No. 23-

In The
Supreme Court of the United States

ADVOCATE CHRIST MEDICAL CENTER, et al.,

Petitioners,

v.

XAVIER BECERRA, Secretary, U.S. Department of Health & Human Services,

Respondent.

On Petition for a Writ of Certiorari to the U.S. Court of Appeals for the D.C. Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Because low-income patients are often costlier to treat, Congress directed the government to reimburse hospitals that treat a disproportionate share of low-income patients at higher Medicare rates. A hospital qualifies for higher payments in part based on the number of days that a hospital provides inpatient care to senior (or disabled) low-income patients, measured as those who "were entitled to benefits under part A of [Medicare] and were entitled to supplementary security income [SSI] benefits." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).

In *Becerra v. Empire Health Foundation*, this Court agreed with the agency that "entitled to [Medicare part A] benefits" included "all those qualifying for the [Medicare] program," whether or not Medicare paid for that hospital stay. 597 U.S. 424, 445 (2022). But *Empire* expressly left open the question of whether "entitled to [SSI] benefits" likewise includes all those who qualify for the SSI program. *Id.* at 434 n.2. The agency still insists, contrary to its Medicare interpretation, that only patients who received an SSI cash payment for the month of their hospital stay are "entitled to benefits." This case thus presents *Empire's* open question:

Does the phrase "entitled … to benefits," used twice in the same sentence of the Medicare Act, mean the same thing for Medicare part A and SSI, such that it includes all who meet basic program eligibility criteria, whether or not benefits are actually received.

PARTIES TO THE PROCEEDINGS

Petitioners are:

Advocate Christ Medical Center a/k/a Advocate Christian Hospital
Advocate Condell Medical Center
Advocate Illinois Masonic Medical Center a/k/a Advocate Northside Health System
Advocate Sherman Hospital
Advocate South Suburban Hospital
Advocate Trinity Hospital; Andalusia Health a/k/a Andalusia Regional Hospital
Anderson Hospital
Ascension Borgess Hospital
Ascension Genesys Hospital
Ascension Macomb-Oakland Hospital Madison Heights Campus
Ascension Macomb-Oakland Hospital Warren Campus
Ascension Providence
Ascension Providence Hospital Southfield Campus
Ascension River District Hospital
Ascension Saint John Hospital, f/k/a Saint John Hospital and Medical Center
Ascension Saint Thomas Dekalb f/k/a Dekalb Community Hospital
Ascension Saint Thomas Highlands Hospital f/k/a Highlands Medical Center
Ascension Saint Thomas River Park
Ascension Saint Thomas Stones River Hospital
Ascension Saint Vincent Evansville f/k/a St. Mary's Medical Center
Ascension Saint Vincent Indianapolis Hospital f/k/a St. Vincent Hospital & Health Center
Ascension Saint Vincent's Birmingham a/k/a St. Vincent's Hospital
Ascension Seton Medical Center Austin a/k/a Seton Medical Center

Ascension Seton Northwest
Ascension Seton Williamson
Ascension St. Vincent Anderson
Ascension St. Vincent Kokomo f/k/a St. Joseph Hospital and Health Center
Ascension Saint Vincent's East
Ascension Saint Vincent's Riverside Hospital f/k/a St. Vincent's Medical Center
Ascension Saint Vincent's Southside Hospital f/k/a St. Luke's Hospital
Ashley Regional Medical Center f/k/a Ashley Valley Medical Center
Aspirus Riverview Hospital
Augusta Health a/k/a Augusta Medical Center
Baptist Easley
Baptist Health Floyd a/k/a Floyd Memorial Hospital
Baxter Regional Medical Center
Beaumont Hospital - Farmington Hills f/k/a Botsford General Hospital
Cape Regional Medical Center
Carle Foundation Hospital
Caromont Regional Medical Center f/k/a Gaston Memorial Hospital
Carondelet Heart & Vascular Institute f/k/a St. Mary's Hospital
Carondelet Saint Joseph's Hospital
Carondelet Saint Mary's Hospital
Castleview Hospital
Centegra Hospital – McHenry a/k/a Northern Illinois Medical Center
Centegra Hospital – Woodstock a/k/a Memorial Medical Center
Christus Good Shepherd Medical Center
Christus Good Shepherd Medical Center Marshall
Clark Memorial Hospital
Comanche County Memorial Hospital
Community Hospital a/k/a Community Healthcare System

Community Hospital Anderson
Community Hospital East a/k/a Community Hospitals of Indiana, Inc.
Community Hospital North
Community Howard Regional Health
Conway Regional Medical Center
Dearborn County Hospital
Dekalb Memorial Hospital
East Alabama Medical Center
Elkhart General Hospital
Fairfield Medical Center
Fayette Regional Health System
Firelands Regional Medical Center – Main Campus
Fitzgibbon Hospital a/k/a John Fitzgibbon Memorial Hospital
Flushing Hospital Medical Center
Franciscan Health Hammond a/k/a Franciscan Saint Margaret Health – Hammond Campus
Franciscan Health Indianapolis f/k/a Franciscan Saint Francis Health – Indianapolis
Franciscan Health Michigan City a/k/a Franciscan St. Anthony Health – Michigan City
Franciscan Health Olympia Fields Campus a/k/a Franciscan Alliance St. James Hospital and Health Center
Franciscan Saint Francis Health - Beech Grove Campus
Froedtert & Medical College of Wisconsin a/k/a Froedtert Memorial Lutheran Hospital
Good Samaritan Hospital
Gundersen Lutheran Medical Center
Hancock Regional Hospital
Havasu Regional Medical Center
HCA Florida Putnam Hospital f/k/a Putnam Community Medical Center
Healthmark Regional Medical Center
Henry Community Health a/k/a Henry County Memorial Hospital

High Point Regional Health
Holland Hospital
Indiana University Health Ball Memorial Hospital
Indiana University Health Bloomington Hospital
Indiana University Health Morgan Hospital
Iredell Memorial Hospital
Jackson Purchase Medical Center
Jamaica Hospital Medical Center
John H. Stroger, Jr. Hospital of Cook County
John T. Mather Memorial Hospital
Johnson Memorial Hospital
Karmanos Cancer Institute
Kent Hospital a/k/a Kent County Memorial Hospital
King's Daughters' Hospital & Health Services
La Porte Hospital
Lake Cumberland Regional Hospital
Lakeland Community Hospital
Little Company of Mary Hospital
Livingston Regional Hospital
Logan Memorial Hospital
Lourdes Hospital
Marion General Hospital
Mayo Clinic Health System in Eau Claire a/k/a Eau Claire Hospital
McLaren Bay Region
McLaren Central Michigan
McLaren Flint
McLaren Lapeer Region
McLaren Macomb
McLaren Oakland
McLaren Port Huron Hospital
Memorial Hospital a/k/a Memorial Hospital of South Bend
Memorial Hospital of Rhode Island
Memorial Medical Center
Mercy Health Partners – Hackley Campus
Mercy Health Partners – Mercy Campus

Mercy Health Saint Mary's a/k/a Saint Mary's Health Care
Mercy Regional Medical Center a/k/a Ville Platte Medical Center
Methodist Hospital
Methodist Hospital of Chicago
Methodist Hospitals–Northlake Campus
MHP Medical Center
Minden Medical Center
Mizell Memorial Hospital
Mount Carmel Saint Ann's a/k/a St. Ann's Hospital
Mount Carmel West
Mount Saint Mary's Hospital and Health Center
Mount Sinai Hospital
North Arkansas Regional Medical Center
North Georgia Medical Center
Northwest Medical Center
Northwestern Medicine Kishwaukee Hospital a/k/a Kishwaukee Community Hospital
Oak Forest Hospital of Cook County
Ohio Valley Medical Center
Opelousas General Hospital–South Campus a/k/a Doctors Hospital of Opelousas
Palestine Regional Medical Center
Palmetto Health Baptist
Palmetto Health Richland
Parkridge West Hospital a/k/a Grandview Medical Center
Parkview Regional Hospital
Parkview Regional Medical Center
Pleasant Valley Hospital
Princeton Community Hospital
ProMedica Bay Park Hospital a/k/a Bay Park Community Hospital
ProMedica Bixby Hospital a/k/a Bixby Medical Center
ProMedica Flower Hospital
ProMedica Monroe Regional Hospital f/k/a Mercy Memorial Hospital

ProMedica Toledo Hospital
Providence Hospital n/k/a USA Health Providence Hospital
Providence Hospital
Provident Hospital of Cook County
Raleigh General Hospital
Regional Medical Center of Orangeburg & Calhoun Counties a/k/a The Regional Medical Center
Reid Hospital
River Parishes Hospital
Riverview Health
RMC Anniston a/k/a Northeast Alabama Regional Medical Center
Rush-Copley Medical Center a/k/a Copley Memorial Hospital
Russell Medical Center
Saint Agnes Medical Center
Saint Bernard Hospital and Health Care Center
Saint Catherine Hospital
Saint Francis Hospital
Saint Francis Hospital Muskogee a/k/a Muskogee Regional Medical Center
Saint John Detroit Riverview Hospital a/k/a St. John Health
Saint John North Shores Hospital
Saint Joseph Mercy Livingston Hospital
Saint Joseph Mercy Oakland a/k/a St. Joseph Mercy Hospital
Saint Luke's Hospital
Saint Mary Medical Center
Saint Mary's Hospital a/k/a Seton Health System
Saint Mary's Hospital at Amsterdam a/k/a St. Mary's Healthcare
Saint Vincent's Blount
Saint Vincent's Medical Center
Saline Memorial Hospital
Schneck Medical Center a/k/a Jackson Co Schneck Memorial Hospital

Sidney and Lois Eskenazi Hospital f/k/a Wishard Memorial Hospital
Skokie Hospital a/k/a Rush North Shore Medical Center
South Shore Hospital
Southern Tennessee Medical Center – Winchester
Southern Tennessee Regional Health System–Lawrenceburg f/k/a Crockett Hospital
Southern Tennessee Regional Health Care–Pulaski f/k/a Hillside Hospital
Sovah Health – Danville f/k/a Danville Regional Medical Center a/k/a Danville Regional Hospital
Sovah Health – Martinsville f/k/a Memorial Hospital of Martinsville and Henry County
Spectrum Health Butterworth Hospital
St. Bernards Medical Center
Starke Hospital
Stonewall Jackson Memorial Hospital
Sumner Regional Medical Center
Thomas Memorial Hospital
UNC Lenoir Health Care a/k/a Lenoir Hospital
Unity Health White County Medical Center
University Medical Center at Brackenridge a/k/a Brackenridge Hospital
University of Illinois Medical Center
University of Iowa Hospitals & Clinics
University of Virginia Medical Center
Valley View Medical Center
Vanderbilt University Hospital
Vaughan Regional Medical Center
Virginia Hospital Center
WakeMed Cary Hospital
WakeMed Raleigh Hospital a/k/a WakeMed Raleigh Campus
Warren Memorial Hospital
Washington Regional Medical Center
Wayne UNC Health Care a/k/a Wayne Memorial Hospital, Inc.

Western Plains Medical Complex
Willamette Valley Medical Center
Winchester Medical Center
Witham Memorial Hospital
Women & Infants Hospital a/k/a Women & Infants Hospital of Rhode Island
Wooster Community Hospital

Petitioners were plaintiffs in the district court and appellants in the court of appeals.

Respondents Baptist Health Medical Center – Little Rock, Baptist Health Medical Center – North Little Rock, Baptist Health Medical Center – Hot Spring County, and Gwinnett Medical Center – Lawrenceville a/k/a Gwinnett Hospital System were plaintiffs in the district court and appellants in the court of appeals.

Respondent Xavier Becerra, Secretary, U.S. Department of Health & Human Services, was a defendant in the district court and appellee in the court of appeals.

CORPORATE DISCLOSURE STATEMENT

The following parent companies or publicly held companies have a 10 percent or greater ownership interest in the below-identified petitioner entities:

a. Petitioners Andalusia Health, Ashley Regional Medical Center, Castleview Hospital, Clark Memorial Hospital, Havasu Regional Medical Center, Jackson Purchase Medical Center, Lake Cumberland Regional Hospital, Livingston Regional Hospital, Logan Memorial Hospital, Memorial Medical Center, Palestine Regional Medical Center, Parkview Regional Hospital, Raleigh General Hospital, River Parishes Hospital, Southern Tennessee–Lawrenceburg, Southern Tennessee–Winchester, Southern Tennessee Regional Health Care–Pulaski, Sovah Health–Danville, Sovah Health–Martinsville, Sumner Regional Medical Center, Valley View Medical Center, Vaughan Regional Medical Center, and Willamette Valley Medical Center:

Apollo Global Management, LLC

b. Petitioners HCA Florida Putnam Hospital and Parkridge West Hospital:

HCA Healthcare, Inc.

c. Petitioner North Georgia Medical Center:

SunLink Health Systems, Inc.

d. Petitioners La Porte Hospital and Starke Hospital:

Community Health Systems, Inc.

e. For all other petitioners, there are no parent companies and no publicly held company owns 10% or more of the petitioner's stock.

STATEMENT OF RELATED PROCEEDINGS

This case arises from and is directly related to the following proceedings:

- *Advocate Christ Medical Center v. Azar*, No. 1:17-cv-1519, U.S. District Court for the District of Columbia. Judgment entered June 8, 2022.

- *Advocate Christ Medical Center v. Becerra*, No. 22-5214, U.S. Court of Appeals for the D.C. Circuit. Judgment entered Sept. 1, 2023.

There are no additional proceedings in any court that are directly related to this case.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners Advocate Christ Medical Center and more than 200 other Medicare-participating hospitals respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the D.C. Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App. 1-17) is reported at 80 F.4th 346. The opinion of the district court (App. 18-45) is not reported but is available at 2022 WL 2064830. The decision of the Administrator of the Centers for Medicare and Medicaid Services (App. 46-93) is not reported. The decisions of the Provider Reimbursement Review Board (App. 94-127) are not reported.

JURISDICTION

The judgment of the court of appeals was entered on September 1, 2023. No rehearing petition was filed. Chief Justice Roberts, Circuit Justice for the United States Court of Appeals for the D.C. Circuit, extended the time to file a petition for writ of certiorari to and including December 29, 2023. This Court's jurisdiction rests on 28 U.S.C. § 1254(1).

RELEVANT STATUTORY AND REGULATORY PROVISIONS

Pertinent statutory and regulatory provisions are reproduced in the appendix (App. 128-41). *See* 42 U.S.C. §§ 1381a; 1382(a),(b),(c),(e)(1)(A)-(B); 1382d; 1395ww(d)(5)(F)(vi).

INTRODUCTION

Petitioners are 209 hospitals in 32 States. Many of them are safety net or rural hospitals facing dire financial instability. They depend upon fair and accurate compensation to keep their doors open and maintain capacity to provide needed services to the Nation's most vulnerable patients.

The Secretary's internally inconsistent reading of "entitled to benefits"—within the same sentence of the same statute—deprives these front-line hospitals of the compensation Congress intended for serving a disproportionate share of low-income patients. The Court addressed part of this issue in its *Empire* decision; now is the time to answer the rest of the question and ensure consistency in implementing a core federal program.

After years of counting patients as "entitled" to a benefit only when that particular benefit was paid (whether the benefit was Medicare part A hospital coverage or supplemental security income (SSI) benefits), the agency flip-flopped its position—but only for Medicare part A, where the abrupt change reduced Medicare payments. *Empire* confirmed the agency's new position—entitled to benefits means eligible for benefits, whether or not paid—as the best reading of the statutory phrase "entitled to benefits." But *Empire* left open the implications of that interpretation for SSI benefits. For SSI benefits, where a corresponding change would *increase* payments to hospitals, the agency continues to consider a patient "entitled" only if she actually received an SSI cash payment for the month of hospitalization.

That internal inconsistency cannot be squared with the Court's understanding of the statute in *Empire* or with the statutory text. Review is urgently needed now. Left standing, the agency's cake-and-eat-it-too position threatens the financial viability of safety net hospitals and impairs their ability to treat low-income elderly and disabled patients and serve their broader communities.

Conclusively resolving the question presented is also essential to forestall continued litigation arising from the agency's inability to otherwise get payments right. Absent this Court's review, the host of practical problems created by the agency's internally inconsistent statutory interpretation will engender never-ending calculation-by-calculation challenges, none of which will solve the fundamental statutory interpretation problem. Only a consistent interpretation of "entitled to benefits" can remain true to the statutory scheme and yield the clear lines that *Empire* recognized were essential for this critical health care program to work. To vindicate congressional intent, hospital compensation must hinge on a stable measure of a patient's statutory status, not on the agency-created vicissitudes of month-by-month payments.

STATEMENT OF THE CASE

A. Statutory and Regulatory Background.

Two federal programs figure in calculating the hospital reimbursements at issue here, Medicare and Supplemental Security Income (SSI).

1. The Medicare program "provides Government-funded health insurance to" a large and growing number—over 66 million—of "elderly or disabled Americans." *Becerra v. Empire Health Found.*, 597 U.S. 424, 428 (2022); Ctrs. for Medicare & Medicaid Servs., *Medicare Monthly Enrollment* (Aug. 2023), https://tinyurl.com/2dntzyb9. "Part A" of Medicare covers inpatient hospital care. *Empire*, 597 U.S. at 428. Individuals 65 and older or those who have been entitled to federal disability benefits for 24 months are "entitled" to Medicare part A benefits. 42 U.S.C. § 426(a)-(b). That "'entitlement' coexists with limitations on payment" of benefits. *Empire*, 597 U.S. at 425. For example, Medicare part A generally will not pay for more than a 90-day hospital stay for a single spell of illness. *Id.* at 426; *see* 42 U.S.C. § 1395d(a)(1).

For payments to hospitals, Medicare starts with "a fixed rate for treating each Medicare patient, … regardless of the hospital's actual costs." *Empire*, 597 U.S. at 429. But Congress required an adjustment to this fixed rate for certain hospitals, because "hospitals with an unusually high percentage of low-income patients generally have higher per-patient costs." *Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 150 (2013). Through this Disproportionate Share Hospital (DSH) adjustment, the Medicare "reimbursement amount is adjusted upward for hospitals that serve a disproportionate share of low-income patients." *Id.* at 149-50.

To "calculate a hospital's DSH adjustment, [the agency] adds together two statutorily described fractions," usually called the Medicare and Medicaid fractions. *Empire*, 597 U.S. at 429. The fractions' key

inputs include the number of days the hospital provided inpatient care to patients who participate in three different government programs: Medicare part A, Medicaid, and SSI. Each program is governed by a different title of the Social Security Act: title XVIII (Medicare part A); title XIX (Medicaid); and title XVI (SSI).

The Medicare fraction "represents the proportion of a hospital's Medicare patients who have low incomes, as identified by their entitlement to supplementary security income (SSI) benefits." *Id.* at 429-30. The Medicaid fraction reflects the share of a hospital's non-Medicare patients who "have low incomes, as identified by their eligibility for Medicaid." *Id.* at 430.

This case involves the Medicare fraction, which turns on the number of patients who are entitled to both Medicare part A and SSI, and specifically when a patient becomes "entitled" to SSI benefits.

2. SSI is "a 'welfare program' providing benefits to 'financially needy individuals' who (like Medicare patients generally) are over 65 or disabled." *Id.* (quoting *Bowen v. Galbreath*, 485 U.S. 74, 75 (1988)).

The SSI program was created "[t]o assist those who cannot work because of age, blindness, or disability." *Schweiker v. Wilson*, 450 U.S. 221, 223 (1981) (quoting S. Rep. No. 92-1230, at 4 (1972)) (alteration in original). From its inception, the program has included multiple benefits; not only income support, but also services to help people with disabilities return to work. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, § 301, 86 Stat. 1329, 1474. Congress recognized that "if the

opportunity for rehabilitation for suitable work were available to [people with disabilities], they could become self-supporting." S. Rep. No. 92-1230, at 390.

SSI benefits thus include not only cash assistance payments, 42 U.S.C. §§ 1382(b), 1382h, but also non-cash benefits like "[r]ehabilitation services for blind and disabled individuals," *id.* § 1382d. SSI beneficiaries are also entitled to medical benefits by virtue of qualifying for SSI. In most States, SSI beneficiaries are automatically eligible for Medicaid. *See* Soc. Security Admin., *Medicaid Information*, https://tinyurl.com/239zj99n. Individuals who are "recipients of [SSI] benefits under subchapter XVI" are also eligible for a subsidy that covers the cost of prescription drug plan premiums under Medicare part D. 42 U.S.C. § 1395w-114(a)(3)(B)(v).

SSI's "[b]asic eligibility for benefits" under title XVI includes "[e]very aged, blind, or disabled individual who is determined … to be eligible on the basis of his income and resources." Social Security Act § 1602, 86 Stat. at 1465 (codified at 42 U.S.C. § 1381a with title "Basic entitlement to benefits"). Each such person "shall, in accordance with and subject to the provisions of this [title], be paid benefits by the [Commissioner of Social Security]." *Id.*

The statute further specifies that "[e]ach aged, blind, or disabled individual" whose annual income and resources meet specified criteria "shall be an eligible individual for purposes of [title XVI]." 42 U.S.C. § 1382(a). Eligibility for cash payments is determined monthly based on the individual's "income, resources, and other relevant characteristics in such month." *Id.* § 1382(c).

Because payment of SSI benefits is "subject to the provisions of this [title XVI]," *id.* § 1381a, an "eligible individual," *id.* § 1382(a), will not receive a cash payment in some months for various reasons carved out by Congress or the Social Security Administration. For example, no payment is due the first month a person is eligible. *Id.* § 1382(c)(7). In addition, "eligible individuals" residing in certain facilities (like some nursing homes) have their payment amount reduced to $0 if their income exceeds $30 (on the theory that the nursing home will meet their basic subsistence needs). *Id.* § 1382(e)(1)(B); S. Rep. No. 92-1230, at 386.

Other reasons, ranging from the mundane to the more substantive, could prevent an "eligible individual" from receiving a cash payment in any given month. If, for example, paying an individual directly "would cause substantial harm," the Commissioner may "defer … or suspend … direct payment" until a "representative payee" is identified. 42 U.S.C. § 1383(a)(2)(B)(viii). Payment may also be suspended for a slew of other administrative reasons, including (quite commonly) lack of a current mailing address. *See* 20 C.F.R. § 416.1320(a); *see also* C.A.J.A. 153 (describing payment suspensions for returned checks or refusal to accept direct deposit). "Whereabouts unknown" ranked as the second most common reason for suspension of SSI payments in 2021. Soc. Security Admin., *Annual Statistical Report 2021*, tbl. 76, https://tinyurl.com/y4s7yxv8 ("2021 Statistical Report").

The cash payment benefit may also be suspended for failure to meet income and resource criteria in a given month. Even then, the individual remains enrolled in SSI and eligible for other SSI benefits, as

Congress recognized the need for continued support as income fluctuates. *See infra* at 27-28. Congress, for example, required continued payment of SSI vocational rehabilitation benefits for 12 months when payment of cash benefits is suspended for reasons other than cessation of disability or blindness. 42 U.S.C. § 1382d(e)(2); 20 C.F.R. § 416.2215.

Vocational rehabilitation services are provided to SSI beneficiaries by state agencies or private organizations and reimbursed through either the Ticket to Work model, 42 U.S.C. § 1320b-19, or (for state agencies) the traditional model, *id.* § 1382d(d)-(e). These services include physical rehabilitation, assistive technology, vocational training, and a host of other "goods and services" that assist with employment. *See* 20 C.F.R. § 416.2214(b). Such benefits are far from de minimis. In 2022, an average of over $13,000 in goods and services was provided to each SSI beneficiary who achieved substantial gainful employment objectives. *See* 42 U.S.C. § 1382d(d); Soc. Security Admin., *VR Reimbursement Claims Processing*, https://tinyurl.com/mryr45e7.

3. Turning back to the Medicare DSH formula, recall that it consists of two fractions "designed to capture two different low-income populations that a hospital serves." *Empire*, 597 U.S. at 429. The Medicare fraction, at issue here, "is a measure of a hospital's senior (or disabled) low-income population." *Id.* at 430. Its calculation turns on counting days for patients who are "entitled" to Medicare part A and SSI benefits. The numerator includes days for patients who are entitled to both Medicare part A and SSI benefits, and the denominator is days for all Medicare part A patients. *Id.*

Under the statute, the key measure is the number of "days … [for] patients who (for such days) were entitled to benefits under part A of [Medicare] and were entitled to [SSI] benefits … under [title] XVI." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The statute excludes from the SSI-entitled category any patients whose only benefit under title XVI is "State supplementation." *Id.*[1]

a. Since enactment of the DSH statute in 1986, a key (and oft-litigated) question has been who counts as "eligible" for or "entitled" to the different benefits within the formula. The agency has not been consistent in its understanding of this phrase, across time, or within the same sentence.

The Medicare and SSI programs both specify eligibility criteria alongside constraints on when benefits are paid. For Medicare part A, individuals qualify once they turn age 65 or if they have received disability benefits for 24 months. 42 U.S.C. § 426(a)-(b). Medicare nonetheless may not pay for qualifying patients' hospital stays due to statutory criteria limiting Medicare payments. *See Empire*, 597 U.S. at 432. For example, Medicare usually will not pay for a hospital stay if it is covered by other insurance, or for more than 90 days of hospitalization for a single "spell of illness." 42 U.S.C. §§ 1395d, 1395y(b)(2)(A).

When first implementing the DSH statute, the agency considered the question of whether patients

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[1] "State supplementation" happens when States provide "further assistance to needy residents," including payments to those whose incomes exceed the threshold for federal SSI cash benefits. *See Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252, 1254 (D.C. Cir. 2023); 42 U.S.C. § 1382e.

who qualify for Medicare are "entitled to benefits under part A of [Medicare]" on days that Medicare part A does not pay for their hospital care. The agency initially said no; a patient was entitled to Medicare part A benefits only on days that Medicare part A actually paid for their hospital care. 51 Fed. Reg. 31,454, 31,460-61 (Sept. 3, 1986). The agency applied the same interpretation to "entitled to [SSI] benefits." *See id.* at 31,459.

In 2004, however, the agency changed its interpretation of "entitled"—but just for Medicare part A benefits—concluding that a patient is so "entitled" if "he qualifies for the Medicare program," "even when Medicare is not paying for part or all of his hospital stay." *Empire*, 597 U.S. at 428. This change generally reduced Medicare payments to hospitals. *Id.* at 433.

b. Changing its interpretation of "entitled" to SSI benefits to match would have increased DSH payments. The agency declined to make this parallel change. Thus, for SSI benefits (only), the agency continues to count a patient as "entitled" to benefits only if a patient received an SSI cash payment for the month of their hospital stay. 75 Fed. Reg. 50,042, 50,280-281 (Aug. 16, 2010); *see* App. 2 (The agency "understands this population to include only patients receiving cash payments during the month in question."). Focusing only on the cash assistance paid to some SSI beneficiaries—without mention of non-cash SSI benefits—the agency explained that "eligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month." 75 Fed. Reg. at 50,280. Absent

receipt of a cash benefit payment, the agency does not consider an SSI-eligible person to be SSI-entitled. *Id*.[2]

The agency thus continues to exclude from its count of SSI-entitled patients several categories of people who are "entitled" in the Medicare understanding of that term (as affirmed in *Empire*). These agency-crafted carve-outs exclude patients who meet eligibility criteria for SSI cash payments but for whom payment is not due or has been suspended for a host of variable administrative reasons. They also exclude patients who meet annual income eligibility criteria and are eligible for non-cash SSI benefits (like vocational rehabilitation services) but to whom cash payments are not due for the relevant month. *See* 75 Fed. Reg. at 50,280-281.

B. Factual and Procedural Background.

1. Hospitals dissatisfied with their Medicare reimbursement may file an appeal with the Provider Reimbursement Review Board. *See Auburn Reg'l Med. Ctr*., 568 U.S. at 148; 42 U.S.C. § 1395oo(a). Petitioners, 209 hospitals located across the country,

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[2] Excluded from the agency's understanding of those "entitled to SSI benefits" are even those who did receive SSI payments for the hospital month in question, but just didn't receive them in time. The agency calculates the Medicare fraction using a report from the Social Security Administration that post-dates the end of the fiscal year. *See* 75 Fed. Reg. at 50,283. Because of that timing, the fraction "account[s] for … the lifting of SSI payment suspensions through" the date of the report. *Id.* at 50,282. The agency does not, however, count as "entitled" any SSI-eligible patients who have not yet received retroactive payment by that time—even if payment is due but suspended for an administrative reason.

including safety net hospitals providing care in historically underserved areas, filed such an appeal challenging the calculation of their Medicare fractions for 2006 to 2009. App. 18; 26.

Petitioners produced evidence that the agency had substantially undercounted the number of patients they treated who were entitled to SSI benefits and therefore under-reimbursed them by hundreds of millions of dollars. *See* App. 106-07; 123-24. The agency violated the Medicare Act, petitioners argued, by limiting the count of SSI-entitled patients to only those who received SSI cash payments for the month of their hospital stay, as opposed to including all those meeting basic SSI program eligibility criteria (the standard used for Medicare Part A entitlement). App. 105; 122. The Board held it lacked authority to grant relief on a challenge to the agency's methodology. App. 110; 126-27.

The Administrator of the Centers for Medicare and Medicaid Services reviewed the Board's decision and rejected the hospitals' challenge to the agency's interpretation of "entitled to [SSI] benefits." App. 46-93.

2. The hospitals then sought review of the Administrator's decision in district court. Holding that the phrase "entitled to [SSI] benefits" was ambiguous, App. 32-37, the district court deferred to the agency's interpretation under *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), App. 37-40.

The D.C. Circuit affirmed. The court held that the only SSI benefits under title XVI were "cash payments for needy individuals who are aged, blind, or disabled,"

and therefore the agency reasonably limited the SSI-entitled category to patients who received cash payments. App. 8-10. The court concluded that non-cash benefits for SSI beneficiaries (like vocational rehabilitation services) were irrelevant because they were "housed" outside of title XVI (at least in part). App. 10-11.

The court discounted the relevance of *Empire* and its interpretation of "entitled to benefits" for Medicare part A based on two distinctions it perceived between Medicare part A and SSI: First, "Part A benefits extend well beyond payment for specific services at specific times." App. 13. Second, the court believed that individuals gain and lose SSI eligibility more readily than they do Medicare. App. 13. The court thus "agree[d] that the Secretary offered the correct interpretation of the Medicare fraction, … without considering any question of *Chevron* deference." App. 14.[3]

REASONS FOR GRANTING THE PETITION

The Court's decision in *Empire* makes three points about the meaning of "entitled to benefits" for Medicare part A benefits. All three hold equally true for SSI benefits.

First, counting all patients who meet program eligibility criteria as "entitled" furthers the purpose of

[3] The court also rejected petitioner hospitals' claims that "even under [the agency's] own construction of the Medicare Act, its matching process was arbitrary and capricious," App. 14, and denied "an order compelling [the agency] to provide" certain "data to verify or challenge [its] calculation of their respective Medicare fractions," App. 15. Petitioners do not renew those claims here.

the Medicare DSH program, by ensuring that low-income patients are not excluded due to some administrative happenstance of program payment. Yet the agency's approach excludes even patients who meet SSI income and resource tests for cash payment in a given month but did not receive a payment for some administrative reason like an invalid mailing address—as well as other patients who meet program eligibility criteria.

Second, defining entitlement by statutory eligibility criteria ensures that the DSH program's structure is guarded by clear congressionally crafted lines, not fuzzy agency-created ones. The latter has patients ping-ponging into and out of fractions when Social Security changes the payment rules. Just as focusing on Medicare eligibility criteria, rather than payment, maintains the static structure essential for the DSH program to function, focusing on whether a patient meets SSI program eligibility criteria provides needed stability, versus tracking the vagaries of payment receipt from month to month. Statutory eligibility criteria also better serve the statutory purpose of measuring the low-income population that will often present complications that make their hospital care more costly. Such complications don't vanish just because Social Security suspended their cash payment one month.

Third, *Empire* also recognized that a person can meet statutory eligibility criteria for benefits—and thus be entitled—even when limitations may apply for payment of certain benefits. Despite the D.C. Circuit's attempt to distinguish the programs, SSI benefits work much the same as Medicare benefits in this regard. A person can have applied, and have been

determined to be eligible for SSI, yet still not receive a cash payment in a given month for many different reasons. And, just as a Medicare patient might be able to receive skilled nursing care even when Medicare no longer pays for inpatient treatment, Congress designed the SSI program to provide non-cash benefits that help SSI beneficiaries transition away from cash assistance. SSI benefits encompass more than cash payments.

The logic underlying *Empire*'s interpretation of "entitled to benefits under [Medicare] part A" thus applies with equal force to "entitled to [SSI] benefits" within the same sentence. Review is needed now of the agency's contrary view, endorsed by the D.C. Circuit.

The question is of exceptional importance to hospitals, especially safety net hospitals that treat the lion's share of the poorest patients. Many such hospitals are already on the verge of closing their doors. Shortchanging them on DSH payments by undercounting SSI-entitled patients has an outsized impact on the Nation's most financially stressed hospitals.

No meaningful path exists to solve the problem, except to fix the agency's inconsistent statutory approach by answering this question that was expressly reserved in *Empire*. Otherwise, atextual insistence on equating SSI entitlement to the happenstance of payment requires the agency, every year, to conduct an error-prone count using highly variable data about payment status.

There is no need to wait and every reason to resolve the question now. Case after case shows that the agency can't get it right. Absent review, hospitals

will continue to challenge the arbitrariness of the agency's process. But even if successful, such ad hoc cases cannot solve the systematic problem. All they can do is embroil the agency and the courts in repeated litigation. Without review, such cases will keep coming, given the insurmountable timing and data obstacles created by the agency's payment-required approach and its lack of transparency regarding the data underlying its decision-making.

Granting review here would obviate the need for such endless litigation and restore the clean statutory line that Congress crafted: counting all "eligible individual[s]" under the SSI statute. This case presents an ideal vehicle to address the question, which is crucially important for safety net hospitals and the vulnerable patients they serve.

I. The Question Presented, Left Open In *Empire*, Is Exceptionally Important And Recurring.

A. Accurate Medicare Payments Are Crucial for Hospitals' Continued Capacity to Serve Needy Patients.

Accurate implementation of the Medicare DSH program is essential. Undercounting the most vulnerable patients—who are the costliest to treat, the *raison d'etre* of the DSH program—poses a survival threat to hospitals that serve low-income communities.

Safety net hospitals face negative operating margins and significant financial instability. *See* America's Essential Hospitals, *Essential Data 2023*, at

13 (Oct. 2023), https://tinyurl.com/bdcpuhmk (reporting operating margin of -8.6% in 2021 for member safety net hospitals, versus -1.4% for all acute care hospitals). Unsurprisingly, financial insolvency is a major driver of hospital closures. Lukas K. Gaffney & Kenneth A. Michelson, *Analysis of Hospital Operating Margins and Provision of Safety Net Services*, JAMA Network Open, at 9 (Apr. 18, 2023), https://tinyurl.com/4e3wdtxr. Hundreds of hospitals have either closed in the past decade or are at risk of closing, especially in rural areas, where the population tends to be older, sicker, poorer, and more likely to be disabled. *See* Ctrs. for Disease Control, *About Rural Health* (Nov. 28, 2023), https://tinyurl.com/mjwmb9aw; Brian Thiede et al., *6 Charts that Illustrate the Divide Between Rural and Urban America*, PBS NewsHour (Mar. 17, 2017), https://tinyurl.com/44hszwu7. At least 130 rural hospitals closed between 2010 and June of 2020. *See* Ayla Ellison, *State-by-State Breakdown of 130 Rural Hospital Closures*, Becker's Hosp. CFO Rep. (June 8, 2020), https://tinyurl.com/yy439yyv.

But this is not just a rural problem. Hospitals "in urban areas that serve a disproportionate amount of uninsured or publicly insured patients are in trouble too." Judith Garber, *What Happens When Safety Net Hospitals Close?*, Lown Inst. (May 4, 2023), https://tinyurl.com/mrbs986x (describing several recent closures in major urban areas).

Because both safety net hospitals and the SSI program, by definition, serve the very poor, the meaning of SSI-entitlement (and the importance of accurately capturing the magnitude of the costs of serving vulnerable patients) is especially important

for the hospitals that are the most financially stressed. *See* Gaffney & Michelson, *supra*, at 4 & tbl. 2.

By undercompensating hospitals for the added costs of providing care to low-income patients, the agency's artificially constrained interpretation of "entitled to [SSI] benefits" magnifies the financial strain on these safety net hospitals. This upside-down result contravenes Congress's intent in providing the DSH adjustment, which was to ease the financial burden of providing such care. For the years in question, Petitioners estimate the agency's parsimonious interpretation of "entitled to [SSI] benefits" reduced hospitals' DSH payments by approximately $1.5 billion annually nationwide.

The neediest patients pay the price, traveling farther and waiting longer for care, if they can obtain it at all. *See* U.S. Gov't Accountability Off., GAO-21-93, Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services (2020), https://tinyurl.com/2s442zt9 (rural hospital closures increased distance to care); Garber, *supra* (describing how urban closures result in longer emergency wait times at nearby hospitals).

Even when hospitals manage to keep their doors open, funding shortfalls require them to curtail crucial services. *See, e.g.*, Shannon McConville, *Mounting Concerns about Safety Net Hospital Closures*, Pub. Pol'y Inst. Cal. (June 12, 2023), http://tinyurl.com/3nvt36wn (describing "severe service cuts" at several California safety net hospitals). By reducing compensation to hospitals already operating on the brink of insolvency, improperly suppressed DSH payments leave patients served by safety net hospitals in peril.

B. Absent Review, the Agency's Blinkered Reading of "Entitled" Will Continue to Thwart Accurate DSH Payments and Engender Seriatim Challenges.

Even if implemented with perfect accuracy, the validity of the agency's payment-required approach would be a crucially important question, because the agency's rule systematically undercounts low-income Medicare patients. But the negative impact of the agency's (non-)statutory approach is even worse—and the importance of the question presented all the greater—because the agency's approach is unworkable.

Absent review of the statutory question presented, the agency's decision to use a receipt-of-SSI-payment proxy—in lieu of the statutory SSI-eligibility bright line that Congress intended—will continue to generate flawed DSH payments. As the Court recognized in *Empire*, linking entitlement to payments, rather than eligibility criteria, "result[s] in patients ping-ponging back and forth" between the DSH fraction components based on "happenstance." 597 U.S. at 443. The agency cannot accurately account for that sort of happenstance in the SSI program. And the agency's inevitable errors will generate repeated calculation-specific challenges by hospitals.

The Court should grant review to pretermit this wave of litigation by restoring Congress's clear and workable SSI-eligibility line.

1. The agency's atextual and internally-inconsistent-within-the-same-sentence choice to tie SSI entitlement to receipt of an SSI payment makes the result highly dependent on when and how the

agency calculates the Medicare fraction. The agency calculates the fraction by "matching … Medicare billing records to individual SSI records." *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, 23 (D.D.C. 2008). This "matching" process creates a series of practical difficulties.

SSI-eligible patients may not receive cash payments until well after their hospital stays are over. *See id.* at 42. And the agency only counts patients who have received an SSI payment as of the match date—15 months after the close of each federal fiscal year. 75 Fed. Reg. at 50,282; *see also supra* note 2. The agency's cabined reading of "entitled" means SSI-eligible patients are counted (or not) based on administrative happenstance, like when a Social Security field office obtains a valid mailing address or finally makes a retroactive payment for allowed benefits, which can take far longer than 15 months. *See* Off. of the Inspector Gen. Soc. Sec. Admin., Audit Rep. No. A-01-10-10177, *Disability Insurance and Supplemental Security Income Claims Allowed But Not Paid*, at 6 (June 20, 2011), https://tinyurl.com/4fcpc2dh (in cases with errors, recipients waited 24 months, on average, for retroactive payment after agency decided to allow benefits). Given that payments are often suspended even for individuals who are undisputedly entitled to cash payments, refusing to count patients unless and until administrative suspensions are resolved puts far too much weight on a match process that has proved it cannot bear it.

After a court ruled that the agency had "us[ed] a flawed process" that "caused a systematic undercalculation of the disproportionate share adjustment" for decades, *Auburn Reg'l*, 568 U.S. at

151, the agency changed the process, *see* 75 Fed. Reg. at 50,277-84. Petitioners do not renew here their claims that the process remains arbitrary. *See* App. 14. But even this purportedly better process can't fix the fundamental problem of hinging SSI entitlement on payment, because there is no easy way to get the payment count right. On the other hand, counting all patients who meet basic SSI program eligibility criteria would use a metric that—besides being the line chosen by Congress—has the added benefit of being much less variable and subject to latency.

2. Absent this Court's review of the threshold question of whether the agency should even be in the SSI-payment-tracking business, scores of calculation-specific challenges are waiting in the wings—and will continue to arise. And there is no realistic possibility that these case-by-case challenges will fix the system, because they are hampered by the agency's refusal to provide hospitals the necessary data.

Recognizing that accurate DSH payments are essential for hospitals, Congress tried to provide hospitals with tools to help check the agency's work. Specifically, since 2003, Congress has required the agency to provide hospitals the "data necessary" for the hospital to "compute the number of patient days" used in its Medicare fraction. *See* Pub. L. No. 108-173, § 951, 117 Stat. 2066, 2427 (2003). In practice, however, compliance has fallen short of the data mandate's promise.

The agency only "tells the hospital which of its patient days … have been matched to patients entitled to SSI benefits" (within the agency's narrow interpretation of "entitled"). *Pomona*, 82 F.4th at 1255. Despite the statutory data mandate, 117 Stat. at 2427,

the agency only requests from Social Security the identifying information for patients assigned three codes purportedly denoting actual receipt of payment and does not request or provide to hospitals the codes that indicate any patient's SSI eligibility or payment status. App. 6 & n.1; 75 Fed. Reg. at 50,276.

It is therefore near impossible for hospitals to cross-check the agency's calculations. But whenever hospitals have been able to peek behind the curtain, even in part, widespread problems are revealed.

By using data for state benefit programs that piggyback on SSI eligibility, hospitals have been able to show that the agency isn't coming close to getting payments right, even under its own approach. In one case, a hospital produced unrebutted evidence that the agency's "matching process missed thousands of Medicare patient days attributable to patients who qualified for SSI benefits," reducing DSH payments for that single hospital by about $3 million over the course of three years. *See Pomona*, 82 F.4th at 1256, 1259. Before the Board, Petitioners similarly produced evidence of patients they treated whose Medicaid eligibility codes indicated they were eligible for Medicaid due to their SSI eligibility, but who were not counted as SSI-entitled. App. 106-07; 123-24. For one hospital, the data showed that in fiscal year 2008, inpatient days for SSI-entitled Medicare patients were up to seven times higher than the agency's count. C.A.J.A. 318. An analysis of Social Security's public use files indicates that for the hospitals and fiscal years before the Court, the agency undercounted SSI days by an average of about 30%, resulting in a 17% cut in DSH payments, or over $300 million.

And these cases are just the tip of the iceberg. In total, Petitioners' counsel alone represents about 460 hospitals with challenges related to these issues covering approximately 2000 fiscal years, including nine cases stayed in district court (D.D.C.) pending the outcome here, and another 129 cases backlogged at the Provider Reimbursement Review Board.[4] Analysis of public use files suggests a cumulative reduction in DSH payments to these hospitals of approximately 15% from 2006-2020.

Absent review, these substantial underpayments not only threaten the survival of hospitals serving the neediest patients but will generate hundreds of calculation-specific challenges to the agency's errors. These systematic undercounts are the result of the agency's overcomplicated methodology that wrongly substitutes payment of cash benefits—a much narrower, more variable and difficult to track criterion—for "entitlement" to SSI benefits as Congress required. The agency's inability to accurately implement its (wrong) statutory choice—a problem that cannot meaningfully be solved in calculation-by-calculation litigation—underscores the

[4] The stayed cases include: *Andalusia Health v. Azar*, No. 18-cv-01756-TSC; *Advocate Christ Med. Ctr. v. Becerra*, No. 20-cv-00199-TSC; *Community Hosp. E. v. Azar*, No. 20-cv-00891-TSC; *Christus Good Shepherd Med. Ctr. Longview v. Azar*, No. 20-cv-01413-TSC; *Aultman Hosp. v. Cochran*, No. 21-cv-00332-TSC; *Advocate Christ Med. Ctr.*, No. 21-cv-02148-TSC; *Ascension Saint Thomas Highlands Hosp. v. Becerra*, No. 21-cv-02453-TSC; *Baxter Reg'l Med. Ctr. v. Becerra*, No. 21-cv-03091-TSC; *Anderson Hosp. v. Becerra*, No. 22-cv-00219-TSC.

urgent need for review of the agency's internally inconsistent reading of "entitled to benefits."

II. The Agency's Interpretation Contravenes The Statutory Text And Is Inconsistent With *Empire*.

Surveying the Medicare Act, *Empire* concluded that "entitled to benefits" under Medicare part A means qualifying for the program, with entitlement to payment under certain conditions. 597 U.S. at 434-37. SSI fundamentally works the same way: a person is an "eligible individual" if they meet certain criteria, and that eligibility entitles them to cash payments under certain conditions. The only reading of "entitled to benefits" that is consistent with *Empire*'s understanding of the DSH statute—and harmonizes the two uses of the phrase within the same sentence—is thus the Medicare reading: A person is "entitled to [SSI] benefits under [title] XVI" if they meet the eligibility criteria for title XVI benefits, regardless of whether a cash payment is due (much less received) for the month of their hospital stay.

The D.C. Circuit's endorsement of the agency's approach—which excludes individuals who meet SSI-eligibility criteria during their hospital stays—is inconsistent with both this Court's precedent and the statutory text. If left standing, hospitals and the communities they serve will pay the price.

A. The D.C. Circuit's Decision Cannot Be Squared with *Empire*.

The D.C. Circuit's endorsement of the agency's narrow construction of "entitled to [SSI] benefits" flies

in the face of *Empire's* analysis of the structure and purpose of the DSH statute.

1. As *Empire* explains, the DSH formula's two-fraction approach creates a "two-population structure" whereby a "low-income Medicare patient always counts in the Medicare fraction." 597 U.S. at 442. Given the statute's purpose of accurately identifying hospitals that treat a high number of low-income patients, the Court accepted the agency's interpretation of "entitled to [Medicare part A] benefits" because it avoided the possibility that a "low-income patient" might not "get counted at all," even though "that person remains just as low income as he ever was, imposing just as high costs on the hospital treating him." *Id.* at 443-44.

Yet the agency's conflicting payment-required approach to SSI entitlement guarantees that many low-income patients—including those meeting the eligibility criteria for SSI cash benefits—will not get counted as Congress intended. For example, every SSI beneficiary hospitalized within the month they are first determined to meet SSI program criteria will be excluded because they are in their first month of eligibility. *See* 75 Fed. Reg. at 50,280.

Still others are excluded for the many non-income-related reasons that Social Security suspends payments. *See id.* at 50,282 (counting only patients where suspensions have been lifted and retroactive payment manually issued). The agency's atextual imposition of an additional constraint—timely receipt of a cash SSI payment—on the low-income proxy selected by Congress (entitlement to SSI benefits) seriously undermines Congress's intent to accurately

compensate DSH hospitals that serve low-income populations.

2. The *Empire* Court emphasized, moreover, the need for bright lines and clear categories in the DSH formula, to avoid patients "ping-ponging back and forth … based on the happenstance of actual Medicare payments, sometimes during a single hospital stay." *Id.* at 427. But the agency's atextual engrafting of a timely-receipt-of-payment factor for SSI fosters just such unnecessary ping-ponging (in and out of the Medicare fraction numerator).

The D.C. Circuit attempted to distinguish the SSI program from Medicare on this point, reasoning that "individuals routinely ping-pong in and out of 'eligibility' depending on fluctuations in their income or wealth from one month to another." App. 13. But the theory that eligibility fluctuates in lockstep with monthly receipt of payment cannot evade the force of *Empire*'s reasoning.

In rejecting the argument that individuals should be counted as "entitled to [Medicare part A] benefits" only "for such days" that Medicare part A pays for their hospitalization, the Court reasoned that the statute required the agency to "ask about a patient on a given day." 597 U.S. at 440. But "the query the agency must make is not whether that patient on that day has received Part A payments." *Id.* Rather, the "query is … whether that patient on that day is qualified to do so," meaning the patient met program eligibility criteria prior to their hospital stay or—if they qualified while in the hospital—that only the days after that qualifying event counted. *Id.* The analogous inquiry here is an individual's satisfaction of program eligibility criteria, which are not

coextensive with cash payment criteria, much less actual receipt of payment.

In addition, assumed income fluctuation is no justification for embracing an agency interpretation that forces payment-based ping-ponging even when an individual's income and resources have *not* varied at all. Even assuming (wrongly) that program eligibility fluctuates monthly with income, payment receipt is much more variable, because Social Security suspends payments for many reasons that have nothing to do with an individual's income or resources. As a practical matter, SSI program eligibility is quite stable: nearly 80% of beneficiaries maintain eligibility for five years or more, regardless of payment status. 2021 Statistical Report, *supra*, at tbl. 78.[5]

Finally, statutory design reveals Congress's intent to foster stability, and to prevent individuals from "routinely ping-pong[ing]" in and out of the SSI program. Congress designed SSI benefits so that individuals who fail to meet eligibility criteria for a specific benefit in one month are buffered through provision of other benefits. For instance, an individual who is no longer disabled may sometimes continue to receive cash assistance while participating in a vocational rehabilitation program. 42 U.S.C. § 1383(a)(6). Non-cash SSI benefits also bridge the gap after suspension of cash payments. As an example,

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[5] It is difficult for SSI beneficiaries to transition out of the program by gaining income. In 2021, only about 2.5% of beneficiaries were terminated from the program for excess income or resources. *See id.* at tbls. 3, 77. Termination generally occurs after twelve months of excess income. 20 C.F.R. § 416.1335.

Congress guarantees SSI beneficiaries' entitlement to vocational rehabilitation benefits for up to a year after suspension of cash benefits. *Id*. § 1382d(e)(2).

In sum, even though eligibility for a cash payment may be assessed monthly, a person's broader entitlement to SSI benefits under title XVI—the statutory metric—does not turn off on a dime. The agency's manufactured timely-payment-required approach thus countenances substantially more (and wholly unnecessary) "ping-ponging" in and out of the Medicare fraction numerator, despite the patient "remain[ing] just as low income as he ever was, [and] imposing just as high costs on the hospital treating him." *Empire*, 597 U.S. at 444.

The D.C. Circuit's acceptance of the agency's approach substitutes an unstable and atextual line for the clear line that Congress chose. This approach is contrary to the agency's own approach—for the same language in the same sentence—to the Medicare Part A counterpart of the statutory formula, and is irreconcilable with *Empire*'s understanding of the DSH program.

B. The D.C. Circuit's Decision Is Wrong.

Neither the agency nor the D.C. Circuit has provided a convincing reason why "entitled to benefits" should mean something different for SSI benefits than for Medicare Part A benefits, in the very same sentence. The text and context of the Medicare Act, the SSI statute, and other parts of the Social Security Act all support equating "entitlement" with satisfying program eligibility criteria. The agency's reading—which equates entitlement with receiving a cash

payment by the moment that the agency performs its calculation—contravenes the statutory text and ignores the broader benefits provided by the SSI program.

1. The statutory text rejects a narrow view of "entitled."

a. Starting with the Medicare DSH statute, the "normal rule of statutory construction [is] that identical words used in different parts of the same act are intended to have the same meaning." *Taniguchi v. Kan Pac. Saipan, Ltd.*, 566 U.S. 560, 571 (2012). This presumption is "surely at its most vigorous when a term is repeated within a given sentence." *Brown v. Gardner*, 513 U.S. 115, 118 (1994).

"Entitled to benefits under part A" means, throughout the Medicare Act, "meeting the basic statutory criteria, not actually receiving payment for a given day's treatment." *Empire*, 597 U.S. at 435. The same phrase—entitled to benefits—is not commonly used within Title XVI (governing SSI).[6] It is thus most sensible to construe the phrase "entitled to [SSI] benefits" in consonance with its term-of-art meaning within the Medicare Act, as meeting basic eligibility requirements—especially when it appears in the same sentence as "entitled to [Medicare part A] benefits,"

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[6] Title XVI uses the "entitled to benefits" phrase in reference to SSI benefits in only two sections. *See* 42 U.S.C. § 1382c(a)(4) (limiting when "[a] recipient of benefits … may be determined not to be entitled to such benefits" based on a new finding of no disability); *id.* § 1383(a)(2)(B)(x) (permitting payment of deferred benefits over time if "in the best interests of the individual entitled to such benefits").

serving the same purpose—measuring a population, *i.e.*, low-income Medicare beneficiaries.

If anything, because the SSI statute (like the Medicaid fraction) focuses on "eligibility"—which naturally lends itself to a broader scope, *see Empire*, 597 U.S. at 435—it reinforces that Congress intended the "broad meaning of 'entitlement'" for SSI, as it did for Medicare part A. *See id.* at 436. And the provision defining "[b]asic eligibility" for SSI benefits (captioned "[b]asic entitlement" in the U.S. Code) functions just as "entitled to benefits" does in the Medicare Act, where eligibility is a threshold determination that can "coexist[] with limitations on payment." *Id.* A person is eligible for SSI if they are "aged, blind, or disabled" and Social Security "determine[s]" that they meet criteria related to "income and resources." 42 U.S.C. § 1381a; *see also id.* § 1382(a) (defining an "eligible individual" based on income and resources for a calendar year). Each such person is entitled to "be paid benefits," but only "in accordance with and subject to the provisions of this [title XVI]." *Compare id.* § 1381a, *with id.* § 426(c)(1) (stating that "entitlement of an individual" to Medicare Part A benefits "consist[s] of entitlement to have payment made under, and subject to the limitations in, part A").[7]

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[7] In a brief discussion addressing the question resolved in *Empire*—not the question presented here—the Sixth Circuit assumed that the SSI statute "interchangeably" uses "both eligibility and entitlement," based on the revisor's caption of § 1381a. *See supra* at 6. In fact, eligibility is the focus of the SSI statute. Regardless, interchangeable use of the terms supports, rather than contradicts, interpreting "entitled to benefits" consistently throughout the DSH statute as meaning "eligible,"

Numerous statutory provisions confirm that a person can be eligible—*i.e.*, have applied for benefits and been determined to be aged or disabled, with limited income and resources—yet receive no cash payment for a particular month. *See supra* at 7.

The D.C. Circuit reasoned that individuals who are eligible but receive no payment are not "entitled to [SSI] benefits" because SSI is only a "cash" benefit, and therefore receipt of a cash payment is the *sine qua non* of entitlement. *See* App. 9-10. That is doubly wrong. As discussed below, cash assistance is not the only SSI benefit. But even if it were, nothing in the Medicare Act or the SSI statute justifies reading entitlement to mean an "absolute right to … payment" for SSI when it means the opposite for Medicare part A. *See Empire*, 597 U.S. at 435 (rejecting equating "entitled" with "absolute right"). Both statutes outline a right for eligible individuals to have benefits paid under certain circumstances; that the benefit is cash in hand versus cash paid to a medical provider is a distinction without a difference. And in both cases, it is meeting the program's eligibility criteria—low-income aged and disabled, for SSI beneficiaries—that matters for the population-measuring purpose of the DSH formula.[8]

b. Other statutory references to SSI beneficiaries make clear that Congress knows how to refer to receipt

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contrary to the Sixth Circuit's acceptance of the agency's inconsistency. *Metro. Hosp. v. U.S. Dep't of Health & Hum. Servs.*, 712 F.3d 248, 268-69 (6th Cir. 2013).

[8] Given the billions of dollars at stake, *supra* at 15, Congress surely would have provided "clear authorization" to enact a payment-receipt carve-out for SSI only. *Biden v. Nebraska*, 143 S. Ct. 2355, 2361 (2023).

or payment of SSI benefits when it wants to. Ironically, the agency interprets these narrower terms elsewhere in the Medicare Act more broadly—*i.e.*, as not requiring receipt of a cash assistance payment—than it does the broader DSH term "entitled to [SSI] benefits."

In Medicare part D, Congress referred to "recipients of [SSI] benefits under [title] XVI" when describing the population entitled to subsidies for Medicare prescription drug coverage. 42 U.S.C. § 1395w-114(a)(3)(B)(v). Despite Congress's limitation to SSI "recipients," the agency applies the part D subsidy based on SSI eligibility, not SSI payment. Any "[b]eneficiary of SSI benefits" is "treated as full subsidy eligible" without having to apply for the subsidy. 42 C.F.R. § 423.773(c)(2). Every SSI-eligible individual receives the Part D subsidy for a minimum of 6 to 18 continuous months, regardless of whether they receive any SSI payment in those months. *Id.*; *see also* 42 C.F.R. § 423.773(c)(1). The agency accepts the initial SSI award letter—reflecting Social Security's determination of eligibility, not receipt of payment—as conclusive proof of eligibility for the part D subsidy. *See* Part D Manual § 70.5.2 (C.A.J.A. 138-39).

References to SSI beneficiaries in the Medicaid Act are also instructive. In most places where a Medicaid provision refers to the SSI program, the Medicaid provision depends upon whether SSI benefits are being "paid" to or "received" by an individual. *See, e.g.*, 42 U.S.C. § 1396d(a) (referring to an individual "with respect to whom [SSI] benefits are being paid under [title] XVI"); *id.* § 1396d(q) (an individual who "received … a payment of [SSI]

benefits"); *id.* § 1396f(4)(A) (an individual "with respect to whom [SSI] benefits are being paid").

By contrast, the only instance within the Medicaid Act where "entitled to [SSI] benefits" occurs is within the provision governing the Medicaid DSH adjustment, within language that tracks the statutory language of the Medicare DSH provision. *Id.* § 1396r-4(g)(2)(B). This limited use of the term "entitled to [SSI] benefits" throughout the Social Security Act, in contrast with repeated references to receipt of benefits, confirms that the phrase, like "entitled to [Medicare part A] benefits," should be read as meeting the SSI program's statutory eligibility criteria, and not atextually cabined to payment of SSI cash benefits.

2. The D.C. Circuit wrongly disregarded non-cash benefits provided by the SSI program.

The SSI program parallels Medicare part A in a second way, reinforcing that a "payment" requirement should not be engrafted onto the meaning of "entitled": even when one specific benefit cannot be paid, a person can still receive different benefits under the program.

Just as a person who has exhausted Medicare inpatient coverage for the year remains "entitled to [Medicare part A] benefits" because part A also provides skilled nursing coverage, *see Empire*, 597 U.S. at 437, a person whose payment of SSI cash benefits is paused can still receive non-cash SSI benefits like vocational rehabilitation services. Such services (and others) are available to the about 85% of beneficiaries who qualified for SSI on account of blindness or disability (rather than age), 2021

Statistical Report, *supra*, at tbl. 5, for a period after their cash assistance payments are suspended (so long as they are still blind or disabled). *See* 42 U.S.C. § 1382d(e); 20 C.F.R. §§ 411.125, 411.155 (Ticket to Work rules); *id.* § 416.2201, 416.2215 (traditional program rules).

The D.C. Circuit agreed that the natural reading of "benefits" encompasses both cash and non-cash benefits, yet held that no non-cash benefits qualified as benefits "under [title] XVI" because it considered all non-cash benefits to be "housed" outside of title XVI. App. 10-11. This was flat wrong.

Considering vocational rehabilitation benefits alone—although there are other non-cash benefits for SSI beneficiaries—is enough to demonstrate the court's error.

Vocational rehabilitation services have been part of the SSI program—and thus an "[SSI] benefit under [title XVI]"—since the program's inception in 1972. From then, through 1986, when the DSH statute was enacted, to today, vocational rehabilitation services are benefits provided to SSI beneficiaries under section 1382d, which is part of title XVI. *See supra* at 7-8.

In rejecting the relevance of such benefits, the D.C. Circuit zeroed in on the Ticket to Work program, which is governed (in part) by a statute located in a different title (title XI). *See* 42 U.S.C. § 1320b-19. The court cast title XVI as merely "a funding mechanism for a [title] XI benefit." App. 12. But even if (counterfactually) Ticket to Work benefits could be disregarded, most vocational rehabilitation services are still provided under the "traditional" model, which

continues running under § 1382d and its implementing regulations—*i.e.*, title XVI. *See* Gina A. Livermore et al., *Ticket to Work Participant Characteristics and Outcomes Under the Revised Regulations*, Ctr. for Studying Disability Pol'y, at 17 (Sept. 24, 2012), http://tinyurl.com/mr2d37cz; 20 C.F.R. § 411.350 (state option to choose Ticket to Work or traditional program).

Also, contrary to the D.C. Circuit's view, App. 12, reorganization of some vocational rehabilitation provisions under Ticket to Work did not eliminate vocational rehabilitation services as SSI benefits. Years after the DSH statute's enactment, Congress compiled some common provisions that govern vocational services for multiple federal programs into a single statutory section. *See* Ticket to Work and Work Incentives Improvement Act of 1999, Pub. L. No. 106-170, § 101, 113 Stat. 1860, 1863-81. A resulting new statutory section (§ 1320b-19) was placed within title XI (covering "general provisions"). But eligibility for rehabilitation services continues to be governed by the referring program. For SSI beneficiaries, this is title XVI. *See* 42 U.S.C. § 1320b-19(k)(2)-(4).

Because the D.C. Circuit has conclusively misread the statute, in irreconcilable tension not only with its text but with this Court's reasoning in *Empire*, certiorari is needed to ensure that hospitals are compensated as Congress intended for the low-income patients they serve.

III. This Case Presents An Ideal Vehicle To Resolve The Question Presented.

This case presents a clean statutory question following a full administrative process. Because the Administrator of the Centers for Medicare & Medicaid Services opted to review the decisions of the Provider Reimbursement Review Board, the record contains the agency's adjudicative decision defending its narrow construction of "entitled to [SSI] benefits" despite its adoption of a conflicting meaning of "entitled" for Medicare part A benefits. *See* App. 46-93. This adjudicative decision supplements the agency's Federal Register discussion, 75 Fed. Reg. at 50,280-50,281, and ensures the issues have been aired.[9]

Resolving the question presented here in favor of a consistent reading of "entitled" would also avoid the need for courts to resolve a parade of future challenges about the many ways the agency's matching process is arbitrary. Given decades showing the agency's approach is unworkable, further percolation is unwarranted, and other cases are stayed pending the outcome of this one. *See, e.g.*, *Empire Health Found. v. Becerra*, No. 2:16-cv-00209 (E.D. Wa. stayed on remand Nov. 13, 2023). Declining review and waiting for a future vehicle—which will cover the same terrain—has no upside, and a clear downside:

[9] The D.C. Circuit declined to consider arguments related to certain payment codes. App. 14-15. This poses no obstacle to review. Those arguments relate to the hospitals' unrenewed claim that the agency's matching process is arbitrary.

continuing to embroil the courts in endless calculation-by-calculation litigation.

Answering the statutory question presented here requires neither delving into payment code details nor grappling with the mechanics of computing the Medicare fraction. And if answered in accord with congressional design—and the textual analysis and rationale of *Empire*—no court will ever become ensnared in that tangle again. The Court should seize this opportunity to review this question of pressing importance, which affects the survival of safety net hospitals across the country and the health of the Nation's most vulnerable communities.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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