No. 23-715

In the Supreme Court of the United States

ADVOCATE CHRIST MEDICAL CENTER, ET AL.,
PETITIONERS

v.

XAVIER BECERRA,
SECRETARY OF HEALTH AND HUMAN SERVICES

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

BRIEF FOR THE RESPONDENT

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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 were entitled to supplementary security income benefits (excluding any State supplementation) under [Title] XVI [of the Social Security Act, 42 U.S.C. 1381 *et seq.*]." 42 U.S.C. 1395ww(d)(5)(F)(vi)(II). The question presented is as follows:

Whether hospital patients are "entitled to supplementary security income benefits * * * under [Title] XVI" only if they are entitled to receive a monthly income-supplementing payment at the time they are hospitalized.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-17) is reported at 80 F.4th 346. The opinion of the district court (Pet. App. 18-45) is not published in the Federal Supplement but is available at 2022 WL 2064830. The decision of the Administrator of the Centers for Medicare & Medicaid Services (Pet. App. 46-93) and the decisions of the Provider Reimbursement Review Board (Pet. App. 94-110, 111-127) are available at 2017 WL 1550303, 2017 WL 1833478, and 2017 WL 2812948.

JURISDICTION

The judgment of the court of appeals was entered on September 1, 2023. On November 8, 2023, the Chief Justice extended the time within which to file a petition for a writ of certiorari to and including December 29, 2023, and

the petition was filed on that date. The petition was granted on June 10, 2024. 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-32a.

STATEMENT

A. Legal Background

1. The Medicare program, established in 1965 as Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.*, provides health insurance 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). The Centers for Medicare & Medicaid Services (CMS) within the Department of Health and Human Services (HHS) administers the Medicare program on behalf of the HHS Secretary (Secretary).

Before 1983, with certain exceptions, "the federal government reimbursed hospitals for the 'reasonable cost' of treating Medicare patients." *Maine Med. Ctr.* v. *Burwell*, 841 F.3d 10, 14 (1st Cir. 2016). 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 reasonable actual costs led to high Medicare expenditures. See *ibid.*

In 1983, Congress replaced that approach with "a prospective payment system." *Maine Med. Ctr.*, 841 F.3d at 14. Under that system, "[t]he Medicare program pays a hospital a fixed rate for treating each Medicare patient, based on the patient's diagnosis and regardless of the hospital's actual costs." *Becerra* v. *Empire Health Found.*, 597 U.S. 424, 429 (2022). "The rates are designed to reflect the amounts an efficiently run hospital, in the same region, would expend to treat a patient with the same diagnosis." *Ibid.*

Congress also recognized, however, that the costs incurred by hospitals may vary for reasons unrelated to efficiency. Since 1983, Congress has established, or authorized HHS to adopt, certain "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).

2. At issue here is one such adjustment—the "'disproportionate share hospital'" (DSH) adjustment—that "gives hospitals serving an 'unusually high percentage of low-income patients' enhanced Medicare payments." *Empire Health*, 597 U.S. at 429 (citation omitted). That adjustment "reflects that low-income individuals are often more expensive to treat than higher income ones, even for the same medical conditions." *Ibid.*

A hospital's eligibility for and amount of a DSH adjustment is calculated in relevant part by adding "two statutorily described fractions, usually called the Medicare fraction and the Medicaid fraction." *Empire Health*, 597 U.S. at 429; see 42 U.S.C. 1395ww(d)(5)(F)(i)(v). Those fractions are "designed to capture two different low-income populations that a hospital serves": low-income Medicare patients and low-income non-Medicare patients. *Empire Health*, 597 U.S. at 429.

This case concerns the Medicare fraction, which "represents the proportion of a hospital's Medicare patients who have low incomes, as identified by their entitlement to supplementary security income (SSI) benefits." *Empire Health*, 597 U.S. at 429-430. The Medicare fraction's "numerator" is defined as "the number of [a] hospital's patient days for" the hospital's "cost reporting period" "which were made up of patients who (for such days) were entitled to benefits under part A of this [Title] and were entitled to supplementary security income benefits (excluding any State supplementation) under [Title] XVI." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). The "denominator" is defined as "the number of such hospital's patient days" for the relevant period "which were made up of patients who (for such days) were entitled to benefits under part A of this [Title]." *Ibid.*

By its terms, the numerator references two different types of benefits provided under two different titles of the Social Security Act: Medicare Part A under Title XVIII (42 U.S.C. 1395 to 1395*lll*) and supplemental security income (SSI) under Title XVI (42 U.S.C. 1381-1383f).[1] Medicare Part A (42 U.S.C. 1395c-1395i-6) provides insurance to elderly and disabled individuals for "inpatient hospital treatment" and "associated physician and skilled nursing services." *Empire Health*, 597 U.S. at 428. In *Empire Health*, this Court explained that the "entitlement to Part A benefits" referenced in the Medicare fraction is "'automatic'" because "[a]ge or disability makes a person 'entitled' to Part A benefits

[1] The Social Security Act is codified as Chapter 7 of Title 42 of the U.S. Code, where the individual titles of the Act are designated as subchapters of Chapter 7. See Pet. App. 2. This brief refers to the titles of the Act and similarly substitutes "Title" for "subchapter" when quoting from the U.S. Code.

without an application or anything more." *Id.* at 436. And that entitlement essentially "never goes away," because even if Part A insurance does not pay for a given "medical service," a qualifying individual is "still insured." *Id.* at 437.

Title XVI, in turn, "provide[s] supplemental security income to [financially needy] individuals" who are aged, blind, or disabled. 42 U.S.C. 1381. Under Title XVI, the "[b]asic entitlement to benefits" is that "[e]very aged, blind, or disabled individual who is determined * * * to be eligible on the basis of his income and resources shall * * * be paid benefits by the Commissioner of Social Security" (Commissioner). 42 U.S.C. 1381a. Before a person may be entitled to benefits, he must submit "an application * * * for benefits." 42 U.S.C. 1382(c)(7). The Commissioner then "determine[s]" whether the applicant is "eligible for SSI benefits" in the month he applied, based on his satisfaction of income, resource, and other requirements "in that month." 20 C.F.R. 416.203(b). If the application is approved, the individual's eligibility in subsequent months is "determined on the basis of the individual's * * * income, resources, and other relevant characteristics in such month." 42 U.S.C. 1382(c)(1). Thus, if an individual's income or resources exceed the relevant threshold in a given month, he lacks "eligibility for a benefit * * * in such month." *Ibid.* And if an individual "is ineligible for benefits * * * for a period of 12 consecutive months," he "may not thereafter become eligible for benefits" until he has successfully "reapplied for benefits." 42 U.S.C. 1383(j)(1)(B). The Social Security Administration (SSA) administers the payment of SSI benefits.

3. Within the Medicare fraction's numerator, the key phrase at issue here is "entitled to [SSI] benefits

(excluding any State supplementation) under [Title] XVI." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). Since Congress enacted that statutory text 38 years ago, HHS has consistently interpreted it to refer to patients who are "entitled to receive SSI benefits during the month" in which they are hospitalized. 75 Fed. Reg. 50,042, 50,281 (Aug. 16, 2010); see 42 C.F.R. 412.106(a)(i) (1986).

To calculate the numerator under this interpretation, HHS obtains information from SSA about whether a patient "was entitled to receive SSI benefits during the month" of hospitalization. 75 Fed. Reg. at 50,281. SSA derives that information from certain "status codes" denoting whether a person was entitled to SSI benefits in a particular month. *Ibid.* In a 2010 rulemaking, HHS rejected a commenter's proposal to begin using additional SSA status codes that, in the commenter's view, "represent individuals who [a]re eligible for SSI, but not eligible for SSI payments" in a particular month, such as persons whose payments "are in a 'suspended' status." *Id.* at 50,280-50,281. HHS explained that "none of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used." *Id.* at 50,281.

In that same rulemaking, HHS also rejected a comment suggesting that HHS was "incorrectly applying a different standard in interpreting the word 'entitled' with respect to SSI entitlement versus Medicare [Part A] entitlement." 75 Fed. Reg. at 50,280. HHS explained that whereas "an individual is automatically 'entitled' to Medicare Part A when the person reaches age 65" or "becomes disabled," the "entitlement to receive SSI benefits is based on income and resources and, therefore, can vary from time to time." *Ibid.* Accordingly,

while the Medicare fraction counts patients as entitled to Medicare Part A even when "payment for an individual inpatient hospital claim is not made," it counts patients as entitled to SSI benefits only in months when they are "entitled to receive SSI benefits during th[at] month." *Id.* at 50,281.

B. The Present Controversy

1. Petitioners, a group of more than 200 hospitals, challenge HHS's calculation of their DSH adjustments for fiscal years 2006 to 2009. Pet. App. 7. They contend that HHS misinterpreted the Medicare fraction because, in their view, "the phrase 'entitled to [SSI] benefits' includes all patients enrolled in the SSI program at the time of hospitalization, even if they did not then qualify for the monthly [SSI] payment." *Ibid.*

After the Provider Reimbursement Review Board denied petitioners relief on procedural grounds, Pet. App. 94-110, 111-127, the CMS Administrator rejected petitioners' interpretation on the merits, *id.* at 46-93, 78-82. The Administrator disagreed with petitioners' suggestion that HHS's interpretation of the entitlement to Medicare Part A benefits was inconsistent with its interpretation of the entitlement to SSI benefits. *Id.* at 78. The Administrator explained that "Part A entitlement is a status determination that, on[c]e established for an individual, does not change regardless of whether the person qualifies for particular Part A benefits," such as payment for a specific medical service. *Ibid.* "By contrast," the Administrator reasoned, an individual "must apply for SSI benefits" and "satisfy more requirements to become eligible (and stay eligible) for SSI benefits." *Id.* at 79-80. In addition, the Administrator observed that whereas Medicare Part A provides a "set of health insurance benefits," including "coverage

of inpatient hospital" and "post-acute care services," SSI "is a cash benefit." *Id.* at 81. Thus, the Administrator concluded that the Medicare fraction's numerator counts only patients who are "entitled to receive [SSI] benefits"—*i.e.*, "cash benefit[s]"—"during the month" of hospitalization. *Id.* at 81-82 (citation omitted).

2. Petitioners sought judicial review, and the district court granted summary judgment to the government. Pet. App. 18-45. Applying *Chevron, U.S.A., Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), the court held that HHS's interpretation "is based on a permissible construction of the statute." Pet. App. 37 (citation omitted). The court found HHS's interpretation of the entitlement to SSI benefits to be "consistent with the nature of the benefits at issue, which are specifically defined under Title XVI as benefits that are 'paid' to qualifying aged, blind, and disabled individuals." *Id.* at 34 (quoting 42 U.S.C. 1381a). The court also rejected petitioners' internal-inconsistency argument, reasoning that "SSI cash benefits are an entitlement that depends on a right to be paid, while one's insured status [under Medicare Part A] is a continuous entitlement that is not contingent on certain payments being made each month." *Id.* at 38. And the court emphasized that petitioners' contrary interpretation "would encompass numerous persons" who are not entitled to SSI benefits—"most common[ly]" because the "person's income exceeds the applicable statutory maximum." *Id.* at 39. The court concluded that "[c]ounting those individuals as 'entitled to [SSI] benefits' seems squarely at odds with the statute." *Id.* at 40 (second set of brackets in original).

3. The court of appeals affirmed. Pet. App. 1-17. As relevant here, the court agreed with HHS that the statutory language at issue "cover[s] only Medicare beneficiaries who are entitled to SSI cash payments at the time of their hospitalization," not (as petitioners argued) those who are "enrolled in the SSI program at the time of the hospitalization" but who are not entitled to "receive a cash payment at that time." *Id.* at 9. The court accordingly upheld HHS's interpretation as "correct," "without considering any question of *Chevron* deference." *Id.* at 14.

The court of appeals explained that "[a]t every turn, [Title] XVI is about cash payments for needy individuals who are aged, blind, or disabled." Pet. App. 9. The court observed that Title XVI's "statement of purpose is 'to provide supplemental security income' to those individuals," and "[i]ts '[b]asic entitlement to benefits' is that aged, blind, or disabled individuals, once determined not to have income or resources above the statutory cutoffs, 'shall, in accordance with and subject to the provisions of this [Title], be paid benefits.'" *Id.* at 9-10 (quoting 42 U.S.C. 1381, 1381a). The court further noted that "Section 1382 sets forth '[t]he benefit under this [Title]'—not simply 'a' benefit—in specific dollar amounts." *Id.* at 10 (quoting 42 U.S.C. 1382(b)) (first set of brackets in original). And the court added that "[s]cores of later provisions elaborate on when and how this cash benefit is to be paid out." *Ibid.*; see *id.* at 10 n.2.

The court of appeals also concluded that 42 U.S.C. 1320b-19—which creates a program called Ticket to Work—"confirms this point." Pet. App. 10. The court explained that the Ticket to Work program under Section 1320b-19 "provides vocational rehabilitation ser-

vices to blind or disabled individuals who are 'eligible for [SSI] benefits under [Title] XVI.'" *Id.* at 10-11 (quoting 42 U.S.C. 1320b-19(k)(4)). And the court emphasized that "section 1320b-19 states expressly that '[t]he term [SSI] benefit under [Title] XVI means a cash benefit under section 1382 or 1382h(a) of this title.'" *Id.* at 11 (quoting 42 U.S.C. 1320b-19(k)(5)) (first set of brackets in original). "Because 'identical words used in different parts of the same act'" generally "'have the same meaning,'" the court determined that the phrase "[SSI] benefits * * * under [Title] XVI" must "bear[] the same meaning in calculating the Medicare fraction in [Title] XVIII that it bears (1) throughout [Title] XVI and (2) in determining eligibility for the Ticket to Work program." *Ibid.* (citation omitted).

The court of appeals acknowledged that in the abstract, "the word 'benefits' can include cash or non-cash benefits," and that a person who at some point was entitled to SSI benefits may also be eligible for non-cash benefits available under provisions outside of Title XVI. Pet. App. 11. But the court emphasized that "the question here turns on what counts as 'income' benefits 'under [Title] XVI.'" *Ibid.* The court then explained that "[n]either of the two benefits that [petitioners] cite fits that description," because "Medicare Part D benefits are housed in [Title] XVIII" and "Ticket to Work benefits * * * are provided under [Title] XI." *Id.* at 11-12.

Finally, the court of appeals rejected petitioners' contention that if "the phrase 'entitled to benefits under part A' covers patients who meet basic eligibility requirements without regard to specific payment decisions," as this Court held in *Empire Health*, "then so too must the adjacent phrase 'entitled to [SSI] benefits.'" Pet. App. 13 (brackets in original). The court de-

termined that petitioners' "argument misses key distinctions between the Part A and SSI schemes." *Ibid.* "First," the court reasoned that "Part A benefits extend well beyond payment for specific services at specific times," whereas "[t]here is no comparable parallel in the SSI context because" SSI benefits are "only cash payments." *Ibid.* "Moreover," the court continued, while "age or chronic disability makes a person eligible for Part A benefits 'without an application or anything more,' and individuals rarely if ever lose this eligibility over time," the "same does not hold true for SSI where individuals routinely ping-pong in and out of 'eligibility' depending on fluctuations in their income or wealth from one month to another." *Ibid.* (citation omitted). "Given this structure," the court concluded, "it makes little sense to say that individuals are 'entitled' to [an SSI] benefit in months when they are not even eligible for it." *Ibid.*

SUMMARY OF ARGUMENT

When applying the Medicare fraction, HHS correctly counts in the numerator only Medicare beneficiaries who were entitled to an SSI cash payment for the month of their hospitalization.

A. HHS's interpretation reflects the best reading of the statutory text and context. The language at issue is "entitled to [SSI] benefits * * * under [Title] XVI." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). Title XVI makes clear that SSI benefits are cash payments made by SSA for a given month to individuals determined to have sufficiently low income and resources in that month. See 42 U.S.C. 1381a, 1382(c)(1). Given the nature of SSI benefits, a person is "entitled to" such benefits only for a month when she is owed a cash payment. That straightforward reading of the text is confirmed by other provi-

sions outside of Title XVI recognizing that SSI benefits under Title XVI are monthly "cash benefit[s]." 42 U.S.C. 1320b-19(k)(5).

Petitioners' contrary reading is untethered from the statutory text and context. That reading turns on a concept of SSI "program eligibility" (Pet. Br. 26) that lacks any foundation in the Medicare fraction or Title XVI. And petitioners' reading further depends on the availability of supposed "non-cash SSI benefits" under Title XVI (*id.* at 40) that are not present in the statute. Petitioners' primary example of such a benefit, vocational-rehabilitation services, is neither an income benefit nor provided under Title XVI.

B. This Court's decision in *Becerra* v. *Empire Health Foundation*, 597 U.S. 424 (2022), supports HHS's interpretation. There, the Court interpreted the phrase "entitled to benefits under [Medicare] part A," 42 U.S.C. 1395ww(d)(5)(F)(vi)(I), by examining the nature of and prerequisites for Medicare Part A benefits. Here, the Court should similarly interpret the phrase "entitled to [SSI] benefits * * * under [Title] XVI," *ibid.*, by examining the nature of and prerequisites for SSI benefits. While the entitlement to Medicare Part A benefits does not depend on payment for any given medical service, the entitlement to SSI benefits depends on the right to receive monthly payments. That difference reflects "key distinctions between the Part A and SSI schemes." Pet. App. 13. Specifically, Medicare Part A provides automatic and ongoing health insurance coverage to persons who are over 65 or have received disability benefits for 24 months, even if Medicare does not pay for a particular medical service. By contrast, SSI provides monthly cash payments only to persons who have applied for SSI and established the requisite financial

need in a particular month. HHS's interpretation of the Medicare fraction's numerator is thus tailored to the different types of entitlements established by Medicare Part A and SSI respectively.

C. The statutory structure, purpose, and history reinforce HHS's interpretation. The Medicare fraction is designed to capture "the proportion of a hospital's Medicare patients who have low incomes." *Empire Health*, 597 U.S. at 429-430. HHS's interpretation furthers that design by counting only individuals who have demonstrated low "income" "in [the] month" of their hospitalization. 42 U.S.C. 1382(c)(1). Conversely, petitioners' interpretation would routinely count individuals who earn too much income to be entitled to an SSI cash payment in their month of hospitalization. Contrary to petitioners' submission, many individuals each year receive an SSI payment in one month and then subsequently become ineligible for payments in later months due to excess income.

D. The deep roots of HHS's interpretation of the language here further confirm that the interpretation is sound. As this Court recognized in *Loper Bright Enterprises* v. *Raimondo*, 144 S. Ct. 2244 (2024), contemporaneous, longstanding, and consistent agency interpretations of technical provisions warrant this Court's respect. HHS's interpretation here firmly satisfies those criteria. Petitioners' repeated characterizations (*e.g.*, Br. 32) of HHS's interpretation as an "actual-receipt rule" reveal a fundamental misunderstanding of the agency's practices. HHS has always counted patients based on their entitlement to—not actual receipt of—SSI benefits.

ARGUMENT

AN INDIVIDUAL IS ENTITLED TO SSI BENEFITS UNDER TITLE XVI FOR PURPOSES OF THE DSH PROVISION WHEN SHE IS DUE AN SSI PAYMENT FOR THE MONTH OF HER HOSPITALIZATION

The statute defining the Medicare fraction directs HHS to count in the numerator a hospital's "patient days * * * which were made up of patients who (for such days) were entitled to benefits under [Medicare] part A" and "were entitled to [SSI] benefits * * * under [Title] XVI." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). The question presented here is which individuals are "entitled to [SSI] benefits * * * under [Title] XVI." *Ibid.* Ever since Congress's enactment of that statutory language 38 years ago, HHS has consistently interpreted it to encompass only individuals who are entitled to SSI cash payments for the month of their hospitalization. That longstanding interpretation follows from the statutory text, context, and structure. And it is supported by this Court's decision in *Becerra* v. *Empire Health Foundation*, 597 U.S. 424 (2022). The court of appeals therefore correctly upheld HHS's interpretation. Petitioners' contrary approach—which is based on concepts of "program eligibility" (Br. 21) and "non-cash SSI benefits" (Br. 40) that lack grounding in the statutory text or context—should be rejected.

A. HHS's Interpretation Reflects The Best Reading Of The Statutory Provision In Light Of Its Text And Context

In *Empire Health*, this Court held that "[t]ext, context, and structure all support" HHS's interpretation of the phrase "'entitled to [Medicare Part A] benefits,'" within the Medicare fraction's numerator. 597 U.S. at 445 (sec-

ond set of brackets in original). Those indicia likewise support HHS's interpretation of the numerator's neighboring phrase "entitled to [SSI] benefits * * * under [Title] XVI." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I).

1. HHS's interpretation reflects the best reading of the statutory text

This case raises the question of when a person is "entitled to SSI benefits under Title XVI" for purposes of the Medicare fraction. The court of appeals correctly held that a person is so entitled only when she is owed an "SSI cash payment[]" for the month of her hospitalization. Pet. App. 9. As the court explained, "[a]t every turn," Title XVI is about monthly "cash payments for needy individuals who are aged, blind, or disabled," *ibid.*—not, as petitioners argue (Br. 34-40), non-cash services. It follows, then, that an individual is "entitled to SSI benefits under Title XVI" only for the months she is owed an SSI cash payment.

The textual analysis begins with the first provision in Title XVI: Section 1381. There, Congress codified its "purpose of establishing a national program to provide supplemental security *income*" to needy "individuals who have attained age 65 or are blind or disabled." 42 U.S.C. 1381 (emphasis added). The ordinary meaning of income is "a gain or recurrent benefit that is usually measured in money and for a given period of time." *Webster's Third New International Dictionary* 1143 (1971) (*Webster's*). Accordingly, by enacting statutory provisions to furnish supplemental income to needy persons, Congress envisioned the payment of money to those persons. This Court's descriptions of SSI reflect that commonsense understanding. See, *e.g.*, *Atkins* v. *Rivera*, 477 U.S. 154, 157 (1986) (describing SSI as "cash assistance" designed "to cover basic necessities").

Congress effectuated that statutory objective of making payments to needy individuals through Title XVI's subsequent provisions. Section 1381a thus states that the "[b]asic entitlement to benefits" is that "[e]very aged, blind, or disabled individual who is determined * * * to be eligible on the basis of his income and resources shall * * * be paid benefits by the Commissioner of Social Security." 42 U.S.C. 1381a. Thus, the basic entitlement is a payment of benefits—*i.e.*, a cash payment—by SSA.

Next, Section 1382(b) specifies the "[a]mount of benefits" SSA is required to pay. 42 U.S.C. 1382(b). Specifically, it states that "*[t]he benefit* under this [Title] for an individual who does not have an eligible spouse shall be payable at the rate of $1,752" per year as of 1974, subject to cost-of-living adjustments in subsequent years and reduced by the individual's income. 42 U.S.C. 1382(b)(1) (emphasis added); see 42 U.S.C. 1382f. By describing *the benefit* under Title XVI as a payment in specific dollar amounts, Congress confirmed that the "[b]asic entitlement" to "be paid benefits by the Commissioner" referenced in the preceding section is an entitlement to be paid money. 42 U.S.C. 1381a. While Congress elsewhere referenced "a benefit" and "benefits" where grammatically appropriate, Pet. Br. 38-39 (emphasis omitted), Congress would not have described cash payments as "*[t]he* benefit under this [Title]," 42 U.S.C. 1382(b)(1), if it had also provided a "suite" of "non-cash SSI benefits," Pet. Br. 17, 40.

Section 1382(c) establishes an application requirement and a monthly "[p]eriod for determination of benefits." 42 U.S.C. 1382(c); see 42 U.S.C. 1382(c)(7). An individual must submit "an application" for benefits. 42 U.S.C. 1382(c)(7); see 42 U.S.C. 1382(c)(2). In that ap-

plication, the individual must show that she "meet[s] the [eligibility] requirements in th[e] month" of her application. 20 C.F.R. 416.203(b). If she does so, SSA approves her application, and thereafter her eligibility for subsequent months is "determined on the basis of [her] * * * income, resources, and other relevant characteristics in such month." 42 U.S.C. 1382(c)(1). If SSA determines that an individual "is ineligible for benefits * * * for a period of 12 consecutive months," she "may not thereafter become eligible for benefits * * * until [she] has reapplied for benefits * * * and been determined to be eligible." 42 U.S.C. 1383(j)(1)(B). In months when an individual is entitled to benefits, Section 1382(c) prescribes rules for determining "the amount" of benefits payable. 42 U.S.C. 1382(c)(1).

Section 1383 in turn provides a "[p]rocedure for payment of benefits." 42 U.S.C. 1383. It states that "[b]enefits under this [Title] shall be paid at such time or times and * * * in such installments as will best effectuate the purposes of this [Title], as determined under regulations." 42 U.S.C. 1383(a)(1). SSA's regulations provide for the monthly payment of benefits to individuals who meet the eligibility criteria for the relevant month. 20 C.F.R. 416.501. As a result, the scheme reflects the nature of supplemental *income*: "recurrent" payments of "money" on a monthly schedule. *Webster's* 1143.

"Scores of" other provisions in Title XVI further "elaborate on when and how th[e] cash benefit is to be paid out." Pet. App. 10; see *id.* at 10 n.2. For instance, Section 1382(e) establishes "rate[s]" of payment for "the benefit under this [Title]" for certain persons in "medical treatment facilit[ies]." 42 U.S.C. 1382(e)(1)(B) and (e)(1)(B)(i). Section 1382(h) prescribes rules for

"determining eligibility for, and the amount of, benefits payable" to individuals who have received other forms of financial assistance. 42 U.S.C. 1382(h). Section 1382f provides for an "[i]ncrease of dollar amounts" in SSI benefits based on "[c]ost-of-living adjustments." 42 U.S.C. 1382f(a). And Section 1383 addresses procedures for "[o]verpayments and underpayments" of SSI benefits. 42 U.S.C. 1383(b)(1)(A).

Collectively, the foregoing provisions in Title XVI reveal a "clear meaning." *Empire Health*, 597 U.S. at 434. They establish a scheme of monetary payments made by SSA to aged, blind, or disabled individuals for each month that SSA finds that those individuals satisfy the criteria of financial need for supplemental income. Indeed, SSA regulations in effect at the time Congress enacted the Medicare fraction expressly defined "'[s]upplemental security income benefit'" to "mean[] the amount *to be paid* to an eligible individual (or eligible individual and his eligible spouse) under title XVI of the Act." 20 C.F.R. 416.120(c)(1) (1986) (emphasis added); see 39 Fed. Reg. 28,625, 28,627 (Aug. 9, 1974). Against that statutory and regulatory backdrop, the Medicare fraction's reference to patients "entitled to SSI benefits under Title XVI" means those patients who are entitled to receive a monetary payment from SSA for the month of their hospitalization—not patients who may obtain other, non-cash benefits under provisions outside of Title XVI. That interpretation, long applied by HHS and adopted by the court of appeals, thus represents the best reading of the statutory text.

2. Other statutory provisions outside of Title XVI confirm HHS's interpretation

This Court "read[s] the words Congress enacted 'in their context and with a view to their place in the overall

statutory scheme.'" *Turkiye Halk Bankasi A. S.* v. *United States*, 598 U.S. 264, 275 (2023) (citation omitted). The statutory context here bolsters HHS's reading of the Medicare fraction.

To start, Title XIX of the Social Security Act, which governs Medicaid, reflects that SSI benefits are monthly monetary payments. Section 1396a provides that individuals "with respect to whom [SSI] benefits are *being paid* under [Title] XVI," and who meet certain other requirements, automatically qualify for Medicaid assistance. 42 U.S.C. 1396a(a)(10)(A)(i)(II) (emphasis added). If SSI benefits under Title XVI also included various "non-cash benefits," as petitioners claim (Br. 34), Congress would not have referred exclusively to SSI benefits under Title XVI "being paid," 42 U.S.C. 1396a(a)(10)(A)(i)(II).

Section 1320b-19, which is in Title XI of the Social Security Act, similarly supports the Secretary's interpretation. Section 1320b-19 requires the Commissioner to "establish a Ticket to Work and Self-Sufficiency Program, under which a disabled beneficiary may * * * obtain" certain "vocational rehabilitation services." 42 U.S.C. 1320b-19(a). In turn, Section 1320b-19 defines "disabled beneficiary" to include a disabled "individual eligible for [SSI] benefits under [Title] XVI" and provides that an individual is an SSI "beneficiary for each month for which such individual is eligible for such benefits." 42 U.S.C. 1320b-19(k)(2) and (4). And importantly here, Section 1320b-19 defines "[t]he term '[SSI] benefit under [Title] XVI'" to "mean[] a cash benefit under section 1382 or 1382h(a)." 42 U.S.C. 1320b-19(k)(5).[2] Ac-

[2] Section 1382h(a) provides SSI benefits "in lieu of" benefits under Section 1382 to certain individuals with severe medical impairments if their earnings in a month "exceed the amount designated

cordingly, Section 1320b-19 regards the entitlement to SSI benefits under Title XVI in the same way the Medicare fraction does: An individual has the entitlement "for each month" that she is due the SSI "cash benefit." 42 U.S.C. 1320b-19(k)(4) and (5).

To be sure, Section 1320b-19's definitions are strictly controlling only "[i]n th[at] section," 42 U.S.C. 1320b-19(k), so this case cannot be resolved by simply transplanting Section 1320b-19(k)(5)'s definition of "SSI benefit under Title XVI" into the Medicare fraction. See Pet. Br. 39. But that definition nonetheless provides vital context for interpreting the same phrase within the Medicare fraction. This Court "presum[es] that 'identical words used in different parts of the same statute' carry 'the same meaning.'" *Henson* v. *Santander Consumer USA Inc.*, 582 U.S. 79, 85 (2017) (citation omitted). And petitioners offer "no persuasive reason" for the Court to "abandon [that] usual presumption" here. *Ibid.* For instance, they nowhere explain why Congress would have defined "[SSI] benefit under [Title] XVI" as a "cash benefit under Section 1382 or 1382h(a)" in one Social Security Act benefits program (Ticket to Work), 42 U.S.C. 1320b-19(k)(5), and yet used the term in an entirely different manner in another Social Security Act benefits program (Medicare). The more natural inference is that when establishing the Ticket to Work program in 1999, see Pub. L. No. 106-170, 113 Stat. 1860, Congress defined "SSI benefits under Title XVI" to mean the same thing it has always meant under Title XVI: a monthly cash payment.

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by the Commissioner * * * ordinarily to represent substantial gainful activity." 42 U.S.C. 1382h(a)(1); see pp. 33-34, *infra*.

3. Petitioners' contrary interpretation is untethered from the statutory text and context

Petitioners offer a novel view of the phrase "entitled to SSI benefits under Title XVI" that no court has ever adopted, premised on concepts like "long term, program eligibility" (Br. 26) and "non-cash SSI benefits" (Br. 40) that do not exist under the statute. Petitioners' proposed reading fundamentally misunderstands the entitlement to SSI benefits under Title XVI.

a. "Entitled to SSI benefits under Title XVI" does not mean eligible for an SSI "program"

Petitioners contend that "someone is 'entitled to [SSI] benefits' as long as she is eligible for or qualifies for the SSI program." Pet. Br. 20 (brackets in original). And they claim that someone qualifies for that "program" based on a showing of "long-term financial need," *id.* at 24, and remains in the "program" until "her ineligibility for payment persists for '12 consecutive months,'" *id.* at 25. On their view, then, someone can be "entitled to SSI benefits under Title XVI" in a given month even if she is not entitled to an SSI cash payment for that month. Petitioners are mistaken.

i. By its terms, the Medicare fraction refers only to persons "entitled to [SSI] benefits * * * under [Title] XVI," 42 U.S.C. 1395ww(d)(5)(F)(vi)(I), not to persons "eligible for the SSI program." And as noted above, Title XVI states that the "[b]asic entitlement to benefits" is the right to "be paid benefits"—*i.e.*, cash payments—"by the Commissioner." 42 U.S.C. 1381a. Thus, the text of the Medicare fraction focuses exclusively on one's entitlement to an SSI cash payment by SSA for a particular month—not on one's eligibility for a so-called SSI "program."

In fact, "program eligibility" is not a cognizable status under Title XVI. When Title XVI references eligibility, it means eligibility for payment of the cash benefit for a given month. See, *e.g.*, 42 U.S.C. 1381a (individuals "eligible" to "be paid benefits by the Commissioner"); 42 U.S.C. 1382(c)(1) ("individual's eligibility for a benefit" of a particular "amount"). Contrary to petitioners' theory, Title XVI never speaks of eligibility for a "program" over and beyond monthly cash payments.

Petitioners' reliance on Section 1382(a)'s definition of "[e]ligible individual" is misplaced. 42 U.S.C. 1382(a). Petitioners assert that "[f]or purposes of an initial application, the SSI statute measures income based on long-term financial need, specifying an income threshold for a 'calendar year.'" Pet. Br. 24 (quoting 42 U.S.C. 1382(a)(1)(A) and (2)(a)). And once an aged, blind, or disabled person meets that threshold, petitioners maintain (*ibid.*), she "qualif[ies] for the SSI program."

Contrary to petitioners' suggestion, the statute does not prescribe an initial program-eligibility determination; rather, it prescribes only monthly determinations of whether a person is entitled to a payment for that month. Section 1382(a) defines an eligible individual based on her "*rate*" of income "for the calendar year," 42 U.S.C. 1382(a)(1)(A) (emphasis added)—not based on her overall yearly earnings. And SSA uses that rate for purposes of determining "[a]n individual's eligibility for a benefit under this [Title] for a month," based on her "income * * * in such month." 42 U.S.C. 1382(c)(1); see 20 C.F.R. 416.1100 ("We count income on a monthly basis."). Indeed, as noted above, even in SSA's "[i]nitial determination[] of [an applicant's] SSI eligibility," SSA "determine[s] that [a person is] eligible for SSI benefits

for a given month if [she] meet[s] the [eligibility] requirements"—including income requirements—"in that month." 20 C.F.R. 416.203(b) (emphasis omitted); see 20 C.F.R. 416.202(c). Petitioners thus err in suggesting (Br. 26) that SSA makes a threshold "program eligibility" determination based on "long-term need."

Nor does "an individual continue[] to be eligible for [an] SSI program until termination." Pet. Br. 25. If an applicant meets the eligibility requirements for an SSI payment for the month of her application, SSA will approve her application. See 20 C.F.R. 416.203(b). The person will then be subject to subsequent payment-eligibility determinations for each month unless and until she has been found "ineligible for benefits * * * for a period of 12 consecutive months." 42 U.S.C. 1383(j)(1)(B). At that point, the person "may not thereafter become eligible for benefits * * * until [she] has reapplied * * * and been determined to be eligible." *Ibid.* But that does not mean the person is "eligible" for an overarching "SSI program" during the intervening months. Pet. Br. 24. To the contrary, Section 1383(j)(1) presupposes that a person "was an eligible individual" only when she was entitled to receive payments, and then loses "such eligibility" in the first month in which she is no longer so entitled. 42 U.S.C. 1383(j)(1).

ii. Petitioners also emphasize (Br. 20) one sentence in *Empire Health* referring to "individuals 'entitled to [Medicare Part A] benefits'" as "all those qualifying for the program." 597 U.S. at 445 (brackets in original). But it makes sense to describe Medicare Part A as a "program" because it consists of long-term inpatient hospital insurance coverage, not just "payment for any given [medical] service," and also provides "'physician services and skilled nursing services' outside the hospital

setting." *Id.* at 437 (citation omitted); see 42 U.S.C. 1395c (describing Part A as an "insurance program"). The same is true of Medicaid. See Pet. Br. 21. Under Medicaid, if a person "exhaust[s] his coverage" for one service, he "remain[s] eligible for Medicaid payment for a host of other services, should he need them." *Cabell Huntington Hosp., Inc.* v. *Shalala*, 101 F.3d 984, 989 (4th Cir. 1996). By contrast, there is no broader SSI "program" beyond cash payments for individuals who have applied and been deemed eligible in a given month.

Petitioners' effort to recharacterize SSI as "an income-insurance program" is also misconceived. Pet. Br. 33. Insurance programs "provide[] basic protection against [certain] costs"—for instance, in Medicare Part A, "the costs of hospital, related post-hospital, home health services, and hospice care." 42 U.S.C. 1395c. SSI does not provide protection against costs. Rather, it "provides a subsistence allowance" to certain needy individuals. *Schweiker* v. *Wilson*, 450 U.S. 221, 223 (1981). That is why this Court has called SSI "a welfare program," distinguishing it from "an insurance program." *Bowen* v. *Galbreath*, 485 U.S. 74, 75 (1988).

iii. The other provisions upon which petitioners rely (Br. 26-27) do not suggest an overarching SSI benefits "program." Section 1383(e) allows SSA to access independent information "to assure that [SSI] benefits are only provided to eligible individuals (or eligible spouses) and that the amounts of such benefits are correct." 42 U.S.C. 1383(e)(1)(B)(i). By referencing benefits "amounts," *ibid.*, that provision contemplates monetary payments. And it makes sense that SSA's access to information "remain[s] effective" until "the cessation of the recipient's eligibility for benefits," 42 U.S.C. 1383(e)(1)(B)(ii)(II)(bb): To ensure that an individual

receives monthly payments only when she is entitled to them, SSA needs access to her financial information in every month that the agency must make a "determination of [her] benefits." 42 U.S.C. 1382(c). But that does not suggest that she is enrolled in an overarching SSI "program" during each of those months.

Petitioners also observe (Br. 26) that Title XVI requires SSA to review, at least "once every 3 years," "the continued eligibility for benefits under this [Title] of each individual who has not attained 18 years of age and is eligible for such benefits by reason of an impairment * * * which is likely to improve." 42 U.S.C. 1382c(a)(1)(H)(ii)(I). That provision recognizes that some individuals who initially become eligible for SSI benefits based on their disability may later have their condition improve. If that occurs and the person is no longer "disabled," she may no longer be entitled to SSI benefits. 42 U.S.C. 1382(a)(1). Congress's directive that SSA keep track of such individuals to avoid improper SSI payments is fully consistent with the government's approach here.

Section 1383(a)(2)(B)(viii) likewise does not assist petitioners. See Pet. Br. 27. That provision states that, in certain circumstances, if SSA "determines that direct *payment* of *the benefit* to [an] individual would cause substantial harm to the individual," SSA "may defer (in the case of initial *entitlement*) or suspend (in the case of existing *entitlement*) direct payment of such benefit to the individual, until such time as the selection of a representative payee is made." 42 U.S.C. 1383(a)(2)(B)(viii) (emphases added). The provision thus contemplates an entitlement to receive monetary payments. Contrary to petitioners' implication (Br. 26-27), SSA's power to defer or suspend those payments in

certain circumstances does not alter the basic nature of the entitlement.[3]

b. The only SSI benefits under Title XVI are monthly monetary payments

Petitioners further contend (Br. 34, 40) that once a person is eligible for the supposed "SSI program," she may receive "all SSI benefits," including "non-cash SSI benefits." In the court of appeals, petitioners cited two alleged "non-cash [SSI] benefits": the Medicare Part D "prescription-drug subsidy" and "Ticket to Work benefits." Pet. App. 11-12. In this Court, petitioners no longer rely on Medicare Part D and place hardly any weight on Ticket to Work—instead, they offer (Br. 22-23) five new alleged SSI benefits, discussed below, that the court of appeals never had an opportunity to address.

Petitioners' new approach is just as meritless as their approach below. While petitioners have identified certain other "benefits" as that term might colloquially be used (Br. 22), they have not identified any "SSI benefits under Title XVI." As already shown, "SSI benefits under Title XVI" are monthly cash payments made by SSA.

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[3] Petitioners also err (Br. 27 n.4, 32) in asserting that CMS "recognizes that SSI eligibility is programmatic" and does not look to "monthly payments" when applying the Medicare Part D prescription-drug subsidy. In fact, to determine eligibility for that subsidy, CMS examines "a *monthly* file of SSI-eligible beneficiaries" sent by SSA. CMS, *Medicare Prescription Drug Benefit Manual* ch. 13, § 40.2.1 (Rev. Oct. 1, 2018) (emphasis added). While eligibility for the Part D subsidy lasts "through the end of the year," *ibid*, that is because the applicable statute states that a Part D subsidy eligibility determination "shall remain in effect for a period specified by the Secretary," 42 U.S.C. 1395w-114(a)(3)(B)(ii), and the Secretary has specified one year, 42 C.F.R. 423.774(b).

i. *Vocational-rehabilitation services*. Petitioners primarily rely (Br. 34-37) on the availability of vocational-rehabilitation services. In the court of appeals, petitioners cited only the vocational-rehabilitation services provided in the Ticket to Work Act. Pet. C.A. Br. 27-28. The court held that "the Ticket to Work benefits cited by the hospitals are provided under [Title] XI," not Title XVI. Pet. App. 12. That holding is plainly correct: Section 1320b-19—which is found in Title XI—establishes the "metes and bounds" of the Ticket to Work benefit through which disabled individuals may access vocational training. *Ibid.*; see, *e.g.*, 42 U.S.C. 1320b-19(a) ("The Commissioner shall establish a Ticket to Work and Self-Sufficiency Program, under which a disabled beneficiary may use a ticket to work and self-sufficiency issued by the Commissioner in accordance with this section to obtain * * * vocational rehabilitation services."); 42 U.S.C. 1320b-19(b)(1) ("The Commissioner may issue a ticket to work and self-sufficiency to disabled beneficiaries for participation in the Program.").

Petitioners scarcely contest the court of appeals' Ticket to Work holding. They briefly observe (Br. 37) that a person may receive Ticket to Work services if she qualifies for SSI, and that SSA may reimburse States that provide certain vocational-rehabilitation services, see 42 U.S.C. 1382d(d). But the question is not whether Ticket to Work services bear some indirect relationship to SSI benefits; it is whether those services *are* "SSI benefits under Title XVI." And Section 1320b-19's text shows that Ticket to Work services are a distinct benefit under Title XI.

Taking a different tack in this Court, petitioners now principally argue (Br. 36) that "*most*" vocational-

rehabilitation services are not provided under the Ticket to Work program, but rather under Section 1382d within Title XVI. That new approach likewise fails for two reasons.

First, just as Title XVI provides no entitlement to Ticket to Work benefits, it provides no entitlement to other vocational-rehabilitation services either. Petitioners' reliance on Section 1382d is misplaced. Section 1382d(a) simply requires SSA to "refer[]" certain blind or disabled minors to a state agency administering a state program "under [Title] V" of the Social Security Act. 42 U.S.C. 1382d(a). The balance of Section 1382d authorizes SSA to "reimburse" a state agency administering "a State plan for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973 [29 U.S.C. 720 *et seq.*]" for certain costs. 42 U.S.C. 1382d(d) (brackets in original); see 42 U.S.C. 1382d(e). Thus, Section 1382d only indirectly refers to vocational-rehabilitation services administered under Title V and approved under the Rehabilitation Act—and an individual receiving those services under those separate provisions would plainly not be "entitled" to them as benefits "under Title XVI." See *National Ass'n of Mfrs.* v. *Department of Def.*, 583 U.S. 109, 124 (2018) (explaining that the term "under" means "'pursuant to' or 'by reason of the authority of'").

Second, even if Title XVI were construed to provide an entitlement to "vocational rehabilitation services," 42 U.S.C. 1382d(d), those *services* would not qualify as "supplementary security *income* benefits" for purposes of the Medicare fraction, 42 U.S.C. 1395ww(d)(5)(F)(vi)(I) (emphasis added). As noted above, the ordinary meaning of supplemental "income" benefits is recurring monetary payments, see p. 15, *supra*, which does not encom-

pass vocational-rehabilitation services like occupational training and employment counseling. Petitioners emphasize (Br. 38) that "income" can sometimes include "in-kind benefits" in different contexts. But in the context of Title XVI—which establishes a comprehensive scheme for "benefits" to "be paid * * * by the Commissioner," 42 U.S.C. 1381a—supplemental security income benefits means monetary payments, not vocational-rehabilitation services.

ii. *Medicaid continuation*. Petitioners also contend (Br. 37) that "Medicaid continuation" is an SSI benefit under Title XVI. Again, petitioners did not press that contention below, so the court of appeals did not address it. And the only court to address a similar argument correctly rejected it. See *Baystate Med. Ctr.* v. *Leavitt*, 545 F. Supp. 2d. 20, 36-39 (D.D.C. 2008).

As noted above, see p. 19, *supra*, in most circumstances, an individual "with respect to whom [SSI] benefits are being paid under [Title] XVI" automatically qualifies for Medicaid assistance. 42 U.S.C. 1396a(a)(10)(A)(i)(II). If that individual were to earn excess income and thus lose her entitlement to SSI benefits, she would ordinarily "also lose[] Medicaid assistance." *Baystate Med. Ctr.*, 545 F. Supp. 2d at 37 n.24.

Section 1382h(b) creates an exception to that rule for certain blind or disabled persons "to avoid creating a disincentive to return to work." *Baystate Med. Ctr.*, 545 F. Supp. 2d at 37. Specifically, it provides that "for purposes of [Title] XIX"—*i.e.*, the title governing Medicaid, 42 U.S.C. 1396-1396v—"any individual who was determined to be a blind or disabled individual eligible to receive a[n] [SSI] benefit under section 1382 of this title" and "who in a subsequent month is ineligible for benefits under this [Title]" due to excess "income" is still

"considered to be receiving [SSI] benefits" and thus can continue receiving Medicaid assistance. 42 U.S.C. 1382h(b). In other words, although the relevant individuals are in fact not entitled to receive SSI benefits, they are treated as though they continue to receive those benefits "for purposes of" Medicaid. *Ibid.* As the relevant Conference Report explains, "when a disabled SSI recipient's earnings rise to the point that he *no longer qualifies for federal SSI benefits*, * * * he would nevertheless continue to retain eligibility for Medicaid * * * *as though he were an SSI recipient*." H.R. Conf. Rep. No. 944, 96th Cong., 2d Sess. 49 (1980) (emphasis added).

Section 1382h(b) does not provide an SSI benefit under Title XVI. Section 1382h(b) expressly limits its operation to Medicaid through the opening phrase, "for purposes of [Title] XIX," which exclusively governs Medicaid. 42 U.S.C. 1382h(b). So while Section 1382h(b) states that an individual covered by that subsection who is "ineligible for benefits under this [Title XVI]" will be "*considered to be* receiving [SSI] benefits"—even though she is not actually receiving them—she will be so considered only "for purposes of [Title] XIX," *i.e.*, Medicaid. *Ibid.* (emphasis added). "Indeed, by describing the individual as 'ineligible for benefits under this [Title] [XVI],'" Section 1382h(b) "makes the very point that Section [1382h(b)] status is not a 'benefit under [Title] XVI.'" *Baystate Med. Ctr.*, 545 F. Supp. 2d at 37-38 (second set of brackets in original).

Petitioners also point to (Br. 37) the phrase "eligible for benefits pursuant to section 1382h(b) of this title" in Section 1383(j)(2), which provides for expedited review of the disability status of certain individuals covered by Section 1382h(b). 42 U.S.C. 1383(j)(2)(A). But that lan-

guage simply indicates that Section 1382h(b) prescribes rules pursuant to which certain disabled individuals may obtain the benefit of Medicaid continuation under Title XIX; it does not establish that Medicaid continuation is itself an SSI benefit under Title XVI. And petitioners' reliance on (Br. 37) Section 1382d(e)'s reference to "assistance under section 1382h(b)," 42 U.S.C. 1382d(e)(1)(B), only undermines their argument. That same provision, which governs reimbursement for vocational-rehabilitation services, distinguishes such Section 1382h(b) assistance, *i.e.*, Medicaid coverage, from "benefits under section 1382," *i.e.*, SSI benefits. 42 U.S.C. 1382d(e)(1)(A). Section 1382d thus further confirms that Medicaid continuation is not an SSI benefit under Title XVI.

iii. *State supplementation payments*. Petitioners also include (Br. 22-23) state supplementation payments in their list of asserted SSI benefits under Title XVI. Such payments "are made by a State" to "individuals who are receiving benefits under this [Title] or who would but for their income be eligible to receive benefits under this [Title]." 42 U.S.C. 1382e(a).

Of course, the Medicare fraction's numerator expressly "exclud[es]" patients entitled to "State supplementation" payments but not SSI benefits. 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). Petitioners therefore do not claim that patients entitled to state supplementation payments alone must be counted in the numerator. Instead, petitioners contend (Br. 23) that because Congress expressly excluded state supplementation payments, "[a]ll other SSI benefits must * * * be included" when calculating the numerator. But as explained already, there are no other SSI benefits under Title XVI beyond monthly monetary payments made by SSA.

Congress's express exclusion of state supplementation payments does not suggest otherwise. Because such payments are made with state funds pursuant to state law, they are not SSI benefits "under Title XVI" of the federal Social Security Act. Nonetheless, this Court has recognized that Congress sometimes includes language that may be "'technically unnecessary'" in order to "remov[e] any doubt" about an issue. *Marx* v. *General Revenue Corp.*, 568 U.S. 371, 383-384 (2013) (citation omitted). Here, even though state supplementation payments are distinct from SSI benefits under Title XVI, Congress may have sought to avoid any confusion about the matter—particularly because state supplementation payments are at least *income* benefits. That drafting choice does not imply that even *non-income* benefits—like vocational-rehabilitation services and Medicaid continuation—are somehow SSI benefits under Title XVI.

iv. *Payments for those whose disability has ceased but are receiving vocational-rehabilitation services.* Petitioners' reliance on (Br. 10, 23) Section 1383(a)(6) also does not advance their position. That provision states that "payment of the [SSI] benefit of" certain blind or disabled individuals "shall not be terminated or suspended because" their blindness or disability "has or may have ceased," so long as they are participating in a vocational-rehabilitation program and continuing in that program will increase the likelihood that they will "be permanently removed from the blindness and disability benefit rolls." 42 U.S.C. 1383(a)(6). Thus, Section 1383(a)(6) identifies certain circumstances under which blind and disabled persons are entitled to SSI benefits themselves under Title XVI. Contrary to petitioners' implication, Section 1383(a)(6) does not create its own

distinct form of SSI benefit. That is why it refers to "payment of *the benefit*," *ibid.* (emphasis added)—*i.e.*, the only form of SSI benefit provided under Title XVI. Accordingly, SSA and HHS count the persons referenced in Section 1383(a)(6) as entitled to SSI benefits under Title XVI for purposes of the Medicare fraction. See 20 C.F.R. 416.1338.

v. *Payments for certain individuals who perform substantial gainful activity despite severe medical impairment.* SSA and HHS similarly count the persons referenced in Section 1382h(a), on which petitioners also rely (Br. 22), as entitled to SSI benefits under Title XVI. See 20 C.F.R. 416.261-416.263. Section 1382h(a) provides that a disabled person who was "eligible to receive benefits under section 1382 of this title * * * for a month and whose earnings in a subsequent month exceed the amount designated by the Commissioner * * * ordinarily to represent substantial gainful activity shall qualify for a monthly benefit under this subsection for such subsequent month," for as long as the person continues to have a disabling impairment and has income not "in excess of the amount which would cause him to be ineligible for payments under section 1382." 42 U.S.C. 1382h(a). The amount of the benefit under Section 1382h(a) is "equal to" the "amount determined under section 1382(b)(1)." 42 U.S.C. 1382h(a)(1).

Section 1382h(a) thus "sets forth a substitute monthly cash benefit for certain individuals who qualify under Section 1382 in some months but not others." Pet. App. 11. Indeed, it makes clear that the relevant disabled persons "qualify for a monthly benefit" in the same "amount" as the ordinary benefit under Section 1382. 42 U.S.C. 1382h(a)(1). So while Section 1382h(a) expands the class of persons entitled to SSI benefits be-

yond the persons who would be entitled under Section 1382 alone, it does not create a distinct form of benefit.

Section 1320b-19 solidifies the point. As noted above, Section 1320b-19(k)(5) defines "'supplemental security income benefit under [Title] XVI'" to "mean[] a cash benefit under section 1382 or 1382h(a)." 42 U.S.C. 1320b-19(k)(5). Accordingly, Congress included Section 1382h(a) payments *within* the definition of SSI benefits.

B. *Empire Health* Supports HHS's Interpretation

This Court's decision in *Empire Health* further supports HHS's interpretation. In *Empire Health*, the Court construed the neighboring phrase within the Medicare fraction's numerator: "entitled to benefits under [Medicare] part A." 42 U.S.C. 1395ww(d)(F)(vi)(I). To determine which individuals are entitled to Medicare Part A benefits, the Court naturally focused on the statutory provisions governing Medicare Part A. *Empire Health*, 597 U.S. at 435-436. Based on those provisions, the Court determined that individuals have an "'automatic' * * * entitlement to Part A benefits" simply when they "[t]urn 65 or receive disability benefits for 24 months." *Id.* at 436 (citation omitted). That entitlement to Part A insurance essentially "never goes away." *Id.* at 437. Nor is the entitlement altered just because the insurance does not pay for "a[] given service"—for instance, because of "some limit on coverage as to" that "service." *Ibid.* After all, a fundamental feature of "health insurance" is that a person is "still insured" even when there is a "stoppage of payment for a[] given service." *Ibid.* As the Court put it, even if a person hit a coverage limit for "eye care," her "policy will pay for more eye care in the next coverage period and meanwhile will pay for [her] knee replacement." *Ibid.*

Applying the same approach to the language at issue here, this Court should focus on the statute creating the relevant entitlement—Title XVI. And as explained above, Title XVI provides that a person is "entitle[d]" to "be paid" SSI benefits for a month only when SSA "determine[s]" that her "income and resources" fall below the relevant thresholds in that month. 42 U.S.C. 1381a; see 42 U.S.C. 1382(c)(1).

It is true that the entitlement to Medicare Part A benefits does not turn on "payment for any given service," *Empire Health*, 597 U.S. at 437, whereas the entitlement to SSI benefits is the right to receive a payment for a given month. But contrary to petitioners' assertion (Br. 19-21), that distinction does not render HHS's interpretation of the Medicare fraction's numerator internally inconsistent. Rather, it simply reflects the different types of "benefits" to which a patient must be "entitled" in order to be counted in the numerator. 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). Indeed, although petitioners repeatedly conflate the numerator's two relevant phrases by paraphrasing both as "entitled to benefits" (*e.g.*, Br. 15, 17, 19), that is not what the statute says. It first says "entitled to benefits under part A," and then separately says "entitled to [SSI] benefits * * * under [Title] XVI." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). So the statute does not use "identical phrase[s]" within "the same sentence," Pet. Br. 19; it uses two distinct phrases to reference two distinct benefits under two distinct statutes. And while the phrases share a term ("entitled to"), this Court has recognized that "[a] given term in the same statute may take on distinct characters from association with distinct statutory objects calling for different implementation strategies." *Environmental Def.* v. *Duke Energy Corp.*, 549 U.S. 561, 574 (2007).

Two differences between Medicare Part A benefits and SSI benefits are especially critical here. See Pet. App. 13 (emphasizing the "key distinctions between the Part A and SSI schemes"); *Metropolitan Hosp.* v. *HHS*, 712 F.3d 248, 268 (6th Cir. 2013) (similar). First, Medicare Part A is health insurance, and the benefit of health insurance is the ongoing insured status that "provides basic protection against [certain] costs." 42 U.S.C. 1395c. Thus, even if a patient's Part A health insurance does not result in "payment for a[] given service," the patient is "still insured"—and her basic "statutory entitlement" is not "affect[ed]." *Empire Health*, 597 U.S. at 437. As the court of appeals recognized, "Part A benefits extend well beyond payment for specific services at specific times." Pet. App. 13. "There is no comparable parallel in the SSI context," *ibid.*, because, as explained above, SSI benefits are cash payments for a given month contingent on an individual's income in that month; unlike with health insurance, SSI provides no ongoing protection separate from those cash payments.

Second, the entitlement to Medicare Part A benefits is "'automatic'"—"[a]ge or disability makes a person 'entitled' to Part A benefits without an application or anything more"—and the entitlement essentially "never goes away." *Empire Health*, 597 U.S. at 436-437 (citation omitted). But "[t]he same does not hold true for SSI," Pet. App. 13, because individuals must apply for SSI benefits, and then their eligibility for benefits must be "determined" (and re-determined) each month based on their "income" and "resources" "in such month," 42 U.S.C. 1382(c); see 42 U.S.C. 1382(c)(7).

In light of those distinctions between Medicare Part A and SSI benefits, HHS's interpretation makes perfect

sense: A person is entitled to Medicare Part A benefits simply when she "[t]urn[s] 65 or receive[s] disability benefits for 24 months," *Empire Health*, 597 U.S. at 436; and she is entitled to SSI benefits when she applies for benefits and is determined by SSA to have sufficiently scarce "income and resources" in a month to "be paid benefits by the Commissioner" for that month, 42 U.S.C. 1381a. HHS thus gives the same basic meaning to "entitled to" in addressing both Medicare Part A and SSI benefits: a person is "entitled to" benefits when she meets the prerequisites established by the underlying statute. The Medicare and SSI statutes simply establish different prerequisites to entitlement.

C. The Statutory Structure, Purpose, And History Reinforce HHS's Interpretation

1. HHS's interpretation accords with the DSH provision's structure and design

As in *Empire Health*, "[t]he structure of the relevant statutory provisions reinforces" HHS's interpretation here. 597 U.S. at 442. The DSH provision "is designed to recompense hospitals for serving low-income patients, who are comparatively more expensive to treat." *Ibid.* And the Medicare fraction specifically is "designed to measure * * * the share of low-income Medicare patients relative to the total." *Id.* at 445.

HHS's interpretation promotes that design. As explained above, Congress provided SSI benefits for certain "financially needy individuals." *Galbreath*, 485 U.S. at 75. But Congress recognized that "[i]n some cases, the financial status of beneficiaries will fluctuate during the year." S. Rep. No. 1230, 92d Cong., 2d Sess. 386 (1972) (Senate Report). Accordingly, Congress required SSA to determine "eligibility" for SSI payments

"for a month" based on the individual's "income" "in such month." 42 U.S.C 1382(c)(1).

HHS's interpretation here incorporates that tailored, month-by-month assessment. By focusing on "Medicare beneficiaries who are entitled to SSI cash payments at the time of their hospitalization," Pet. App. 9, HHS counts only patients who have demonstrated a scarcity of "income" "in [the] month" of their hospitalization, 42 U.S.C. 1382(c)(1). That interpretation therefore captures the population that "the DSH provisions care about": "low-income patients." *Empire Health*, 597 U.S. at 444.

Petitioners assert (Br. 46) that HHS's interpretation "drop[s] patients from the Medicare fraction numerator even though they are low-income *and* meet all eligibility criteria for a cash payment during the hospitalization month." That assertion erroneously conflates the entitlement to SSI payment and the amount of the payment. The "amount" of an SSI payment is generally determined "on the basis of income and other characteristics" in a "preceding" month. 42 U.S.C. 1382(c)(1). But SSI payment entitlement for a month "shall be determined on the basis of the individual's * * * income, resources, and other relevant characteristics *in such month*." *Ibid.* (emphasis added); see 20 C.F.R. 416.203(b). Thus, contrary to petitioners' suggestion (Br. 45-46), HHS's interpretation captures patients who are low-income—as the statute defines it—during the month of their hospitalization. See Pet. App. 14-15.

Correspondingly, HHS's interpretation properly excludes individuals who have higher incomes during the month of their hospitalization. Some individuals may be entitled to SSI benefits in one month, but then earn more income in subsequent months. While those indi-

viduals would no longer be entitled to SSI benefits because of their higher "income," 42 U.S.C. 1382(c)(1), they would not have to "reappl[y] for benefits" until they earned excess income for "12 consecutive months," 42 U.S.C. 1383(j)(1)(B).

Under HHS's interpretation, those individuals are not counted as "low-income patients" in the months when they earn too much income to be entitled to an SSI payment. *Empire Health*, 597 U.S. at 444. But under petitioners' interpretation (Br. 24), those individuals would be counted, because they would remain within petitioners' (erroneous) construct of an "SSI program." For example, suppose a person received an SSI payment in January, but then obtained employment and earned income greatly exceeding applicable limits from February through the end of the year. If that person were hospitalized in December, petitioners would count her as a low-income patient under the Medicare fraction's numerator—even though she in fact earns substantial income. HHS, in contrast, excludes that person from the numerator. For that reason, HHS's interpretation more closely tracks a patient's low-income status.

Petitioners insist (Br. 48) that "it isn't realistic" to think that their approach would count individuals who are no longer financially needy. But SSA's annual statistical report for 2009 (the last cost year at issue in this case) shows that 618,609 individuals who had received SSI benefits in some month later became ineligible for SSI benefits due to excess income. C.A. App. 146; see Pet. App. 40 (similar figures in 2010). Indeed, excess income was by far the most common reason for SSI benefits suspension in the period at issue, accounting for more than 50% of all suspensions. C.A. App. 145-146. Nor are petitioners correct that "SSI beneficiaries

rarely move from suspension to full termination." Pet. Br. 48. In 2009, 354,770 individuals earned excess income for 12 consecutive months and thus would have had to reapply to again establish entitlement to SSI benefits. C.A. App. 147.

Petitioners also observe (Br. 29) that if a person's income "briefly pop[ped] above the limit" for SSI entitlement in a given month, HHS would not count the person as low-income if she happened to be hospitalized in that month. But if the person's income increase is indeed "brief[ ]," then her income would soon "pop" back below the limit. *Ibid.* And when it did so, HHS would again count her as low-income. That is a virtue, not a vice, in HHS's interpretation: It is sensitive to changes in the criterion that matters under the DSH provision, *i.e.*, the patient's low-income status when hospitalized.

Petitioners' assertion (Br. 28) that HHS fails to count certain low-income patients does not advance their position. It is true that Congress chose not to extend SSI benefits to some people who may have low incomes, such as "inmate[s] of a public institution," 42 U.S.C. 1382(e)(1)(A), and certain individuals who reside "in an institution receiving Medicaid benefits for the[ir] care," *Wilson*, 450 U.S. at 225; see 42 U.S.C. 1382(e)(1)(B). Congress determined that for such individuals, "most subsistence needs are met by the institution and full benefits are not needed." Senate Report 386. Congress's exclusion of such individuals simply shows that while SSI "is broad in its reach, its coverage is not complete." *Wilson*, 450 U.S. at 224.

Another category of people may have SSI payments suspended "for administrative reasons"—*e.g.*, if a person has mail "returned as undeliverable" and her whereabouts are unknown. 20 C.F.R. 416.1320(a). Having a

known address is not itself a "requirement[] of eligibility" for SSI benefits, *ibid.*, but it is necessary to allow SSA to "determine[]" whether a person meets other requirements, 42 U.S.C. 1382(c)(1), such as resource thresholds and residency in the United States, 20 C.F.R. 416.202(b) and (d). If a person moves in rent-free with a relative, for example, that could affect whether she remains entitled to a monthly SSI payment. But if a person simply moves to a different home of the same nature, later notifies SSA of that change, and SSA confirms that she met all eligibility requirements in the months when her whereabouts were unknown, SSA would retroactively reinstate her benefits for those months. See SSA, *Program Operations Manual System (POMS)*, SI 02301.240 (Feb. 17, 2023). HHS would therefore count her as entitled to SSI benefits for those months for purposes of the Medicare fraction. See 75 Fed. Reg. at 50,282. The same basic principles apply to other types of administrative suspensions. See, *e.g.*, 20 C.F.R. 416.611(c) (suspensions of benefits based on need to find representative payee); 20 C.F.R. 416.1322(a) (suspensions of benefits for failure to comply with request for information).

In all events, the Medicare fraction invokes the entitlement to SSI benefits only as a "proxy measure for low-income," H.R. Rep. No. 241, 99th Cong., 1st Sess. 16 (1985)—not as a perfect measure of low income in every instance. Indeed, Congress knew that the entitlement to SSI benefits turns not only on "income," but also on "resources" and "other relevant characteristics." 42 U.S.C. 1382(c)(1). And it knew that SSI benefits are paid "in accordance with and subject to the provisions of [Title XVI]," including its limitations. 42 U.S.C. 1381a. So even if there are isolated low-income

patients whom HHS's calculation fails to count, that is simply the natural consequence of Congress's choice of a proxy that—while generally focused on "needy" individuals—has also always "excluded" some such individuals "from eligibility." *Wilson*, 450 U.S. at 223-224. And that consequence is more consistent with Congress's design than the consequence of petitioners' interpretation—namely, the routine counting of individuals who earn too much income to be entitled to SSI payments.[4]

2. HHS's interpretation follows from the SSI program's history

In construing a statute, courts appropriately consider the "[s]tatutory history." *Wooden* v. *United States*, 595 U.S. 360, 371 (2022). Because this case turns on the meaning of "entitled to SSI benefits under Title XVI," the history of SSI benefits is illuminating.

Before Congress's enactment of SSI in 1972, the federal government had provided funding for States to administer public-assistance programs for the aged, blind, and disabled. See *Wilson*, 450 U.S. at 223 n.1. Under that regime, States made "assistance payments" to eligible individuals, based on state-established "payment levels." Senate Report 13, 75.

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[4] Just as Congress's use of SSI entitlement as a low-income proxy may be underinclusive in some respects, it may operate as overinclusive in other respects. For instance, petitioners note (Br. 47) that in fiscal year 2018, 9.7% of SSI payments were improper. But that 9.7% figure breaks down to 8.2% *overpayments* and only 1.5% underpayments. See SSA, *Agency Financial Report*: *Fiscal Year 2019*, at 172 (Nov. 12, 2019). Thus, to the extent monthly SSI payment determinations "import * * * errors in[to] the DSH formula," Pet. Br. 47, those errors may ultimately count more patients in the numerator.

With SSI, Congress sought to "largely replace the payments [then] being made to the needy, aged, blind, and disabled under State public assistance programs." Senate Report 531. Instead of state-run cash-assistance programs, the federal government would "assum[e] responsibility for both funding payments and setting standards of need." *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 38 (1981).

Thus, as the Senate Report on the initial SSI bill explained, Congress intended to "set a Federal guaranteed minimum income level for aged, blind, and disabled persons." Senate Report 12; see *Wilson*, 450 U.S. at 223. Under the federal scheme, "aged, blind, and disabled individuals would be assured a monthly income of" specified dollar amounts "for an individual" or "a couple." Senate Report 13; see *id.* at 388. In short, the law aimed "to provide a positive assurance that the Nation's aged, blind, and disabled people would no longer have to subsist on below-poverty-level incomes." *Id.* at 384.

The origins of SSI thus show that it is unequivocally a federal cash-benefits scheme. Rather than relying on States to make payments to needy aged, blind, and disabled individuals based on varying state-law standards, Congress ensured that SSA would make those payments pursuant to "federal standards." *Wilson*, 450 U.S. at 223. And the statutory history nowhere suggests that SSI benefits under Title XVI consist of anything other than those payments.

Petitioners cite (Br. 23) the Senate Report on the bill establishing the Medicare fraction, which references "Medicare patients who are also enrolled in the * * * (SSI) program." S. Rep. No. 146, 99th Cong., 1st Sess. 291 (1985). But the statutory text clearly counts only patients "entitled to SSI benefits under Title XVI"—not

patients "enrolled in the SSI program"—so this Court "need not consider" petitioners' proffered "legislative history," *NLRB* v. *SW Gen., Inc.*, 580 U.S. 288, 305 (2017). In any event, the cited Senate Report language does not appear in the ultimate "[c]onference agreement" harmonizing the House and Senate bills. H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. 461 (1985). That agreement instead simply references SSI "beneficiaries." *Ibid.* The Court should thus reject petitioners' effort to use "ambiguous legislative history to muddy clear statutory language." *Azar* v. *Allina Health Servs.*, 587 U.S. 566, 579 (2019) (citation omitted).

D. The Longstanding And Consistent Nature Of HHS's Interpretation Further Confirms That It Is Sound

Ever since Congress's enactment of the DSH provision nearly four decades ago, HHS has consistently read the Medicare fraction's numerator to count only Medicare beneficiaries who were entitled to an SSI payment for the month of their hospitalization. This Court should accord respect to that longstanding and unwavering interpretation of a technical statutory provision. And the Court should reject petitioners' mischaracterization of HHS's interpretation as an actual-receipt rule.

1. HHS's interpretation is due respect

This Court recently explained that "in determining the meaning of statutory provisions," courts have long sought "aid from the interpretations of those responsible for implementing particular statutes." *Loper Bright Enters.* v. *Raimondo*, 144 S. Ct. 2244, 2262 (2024). "Such interpretations," the Court made clear, "'constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance' consistent with the APA." *Ibid.* (quoting *Skidmore* v.

Swift & Co., 323 U.S. 134, 140 (1944)). The Court emphasized that agency "interpretations issued contemporaneously with the statute at issue, and which have remained consistent over time, may be especially useful in determining the statute's meaning." *Ibid.* And the Court recognized that in a case involving a "technical matter," an agency's "subject matter expertise" has "always been one of the factors which may give an Executive Branch interpretation particular 'power to persuade.'" *Id.* at 2267 (citation omitted).

Each of those principles applies forcefully here, thus entitling HHS's interpretation of the Medicare fraction to "considerable" "respect." *Skidmore*, 323 U.S. at 140. That interpretation is "especially useful," *Loper Bright*, 144 S. Ct. at 2262, because it reflects the agency's consistent construction since Congress enacted the statutory language in 1986. See Pub. L. No. 99-272, § 9105, 100 Stat. 158-160. The agency's initial regulation interpreting the Medicare fraction provided that the numerator counts "patients who are entitled during th[e] month [of hospitalization] to both Medicare Part A and Supplemental Security Income benefits under title XVI." 42 C.F.R. 412.106(a)(i) (1986). In a 2010 rulemaking, HHS reaffirmed that the statute requires it to "capture[] all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits." 75 Fed. Reg. at 50,281; see *id.* at 50,280 & n.19. And as noted above, HHS's understanding of the phrase "SSI benefits under Title XVI" in the Medicare fraction has always mirrored SSA's longstanding and consistent regulatory definition of "[s]upplemental security income benefit." 20 C.F.R. 416.120(c)(1); see p. 18, *supra*.

In addition, HHS's interpretation implicates a "technical matter" about which HHS possesses substantial

"subject matter expertise." *Loper Bright*, 144 S. Ct. at 2267. As the Court observed in *Empire Health*, the Medicare fraction is "technical" and "'must be read by judges with the minds of the specialists.'" 597 U.S. at 434 (citation omitted). HHS is staffed with Medicare specialists, and its views here also incorporate SSA's expertise on SSI. And beyond the Medicare fraction itself, the correct understanding of the complex interrelationship of the numerous other statutory provisions involved in this case is properly informed by the experience and expertise of HHS and SSA. In construing the Medicare fraction, the Court accordingly should give "due respect" to HHS's views. *Loper Bright*, 144 S. Ct. at 2267.

2. HHS has never employed an "actual receipt rule," so petitioners' attacks on such a rule are irrelevant

Petitioners mischaracterize (*e.g.*, Br. 30-32) HHS's interpretation as "an 'actual receipt' rule." As noted above, contemporaneous with the statute's enactment, the agency counted "patients who are *entitled* during th[e] month [of hospitalization] to both Medicare Part A and [SSI] benefits." 42 C.F.R. 412.106(a)(i) (1986) (emphasis added). Likewise, HHS's 2010 rulemaking explained that the agency counts patients based on "SSA codes that reflect 'entitlement to' receive SSI benefits" —not actual receipt—in a "particular month." 75 Fed. Reg. at 50,280. Indeed, HHS counts patients who did not receive a timely SSI payment for the month of their hospitalization but then were "retroactive[ly]" deemed entitled to payment, or had a "payment suspension[]" lifted, for that month. *Id.* at 50,277; see *id.* at 50,282. And HHS also counts patients who did not receive an SSI payment because the amount of that payment was

credited to offset "an overpayment from another SSA program." Pet. App. 14.

Further confirming that entitlement-based approach, HHS's 2010 rulemaking rejected a commenter's suggestion to incorporate additional SSA status codes in its calculations on the ground that "none of the SSI status codes that the commenter mentioned would be used to describe an individual who was *entitled* to receive SSI benefits during the month that one of those status codes was used." 75 Fed. Reg. at 50,281 (emphasis added). "SSI entitlement can change from time to time," HHS explained, "and [HHS] believe[s] that including [three SSI status codes] accurately captures all SSI-*entitled* individuals during the month(s) that they are *entitled* to receive SSI benefits." *Ibid.* (emphasis added).

Disregarding the regulatory text just discussed, petitioners primarily cite (Br. 32) stray remarks from the administrative decisions in this case. Two of those remarks are simply shorthand descriptions of the 2010 rulemaking, see Pet. App. 82, 119; obviously, the rulemaking text itself controls over attempts to describe it. The final remark imprecisely refers to persons being "actually paid the[] benefits," *id.* at 81; but elsewhere on the same page, the CMS Administrator correctly refers to persons "actually eligible for SSI benefits," *ibid.*

Nor did the court of appeals misunderstand HHS's position. Contra Pet. Br. 30, 32. In the section of its opinion analyzing the question presented, the court accurately observed that "HHS reads [the Medicare fraction's numerator] to cover only Medicare beneficiaries who are entitled to SSI cash payments at the time of their hospitalization." Pet. App. 9.

In their only attempt (Br. 32) to grapple with HHS's 2010 rulemaking, petitioners inaccurately describe it as "count[ing] [patients] only if payment is received by the time CMS runs its count of SSI-entitled patients." In fact, CMS uses an "SSI *eligibility* file" reflecting payment-eligibility status codes that "are updated 15 months after the end of the [relevant] Federal fiscal year," so that CMS can best "account for all retroactive changes in SSI *eligibility* and the lifting of SSI payment suspensions through that date." 75 Fed. Reg. at 50,282 (emphasis added). And HHS explained why the information it uses is "the best and latest available SSI *eligibility* data at the time of [a hospital's] cost report settlement." *Ibid.* (emphasis added). Petitioners' repeated attacks (Br. 32) on "CMS's actual-receipt rule" thus reflect a fundamental misunderstanding of the agency's practices.

Petitioners are likewise wrong to insist (Br. 46) that HHS's approach is "exceedingly difficult to administer." That argument criticizes an "actual-receipt approach" (Br. 47) that HHS does not use. The SSI-entitlement approach that HHS uses has worked effectively for years by relying on an established "data matching process" involving three "SSA codes that reflect 'entitlement to' receive SSI benefits." 75 Fed. Reg. at 50,280. Petitioners' approach would add 74 new codes to that process, Pet. App. 39—making it more time consuming and error prone.

More fundamentally, petitioners' proposed additional codes do not denote patients who are entitled to SSI benefits. See 75 Fed. Reg. at 50,281. In fact, "at least fifty" of those codes "are used to identify persons" who are plainly ineligible for SSI benefits—"the most common reason [for that ineligibility] being that a per-

son's income exceeds the applicable statutory maximum." Pet. App. 39. Such persons are not entitled to SSI benefits and should not be counted under the Medicare fraction's numerator.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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APPENDIX

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APPENDIX

1. 42 U.S.C. 1320b-19 provides in pertinent part:

The Ticket to Work and Self-Sufficiency Program

(a) In general

The Commissioner shall establish a Ticket to Work and Self-Sufficiency Program, under which a disabled beneficiary may use a ticket to work and self-sufficiency issued by the Commissioner in accordance with this section to obtain employment services, vocational rehabilitation services, or other support services from an employment network which is of the beneficiary's choice and which is willing to provide such services to such beneficiary.

(b) Ticket system

(1) Distribution of tickets

The Commissioner may issue a ticket to work and self-sufficiency to disabled beneficiaries for participation in the Program.

(2) Assignment of tickets

A disabled beneficiary holding a ticket to work and self-sufficiency may assign the ticket to any employment network of the beneficiary's choice which is serving under the Program and is willing to accept the assignment.

(3) Ticket terms

A ticket issued under paragraph (1) shall consist of a document which evidences the Commissioner's agreement to pay (as provided in paragraph (4)) an employment network, which is serving under the

Program and to which such ticket is assigned by the beneficiary, for such employment services, vocational rehabilitation services, and other support services as the employment network may provide to the beneficiary.

(4) Payments to employment networks

The Commissioner shall pay an employment network under the Program in accordance with the outcome payment system under subsection (h)(2) or under the outcome-milestone payment system under subsection (h)(3) (whichever is elected pursuant to subsection (h)(1)). An employment network may not request or receive compensation for such services from the beneficiary.

* * * * *

(k) Definitions

In this section:

(1) Commissioner

The term "Commissioner" means the Commissioner of Social Security.

(2) Disabled beneficiary

The term "disabled beneficiary" means a title II disability beneficiary or a title XVI disability beneficiary.

(3) Title II disability beneficiary

The term "title II disability beneficiary" means an individual entitled to disability insurance benefits under section 423 of this title or to monthly insurance benefits under section 402 of this title based on such

individual's disability (as defined in section 423(d) of this title). An individual is a title II disability beneficiary for each month for which such individual is entitled to such benefits.

(4) Title XVI disability beneficiary

The term "title XVI disability beneficiary" means an individual eligible for supplemental security income benefits under subchapter XVI on the basis of blindness (within the meaning of section 1382c(a)(2) of this title) or disability (within the meaning of section 1382c(a)(3) of this title). An individual is a title XVI disability beneficiary for each month for which such individual is eligible for such benefits.

(5) Supplemental security income benefit

The term "supplemental security income benefit under subchapter XVI" means a cash benefit under section 1382 or 1382h(a) of this title, and does not include a State supplementary payment, administered federally or otherwise.

* * * * *

2. 42 U.S.C. 1381 provides:

Statement of purpose; authorization of appropriations

For the purpose of establishing a national program to provide supplemental security income to individuals who have attained age 65 or are blind or disabled, there are authorized to be appropriated sums sufficient to carry out this subchapter.

3. 42 U.S.C. 1381a provides:

Basic entitlement to benefits

Every aged, blind, or disabled individual who is determined under part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this subchapter, be paid benefits by the Commissioner of Social Security.

4. 42 U.S.C. 1382(a)-(e) provide:

Eligibility for benefits

(a) "Eligible individual" defined

(1) Each aged, blind, or disabled individual who does not have an eligible spouse and—

(A) whose income, other than income excluded pursuant to section 1382a(b) of this title, is at a rate of not more than $1,752 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974 or any calendar year thereafter, and

(B) whose resources, other than resources excluded pursuant to section 1382b(a) of this title, are not more than (i) in case such individual has a spouse with whom he is living, the applicable amount determined under paragraph (3)(A), or (ii) in case such individual has no spouse with whom he is living, the applicable amount determined under paragraph (3)(B),

shall be an eligible individual for purposes of this subchapter.

(2) Each aged, blind, or disabled individual who has an eligible spouse and—

(A) whose income (together with the income of such spouse), other than income excluded pursuant to section 1382a(b) of this title, is at a rate of not more than $2,628 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974, or any calendar year thereafter, and

(B) whose resources (together with the resources of such spouse), other than resources excluded pursuant to section 1382b(a) of this title, are not more than the applicable amount determined under paragraph (3)(A),

shall be an eligible individual for purposes of this subchapter.

(3)(A) The dollar amount referred to in clause (i) of paragraph (1)(B), and in paragraph (2)(B), shall be $2,250 prior to January 1, 1985, and shall be increased to $2,400 on January 1, 1985, to $2,550 on January 1, 1986, to $2,700 on January 1, 1987, to $2,850 on January 1, 1988, and to $3,000 on January 1, 1989.

(B) The dollar amount referred to in clause (ii) of paragraph (1)(B), shall be $1,500 prior to January 1, 1985, and shall be increased to $1,600 on January 1, 1985, to $1,700 on January 1, 1986, to $1,800 on January 1, 1987, to $1,900 on January 1, 1988, and to $2,000 on January 1, 1989.

(b) Amount of benefits

(1) The benefit under this subchapter for an individual who does not have an eligible spouse shall be payable at the rate of $1,752 (or, if greater, the amount deter-

mined under section 1382f of this title) for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to section 1382a(b) of this title, of such individual.

(2) The benefit under this subchapter for an individual who has an eligible spouse shall be payable at the rate of $2,628 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to section 1382a(b) of this title, of such individual and spouse.

(c) Period for determination of benefits

(1) An individual's eligibility for a benefit under this subchapter for a month shall be determined on the basis of the individual's (and eligible spouse's, if any) income, resources, and other relevant characteristics in such month, and, except as provided in paragraphs (2), (3), (4), (5), and (6), the amount of such benefit shall be determined for such month on the basis of income and other characteristics in the first or, if the Commissioner of Social Security so determines, second month preceding such month. Eligibility for and the amount of such benefits shall be redetermined at such time or times as may be provided by the Commissioner of Social Security.

(2) The amount of such benefit for the month in which an application for benefits becomes effective (or, if the Commissioner of Social Security so determines, for such month and the following month) and for any month immediately following a month of ineligibility for such benefits (or, if the Commissioner of Social Security

so determines, for such month and the following month) shall—

(A) be determined on the basis of the income of the individual and the eligible spouse, if any, of such individual and other relevant circumstances in such month; and

(B) in the case of the first month following a period of ineligibility in which eligibility is restored after the first day of such month, bear the same ratio to the amount of the benefit which would have been payable to such individual if eligibility had been restored on the first day of such month as the number of days in such month including and following the date of restoration of eligibility bears to the total number of days in such month.

(3) For purposes of this subsection, an increase in the benefit amount payable under subchapter II (over the amount payable in the preceding month, or, at the election of the Commissioner of Social Security, the second preceding month) to an individual receiving benefits under this subchapter shall be included in the income used to determine the benefit under this subchapter of such individual for any month which is—

(A) the first month in which the benefit amount payable to such individual under this title is increased pursuant to section 1382f of this title, or

(B) at the election of the Commissioner of Social Security, the month immediately following such month.

(4)(A) Notwithstanding paragraph (3), if the Commissioner of Social Security determines that reliable information is currently available with respect to the in-

come and other circumstances of an individual for a month (including information with respect to a class of which such individual is a member and information with respect to scheduled cost-of-living adjustments under other benefit programs), the benefit amount of such individual under this subchapter for such month may be determined on the basis of such information.

(B) The Commissioner of Social Security shall prescribe by regulation the circumstances in which information with respect to an event may be taken into account pursuant to subparagraph (A) in determining benefit amounts under this subchapter.

(5) Notwithstanding paragraphs (1) and (2), any income which is paid to or on behalf of an individual in any month pursuant to (A) a State program funded under part A of subchapter IV, (B) section 672 of this title (relating to foster care assistance), (C) section 1522(e) of title 8 (relating to assistance for refugees), (D) section 501(a) of Public Law 96-422 (relating to assistance for Cuban and Haitian entrants), or (E) section 13 of title 25 (relating to assistance furnished by the Bureau of Indian Affairs), shall be taken into account in determining the amount of the benefit under this subchapter of such individual (and his eligible spouse, if any) only for that month, and shall not be taken into account in determining the amount of the benefit for any other month.

(6) The dollar amount in effect under subsection (b) as a result of any increase in benefits under this subchapter by reason of section 1382f of this title shall be used to determine the value of any in-kind support and maintenance required to be taken into account in determining the benefit payable under this subchapter to an individual (and the eligible spouse, if any, of the individ-

ual) for the 1st 2 months for which the increase in benefits applies.

(7) For purposes of this subsection, an application of an individual for benefits under this subchapter shall be effective on the later of—

(A) the first day of the month following the date such application is filed, or

(B) the first day of the month following the date such individual becomes eligible for such benefits with respect to such application.

(8) The Commissioner of Social Security may waive the limitations specified in subparagraphs (A) and (B) of subsection (e)(1) on an individual's eligibility and benefit amount for a month (to the extent either such limitation is applicable by reason of such individual's presence throughout such month in a hospital, extended care facility, nursing home, or intermediate care facility) if such waiver would promote the individual's removal from such institution or facility. Upon waiver of such limitations, the Commissioner of Social Security shall apply, to the month preceding the month of removal, or, if the Commissioner of Social Security so determines, the two months preceding the month of removal, the benefit rate that is appropriate to such individual's living arrangement subsequent to his removal from such institution or facility.

(9)(A) Notwithstanding paragraphs (1) and (2), any nonrecurring income which is paid to an individual in the first month of any period of eligibility shall be taken into account in determining the amount of the benefit under this subchapter of such individual (and his eligible spouse, if any) only for that month, and shall not be

taken into account in determining the amount of the benefit for any other month.

(B) For purposes of subparagraph (A), payments to an individual in varying amounts from the same or similar source for the same or similar purpose shall not be considered to be nonrecurring income.

(10) For purposes of this subsection, remuneration for service performed as a member of a uniformed service may be treated as received in the month in which it was earned, if the Commissioner of Social Security determines that such treatment would promote the economical and efficient administration of the program authorized by this subchapter.

(d) Limitation on amount of gross income earned; "gross income" defined

The Commissioner of Social Security may prescribe the circumstances under which, consistently with the purposes of this subchapter, the gross income from a trade or business (including farming) will be considered sufficiently large to make an individual ineligible for benefits under this subchapter. For purposes of this subsection, the term "gross income" has the same meaning as when used in chapter 1 of the Internal Revenue Code of 1986.

(e) Limitation on eligibility of certain individuals

(1)(A) Except as provided in subparagraphs (B), (C), (D), (E), and (G), no person shall be an eligible individual or eligible spouse for purposes of this subchapter with respect to any month if throughout such month he is an inmate of a public institution.

(B) In any case where an eligible individual or his eligible spouse (if any) is, throughout any month (subject to subparagraph (G)), in a medical treatment facility receiving payments (with respect to such individual or spouse) under a State plan approved under subchapter XIX, or an eligible individual is a child described in section 1382c(f)(2)(B) of this title, or, in the case of an eligible individual who is a child under the age of 18, receiving payments (with respect to such individual) under any health insurance policy issued by a private provider of such insurance the benefit under this subchapter for such individual for such month shall be payable (subject to subparagraph (E))—

(i) at a rate not in excess of $360 per year (reduced by the amount of any income not excluded pursuant to section 1382a(b) of this title) in the case of an individual who does not have an eligible spouse;

(ii) in the case of an individual who has an eligible spouse, if only one of them is in such a facility throughout such month, at a rate not in excess of the sum of—

(I) the rate of $360 per year (reduced by the amount of any income, not excluded pursuant to section 1382a(b) of this title, of the one who is in such facility), and

(II) the applicable rate specified in subsection (b)(1) (reduced by the amount of any income, not excluded pursuant to section 1382a(b) of this title, of the other); and

(iii) at a rate not in excess of $720 per year (reduced by the amount of any income not excluded pursuant to section 1382a(b) of this title) in the case of

an individual who has an eligible spouse, if both of them are in such a facility throughout such month.

For purposes of this subsection, a medical treatment facility that provides services described in section 1396p(c)(1)(C) of this title shall be considered to be receiving payments with respect to an individual under a State plan approved under subchapter XIX during any period of ineligibility of such individual provided for under the State plan pursuant to section 1396p(c) of this title.

(C) As used in subparagraph (A), the term "public institution" does not include a publicly operated community residence which serves no more than 16 residents.

(D) A person may be an eligible individual or eligible spouse for purposes of this subchapter with respect to any month throughout which he is a resident of a public emergency shelter for the homeless (as defined in regulations which shall be prescribed by the Commissioner of Social Security); except that no person shall be an eligible individual or eligible spouse by reason of this subparagraph more than 6 months in any 9-month period.

(E) Notwithstanding subparagraphs (A) and (B), any individual who—

(i)(I) is an inmate of a public institution, the primary purpose of which is the provision of medical or psychiatric care, throughout any month as described in subparagraph (A), or

(II) is in a medical treatment facility throughout any month as described in subparagraph (B),

(ii) was eligible under section 1382h(a) or (b) of this title for the month preceding such month, and

(iii) under an agreement of the public institution or the medical treatment facility is permitted to retain any benefit payable by reason of this subparagraph,

may be an eligible individual or eligible spouse for purposes of this subchapter (and entitled to a benefit determined on the basis of the rate applicable under subsection (b)) for the month referred to in subclause (I) or (II) of clause (i) and, if such subclause still applies, for the succeeding month.

(F) An individual who is an eligible individual or an eligible spouse for a month by reason of subparagraph (E) shall not be treated as being eligible under section 1382h(a) or (b) of this title for such month for purposes of clause (ii) of such subparagraph.

(G) A person may be an eligible individual or eligible spouse for purposes of this subchapter, and subparagraphs (A) and (B) shall not apply, with respect to any particular month throughout which he or she is an inmate of a public institution the primary purpose of which is the provision of medical or psychiatric care, or is in a medical treatment facility receiving payments (with respect to such individual or spouse) under a State plan approved under subchapter XIX or, in the case of an individual who is a child under the age of 18, under any health insurance policy issued by a private provider of such insurance, if it is determined in accordance with subparagraph (H) or (J) that—

(i) such person's stay in that institution or facility (or in that institution or facility and one or more other such institutions or facilities during a continuous period of institutionalization) is likely (as certi-

fied by a physician) not to exceed 3 months, and the particular month involved is one of the first 3 months throughout which such person is in such an institution or facility during a continuous period of institutionalization; and

(ii) such person needs to continue to maintain and provide for the expenses of the home or living arrangement to which he or she may return upon leaving the institution or facility.

The benefit of any person under this subchapter (including State supplementation if any) for each month to which this subparagraph applies shall be payable, without interruption of benefit payments and on the date the benefit involved is regularly due, at the rate that was applicable to such person in the month prior to the first month throughout which he or she is in the institution or facility.

(H) The Commissioner of Social Security shall establish procedures for the determinations required by clauses (i) and (ii) of subparagraph (G), and may enter into agreements for making such determinations (or for providing information or assistance in connection with the making of such determinations) with appropriate State and local public and private agencies and organizations. Such procedures and agreements shall include the provision of appropriate assistance to individuals who, because of their physical or mental condition, are limited in their ability to furnish the information needed in connection with the making of such determinations.

(I)(i) The Commissioner shall enter into an agreement, with any interested State or local institution com-

prising a jail, prison, penal institution, or correctional facility, or with any other interested State or local institution a purpose of which is to confine individuals as described in section 402(x)(1)(A)(ii) of this title, under which—

(I) the institution shall provide to the Commissioner, on a monthly basis and in a manner specified by the Commissioner, the first, middle, and last names, social security account numbers or taxpayer identification numbers, prison assigned inmate numbers, last known addresses, dates of birth, confinement commencement dates, dates of release or anticipated dates of release, dates of work release, and, to the extent available to the institution, such other identifying information concerning the inmates of the institution as the Commissioner may require for the purpose of carrying out this paragraph and clause (iv)[1] of this subparagraph and the other provisions of this subchapter; and

(II) the Commissioner shall pay to any such institution, with respect to each individual who receives in the month preceding the first month throughout which such individual is an inmate of the jail, prison, penal institution, or correctional facility that furnishes information respecting such individual pursuant to subclause (I), or is confined in the institution (that so furnishes such information) as described in section 402(x)(1)(A)(ii) of this title, a benefit under this subchapter for such preceding month, and who is determined by the Commissioner to be ineligible for benefits under this subchapter by reason of confine-

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[1] So in original. Probably should refer to cl. (iii).

ment based on the information provided by such institution, $400 (subject to reduction under clause (ii)) if the institution furnishes the information described in subclause (I) to the Commissioner within 15 days after the date such individual becomes an inmate of such institution, or $200 (subject to reduction under clause (ii)) if the institution furnishes such information after 15 days after such date but within 90 days after such date.

(ii) The dollar amounts specified in clause (i)(II) shall be reduced by 50 percent if the Commissioner is also required to make a payment to the institution with respect to the same individual under an agreement entered into under section 402(x)(3)(B) of this title.

(iii) The Commissioner shall maintain, and shall provide on a reimbursable basis, information obtained pursuant to agreements entered into under clause (i) to any Federal or federally-assisted cash, food, or medical assistance program for eligibility and other administrative purposes under such program, for statistical and research activities conducted by Federal and State agencies, and to the Secretary of the Treasury for the purposes of tax administration, debt collection, and identifying, preventing, and recovering improper payments under federally funded programs.

(iv) Payments to institutions required by clause (i)(II) shall be made from funds otherwise available for the payment of benefits under this subchapter and shall be treated as direct spending for purposes of the Balanced Budget and Emergency Deficit Control Act of 1985 [2 U.S.C. 900 et seq.].

(v)(I) The Commissioner may disclose information received pursuant to this paragraph to any officer, employee, agent, or contractor of the Department of the Treasury whose official duties require such information to assist in the identification, prevention, and recovery of improper payments or in the collection of delinquent debts owed to the United States, including payments certified by the head of an executive, judicial, or legislative paying agency, and payments made to individuals whose eligibility, or continuing eligibility, to participate in a Federal program (including those administered by a State or political subdivision thereof) is being reviewed.

(II) Notwithstanding the provisions of section 552a of title 5 or any other provision of Federal or State law, the Secretary of the Treasury may compare information disclosed under subclause (I) with any other personally identifiable information derived from a Federal system of records or similar records maintained by a Federal contractor, a Federal grantee, or an entity administering a Federal program or activity and may redisclose such comparison of information to any paying or administering agency and to the head of the Federal Bureau of Prisons and the head of any State agency charged with the administration of prisons with respect to inmates whom the Secretary of the Treasury has determined may have been issued, or facilitated in the issuance of, an improper payment.

(III) The comparison of information disclosed under subclause (I) shall not be considered a matching program for purposes of section 552a of title 5.

(J) For the purpose of carrying out this paragraph, the Commissioner of Social Security shall conduct peri-

odic computer matches with data maintained by the Secretary of Health and Human Services under subchapter XVIII or XIX. The Secretary shall furnish to the Commissioner, in such form and manner and under such terms as the Commissioner and the Secretary shall mutually agree, such information as the Commissioner may request for this purpose. Information obtained pursuant to such a match may be substituted for the physician's certification otherwise required under subparagraph (G)(i).

(2) No person shall be an eligible individual or eligible spouse for purposes of this subchapter if, after notice to such person by the Commissioner of Social Security that it is likely that such person is eligible for any payments of the type enumerated in section 1382a(a)(2)(B) of this title, such person fails within 30 days to take all appropriate steps to apply for and (if eligible) obtain any such payments.

(3) Notwithstanding anything to the contrary in the criteria being used by the Commissioner of Social Security in determining when a husband and wife are to be considered two eligible individuals for purposes of this subchapter and when they are to be considered an eligible individual with an eligible spouse, the State agency administering or supervising the administration of a State plan under any other program under this chapter may (in the administration of such plan) treat a husband and wife living in the same medical treatment facility described in paragraph (1)(B) as though they were an eligible individual with his or her eligible spouse for purposes of this subchapter (rather than two eligible individuals), after they have continuously lived in the same such facility for 6 months, if treating such husband and

wife as two eligible individuals would prevent either of them from receiving benefits or assistance under such plan or reduce the amount thereof.

(4)(A) No person shall be considered an eligible individual or eligible spouse for purposes of this subchapter with respect to any month if during such month the person is—

(i) fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the place from which the person flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the person flees, or, in jurisdictions that do not define crimes as felonies, is punishable by death or imprisonment for a term exceeding 1 year regardless of the actual sentence imposed; or

(ii) violating a condition of probation or parole imposed under Federal or State law.

(B) Notwithstanding subparagraph (A), the Commissioner shall, for good cause shown, treat the person referred to in subparagraph (A) as an eligible individual or eligible spouse if the Commissioner determines that—

(i) a court of competent jurisdiction has found the person not guilty of the criminal offense, dismissed the charges relating to the criminal offense, vacated the warrant for arrest of the person for the criminal offense, or issued any similar exonerating order (or taken similar exonerating action), or

(ii) the person was erroneously implicated in connection with the criminal offense by reason of identity fraud.

(C) Notwithstanding subparagraph (A), the Commissioner may, for good cause shown based on mitigating circumstances, treat the person referred to in subparagraph (A) as an eligible individual or eligible spouse if the Commissioner determines that—

(i) the offense described in subparagraph (A)(i) or underlying the imposition of the probation probation or parole described in subparagraph (A)(ii) was nonviolent and not drug-related, and

(ii) in the case of a person who is not considered an eligible individual or eligible spouse pursuant to subparagraph (A)(ii), the action that resulted in the violation of a condition of probation or parole was nonviolent and not drug-related.

(5) Notwithstanding any other provision of law (other than section 6103 of the Internal Revenue Code of 1986 and section 1306(c) of this title), the Commissioner shall furnish any Federal, State, or local law enforcement officer, upon the written request of the officer, with the current address, Social Security number, and photograph (if applicable) of any recipient of benefits under this subchapter, if the officer furnishes the Commissioner with the name of the recipient, and other identifying information as reasonably required by the Commissioner to establish the unique identity of the recipient, and notifies the Commissioner that—

(A) the recipient is described in clause (i) or (ii) of paragraph (4)(A); and

(B) the location or apprehension of the recipient is within the officer's official duties.

5. 42 U.S.C. 1382d provides in pertinent part:

Rehabilitation services for blind and disabled Individuals

(a) Referral by Commissioner of eligible individuals to appropriate State agency

In the case of any blind or disabled individual who—

(1) has not attained age 16; and

(2) with respect to whom benefits are paid under this subchapter,

the Commissioner of Social Security shall make provision for referral of such individual to the appropriate State agency administering the State program under subchapter V.

* * * * *

(d) Reimbursement by Commissioner to State agency of costs of providing services to referred individuals

The Commissioner of Social Security is authorized to reimburse the State agency administering or supervising the administration of a State plan for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973 [29 U.S.C. 720 et seq.] for the costs incurred under such plan in the provision of rehabilitation services to individuals who are referred for such services pursuant to subsection (a), (1) in cases where the furnishing of such services results in the performance by such individuals of substantial gainful activity for a continuous period of nine months, (2) in cases where such individuals receive benefits as a result of section 1383(a)(6) of this title (except that no reimbursement under this subsection shall be made for services furnished to any individual receiving such benefits for

any period after the close of such individual's ninth consecutive month of substantial gainful activity or the close of the month with which his or her entitlement to such benefits ceases, whichever first occurs), and (3) in cases where such individuals, without good cause, refuse to continue to accept vocational rehabilitation services or fail to cooperate in such a manner as to preclude their successful rehabilitation. The determination that the vocational rehabilitation services contributed to the successful return of an individual to substantial gainful activity, the determination that an individual, without good cause, refused to continue to accept vocational rehabilitation services or failed to cooperate in such a manner as to preclude successful rehabilitation rehabilitation, and the determination of the amount of costs to be reimbursed under this subsection shall be made by the Commissioner of Social Security in accordance with criteria determined by the Commissioner in the same manner as under section 422(d)(1) of this title.

(e) Reimbursement for vocational rehabilitation services furnished during certain months of nonpayment of insurance benefits

The Commissioner of Social Security may reimburse the State agency described in subsection (d) for the costs described therein incurred in the provision of rehabilitation services—

(1) for any month for which an individual received—

(A) benefits under section 1382 or 1382h(a) of this title;

(B) assistance under section 1382h(b) of this title; or

(C) a federally administered State supplementary payment under section 1382e of this title or section 212(b) of Public Law 93-66; and

(2) for any month before the 13th consecutive month for which an individual, for a reason other than cessation of disability or blindness, was ineligible for—

(A) benefits under section 1382 or 1382h(a) of this title;

(B) assistance under section 1382h(b) of this title; or

(C) a federally administered State supplementary payment under section 1382e of this title or section 212(b) of Public Law 93-66.

6. 42 U.S.C. 1382e(a) and (b) provide:

Supplementary assistance by State or subdivision to needy individuals

(a) Exclusion of cash payments in determination of income of individuals for purposes of eligibility for benefits; agreement by Commissioner and State for Commissioner to make supplementary payments on behalf of State or subdivision

Any cash payments which are made by a State (or political subdivision thereof) on a regular basis to individuals who are receiving benefits under this subchapter or who would but for their income be eligible to receive benefits under this subchapter, as assistance based on need in supplementation of such benefits (as determined by the Commissioner of Social Security), shall be ex-

cluded under section 1382a(b)(6) of this title in determining the income of such individuals for purposes of this subchapter and the Commissioner of Social Security and such State may enter into an agreement which satisfies subsection (b) under which the Commissioner of Social Security will, on behalf of such State (or subdivision) make such supplementary payments to all such individuals.

(b) Agreement between Commissioner and State; contents

Any agreement between the Commissioner of Social Security and a State entered into under subsection (a) shall provide—

(1) that such payments will be made (subject to subsection (c)) to all individuals residing in such State (or subdivision) who are receiving benefits under this subchapter, and

(2) such other rules with respect to eligibility for or amount of the supplementary payments, and such procedural or other general administrative provisions, as the Commissioner of Social Security finds necessary (subject to subsection (c)) to achieve efficient and effective administration of both the program which the Commissioner conducts under this subchapter and the optional State supplementation.

At the option of the State (but subject to paragraph (2) of this subsection), the agreement between the Commissioner of Social Security and such State entered into under subsection (a) shall be modified to provide that the Commissioner of Social Security will make supplementary payments, on and after an effective date to be specified in the agreement as so modified, to individuals re-

ceiving benefits determined under section 1382(e)(1)(B) of this title.

7. 42 U.S.C. 1382f(a) provides:

Cost-of-living adjustments in benefits

(a) Increase of dollar amounts

Whenever benefit amounts under subchapter II are increased by any percentage effective with any month as a result of a determination made under section 415(i) of this title—

(1) each of the dollar amounts in effect for such month under subsections (a)(1)(A), (a)(2)(A), (b)(1), and (b)(2) of section 1382 of this title, and subsection (a)(1)(A) of section 211 of Public Law 93-66, as specified in such subsections or as previously increased under this section, shall be increased by the amount (if any) by which—

(A) the amount which would have been in effect for such month under such subsection but for the rounding of such amount pursuant to paragraph (2), exceeds

(B) the amount in effect for such month under such subsection; and

(2) the amount obtained under paragraph (1) with respect to each subsection shall be further increased by the same percentage by which benefit amounts under subchapter II are increased for such month, or, if greater (in any case where the increase under subchapter II was determined on the basis of the wage increase percentage rather than the CPI in-

crease percentage), the percentage by which benefit amounts under subchapter II would be increased for such month if the increase had been determined on the basis of the CPI increase percentage, (and rounded, when not a multiple of $12, to the next lower multiple of $12), effective with respect to benefits for months after such month.

8. 42 U.S.C. 1382h provides:

Benefits for individuals who perform substantial gainful activity despite severe medical impairment

(a) Eligible individuals

(1) Except as provided in section 1383(j) of this title, any individual who was determined to be an eligible individual (or eligible spouse) by reason of being under a disability and was eligible to receive benefits under section 1382 of this title (or a federally administered State supplementary payment) for a month and whose earnings in a subsequent month exceed the amount designated by the Commissioner of Social Security ordinarily to represent substantial gainful activity shall qualify for a monthly benefit under this subsection for such subsequent month (which shall be in lieu of any benefit under section 1382 of this title) equal to an amount determined under section 1382(b)(1) of this title (or, in the case of an individual who has an eligible spouse, under section 1382(b)(2) of this title), and for purposes of subchapter XIX shall be considered to be receiving supplemental security income benefits under this subchapter, for so long as—

(A) such individual continues to have the disabling physical or mental impairment on the basis of

which such individual was found to be under a disability; and

(B) the income of such individual, other than income excluded pursuant to section 1382a(b) of this title, is not equal to or in excess of the amount which would cause him to be ineligible for payments under section 1382 of this title and such individual meets all other non-disability-related requirements for eligibility for benefits under this subchapter.

(2) The Commissioner of Social Security shall make a determination under paragraph (1)(A) with respect to an individual not later than 12 months after the first month for which the individual qualifies for a benefit under this subsection.

(b) Blind or disabled individuals receiving supplemental security income benefits

(1) Except as provided in section 1383(j) of this title, for purposes of subchapter XIX, any individual who was determined to be a blind or disabled individual eligible to receive a benefit under section 1382 of this title or any federally administered State supplementary payment for a month and who in a subsequent month is ineligible for benefits under this subchapter (and for any federally administered State supplementary payments) because of his or her income shall, nevertheless, be considered to be receiving supplemental security income benefits for such subsequent month provided that the Commissioner of Social Security determines under regulations that—

(A) such individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, meets all

non-disability-related requirements for eligibility for benefits under this subchapter;

(B) the income of such individual would not, except for his earnings and increases pursuant to section 415(i) of this title in the level of monthly insurance benefits to which the individual is entitled under subchapter II that occur while such individual is considered to be receiving supplemental security income benefits by reason of this subsection, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1382(b) of this title (if he were otherwise eligible for such payments);

(C) the termination of eligibility for benefits under subchapter XIX would seriously inhibit his ability to continue his employment; and

(D) such individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under this subchapter (including any federally administered State supplementary payments), benefits under subchapter XIX, and publicly funded attendant care services (including personal care assistance), which would be available to him in the absence of such earnings.

(2)(A) Determinations made under paragraph (1)(D) shall be based on information and data updated no less frequently than annually.

(B) In determining an individual's earnings for purposes of paragraph (1)(D), there shall be excluded from such earnings an amount equal to the sum of any amounts which are or would be excluded under clauses (ii) and (iv) of section 1382a(b)(4)(B) of this title (or un-

der clauses (ii) and (iii) of section 1382a(b)(4)(A) of this title) in determining his or her income.

(3) In the case of a State that exercises the option under section 1396a(f) of this title, any individual who—

(A)(i) qualifies for a benefit under subsection (a), or

(ii) meets the requirements of paragraph (1); and

(B) was eligible for medical assistance under the State plan approved under subchapter XIX in the month immediately preceding the first month in which the individual qualified for a benefit under such subsection or met such requirements,

shall remain eligible for medical assistance under such plan for so long as the individual qualifies for a benefit under such subsection or meets such requirements.

(c) Continuing disability or blindness reviews; limitation

Subsection (a)(2) and section 1383(j)(2)(A) of this title shall not be construed, singly or jointly, to require more than 1 determination during any 12-month period with respect to the continuing disability or blindness of an individual.

(d) Information and training programs

The Commissioner of Social Security and the Secretary of Education shall jointly develop and disseminate information, and establish training programs for staff personnel, with respect to the potential availability of benefits and services for disabled individuals under the provisions of this section. The Commissioner of Social

Security shall provide such information to individuals who are applicants for and recipients of benefits based on disability under this subchapter and shall conduct such programs for the staffs of the district offices of the Social Security Administration. The Secretary of Education shall conduct such programs for the staffs of the State Vocational Rehabilitation agencies, and in cooperation with such agencies shall also provide such information to other appropriate individuals and to public and private organizations and agencies which are concerned with rehabilitation and social services or which represent the disabled.

9. 42 U.S.C. 1395ww(d)(5)(F)(v) and (vi) provide:

Payments to hospitals for inpatient hospital services

(d) Inpatient hospital service payments on basis of prospective rates; Medicare

(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.

10. 20 C.F.R. 416.120(c)(1) provides:

General definitions and use of terms

(c) *Miscellaneous*. As used in this part unless otherwise indicated:

(1) *Supplemental security income benefit* means the amount to be paid to an eligible individual (or eligible individual and his eligible spouse) under title XVI of the Act.