provisions, see 42 U.S.C. 1395y(b)(2)(A) (emphasis omitted), the Medicare program generally will not pay for care that is covered by another, "primary" payer—such as a private insurance plan. See, *e.g.*, *MSP Recovery Claims, Series LLC* v. *ACE Am. Ins. Co.*, 974 F.3d 1305, 1308 (11th Cir. 2020), cert. denied, No. 20-1424 (June 14, 2021).

HHS's prior approach of excluding from the Medicare fraction patient days for which Medicare did not pay was based on an interpretation of the specific language of the disproportionate-share-hospital adjustment—specifically, the parenthetical phrase "(for such days)" in both the Medicare fraction's numerator and denominator. 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). Both the numerator and denominator refer to "patient days * * * which were made up of patients who *(for such days)* were entitled to benefits under [Medicare] part A." *Ibid.* (emphasis added). The same parenthetical also appears in the Medicaid fraction's numerator, which refers to "patients who (for such days) were eligible for [Medicaid]." 42 U.S.C. 1395ww(d)(5)(F)(vi)(II). HHS originally understood those parentheticals in both fractions as directing the agency to focus only on patient days for which Medicare or Medicaid, respectively, was responsible to pay. See 51 Fed. Reg. 31,454, 31,460 (Sept. 3, 1986) (discussing Medicaid fraction); *id.* at 31,460-31,461 (discussing Medicare fraction). Thus, for

example, HHS counted in the Medicaid fraction's numerator only patient days "for which benefits are *payable*" under the Medicaid program. *Monmouth Med. Ctr.* v. *Thompson*, 257 F.3d 807, 810 (D.C. Cir. 2001) (quoting 51 Fed. Reg. 16,772, 16,777 (May 6, 1986)).

In contrast, HHS interpreted the proviso in the Medicaid fraction that excludes from that fraction's numerator the patient days of Medicaid-eligible patients who were also "entitled to benefits under [Medicare] part A"—which is not modified by a similar "(for such days)" parenthetical, 42 U.S.C. 1395ww(d)(5)(F)(vi)(II)—as excluding *all* patient days of Medicare Part A beneficiaries, regardless of whether Medicare had paid the hospital for those days. See *Edgewater Med. Ctr.*, 2000 WL 1146601, at *4-*5. Based on that Medicare-patient proviso in the Medicaid fraction, HHS did not count in the Medicaid fraction's numerator patient days of Medicaid-eligible patients who also met the requirements for Medicare Part A benefits (referred to as dual-eligible patients)—whether or not the Medicare program ultimately paid for those days. See *ibid.*; *Catholic Health Initiatives*, 718 F.3d at 918, 921.

HHS subsequently revisited its approach following a series of judicial decisions rejecting the agency's approach to the *Medicaid* fraction and its "(for such days)" qualifier with respect to "eligib[ility]" for Medicaid. 42 U.S.C. 1395ww(d)(5)(F)(vi)(II). By 1997, four courts of appeals had rejected HHS's interpretation of the Medicaid fraction's numerator as counting only patient days actually paid by the Medicaid program. See *Monmouth Med. Ctr.*, 257 F.3d at 810 (citing *Cabell Huntington Hosp.*, *supra* (4th Cir.); *Legacy Emanuel Hosp. & Health Ctr.* v. *Shalala*, 97 F.3d 1261 (9th Cir. 1996); *Deaconess Health Servs. Corp.* v. *Shalala*, 83 F.3d

1041 (8th Cir. 1996) (per curiam); and *Jewish Hosp.*, *supra* (6th Cir.)). Three of those courts expressly rejected the agency's interpretation of "(for such days)," see *Cabell Huntington Hosp.*, 101 F.3d at 989-990; *Legacy Emanuel*, 97 F.3d at 1266; *Jewish Hosp.*, 19 F.3d at 274, and the fourth adopted the reasoning of a district-court decision that had done so, see *Deaconess Health Servs.*, *supra*, aff'g 912 F. Supp. 438, 445-447 (E.D. Mo. 1995). In 1997, CMS, then known as the Health Care Financing Administration (HCFA), issued a ruling that acquiesced nationwide in those courts' interpretation and "established a new interpretation" of the Medicaid fraction, under which "Medicaid eligible days *would* be counted 'whether or not the hospital received payment for those inpatient hospital services'" from a State's Medicaid program. *Monmouth Med. Ctr.*, 257 F.3d at 810 (quoting HCFA, HHS, *HCFA Ruling No. 97-2* (Feb. 27, 1997), https://go.usa.gov/xsn8W) (emphasis added).

b. In the rulemaking proceedings that culminated in the 2004 rule at issue here, HHS similarly revisited its approach to the *Medicare* fraction. Although the agency initially proposed a different approach for the Medicare fraction, HHS ultimately adopted for that fraction the same basic approach it had adopted for the Medicaid fraction's numerator—counting in the Medicare fraction's numerator and denominator patient days of individuals who meet the requirements for Medicare Part A, regardless of whether Medicare paid for those days.

i. In 2003, HHS published a notice of proposed rulemaking (for the 2004 fiscal year) in which it proposed to modify its regulations to count in the Medicaid fraction's numerator the patient days of persons who are eligible for Medicaid and meet the requirements for Medicare Part A but who (as of those patient days) had

exhausted their Medicare inpatient benefits—patient days for which the Medicare program did not pay. 68 Fed. Reg. 27,154, 27,207-27,208, 27,416 (May 19, 2003) (J.A. 45-48, 52-53). The proposed rule's preamble stated, correctly, that HHS's existing approach was generally to count patient days of such "dual-eligible" patients in the Medicare fraction and not in the Medicaid fraction. *Id.* at 27,207 (J.A. 45). But the preamble additionally stated, incorrectly, that HHS's then-current policy was to count such dual-eligible patient days in the Medicare fraction "even after the patient's Medicare coverage is exhausted." *Ibid.* (J.A. 45-46). In fact, such dual-eligible exhausted-coverage days were not counted in either the Medicare fraction (in its numerator or denominator) or in the Medicaid fraction's numerator. Pet. App. 7a-8a. The Secretary proposed counting them in the Medicaid fraction's numerator. 68 Fed. Reg. at 27,207-27,208 (J.A. 45-48).[2]

In proposing that new approach, the Secretary did not assert that it was compelled by the statutory language. To the contrary, the agency recognized that the inverse approach—counting such days in both parts of the Medicare fraction instead (and not counting them in the Medicaid fraction), which the proposed rule had mistakenly described as HHS's existing practice—was also consistent with the statutory language. 68 Fed. Reg. at 27,208 (J.A. 46). Instead, the agency stated that the approach being proposed embodied "[an]other plausible interpretation[]." *Ibid.* HHS additionally reasoned that "it [wa]s often difficult for" HHS contractors that determine Medicare payments in the first

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[2] In 2004, during a second comment period encompassing HHS's proposal, HHS published on its website a notice correcting the error in the 2003 proposed rule's description of the agency's then-current practice. J.A. 93-94; 69 Fed. Reg. at 49,098 (J.A. 170-171).

instance to "differentiate the days for dual-eligible patients whose Part A coverage has been exhausted," and it proposed to avoid that problem by counting all dual-eligible exhausted-coverage days in the Medicaid fraction's numerator. *Ibid.*

HHS received many comments in the 2003 rulemaking on its proposed modification of its regulations to include exhausted-Medicare-coverage days of dual-eligible patients in the Medicaid fraction. The vast majority of the comments opposed the agency's proposal. See, *e.g.*, J.A. 54-55, 59-60, 66, 68-69, 71-74, 77-82. In contrast, only three comments supported the agency's proposal to count such days in the Medicaid fraction (two of which noted the mistaken description of HHS's current policy in the proposed rule's preamble). See J.A. 56-57, 61-63, 83-85.

In the final rule adopted later in 2003, HHS ultimately reserved judgment on its proposal, noting that it was "still reviewing the large number of comments received," and the agency deferred addressing the issue until its next annual rulemaking in 2004 (for the 2005 fiscal year). 68 Fed. Reg. 45,346, 45,421 (Aug. 1, 2003) (J.A. 86); see 69 Fed. Reg. 28,196, 28,286 (May 18, 2004) (J.A. 87-88). During the comment period in the 2004 rulemaking process, HHS received many additional comments on its proposal, virtually all of which opposed HHS's proposal to count exhausted-coverage days in the numerator of the Medicaid fraction, and instead urged HHS to include such days in the Medicare fraction. See, *e.g.*, J.A. 90-92, 113-116, 132-133, 134-135, 147-151, 153-156; C.A. E.R. 69-70, 79, 81, 87-88, 90, 92-94, 96-97, 99-100, 106-108, 110-111, 113, 115, 118-119.[3]

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[3] HHS published its correction of the mistaken description of existing policy in the 2003 proposed rule's preamble before the end of the 2004 comment period. See J.A. 93-94; 69 Fed. Reg. at 28,196.

ii. In August 2004, the Secretary adopted the final rule (applicable in the 2005 fiscal year) at issue here. 69 Fed. Reg. 48,916. The agency explained that it "ha[d] decided not to finalize [its] proposed rule to include dual-eligible beneficiaries who have exhausted their [Medicare] Part A hospital coverage in the Medicaid fraction." *Id.* at 49,099 (J.A. 173); see *id.* at 49,098-49,099 (J.A. 169-174). Instead, the 2004 final rule embodied the inverse approach of "includ[ing] the days associated with dual-eligible beneficiaries in the *Medicare* fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage." *Id.* at 49,099 (J.A. 173-174) (emphasis added).

The 2004 rule implemented that interpretation by replacing the direction in HHS's Medicare-fraction regulations to "[d]etermine[] the number of *covered* patient days" of Medicare Part A beneficiaries, 42 C.F.R. 412.106(b)(2)(i) (2003) (emphasis added), with a direction to "[d]etermine[] the number of patient days" of Medicare Part A patients simpliciter, 69 Fed. Reg. at 49,246 (J.A. 174); see Pet. App. 77a. As a result, under the 2004 rule, all patient days of Medicare Part A beneficiaries are included in the Medicare fraction, regardless of whether Medicare paid for those particular days. See 69 Fed. Reg. at 49,099 (J.A. 173-174). All patient days attributable to Medicare Part A beneficiaries are counted in the Medicare fraction's denominator, and all patient days of such individuals who were also entitled to SSI benefits are counted in the Medicare fraction's numerator. *Ibid.*; 42 C.F.R. 412.106(b)(2)(i) and (iii).[4]

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[4] Consistent with its decision to include all patient days of Medicare Part A beneficiaries in the Medicare fraction, the 2004 rule continued to exclude all patient days of Medicare Part A beneficiaries from the numerator of the Medicaid fraction, regardless of whether those days were paid for by Medicare. See 69 Fed. Reg. at 49,099 (J.A. 173-174).

The Secretary observed that a Medicare Part A beneficiary who exhausts her covered inpatient days for a benefit period does not thereby lose her entitlement to Medicare Part A benefits altogether. See 69 Fed. Reg. at 49,098 (J.A. 173). To the contrary, the agency noted, Medicare "beneficiaries who have exhausted their Medicare Part A inpatient coverage may still be entitled to other Part A benefits." *Ibid.* For example, although a beneficiary's entitlement to inpatient care may be exhausted, "other items and services * * * still might be covered under Part A," such as "certain physician services and skilled nursing services." CMS, HHS, *CMS Ruling No. CMS-1498-R*, at 10 (Apr. 28, 2010) (*Ruling No. CMS-1498-R)*, https://go.usa.gov/xsnnz. The Secretary accordingly endorsed a commenter's observations "that a patient who exhausts coverage for inpatient hospital services still remains entitled to other Medicare Part A benefits," and that it is "difficult to reconcile" that fact with an interpretation of the statute that deems Medicare beneficiaries who have exhausted inpatient days to be "not entitled to Medicare Part A benefits" at all. 69 Fed. Reg. at 49,098 (J.A. 172-173).

The Secretary additionally observed that "[n]umerous commenters" had "opposed [the agency's] proposal" and had "objected that the proposal would result in a reduction of [disproportionate-share-hospital] payments." 69 Fed. Reg. at 49,098 (J.A. 171). HHS agreed with a commenter that counting in the Medicare fraction exhausted patient days of Medicare Part A patients would "ha[ve] a greater impact on a hospital's [disproportionate-share-hospital patient percentage] than including the days in the Medicaid fraction," because the Medicaid fraction's denominator (which includes all of a hospital's patient days) is necessarily larger than the Medicare fraction's denominator.

Ibid. (J.A. 173). HHS noted, however, that the effect of its approach on a particular hospital would vary depending on the makeup of its patient population. See *ibid.* For example, under the 2004 rule's approach, each additional Medicare beneficiary who is not entitled to SSI benefits would reduce a hospital's Medicare fraction because the beneficiary's patient days would be counted in the Medicare fraction's denominator but (unlike a patient who is entitled to SSI benefits) not in its numerator. See *ibid.*

B. The Present Controversy

1. Valley Hospital Medical Center operated a short-term acute-care hospital that participated as a provider in the Medicare program. Compl. ¶ 5. Respondent acquired Valley Hospital's right to payment from Medicare for (as relevant here) fiscal year 2008. Pet. App. 10a.

"Dissatisfied with its total reimbursement amount" for 2008 as determined by the Medicare contractor that calculated Valley Hospital's payment, respondent appealed to the Provider Reimbursement Review Board within HHS. Pet. App. 10a-11a. Respondent contended (as relevant here) that the 2004 rule's treatment of patient days of Medicare beneficiaries for days which were not covered was inconsistent with the Medicare Act's text. *Id.* at 77a-78a. Respondent requested, and the Board granted, expedited judicial review under 42 U.S.C. 1395*oo*(f)(1), which allows a provider to seek review of a Medicare contractor's action directly in district court over matters the Board determines it lacks authority to resolve. Pet. App. 11a n.13; see *id.* at 83a.

2. Respondent commenced this action in the district court challenging the 2004 rule as substantively and procedurally invalid. Pet. App. 25a. Respondent contended that "the Secretary's interpretation of the phrase 'entitled to benefits under [Medicare Part A]'" in Section

1395ww(d)(5)(F)(vi)(I) conflicts with the statutory language and Ninth Circuit precedent. *Ibid.* (citation omitted; brackets in original). Respondent additionally contended that the Secretary had failed to comply with the notice-and-comment requirements of the Administrative Procedure Act, 5 U.S.C. 551 *et seq.*, 701 *et seq.*, in promulgating the final rule. Pet. App. 51a; see generally J.A. 35-37.

The district court granted partial summary judgment to respondent. Pet. App. 23a-75a. The court rejected respondent's substantive challenge to the relevant portion of the 2004 rule, finding the Secretary's interpretation of the Medicare fraction to be permissible. *Id.* at 39a-51a. The court concluded, however, that the rule was "not a logical outgrowth" of the agency's proposed rule and thus was procedurally invalid. *Id.* at 70a; see *id.* at 51a-72a. The court enjoined HHS from applying the challenged portion of the rule to respondent and directed the agency to recalculate respondent's disproportionate-share-hospital adjustment for fiscal year 2008 in accordance with the court's order. *Id.* at 74a-75a.

3. The court of appeals affirmed, but on different grounds. Pet. App. 1a-22a. It first determined that the final rule was a logical outgrowth of the agency's proposed rule and that the district court thus erred in vacating the rule on procedural grounds. *Id.* at 12a-16a.[5]

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[5] Respondent filed a conditional cross-petition for a writ of certiorari contending that, if the Court granted the government's petition for a writ of certiorari seeking review of the statutory merits, it should also review the court of appeals' determination that the 2004 rule was a logical outgrowth of the 2003 proposed rule. See 20-1486 Conditional Cross-Petition 14-29. The Court granted the government's petition but denied respondent's conditional cross-petition. *Becerra* v. *Empire Health Found.*, No. 20-1312 (July 2, 2021); *Empire Health Found.* v. *Becerra*, No. 20-1486 (July 2, 2021).

The court of appeals further held, however, that the 2004 rule is "substantively invalid." Pet. App. 21a. The court reasoned that the Secretary's interpretation of the Medicare fraction embodied in the 2004 rule was foreclosed by the Ninth Circuit's prior decision in *Legacy Emanuel*, *supra*, which had addressed the Medicaid fraction. Pet. App. 18a-21a. In *Legacy Emanuel*, the Ninth Circuit rejected HHS's previous approach of excluding from the Medicaid fraction's numerator those patient days of an individual who satisfied the criteria for Medicaid eligibility under the relevant State's Medicaid plan but for which the Medicaid program did not ultimately pay—including because the individual had exhausted the number of days of inpatient care the State's Medicaid plan would cover. 97 F.3d at 1263-1266; see *id.* at 1265. The Ninth Circuit in *Legacy Emanuel* relied in part on "Congress's use of the word 'eligible' rather than 'entitled'" when referring to Medicaid. *Id.* at 1265. The court "presum[ed]" that Congress, in using the terms "'eligible'" when referring to Medicaid and "'entitled'" when referring to Medicare, "intended [them] to have different meanings." *Ibid.* (citation omitted). The *Legacy Emanuel* court interpreted "entitled" to "'mean[] that one possesses the right or title to [a] benefit'" for the particular service, and it construed "'eligible'" to be "broader" and not to be limited to "only those days actually paid for by Medicaid." *Id.* at 1264-1265 (citation and emphases omitted).

In the decision below, the Ninth Circuit held that its decision in *Legacy Emanuel* had resolved the meaning of "entitled" in Section 1395ww(d)(5)(F)(vi) at "step one" of the inquiry under *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), and so had left no room for a further or contrary interpretation

by the agency. Pet. App. 18a. The decision below described *Legacy Emanuel* as definitively "interpret[ing] the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" under the relevant federal program, not that the "patient simply meets the [program's] statutory criteria." *Ibid.* (citation omitted). The court acknowledged that its interpretation conflicted with decisions of the D.C. and Sixth Circuits that have upheld the agency's interpretation, but the Ninth Circuit believed itself bound to reject those rulings based on *Legacy Emanuel*. *Id.* at 19a-21a (citing *Catholic Health Initiatives*, 718 F.3d at 920, and *Metropolitan Hosp.*, 712 F.3d at 270).

Based on that interpretation, the court of appeals held that the statute foreclosed the 2004 rule's approach of counting in the Medicare fraction "patient days for which Medicare coverage is exhausted (i.e., for which there is no absolute right to payment)." Pet. App. 18a. The court accordingly "affirm[ed], on different grounds, the district court's order * * * vacating the [2004] Rule," and it "reinstated the prior version of 42 C.F.R. § 412.106(b)(2)(i), which embraced only 'covered' patient days" in the Medicare fraction. *Id.* at 22a (capitalization and emphasis omitted).

4. The court of appeals denied the government's petition for rehearing en banc. Pet. App. 84a-85a.

SUMMARY OF ARGUMENT

I. The Medicare Act directs the Secretary, in calculating a hospital's Medicare fraction, to include "patient days * * * which were made up of patients who (for such days) were entitled to benefits under [Medicare] part A." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). The Secretary permissibly interpreted that language to encompass all persons who meet the statutory requirements to be "entitled to" benefits under the Medicare Part A program.

A. The Secretary's interpretation embodies the best reading of the statutory text in light of its context, structure, history, and purpose.

1. Congress has set forth in the statutory text which persons are "entitled to" Medicare Part A benefits: all individuals who meet specified requirements, such as individuals over 65 who are also entitled to traditional Social Security benefits. 42 U.S.C. 426(a) and (b). Congress has further defined the import of that entitlement as a qualified right to have payment made by Medicare, *i.e.*, a right "subject to" various limitations imposed by statute. 42 U.S.C. 426(c)(1), 1395d(a). The Secretary appropriately construed "patients who * * * were entitled to benefits under [Medicare] part A," 42 U.S.C. 1395ww(d)(5)(F)(vi)(I), to mean individuals who meet the statutory requirements, even if a particular individual was not able to have the Medicare program pay for a particular service because of one of the statute's limitations. Moreover, as the Secretary recognized, a Medicare Part A beneficiary who has exhausted one particular Part A benefit, such as inpatient hospital care, still can access other Part A benefits. Such a person is naturally described as "entitled to benefits under [Medicare] part A." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). No other language in the statute calls for a contrary result.

2. Other provisions of the Medicare Act confirm the Secretary's interpretation that an individual who meets the statutory requirements is entitled to Part A benefits even though payment by Medicare for certain services is unavailable. Some provisions expressly distinguish patients who are "entitled to" Part A benefits but have "exhausted" inpatient care from patients "not * * * entitled" to Part A benefits at all. *E.g.*, 42 U.S.C. 1395*l*(t)(1)(B)(ii). Other provisions condition an individual's entitlement to benefits

under other portions of Medicare, and HHS's obligation to provide various notices, on the individual's "entitlement" to Part A benefits. Those provisions would make little sense if an individual were entitled to benefits only with respect to specific increments of care for which Medicare pays.

3. The broader statutory structure, history, and purpose bolster the Secretary's reading. Congress designed the disproportionate-share-hospital adjustment to gauge a hospital's proportion of low-income patients by separately assessing two separate populations: low-income patients who are Medicare Part A beneficiaries, and low-income patients who are not. That two-track approach was a compromise that combined competing proposals focused on those respective groups. The Secretary's approach, which treats entitlement to Part A benefits as a legal status of the patient—a status that is binary and, though not perfectly static, generally stable—fits well with that bifurcated framework. In contrast, an approach that determines an individual's entitlement to Part A benefits based on the happenstance that Medicare did or did not pay for a particular unit of care for unrelated reasons fits poorly with Congress's framework. Such an approach would produce perplexing results and compound the difficulties and complexities of administering this already-complicated scheme.

B. At a minimum, as the Sixth and D.C. Circuits have recognized, the Secretary's interpretation represents a reasonable reading of the statute that is entitled to deference under *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). To the extent the statute does not unambiguously compel the Secretary's interpretation, it at least permits that approach. The Court can resolve this case on that basis without determining whether HHS's reading is the best or only reasonable one.

II. Whichever path the Court takes, it should reject the court of appeals' conclusion that the Medicare Act unambiguously precludes the Secretary's approach. That court did not confront key portions of the statutory text. It failed to consider multiple aspects of the statute's context, structure, and purpose that further support the Secretary's interpretation. And it misread the isolated terms on which it did focus by misapplying an interpretive tool, which it mistook for an inflexible rule.

ARGUMENT

I. THE SECRETARY HAS PERMISSIBLY INCLUDED IN THE MEDICARE FRACTION ALL PATIENT DAYS OF PATIENTS WHO SATISFY THE REQUIREMENTS TO BE "ENTITLED TO" BENEFITS UNDER THE MEDICARE PART A PROGRAM

Aware that "hospitals that serve a disproportionate share of low-income patients * * * generally have higher per-patient costs," Congress has directed that "such hospitals * * * should receive higher [Medicare] reimbursement rates." *Sebelius* v. *Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 149 (2013). To that end, Congress has prescribed a formula for identifying such a "disproportionate share hospital" and for determining the amount of its increased payment. 42 U.S.C. 1395ww(r)(1); see 42 U.S.C. 1395ww(d)(5)(F). The formula that Congress enacted consists of two fractions—separate but interrelated proxy measures of a hospital's low-income patients. The first proxy—the Medicare (or SSI) fraction, at issue here—calculates the proportion of a hospital's patients who were Medicare beneficiaries and who had low incomes, using entitlement to SSI benefits to gauge low-income status. 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). The second proxy, the Medicaid fraction, calculates the proportion of a hospital's total patient population who were *not*

Medicare beneficiaries and had low incomes, measuring low-income status based on eligibility for medical assistance under Medicaid. 42 U.S.C. 1395ww(d)(5)(F)(vi)(II). Individually, each proxy offers only a partial picture, yielding two separate estimates of different subsets of a hospital's low-income patients. But those two separate proxies are "summed together," yielding a single, composite "proxy for the [hospital's] total low-income patient percentage." *Catholic Health Initiatives Iowa Corp.* v. *Sebelius*, 718 F.3d 914, 916 (D.C. Cir. 2013).

The dispute here concerns the computation of the Medicare fraction. The statute directs the Secretary to count in the numerator and denominator of that fraction patient days of "patients who (for such days) were entitled to benefits under [Medicare] part A." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). The precise question is whether the Secretary should count patient days of all individuals who satisfied the statutory requirements to be "entitled" to benefits under the Medicare Part A program, 42 U.S.C. 426(a) and (b), or instead must exclude patient days for which the Medicare program did not ultimately pay for other reasons—for example, because a patient had exhausted the allotted number of inpatient days Medicare will cover, or because another payer (such as a private insurer) was responsible to pay. In the 2004 rule, the Secretary properly determined that the phrase "entitled to benefits under [Medicare] part A" in the Medicare fraction means what it says: a person is entitled to Part A benefits if he or she meets the requirements set forth in the statute for a person to be "entitled" to participate in the Part A program. 69 Fed. Reg. at 49,098-49,099 (J.A. 169-174). That interpretation reflects the best, most natural reading of the statutory text. Context, structure, history, and purpose all strongly reinforce that construction.

At a minimum, HHS's interpretation of the Medicare fraction reflects "a reasonable construction of the statute" that is entitled to deference. *Holder* v. *Martinez Gutierrez*, 566 U.S. 583, 591 (2012) (citing *Chevron U.S.A. Inc.* v. *Natural Res. Def. Council, Inc.*, 467 U.S. 837, 843-844 (1984)). Thus, although the Court may uphold that interpretation simply because it is the better one, without addressing the additional weight due under *Chevron*, see *Coventry Health Care of Mo., Inc.* v. *Nevils*, 137 S. Ct. 1190, 1198 n.3 (2017), the Court alternatively may uphold HHS's interpretation without resolving "whether or not it is the only possible interpretation or even the one a court might think best," *Martinez Gutierrez*, 566 U.S. at 591. Either way, the Secretary's interpretation is sound and should be sustained.

A. The Secretary's Approach To The Medicare Fraction Embodies The Best Reading Of The Statute's Text In Light Of Its Context, Structure, History, And Purpose

The statute defining the Medicare fraction directs HHS to count in that fraction a hospital's "patient days * * * which were made up of patients who (for such days) were entitled to benefits under [Medicare] part A." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). All such patient days are counted in the Medicare fraction's denominator, and such days of patients who were also entitled to SSI benefits are counted in the numerator. *Ibid.* The statute contains no other conditions or exceptions, and courts should be loath to read in other criteria that Congress did not specify. See, *e.g.*, *Jennings* v. *Rodriguez*, 138 S. Ct. 830, 844 (2018). The dispositive question is therefore which individuals are "entitled to benefits under [Medicare] part A." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I).

The Secretary properly determined that the statute's text answers that question by explicitly identifying the individuals who are "entitled to" Part A benefits, and by further defining that "entitlement" as a legal status that coexists alongside limitations on an individual's access to particular benefits. 42 U.S.C. 426(a) and (b); see 42 U.S.C. 1395d(a). Other provisions of the Medicare Act that refer to persons "entitled to" Part A benefits reinforce that straightforward understanding. And interpreting the Medicare fraction to include patient days of all individuals who satisfy the statutory requirements to be entitled to benefits under the Medicare Part A program, as the 2004 rule does, dovetails with the statutory design, reflected in its structure and history. Traditional tools thus all point to the Secretary's interpretation of the Medicare fraction as the best one.

1. The Secretary's approach to the Medicare fraction reflects the best reading of the relevant statutory text

a. In construing any statute, "a court's proper starting point lies in a careful examination of the ordinary meaning and structure of the law itself." *Food Mktg. Inst.* v. *Argus Leader Media*, 139 S. Ct. 2356, 2364 (2019). Where the statute itself specifies the meaning of a term, however, courts "'must follow that definition,' even if it varies from [the] term's ordinary meaning." *Digital Realty Trust, Inc.* v. *Somers*, 138 S. Ct. 767, 776 (2018) (citation omitted). The Medicare Act defines the phrase "patients who * * * were entitled to benefits under [Medicare] part A" by specifying which individuals are "entitled to" those benefits. 42 U.S.C. 426(a) and (b), 1395ww(d)(5)(F)(vi)(I).

Section 426, captioned "[e]ntitlement to hospital insurance benefits," provides that certain categories of individuals who satisfy specified criteria are "entitled to hospital insurance benefits under part A of subchapter XVIII," *i.e.*, Medicare Part A. 42 U.S.C. 426(a) and (b) (emphasis omitted). For example, Section 426(a) states that "[e]very individual who * * * has attained age 65" and who is "entitled" to traditional Social Security benefits under 42 U.S.C. 402 is automatically "entitled" to Medicare Part A benefits. 42 U.S.C. 426(a); see *Hall* v. *Sebelius*, 667 F.3d 1293, 1295 (D.C. Cir. 2012), cert. denied, 568 U.S. 1085 (2013). Similarly, Section 426(b) provides that "[e]very individual" under age 65 who has been entitled for 24 months (and remains entitled) to certain federal disability benefits is entitled to Medicare Part A benefits as well. 42 U.S.C. 426(b). Although Section 426 appears in a different portion of the Social Security Act (Title II) than Medicare Part A (Title XVIII), by its terms it governs entitlement to Part A benefits under Title XVIII. 42 U.S.C. 426(a) and (b). Indeed, Congress enacted Section 426 in the same 1965 law that, in the very next section, added Title XVIII to the Social Security Act and thereby established Medicare Part A. See Health Insurance for the Aged Act, Pub. L. No. 89-97, Tit. I, Pt. 1, sec. 101, § 226, 79 Stat. 290-291 (42 U.S.C. 426); *id.* sec. 102, §§ 1801-1875, 79 Stat. 291-332 (42 U.S.C. 1395 *et seq.*).

Section 426's text thus establishes that a person who satisfies the criteria specified in Section 426(a) or (b) is, without more, "entitled to" Medicare Part A benefits. That entitlement to benefits is a legal status that one obtains, and maintains, by virtue of possessing the characteristics enumerated in the statute, such as age or a qualifying disability. That status is not always static;

an individual under age 65 typically becomes entitled to benefits upon reaching that age, and entitlement based on a disability under Section 426(b) may vary over time. See *Northeast Hosp. Corp.* v. *Sebelius*, 657 F.3d 1, 12 (D.C. Cir. 2011). But by making "[e]ntitlement to [Part A] benefits" automatic for those who meet the specified statutory requirements when treated, 42 U.S.C. 426 (emphasis omitted), Congress defined that "entitlement" as an attribute an individual possesses simply by virtue of satisfying the enumerated requirements.

Section 426(c)(1), as well as a provision of Part A itself, confirms that conclusion by defining the principal legal effect of the entitlement that Section 426 confers. Section 426(c)(1) provides that the beneficiary has a right to have payment made for Part A services, but a right that is qualified by various limitations. It states that, "[f]or purposes of [Section 426(a)]," with certain exceptions, "entitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, *and subject to the limitations in*, part A of subchapter XVIII on his behalf for" specified services that are "furnished" to the individual "during such month." 42 U.S.C. 426(c)(1) (emphasis added). Section 1395d(a), which appears in Part A and specifies the "[s]cope" of Part A benefits, similarly states that "[t]he benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf * * * (*subject to the provisions of this part*) for" specified services. 42 U.S.C. 1395d(a) (emphasis altered).

As the language of both of those provisions reflects, the right of a Medicare Part A beneficiary to have payment made for services is not unlimited. The Medicare Act defines the scope of Part A benefits, see 42 U.S.C.

1395d, and otherwise limits the circumstances in which such payment will be made and in what amounts. *E.g.*, 42 U.S.C. 1395f. Sections 426(c)(1) and 1395d(a) account for such constraints and expressly distinguish them from the individual's underlying "entitlement" to Part A benefits. 42 U.S.C. 426(c)(1), 1395d(a). Those provisions thus confirm that entitlement to Part A benefits is a legal status that, in turn, triggers both the individual's right to have Medicare make payment for particular services and the limitations on that right. An individual's entitlement, in other words, is not contingent on or limited by the Medicare program's obligation to pay for particular services on a specific occasion, and it does not lapse merely because other provisions of the Act make payment by Medicare for certain services unavailable. Instead, the text reflects that an individual who meets the statutory requirements remains entitled to benefits under the Medicare Part A program.

Neither the Medicare fraction's language nor the meaning of an "entitlement" to Part A benefits that Congress established in Sections 426 and 1395d(a) accords significance to whether the Medicare program paid for a particular patient day. Nothing in the text of those provisions directs the Secretary to exclude patient days for which the Medicare program ultimately was not responsible—for example, those of an individual who had exhausted the number of inpatient days that Medicare Part A will cover, see 42 U.S.C. 1395d(b), or who was injured by a third party whose private insurer must be the payer of first resort, see 42 U.S.C. 1395y(b)(2)(A). The statutory text makes entitlement to Part A benefits the touchstone and defines which individuals have such an entitlement. The Secretary thus

appropriately determined to include patient days of such individuals in computing the Medicare fraction.

b. Even if the phrase "entitled to" in Section 1395ww(d)(5)(F)(vi)(I) were properly read to refer to persons with an unqualified right to have payment made for a service, the text still would support the Secretary's approach of counting in the Medicare fraction patient days of all patients who meet the statutory requirements for entitlement. Section 1395ww(d)(5)(F)(vi)(I) does not refer to individuals who were "entitled to" benefits for a specific increment of services that they received on a particular day. Instead, it refers more broadly to "patients who (for such days) were entitled to *benefits under* [*Medicare*] *part A*." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I) (emphasis added). That phrasing is significant because an individual who is entitled to Medicare Part A benefits and who, by virtue of the Medicare Act's limitations, lacks a right to have payment made for one Part A service (such as inpatient hospital care) on a specific occasion ordinarily still has a right to have payment made for *other* Part A services.

As the Secretary explained in adopting the 2004 rule, "beneficiaries who have exhausted their Medicare Part A inpatient coverage may still be entitled to other Part A benefits." 69 Fed. Reg. at 49,098 (J.A. 173). In addition to hospital inpatient care, Part A also provides, "for example, certain physician services and skilled nursing services." *Ruling No. CMS-1498-R*, at 10; see 42 U.S.C. 1395d(a). Medicare Part A beneficiaries whose inpatient "hospital benefits have been exhausted" thus "still might be covered" for such "other items and services" under Part A. *Ruling No. CMS-1498-R*, at 10. As the Secretary noted (endorsing a commenter's observation), it is "difficult to reconcile" the view that individuals who have

exhausted inpatient coverage are "not entitled to Medicare Part A benefits" with the reality that "they can receive other covered Part A services." 69 Fed. Reg. at 49,098 (J.A. 171). Even on a narrower reading of "entitled" that connotes an absolute right to have payment made, it would be perfectly natural to describe a person who lacks a right to have payment made for one Part A service but who has a right to have payment made for other Part A services as "entitled to benefits under [Medicare] part A." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). It would be inaccurate, and at a minimum confusing, to describe such a person as not "entitled to" Medicare Part A benefits at all.

Similarly, it would be anomalous to conclude that a patient is not entitled to Medicare Part A benefits whenever, under the secondary-payer provisions, the Medicare program is not responsible to pay for particular patient days because another, primary payer is responsible to pay in the first instance. See p. 11, *supra*. Such a patient would be entitled to have payment made by Medicare but for the fact that another source has an obligation to pay first.

c. As the government has acknowledged (*e.g.*, Pet. 7-8), prior to adopting the 2004 rule, HHS had taken the position that a different aspect of the Medicare fraction's text compelled a different result. Although since at least 1983 the agency has generally interpreted the term "entitled" in the context of Medicare benefits to describe a status applicable to any person who satisfies the criteria set forth in the statute, see 48 Fed. Reg. at 12,535 (42 C.F.R. 400.202), HHS initially understood the parenthetical qualifiers "(for such days)" in the numerator and denominator of the Medicare fraction to require counting only patient days that were "covered,"

i.e., actually payable, by the Medicare program. 51 Fed. Reg. at 31,460-31,461. Before 1997, HHS had likewise taken the same view of the "(for such days)" qualifier with respect to Medicaid eligibility in the Medicaid fraction. 42 U.S.C. 1395ww(d)(5)(F)(vi)(II); see pp. 10-13, *supra*. As discussed above, however, and as the government has explained in lower-court litigation in this case and others, the Secretary has long since recognized that the "(for such days)" parentheticals do not support that approach. See, *e.g.*, Gov't C.A. Resp. & Reply Br. 33-34; Gov't C.A. Br. at 17, *Metropolitan Hosp.* v. *United States Dep't of HHS*, 712 F.3d 248 (6th Cir. 2013) (No. 11-2466).

By 1997, four courts of appeals (including the Ninth Circuit) had rejected the Secretary's previous approach to the Medicaid fraction in general, and to the phrase "(for such days)" in particular. See *Cabell Huntington Hosp., Inc.* v. *Shalala*, 101 F.3d 984, 985-986 (4th Cir. 1996); *Legacy Emanuel Hosp. & Health Ctr.* v. *Shalala*, 97 F.3d 1261 (9th Cir. 1996); *Deaconess Health Servs. Corp.* v. *Shalala*, 83 F.3d 1041, 1041 (8th Cir. 1996) (per curiam) (affirming on basis of district court's decision rejecting that approach), aff'g 912 F. Supp. 438, 445-447 (E.D. Mo. 1995); *Jewish Hosp., Inc.* v. *Secretary of HHS*, 19 F.3d 270, 274 (6th Cir. 1994). In 1997, HHS acquiesced in those decisions with respect to the Medicaid fraction. See p. 13, *supra*. In the 2004 rule, HHS carried over that revised view to the Medicare fraction.

The Secretary thus has taken the view that the "(for such days)" parentheticals do not require excluding patient days not actually paid for by the Medicare and Medicaid programs, respectively. Those parentheticals are best understood as merely clarifying the time at which an individual must be entitled to Medicare Part A benefits (or eligible for Medicaid benefits)—*i.e.*, on the

patient day(s) in question—not as obliquely transforming the Medicare and Medicaid fractions' substantive scopes. That clarification serves an important function, because an individual's entitlement to Medicare Part A is largely but not perfectly static, and "[n]ot every patient who meets the criteria * * * during some portion of his hospital stay will meet those criteria for all of the stay." *Northeast Hosp.*, 657 F.3d at 12. For example, "a person who collects Social Security and who turns 65 during his hospital stay will become 'entitled' to benefits under Part A on his sixty-fifth birthday," and "a person under age 65 who reaches his twenty-fifth calendar month of entitlement to disability benefits under § 423 during his hospital stay will become 'entitled' to benefits under Part A upon reaching his twenty-fifth month of disability entitlement." *Ibid.*

As the D.C. Circuit explained in *Northeast Hospital*, "the fractions' focus on specific patient days works perfectly well under the Secretary's view that 'entitled' means 'meeting the statutory criteria in § 426(a) and (b).'" 657 F.3d at 12. They make clear that the Medicare and Medicaid fractions count a patient day only if the patient was entitled to Medicare (or eligible for Medicaid) benefits on that day—not merely because the patient previously was (or later became) entitled to or eligible for such benefits. Those portions of the statutory text are thus fully compatible with the approach embodied in the 2004 rule.

2. Other provisions of the Medicare Act confirm the Secretary's interpretation of the Medicare fraction

"Statutory construction * * * is a holistic endeavor," and "[a] provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme"—for example, where "the same terminology is

used elsewhere in a context that makes its meaning clear," or where "only one of the permissible meanings produces a substantive effect that is compatible with the rest of the law." *United Sav. Ass'n* v. *Timbers of Inwood Forest Assocs., Ltd.*, 484 U.S. 365, 371 (1988) (Scalia, J.). The broader statutory context here bolster's the Secretary's reading of the Medicare fraction in those ways.

a. Other provisions of the Medicare Act expressly contemplate that a person may be entitled to Medicare Part A benefits even though the Medicare program will not pay for a particular increment of service—including because the individual's Part A benefits for that particular service have been exhausted. For example, Congress has specified that covered outpatient services include certain hospital inpatient services that are furnished to an individual who "(I) *is entitled* to benefits under part A *but has exhausted* benefits for inpatient hospital services during a spell of illness, *or* (II) is not so entitled." 42 U.S.C. 1395*l*(t)(1)(B)(ii) (emphases added). Similarly, in prescribing the amount that Medicare will pay for outpatient physical-therapy services, Congress specified that the amount prescribed applies to an outpatient or to a hospital inpatient "who *is entitled* to benefits under part A *but has exhausted* benefits for inpatient hospital services during a spell of illness *or* is not so entitled to benefits under part A." 42 U.S.C. 1395*l*(a)(8)(B)(i) (emphases added).

The text of those provisions—referring to a patient who "is entitled to benefits under part A," but who has exhausted benefits for certain services—confirms that entitlement to and exhaustion of benefits can coexist. And their language distinguishing beneficiaries who are entitled to Part A benefits but have exhausted those benefits

from individuals who are not entitled to Part A benefits at all demonstrates that exhaustion of Part A benefits does not nullify a beneficiary's basic entitlement under Part A. Congress's use of that "same terminology" of entitlement to Part A benefits, "in a context that makes its meaning clear," strongly supports the Secretary's understanding of the corresponding language in the Medicare fraction. *United Sav. Ass'n*, 484 U.S. at 371.

b. A contrary reading of "entitled to benefits under [Medicare] part A" in 42 U.S.C. 1395ww(d)(5)(F)(vi)(I) that excludes patient days for which Medicare does not pay also would create incongruous results under other Medicare Act provisions. For example, an individual's ability to enroll in Medicare Part B (which covers outpatient and other services not covered by Part A), Medicare Part C (which provides for coverage through privately administered Medicare Advantage plans), and Medicare Part D (which provides prescription-drug benefits) is generally predicated upon the individual's being "entitled to" Part A benefits. 42 U.S.C. 1395*o*(a)(1), 1395w-21(a)(3), 1395w-101(a)(3)(A). No sound basis exists to suppose that Congress intended an otherwise-eligible individual's ability to enroll in Parts B, C, and D to evaporate because the Medicare program did not pay for particular past Part A services—either because the individual had exhausted those particular benefits, because another payer (such as the private insurer of a tortfeasor who injured the beneficiary) was responsible to pay in the first instance, or for other reasons.

Similarly, another Medicare Act provision requires HHS to notify "individuals entitled to benefits under part A" of their benefit information, including information about the "limitations on payment * * * that are imposed under [Medicare Part A]." 42 U.S.C. 1395b-2(a)(2). It is

highly unlikely that Congress intended the agency's statutory obligation to provide notice to all Medicare beneficiaries of benefit information to phase out temporarily for each particular beneficiary who exhausts a particular Part A benefit or receives treatment for which a third party is the primary payer, and then to phase back in when Medicare's obligation to pay for that individual's treatment resumes.

3. The statutory structure, history, and purpose further support the Secretary's interpretation

In construing a statute "holistic[ally]," *United Sav. Ass'n*, 484 U.S. at 371, courts also appropriately consider a statute's broader "structure, history, and purpose," *Abramski* v. *United States*, 573 U.S. 169, 179 (2014) (citation omitted). The basic architecture and overarching aim of the disproportionate-share-hospital adjustment of which the Medicare fraction is a part further support the Secretary's approach.

Congress enacted the disproportionate-share-hospital adjustment to identify hospitals that "serve a disproportionate share of low-income patients." *Auburn Reg'l Med. Ctr.*, 568 U.S. at 150. Congress recognized that such hospitals "generally have higher per-patient costs," and it determined that they "should receive higher reimbursement rates" for services that they provide to Medicare patients. *Ibid.*; see pp. 4-5, *supra*. The disproportionate-share-hospital adjustment was designed to "provide a proxy for the [hospital's] total low-income patient percentage." *Catholic Health Initiatives*, 718 F.3d at 916.

The signal feature of the proxy that Congress crafted is its bifurcated structure. The disproportionate-patient percentage at the heart of the adjustment consists of two fractions that separately consider two distinct patient populations: a hospital's low-income patients who are

Medicare beneficiaries, and those who are not. Congress adopted distinct methodologies for assessing those two groups. It directed HHS to evaluate a hospital's Medicare beneficiaries by calculating the percentage of all Medicare patients who were entitled to SSI benefits. 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). In contrast, Congress directed HHS to assess non-Medicare patients using a different gauge of low-income status—*i.e.*, eligibility for medical assistance under a State Medicaid plan—and in comparison to the hospital's entire patient pool. 42 U.S.C. 1395ww(d)(5)(F)(vi)(II).

That hybrid approach to approximating low-income patients by separately analyzing Medicare beneficiaries and non-Medicare beneficiaries was a considered choice. Congress could have chosen a single measure of a hospital's low-income patients. Indeed, both the Senate's and House's proposals would have done so. The Senate preferred a proxy that focused exclusively on a hospital's Medicare Part A patients and determined the proportion of them with low incomes based on their enrollment in SSI benefits. Conference Report 460. The House, in contrast, would have keyed a hospital's additional payment (if any) to the proportion of low-income patients in its entire patient population, using eligibility for Medicaid benefits to measure low-income patients. *Id.* at 459. Instead, however, the final legislation combined the core elements of each approach. *Id.* at 461; *Jewish Hosp.*, 19 F.3d at 282-283 (Batchelder, J., dissenting).

The dividing line that Congress adopted to separate patient days counted in one fraction from those counted in the other is an attribute of each patient: entitlement vel non to Medicare Part A benefits. Congress evidently determined that patients who are "entitled to" such

benefits warrant separate analysis from those who are not. 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). Congress might have perceived potential differences between Medicare and non-Medicare patients' typical costs, which could justify estimating the low-income patients in each group separately. Alternatively, or in addition, Congress may have sought to ensure that the analytical approaches underlying the Senate and House proposals that it blended were both reflected in the statutory formula, using separate measures of, and giving independent (and generally unequal) weight to, a hospital's Medicare and non-Medicare patients with low incomes. As the Secretary noted in adopting the 2004 rule, adding or subtracting a patient from the Medicare fraction may have a greater effect on a hospital's disproportionate-patient percentage because of that fraction's smaller denominator. See 69 Fed. Reg. at 49,098 (J.A. 173).

Whatever Congress's precise rationale for combining two metrics—each focused on a distinct patient pool—the legislation Congress enacted "has all the earmarks of a compromise," and courts should give effect to the balance it struck. *Obduskey* v. *McCarthy & Holthus LLP*, 139 S. Ct. 1029, 1038 (2019). The Secretary's approach in the 2004 rule does so and fits comfortably within that statutory design. The Secretary's interpretation of "entitle[ment] to benefits under [Medicare] part A," 42 U.S.C. 1395ww(d)(5)(F)(vi)(I)—as marking a boundary between two categories of individuals based on their legal status as a Medicare beneficiary—facilitates Congress's objective, embedded in the structure of the disproportionate-share-hospital formula, of considering those two categories of patients separately, providing a complete picture of each group of patients. An individual's status as entitled to Medicare Part A benefits is

also binary and relatively easy to determine. Once each patient's status is ascertained, the separate calculations Congress called for can proceed straightforwardly. A status-based understanding of entitlement to Medicare Part A benefits aligns well with the statutory design.

In contrast, the divided framework that Congress engineered, which applies different metrics to different subsets of a hospital's low-income patient pool, would be an unusual choice if Congress had intended each patient day to be classified individually and incorporated into one fraction or the other based on whether it was actually paid for by Medicare. It is far from clear why Congress, in creating a mechanism to adjust hospitals' Medicare payments to account for the generally higher cost of treating low-income patients, see *Auburn Reg'l Med. Ctr.*, 568 U.S. at 150, would view patient days of Medicare beneficiaries for which the Medicare program did not happen to pay for unrelated reasons as shedding less or different light on a hospital's relative costs of care than those for which the program did pay, and would intend to exclude that subset of patients in assessing its patient days for Medicare patients. The happenstance of whether Medicare—as opposed to another payer—ultimately bore the cost of a particular increment of care bears no apparent relationship to the proportion of low-income patients a hospital serves. For example, it would seem arbitrary to accord different treatment to patient days for which the Medicare program is not responsible to pay merely because another, primary payer—such as the insurer of a tortfeasor who injured the patient—is responsible to pay under the secondary-payer provisions.

Moreover, deeming a patient "entitled to benefits under [Medicare] part A" on a day only if the Medicare program ultimately paid for that particular day could lead to puzzling results. For example, if the same reading of that phrase also applied in the Medicaid fraction, it could cause the same patient to oscillate between the Medicare and Medicaid fractions during the same hospital stay. A dual-eligible beneficiary entitled to SSI benefits might be counted in the Medicare fraction for the initial part of a hospital stay, in the Medicaid fraction for a subsequent part of the same stay once the patient exhausted Medicare inpatient coverage, and then again in the Medicare fraction in the next benefit period. It is not apparent why Congress would have intended the same patient to bounce back and forth between the two fractions, and for the patient days in each portion to be analyzed differently and accorded different weight.

To be sure, patient days for which the Medicare program pays differ from days it does not cover in that the Medicare program funds only the former. But the structure of the statute shows clearly that Congress did not intend the disproportionate-share-hospital adjustment to measure only the cost of each unit of Medicare benefits for which the program pays. The Medicaid fraction focuses entirely on identifying low-income patients who are *not* "entitled to" receive Medicare benefits. 42 U.S.C. 1395ww(d)(5)(F)(vi)(II). Congress made a judgment that a hospital's Medicare payment rates should be adjusted to reflect not only the proportion of low-income Medicare patients it serves, but also its proportion of low-income non-Medicare patients; it simply determined that those groups of patients should be evaluated separately. The Secretary's approach effectuates that judgment.

B. The Secretary's Approach Embodies At A Minimum A Reasonable Interpretation That Warrants Deference

For all of the foregoing reasons, the Secretary's interpretation of the Medicare fraction represents the best reading of its text in light of its context, structure, history, and purpose. As Judge Silberman observed for the D.C. Circuit, the Secretary's interpretation, even if "not quite inevitable," "is the better one." *Catholic Health Initiatives*, 718 F.3d at 920. But at the very least, as that court and the Sixth Circuit have recognized, the Secretary's approach reflects "a reasonable construction of the statute" and is therefore entitled to deference. *Martinez Gutierrez*, 566 U.S. at 591 (citing *Chevron*, 467 U.S. at 843-844); see *Catholic Health Initiatives*, 718 F.3d at 920; *Metropolitan Hosp.* v. *United States Dep't of HHS*, 712 F.3d 248, 270 (6th Cir. 2013).

An agency's interpretation, codified in a notice-and-comment regulation, of a statute that it administers is entitled to "controlling weight" so long as it "fills a gap or defines a term in a reasonable way in light of the Legislature's design," even if that reading "is not the answer 'the court would have reached if the question initially had arisen in a judicial proceeding.'" *Regions Hosp.* v. *Shalala*, 522 U.S. 448, 457 (1998) (citation omitted). The Medicare fraction and the broader statutory scheme are undeniably intricate and technical, and not every portion of the statute is pellucid. Cf., *e.g.*, *Northeast Hosp.*, 657 F.3d at 13, 17. Moreover, as the Secretary has acknowledged, the disproportionate-share-hospital adjustment provision's text standing alone may be susceptible of more than one plausible interpretation. 68 Fed. Reg. at 27,208 (J.A. 46). But to the extent Congress did not unequivocally require the approach that the Secretary adopted, at the very least Congress did not clearly

foreclose it. Even if the language of the Medicare fraction referring to patients who "were entitled to benefits under [Medicare] part A," 42 U.S.C. 1395ww(d)(5)(F)(vi)(I), and of the provisions defining who is "entitled to" Medicare Part A benefits, 42 U.S.C. 426(a) and (b), does not mandate counting in that fraction every individual who meets the requirements for entitlement, the text at least allows that approach. Likewise, even if the statutory context and overall design can also be reconciled with equating entitlement to benefits with whether Medicare pays for each specific increment of care, those indicia of congressional intent are at least fully consonant with the Secretary's approach as well and thus leave room for his interpretive judgment and discretion.

The Secretary exercised that judgment and discretion reasonably in adopting the 2004 rule. That approach effectuates Congress's objective in the Medicare fraction while harmonizing the Medicare Act's interlocking provisions. See pp. 34-41, *supra*. It also embodies a reasonable policy choice consistent with the statute's objectives. Many commenters observed during the rulemaking, for example, that an approach that required hospitals to classify each patient separately based on whether Medicare ultimately paid for that day—an approach the Secretary proposed but ultimately rejected—would give rise to significant recordkeeping and other administrative burdens. See J.A. 59-60, 68-69, 73-74, 79-80, 91, 114, 132-133, 150. The agency's approach avoids adding a further layer of complexity to an already-intricate scheme.

Contrary to respondent's suggestion at the petition stage (Br. in Opp. 1-2, 10-11), the 2004 rule did not embody an effort to minimize disproportionate-share-hospital payments. Indeed, as HHS noted in adopting the 2004 rule, "[n]umerous commenters opposed" HHS's original

proposal to adopt a policy in line with respondent's reading of the statute because they believed that the approach the 2004 rule rejected would have reduced their payments. 69 Fed. Reg. at 49,098 (J.A. 171); see, *e.g.*, J.A. 54-55, 59-60, 66, 68-69, 71-74, 77-82, 90-92, 113-116, 132-133, 134-135, 147-151, 153-156. In any event, HHS did not adopt the 2004 rule with a view to decreasing or increasing hospitals' payments across the board. As the Secretary explained, the final rule's approach neither uniformly increases nor uniformly decreases hospitals' Medicare payments; its effect on a particular hospital depends on the composition of that hospital's patient population. See 69 Fed. Reg. at 49,098 (J.A. 171). Under the 2004 rule, each of a hospital's patients who is entitled to Medicare Part A benefits and SSI benefits yields a greater increase in its disproportionate-patient percentage than HHS's pre-2004 approach (which did not count such patient days in either fraction's numerator) or the 2003 proposal (which would have counted them in the Medicaid fraction's numerator). In contrast, each individual who is entitled to Part A benefits but not SSI benefits will decrease a hospital's disproportionate-patient percentage. The agency recognized and accepted those consequences. See *id.* at 49,098-49,099 (J.A. 171-174).

Accordingly, although the Court may decide this case on the ground that the Secretary's interpretation is correct, it may alternatively uphold that interpretation without resolving "whether or not it is the only possible interpretation or even the one a court might think best." *Martinez Gutierrez*, 566 U.S. at 591. Because the Secretary's approach is at least a reasonable one, the Court can sustain it without "decid[ing] if the statute permits any other construction." *Ibid.*; see *Entergy Corp.* v. *Riverkeeper, Inc.*, 556 U.S. 208, 218 & n.4 (2009).

II. THE COURT OF APPEALS ERRED IN CONCLUDING THAT THE MEDICARE ACT CLEARLY FORECLOSES THE SECRETARY'S INTERPRETATION

The court of appeals nevertheless rejected the Secretary's position as contrary to the unambiguous meaning of the statute. Pet. App. 16a-21a. In doing so, however, the court did not confront any of the textual and contextual indicia discussed above that support the Secretary's position. Instead, the court seized on two words—"entitled" in the Medicare fraction, versus "eligible" in the Medicaid fraction—and concluded that Congress's use of those terms is dispositive. *Id.* at 18a-19a. Specifically, the court reasoned as follows: the court construed its prior decision in *Legacy Emanuel*, *supra*, as holding that the terms "'entitled'" and "'eligible'" in close proximity must mean different things, and that "'entitled' * * * mean[s] that a patient has an 'absolute right . . . to payment.'" Pet. App. 18a (quoting *Legacy Emanuel*, 97 F.3d at 1265). From those premises, the court concluded that a Medicare beneficiary is not entitled to Medicare Part A benefits with respect to any days for which the Medicare program does not pay because the patient had already exhausted inpatient coverage for that period. *Ibid.* Because such a patient lacks an "absolute right . . . to payment" for those days, the court deemed that patient not "entitled" to Part A benefits. *Ibid.* (citation omitted). That reasoning is wrong at every turn.

It is debatable at best that *Legacy Emanuel*'s holding, which concerned the Medicaid fraction, encompassed a definitive interpretation of "entitled" in the Medicare fraction as referring to an absolute right to have payment made. See *Northeast Hosp.*, 657 F.3d at 13 n.7; Pet. 29. In any event, regardless of whether the panel below was bound to accept that interpretation of

"entitled," this Court should reject that interpretation because it is incorrect as an original matter. As discussed above, the Medicare Act itself establishes the meaning of "entitled" in the specific context of Part A benefits: it defines categories of persons who meet certain statutory requirements as "entitled to" such benefits, and it further defines that "entitlement" as one that is not absolute, but qualified by "limitations" and other "provisions" of the statute. 42 U.S.C. 426(a)-(b) and (c)(1), 1395d(a); see pp. 27-31, *supra*. Whatever "entitled" might mean in other settings, the context-specific meaning that Congress prescribed in the statute should control here. See *Digital Realty,* 138 S. Ct. at 777.

The court of appeals did not address those provisions. Nor did it confront the fact that an individual who has exhausted one Part A benefit, such as inpatient hospital care, for a given period still can access other Part A benefits. See pp. 31-32, *supra*. And it disregarded the other specific provisions of the Medicare Act and the statute's broader design that strengthen the Secretary's interpretation and cut against the court of appeals' view that "entitled" in the Medicare fraction means an absolute right to payment. See pp. 34-41, *supra*.

Moreover, the only reason the court of appeals gave for construing "'entitled'" in that manner—Congress's use in the adjacent Medicaid fraction of the term "'eligible,'" which the court understood "to mean that a patient simply meets the Medicaid statutory criteria," Pet. App. 18a (citation omitted)—is unpersuasive on its own terms. This Court "ha[s] recognized, as a general rule, that Congress' use of 'certain language in one part of the statute and different language in another' can indicate that 'different meanings were intended.'" *Auburn Reg'l Med. Ctr.*, 568 U.S. at 156 (citation omitted).

"But th[at] interpretive guide * * * is 'no more than a rule of thumb' that can tip the scales" in close cases. *Ibid.* (brackets and citation omitted). And here the scales are not in equipoise because the Medicare statute specifies who is entitled to Part A benefits and what that entitlement entails.

The interpretive guide on which the court of appeals relied carries especially "little weight" here because Congress's use in the Medicare and Medicaid fractions of "entitled" and "eligible" in referring to the Medicare and Medicaid programs, respectively, merely reflects Congress's usage of different terminology in the underlying Medicare and Medicaid statutes. *Northeast Hosp.*, 657 F.3d at 12. "Congress has, throughout the various Medicare and Medicaid statutory provisions, consistently used the words 'eligible' to refer to potential Medicaid beneficiaries and 'entitled' to refer to potential Medicare beneficiaries." *Ibid.* (quoting *Cabell Huntington Hosp.*, 101 F.3d at 992 (Luttig, J., dissenting)). "To the extent Congress was merely borrowing these terms from elsewhere in the statute, it would be a mistake to read too much into the difference in nomenclature." *Id.* at 13.

At a more basic level, the court of appeals' reasoning has things backwards. The court conflated the principal consequence of being "entitled to" Part A benefits—a right to have the Medicare program make payment—with the category of "patients who * * * [a]re entitled to" such benefits. 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). Starting from that consequence, the court concluded that any individual for whom that consequence did not obtain with respect to a specific unit of care—*i.e.*, a patient for whose inpatient care on a particular day Medicare did not pay—was not "entitled to" Part A benefits

on that day in the first place. See Pet. App. 18a-19a. Instead, the court should have begun by identifying which patients the statute provides are "entitled to" Part A benefits. And because the statute does not make the existence of that entitlement contingent on whether the Medicare program ultimately pays for a particular unit of service, the court should have ended there as well.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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SEPTEMBER 2021

APPENDIX

1. 42 U.S.C. 426(a)-(c) provides:

Entitlement to hospital insurance benefits

(a) Individuals over 65 years

Every individual who—

(1) has attained age 65, and

(2)(A) is entitled to monthly insurance benefits under section 402 of this title, would be entitled to those benefits except that he has not filed an application therefor (or application has not been made for a benefit the entitlement to which for any individual is a condition of entitlement therefor), or would be entitled to such benefits but for the failure of another individual, who meets all the criteria of entitlement to monthly insurance benefits, to meet such criteria throughout a month, and, in conformity with regulations of the Secretary, files an application for hospital insurance benefits under part A of subchapter XVIII,

(B) is a qualified railroad retirement beneficiary, or

(C)(i) would meet the requirements of subparagraph (A) upon filing application for the monthly insurance benefits involved if medicare qualified government employment (as defined in section 410(p) of this title) were treated as employment (as defined in section 410(a) of this title) for purposes of this subchapter, and (ii) files an application, in conformity with regulations of the Secretary, for hospital insurance benefits under part A of subchapter XVIII,

shall be entitled to hospital insurance benefits under part A of subchapter XVIII for each month for which he meets the condition specified in paragraph (2), beginning with the first month after June 1966 for which he meets the conditions specified in paragraphs (1) and (2).

(b) Individuals under 65 years

Every individual who—

(1) has not attained age 65, and

(2)(A) is entitled to, and has for 24 calendar months been entitled to, (i) disability insurance benefits under section 423 of this title or (ii) child's insurance benefits under section 402(d) of this title by reason of a disability (as defined in section 423(d) of this title) or (iii) widow's insurance benefits under section 402(e) of this title or widower's insurance benefits under section 402(f) of this title by reason of a disability (as defined in section 423(d) of this title), or

(B) is, and has been for not less than 24 months, a disabled qualified railroad retirement beneficiary, within the meaning of section 231f(d) of title 45, or

(C)(i) has filed an application, in conformity with regulations of the Secretary, for hospital insurance benefits under part A of subchapter XVIII pursuant to this subparagraph, and

(ii) would meet the requirements of subparagraph (A) (as determined under the disability criteria, including reviews, applied under this subchapter), including the requirement that he has been entitled to the specified benefits for 24 months, if—

(I) medicare qualified government employment (as defined in section 410(p) of this title) were treated as employment (as defined in section 410(a) of this title) for purposes of this subchapter, and

(II) the filing of the application under clause (i) of this subparagraph were deemed to be the filing of an application for the disability-related benefits referred to in clause (i), (ii), or (iii) of subparagraph (A),

shall be entitled to hospital insurance benefits under part A of subchapter XVIII for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and ending (subject to the last sentence of this subsection) with the month following the month in which notice of termination of such entitlement to benefits or status as a qualified railroad retirement beneficiary described in paragraph (2) is mailed to him, or if earlier, with the month before the month in which he attains age 65. In applying the previous sentence in the case of an individual described in paragraph (2)(C), the "twenty-fifth month of his entitlement" refers to the first month after the twenty-fourth month of entitlement to specified benefits referred to in paragraph (2)(C) and "notice of termination of such entitlement" refers to a notice that the individual would no longer be determined to be entitled to such specified benefits under the conditions described in that paragraph. For purposes of this subsection, an individual who has had a period of trial work which ended as provided in section 422(c)(4)(A) of this title,

and whose entitlement to benefits or status as a qualified railroad retirement beneficiary as described in paragraph (2) has subsequently terminated, shall be deemed to be entitled to such benefits or to occupy such status (notwithstanding the termination of such entitlement or status) for the period of consecutive months throughout all of which the physical or mental impairment, on which such entitlement or status was based, continues, and throughout all of which such individual would have been entitled to monthly insurance benefits under this subchapter or as a qualified railroad retirement beneficiary had such individual been unable to engage in substantial gainful activity, but not in excess of 78 such months. In determining when an individual's entitlement or status terminates for purposes of the preceding sentence, the term "36 months" in the second sentence of section 423(a)(1) of this title, in section 402(d)(1)(G)(i) of this title, in the last sentence of section 402(e)(1) of this title, and in the last sentence of section 402(f)(1) of this title shall be applied as though it read "15 months".

(c) Conditions

For purposes of subsection (a)—

(1) entitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, part A of subchapter XVIII on his behalf for inpatient hospital services, post-hospital extended care services, and home health services (as such terms are defined in part E of subchapter XVIII) furnished him in the United States (or outside the United States in the case of inpatient hospital services furnished under the conditions described in section 1395f(f) of this title) during such month; except

that (A) no such payment may be made for post-hospital extended care services furnished before January 1967, and (B) no such payment may be made for post-hospital extended care services unless the discharge from the hospital required to qualify such services for payment under part A of subchapter XVIII occurred (i) after June 30, 1966, or on or after the first day of the month in which he attains age 65, whichever is later, or (ii) if he was entitled to hospital insurance benefits pursuant to subsection (b), at a time when he was so entitled; and

(2) an individual shall be deemed entitled to monthly insurance benefits under section 402 or section 423 of this title, or to be a qualified railroad retirement beneficiary, for the month in which he died if he would have been entitled to such benefits, or would have been a qualified railroad retirement beneficiary, for such month had he died in the next month.

2. 42 U.S.C. 1395b-2(a) provides:

Notice of medicare benefits; medicare and medigap information

(a) Notice of medicare benefits

The Secretary shall prepare (in consultation with groups representing the elderly and with health insurers) and provide for distribution of a notice containing—

(1) a clear, simple explanation of the benefits available under this subchapter and the major categories of health care for which benefits are not available under this subchapter,

(2) the limitations on payment (including deductibles and coinsurance amounts) that are imposed under this subchapter, and

(3) a description of the limited benefits for long-term care services available under this subchapter and generally available under State plans approved under subchapter XIX.

Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this subchapter and when an individual applies for benefits under part A or enrolls under part B of this subchapter.

3. 42 U.S.C. 1395d provides in pertinent part:

Scope of benefits

(a) Entitlement to payment for inpatient hospital services, post-hospital extended care services, home health services, and hospice care

The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1395f(d)(2) of this title to him (subject to the provisions of this part) for—

(1) inpatient hospital services or inpatient critical access hospital services for up to 150 days during any spell of illness minus 1 day for each day of such services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of

the Secretary that he does not desire to have such payment made);

(2)(A) post-hospital extended care services for up to 100 days during any spell of illness, and (B) to the extent provided in subsection (f), extended care services that are not post-hospital extended care services;

(3) in the case of individuals not enrolled in part B, home health services, and in the case of individuals so enrolled, post-institutional home health services furnished during a home health spell of illness for up to 100 visits during such spell of illness;

(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each and an unlimited number of subsequent periods of 60 days each with respect to which the individual makes an election under subsection (d)(1); and

(5) for individuals who are terminally ill, have not made an election under subsection (d)(1), and have not previously received services under this paragraph, services that are furnished by a physician (as defined in section 1395x(r)(1) of this title) who is either the medical director or an employee of a hospice program and that—

(A) consist of—

(i) an evaluation of the individual's need for pain and symptom management, including the individual's need for hospice care; and

(ii) counseling the individual with respect to hospice care and other care options; and

(B) may include advising the individual regarding advanced care planning.

(b) Services not covered

Payment under this part for services furnished an individual during a spell of illness may not (subject to subsection (c)) be made for—

(1) inpatient hospital services furnished to him during such spell after such services have been furnished to him for 150 days during such spell minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services furnished to him during such spell after such services have been furnished to him for 100 days during such spell; or

(3) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.

Payment under this part for post-institutional home health services furnished an individual during a home health spell of illness may not be made for such services beginning after such services have been furnished for a total of 100 visits during such spell.

* * * * *

(g) "Spell of illness" defined

For definitions of "spell of illness", and for definitions of other terms used in this part, see section 1395x of this title.

4. 42 U.S.C. 1395*l* provides in pertinent part:

Payment of benefits

(a) Amounts

Except as provided in section 1395mm of this title, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

* * * * *

(8) in the case of—

(A) outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy services furnished—

(i) by a rehabilitation agency, public health agency, clinic, comprehensive outpatient rehabilitation facility, or skilled nursing facility,

(ii) by a home health agency to an individual who is not homebound, or

(iii) by another entity under an arrangement with an entity described in clause (i) or (ii); and

(B) outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy services furnished—

(i) by a hospital to an outpatient or to a hospital inpatient who is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness or is not so entitled to benefits under part A, or

(ii) by another entity under an arrangement with a hospital described in clause (i),

the amounts described in section 1395m(k) of this title; and

* * * * *

(t) Prospective payment system for hospital outpatient department services

(1) Amount of payment

(A) In general

With respect to covered OPD services (as defined in subparagraph (B)) furnished during a year beginning with 1999, the amount of payment under this part shall be determined under a prospective payment system established by the Secretary in accordance with this subsection.

(B) Definition of covered OPD services

For purposes of this subsection, the term "covered OPD services"—

(i) means hospital outpatient services designated by the Secretary;

(ii) subject to clause (iv), includes inpatient hospital services designated by the Secretary that are covered under this part and furnished to a hospital inpatient who (I) is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness, or (II) is not so entitled;

* * * * *

5. 42 U.S.C. 1395*o*(a) provides:

Eligible individuals

(a) In general

Every individual who—

(1) is entitled to hospital insurance benefits under part A, or

(2) has attained age 65 and is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part,

is eligible to enroll in the insurance program established by this part.

6. 42 U.S.C. 1395w-21 provides in pertinent part:

Eligibility, election, and enrollment

(a) Choice of medicare benefits through Medicare+ Choice plans

(1) In general

Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits (other than qualified prescription drug benefits) under this subchapter—

(A) through the original medicare fee-for-service program under parts A and B, or

(B) through enrollment in a Medicare+Choice plan under this part,

and may elect qualified prescription drug coverage in accordance with section 1395w-101 of this title.

* * * * *

(3) Medicare+Choice eligible individual

In this subchapter, the term "Medicare+Choice eligible individual" means an individual who is entitled to benefits under part A and enrolled under part B.

* * * * *

7. 42 U.S.C. 1395w-101 provides in pertinent part:

Eligibility, enrollment, and information

(a) Provision of qualified prescription drug coverage through enrollment in plans

(1) In general

Subject to the succeeding provisions of this part, each part D eligible individual (as defined in paragraph (3)(A)) is entitled to obtain qualified prescription drug coverage (described in section 1395w–102(a) of this title) as follows:

(A) Fee-for-service enrollees may receive coverage through a prescription drug plan

A part D eligible individual who is not enrolled in an MA plan may obtain qualified prescription drug coverage through enrollment in a prescription drug plan (as defined in section 1395w-151(a)(14) of this title).

(B) Medicare Advantage enrollees

(i) Enrollees in a plan providing qualified prescription drug coverage receive coverage through the plan

A part D eligible individual who is enrolled in an MA-PD plan obtains such coverage through such plan.

(ii) Limitation on enrollment of MA plan enrollees in prescription drug plans

Except as provided in clauses (iii) and (iv), a part D eligible individual who is enrolled in an

MA plan may not enroll in a prescription drug plan under this part.

(iii) Private fee-for-service enrollees in MA plans not providing qualified prescription drug coverage permitted to enroll in a prescription drug plan

A part D eligible individual who is enrolled in an MA private fee-for-service plan (as defined in section 1395w-28(b)(2) of this title) that does not provide qualified prescription drug coverage may obtain qualified prescription drug coverage through enrollment in a prescription drug plan.

(iv) Enrollees in MSA plans permitted to enroll in a prescription drug plan

A part D eligible individual who is enrolled in an MSA plan (as defined in section 1395w–28(b)(3) of this title) may obtain qualified prescription drug coverage through enrollment in a prescription drug plan.

* * * * *

(3) Definitions

For purposes of this part:

(A) Part D eligible individual

The term "part D eligible individual" means an individual who is entitled to benefits under part A or enrolled under part B (but not including an individual enrolled solely for coverage of immunosuppressive drugs under section 1395*o*(b) of this title).

(B) MA plan

The term "MA plan" has the meaning given such term in section 1395w-28(b)(1) of this title.

(C) MA-PD plan

The term "MA-PD plan" means an MA plan that provides qualified prescription drug coverage.

* * * * *

8. 42 U.S.C. 1395x(a) provides:

Definitions

For purposes of this subchapter—

(a) Spell of illness

The term "spell of illness" with respect to any individual means a period of consecutive days—

(1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services, inpatient critical access hospital services or extended care services, and (B) which occurs in a month for which he is entitled to benefits under part A, and

(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital or critical access hospital nor an inpatient of a facility described in section 1395i-3(a)(1) of this title or subsection (y)(1).

9. 42 U.S.C. 1395y(b)(2)(A) provides:

Exclusions from coverage and medicare as secondary payer

(b) Medicare as secondary payer

(2) Medicare secondary payer

(A) In general

Payment under this subchapter may not be made, except as provided in subparagraph (B), with respect to any item or service to the extent that—

(i) payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under paragraph (1), or

(ii) payment has been made[3] or can reasonably be expected to be made[3] under a workmen's compensation law or plan of the United States or a State or under an automobile or liability insurance policy or plan (including a self-insured plan) or under no fault insurance.

In this subsection, the term "primary plan" means a group health plan or large group health plan, to the extent that clause (i) applies, and a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance, to the extent that clause (ii) applies. An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own

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[3] So in original. Probably should be "made,".

risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

10. 42 U.S.C. 1395ww(d)(5)(F) provides:

Payments to hospitals for inpatient hospital services

(d) Inpatient hospital service payments on basis of prospective rates; Medicare Geographical Classification Review Board

(5)(F)(i) Subject to subsection (r), for discharges occurring on or after May 1, 1986, the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which—

(I) serves a significantly disproportionate number of low-income patients (as defined in clause (v)), or

(II) is located in an urban area, has 100 or more beds, and can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to this subchapter or State plans approved under subchapter XIX), during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceed 30 percent of its total of such net inpatient care revenues during the period.

(ii) Subject to clause (ix), the amount of such payment for each discharge shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount deter-

mined under paragraph (1)(A)(iii)) and, for cases qualifying for additional payment under subparagraph (A)(i), the amount paid to the hospital under subparagraph (A) for that discharge, by (II) the disproportionate share adjustment percentage established under clause (iii) or (iv) for the cost reporting period in which the discharge occurs.

(iii) The disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (i)(II) is equal to 35 percent.

(iv) The disproportionate share adjustment percentage for a cost reporting period for a hospital that is not described in clause (i)(II) and that—

(I) is located in an urban area and has 100 or more beds or is described in the second sentence of clause (v), is equal to the percent determined in accordance with the applicable formula described in clause (vii);

(II) is located in an urban area and has less than 100 beds, is equal to 5 percent or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xiii);

(III) is located in a rural area and is not described in subclause (IV) or (V) or in the second sentence of clause (v), is equal to 4 percent or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xii);

(IV) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is

classified as a sole community hospital under subparagraph (D), is equal to 10 percent or, if greater, the percent determined in accordance with the applicable formula described in clause (viii) or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, the greater of the percentages determined under clause (x) or (xi);

(V) is located in a rural area, is classified as a rural referral center under subparagraph (C), and is not classified as a sole community hospital under subparagraph (D), is equal to the percent determined in accordance with the applicable formula described in clause (viii) or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (xi); or

(VI) is located in a rural area, is classified as a sole community hospital under subparagraph (D), and is not classified as a rural referral center under subparagraph (C), is 10 percent or, subject to clause (xiv) and for discharges occurring on or after April 1, 2001, is equal to the percent determined in accordance with clause (x).

(v) In this subparagraph, a hospital "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals, or exceeds—

(I) 15 percent, if the hospital is located in an urban area and has 100 or more beds,

(II) 30 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is

located in a rural area and has more than 100 beds, or is located in a rural area and is classified as a sole community hospital under subparagraph (D),

(III) 40 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in an urban area and has less than 100 beds, or

(IV) 45 percent (or 15 percent, for discharges occurring on or after April 1, 2001), if the hospital is located in a rural area and is not described in subclause (II).

A hospital located in a rural area and with 500 or more beds also "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals or exceeds a percentage specified by the Secretary.

(vi) In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of—

(I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter, and

(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under subchapter XI.

(vii) The formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(I) is—

(I) in the case of such a hospital with a disproportionate patient percentage (as defined in clause (vi)) greater than 20.2—

(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, (P-20.2)(.65) + 5.62,

(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, (P-20.2)(.7) + 5.62,

(c) for discharges occurring on or after October 1, 1993, and on or before September 30, 1994, (P-20.2)(.8) + 5.88, and

(d) for discharges occurring on or after October 1, 1994, (P-20.2)(.825) + 5.88; or

(II) in the case of any other such hospital—

(a) for discharges occurring on or after April 1, 1990, and on or before December 31, 1990, (P-15)(.6) + 2.5,

(b) for discharges occurring on or after January 1, 1991, and on or before September 30, 1993, (P-15)(.6) + 2.5,[6]

(c) for discharges occurring on or after October 1, 1993, (P-15)(.65) + 2.5,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(viii) Subject to clause (xiv), the formula used to determine the disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (iv)(IV) or (iv)(V) is the percentage determined in accordance with the following formula: (P-30)(.6) + 4.0, where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(ix) In the case of discharges occurring—

(I) during fiscal year 1998, the additional payment amount otherwise determined under clause (ii) shall be reduced by 1 percent;

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[6] So in original. Probably should be followed by "and".

(II) during fiscal year 1999, such additional payment amount shall be reduced by 2 percent;

(III) during fiscal years 2000 and 2001, such additional payment amount shall be reduced by 3 percent and 2 percent, respectively;

(IV) during fiscal year 2002, such additional payment amount shall be reduced by 3 percent; and

(V) during fiscal year 2003 and each subsequent fiscal year, such additional payment amount shall be reduced by 0 percent.

(x) Subject to clause (xiv), for purposes of clause (iv)(VI) (relating to sole community hospitals), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P-15)(.65) + 2.5;

(II) is equal to or exceeds 19.3, but is less than 30.0, such adjustment percentage is equal to 5.25 percent; or

(III) is equal to or exceeds 30, such adjustment percentage is equal to 10 percent,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xi) Subject to clause (xiv), for purposes of clause (iv)(V) (relating to rural referral centers), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P-15)(.65) + 2.5;

(II) is equal to or exceeds 19.3, but is less than 30.0, such adjustment percentage is equal to 5.25 percent; or

(III) is equal to or exceeds 30, such adjustment percentage is determined in accordance with the following formula: (P-30)(.6) + 5.25,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xii) Subject to clause (xiv), for purposes of clause (iv)(III) (relating to small rural hospitals generally), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P-15)(.65) + 2.5; or

(II) is equal to or exceeds 19.3, such adjustment percentage is equal to 5.25 percent,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xiii) Subject to clause (xiv), for purposes of clause (iv)(II) (relating to urban hospitals with less than 100 beds), in the case of a hospital for a cost reporting period with a disproportionate patient percentage (as defined in clause (vi)) that—

(I) is less than 19.3, the disproportionate share adjustment percentage is determined in accordance with the following formula: (P-15)(.65) + 2.5; or

(II) is equal to or exceeds 19.3, such adjustment percentage is equal to 5.25 percent,

where "P" is the hospital's disproportionate patient percentage (as defined in clause (vi)).

(xiv)(I) In the case of discharges occurring on or after April 1, 2004, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

(II) Under subclause (I), the disproportionate share adjustment percentage shall not exceed 12 percent for a hospital that is not classified as a rural referral center under subparagraph (C) or, in the case of discharges occurring on or after October 1, 2006, as a medicare-dependent, small rural hospital under subparagraph (G)(iv).

11. 42 C.F.R. 400.202 provides in pertinent part:

Definitions specific to Medicare.

As used in connection with the Medicare program, unless the context indicates otherwise—

* * * * *

Entitled means that an individual meets all the requirements for Medicare benefits.

* * * * *

12. 42 C.F.R. 409.3 provides in pertinent part:

Definitions.

As used in this part, unless the context indicates otherwise—

* * * * *

Covered refers to services for which the law and the regulations authorize Medicare payment.

* * * * *

13. 42 C.F.R. 409.61 provides:

General limitations on amount of benefits.

(a) *Inpatient hospital or inpatient CAH services*—(1) *Regular benefit days.* Up to 90 days are available in each benefit period, subject to the limitations on days for psychiatric hospital services set forth in §§ 409.62 and 409.63.

(i) For the first 60 days (referred to in this subpart as *full benefit days*), Medicare pays the hospital or CAH for all covered services furnished the beneficiary, except for a deductible which is the beneficiary's responsibility. (Section 409.82 specifies the requirements for the inpatient hospital deductible.)

(ii) For the next 30 days (referred to in this subpart as *coinsurance days*), Medicare pays for all covered services except for a daily coinsurance amount, which is the beneficiary's responsibility. (Section 409.83 specifies the inpatient hospital coinsurance amounts.)

(2) *Lifetime reserve days.* Each beneficiary has a non-renewable lifetime reserve of 60 days of inpatient hospital or inpatient CAH services that he may draw upon whenever he is hospitalized for more than 90 days in a benefit period. Upon exhaustion of the regular benefit days, the reserve days will be used unless the beneficiary elects not to use them, as provided in § 409.65. For lifetime reserve days, Medicare pays for all covered services except for a daily coinsurance amount that is the beneficiary's responsibility. (See § 409.83.)

(3) *Order of payment for inpatient hospital or inpatient CAH services.* Medicare pays for inpatient hospital services in the following order.

(i) The 60 full benefit days;

(ii) The 30 coinsurance days;

(iii) The remaining lifetime reserve days.

(b) *Posthospital SNF care furnished by a SNF, or by a hospital or a CAH with a swing-bed approval.* Up to 100 days are available in each benefit period after discharge from a hospital or CAH. For the first 20 days, Medicare pays for all covered services. For the 21st through 100th day, Medicare pays for all covered services except for a daily coinsurance amount that is the beneficiary's responsibility.

(c) *Renewal of inpatient benefits.* The beneficiary's full entitlement to the 90 inpatient hospital or inpatient CAH regular benefit days, and the 100 SNF benefit days, is renewed each time he or she begins a benefit period. However, once lifetime reserve days are used, they can never be renewed.

(d) *Home health services.* Medicare Part A pays for all covered home health services[1] with no deductible, and subject to the following limitations on payment for durable medical equipment (DME):

(1) For DME furnished by an HHA that is a nominal charge provider, Medicare Part A pays 80 percent of fair compensation.

(2) For DME furnished by an HHA that is not a nominal charge provider, Medicare Part A pays the lesser of the following:

(i) 80 percent of the reasonable cost of the service.

(ii) The reasonable cost of, or the customary charge for, the service, whichever is less, minus 20 percent of the customary (insofar as reasonable) charge for the service.

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[1] Before July 1, 1981, Medicare Part A paid for not more than 100 home health visits during one year following beneficiary's most recent discharge from a hospital or a SNF.

14. 42 C.F.R. 412.106(b) provides:

Special treatment: Hospitals that serve a disproportionate share of low-income patients.

(b) *Determination of a hospital's disproportionate patient percentage*—(1) *General rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.

(2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—

(i) Determines the number of patient days that—

(A) Are associated with discharges occurring during each month; and

(B) Are furnished to patients who during that month were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;

(ii) Adds the results for the whole period;

(iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that—

(A) Are associated with discharges that occur during that period; and

(B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).

(3) *First computation: Cost reporting period.* If a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish to

CMS, through its intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period.

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

(iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with

the State that a patient was eligible for Medicaid during each claimed patient hospital day.

(iv) For cost reporting periods beginning on or after October 1, 2009, the hospital must report the days in the numerator of the fraction in the second computation in a cost reporting period based on the date of discharge, the date of admission, or the dates of service. If a hospital seeks to change its methodology for reporting days in the numerator of the fraction in the second computation, the hospital must notify CMS, through its fiscal intermediary or MAC, in writing at least 30 days before the beginning of the cost reporting period in which the change would apply. The written notification must specify the methodology the hospital will use, the cost reporting period to which the requested change would apply, and the current methodology being used. Such a change will be effective only on the first day of a cost reporting period. If a hospital changes its methodology for reporting such days, CMS or the fiscal intermediary or MAC may adjust the number of days reported for a cost reporting period if it determines that any of those days have been counted in a prior cost reporting period.

(5) *Disproportionate patient percentage.* The intermediary adds the results of the first computation made under either paragraph (b)(2) or (b)(3) of this section and the second computation made under paragraph (b)(4) of this section and expresses that sum as a percentage. This is the hospital's disproportionate patient percentage, and is used in paragraph (c) of this section.