No. 23-715

In The
Supreme Court of the United States

ADVOCATE CHRIST MEDICAL CENTER, ET AL.,
Petitioners,

v.

XAVIER BECERRA,
SECRETARY OF HEALTH & HUMAN SERVICES,
Respondent.

On Writ of Certiorari
to the United States Court of Appeals
for the District of Columbia Circuit

BRIEF FOR PETITIONERS

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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 County 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.

Respondent Xavier Becerra, Secretary of Health & Human Services, was a defendant in the district court and an 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, Havasu Regional Medical Center, Jackson Purchase Medical Center, Lake Cumberland Regional Hospital, Livingston Regional Hospital, Logan Memorial Hospital, Memorial Medical Center, Minden Medical Center, Palestine Regional Medical Center, Parkview Regional Hospital, Raleigh General Hospital, River Parishes Hospital, Saline Memorial Hospital, Southern Tennessee — Lawrenceburg, Southern Tennessee — Winchester, Southern Tennessee Regional Health Care — Pulaski, Sovah Health — Danville, Sovah Health — Martinsville, Starke Hospital, 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. For petitioners Carondelet Heart & Vascular Institute, Carondelet Saint Joseph's Hospital, and Carondelet Saint Mary's Hospital, the claims asserted in this action are for fiscal years when these

petitioners were owned and operated by a non-profit entity, and the right to any reimbursement for services provided during those fiscal years is retained by that entity; however, presently and for purposes of disclosure, these hospital facilities are operated by for-profit entities in which an ownership interest is held by:

Tenet Healthcare Corporation

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

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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 reported but is available at 2022 WL 2064830. The decision of the Administrator of the Centers for Medicare and Medicaid Services (CMS) (Pet. App. 46-93) is not reported but is available at 2017 WL 2812948. The decisions of the Provider Reimbursement Review Board (Pet. App. 94-127) are not reported but are available at 2017 WL 1550303 and 2017 WL 1833478.

JURISDICTION

The judgment of the court of appeals was entered on September 1, 2023. No rehearing petition was filed. The Chief Justice extended the time to file a petition for a writ of certiorari to and including December 29, 2023. The petition for a writ of certiorari was filed on that date, and was granted on June 10, 2024. This Court has jurisdiction under 28 U.S.C. § 1254(1).

RELEVANT STATUTORY AND REGULATORY PROVISIONS

Pertinent statutory and regulatory provisions are reproduced in the addendum (Add. 1a-47a).

INTRODUCTION

All hospitals, but especially safety-net and rural hospitals, depend on fair and accurate compensation to keep their doors open and maintain capacity to provide needed services to the Nation's most vulnerable patients. Congress recognized that low-

income patients are costlier to treat, and designed a program (the "DSH" program) to compensate hospitals that serve a disproportionate share of low-income patients. The DSH formula seeks to measure a hospital's low-income patient population by counting patients "entitled to benefits" under three different entitlement programs: Medicare part A, Supplemental Security Income (SSI), and Medicaid.

The question for the Court is what "entitled to benefits" means in the DSH provision. Just two Terms ago, the Court answered that question for Medicare part A: entitled to benefits means eligible for or qualifying for the Medicare program. *Becerra v. Empire Health Found.*, 597 U.S. 424, 445 (2022). And the courts of appeals answered that question for Medicaid: eligible for benefits means qualifying for the Medicaid program. *E.g.*, *Cabell Huntington Hosp., Inc. v. Shalala*, 101 F.3d 984, 989 (4th Cir. 1996). The government agrees as to both. *Empire* adopted the government's interpretation of the Medicare portion of the Medicare fraction (which generally decreased hospital reimbursements). And the agency ultimately acquiesced as to the Medicaid fraction.

The only open question is whether the same phrase, in the same sentence, means the same thing for SSI benefits. The answer should be obvious: entitled to SSI benefits means eligible for or qualifying for the SSI program. That follows from the statutory text and context. And it has the virtue of actually measuring the low-income patient population Congress intended to capture.

Yet the government resists that interpretation and the court of appeals agreed. The government insists the SSI program should stand alone as the only DSH component to still turn on payment status.

Apart from costing the government less money, that anomalous result has nothing to commend it. A proxy designed to measure a financially fragile, medically vulnerable, and costly-to-treat population would become meaningless and cumbersome. This Court should finish what it started in *Empire*, adopt a consistent reading of the DSH provision, and reverse the judgment below.

STATEMENT OF THE CASE

A. Legal Background

Hospitals generally receive higher Medicare reimbursements when they serve a disproportionate share of low-income patients. The Medicare statute measures that low-income share using two fractions: the "Medicare fraction" and the "Medicaid fraction." The Medicare fraction uses the share of a hospital's Medicare part A patients entitled to SSI benefits as a proxy for low-income patients. This case concerns the method for counting that SSI-entitled population.

1. Medicare "provides Government-funded health insurance to" a large and growing number of "elderly or disabled Americans." *Empire*, 597 U.S. at 428. Medicare "part A" covers inpatient hospital care. *Id.*

Medicare generally pays hospitals "a fixed rate for treating each Medicare patient, . . . regardless of the hospital's actual costs." *Id.* at 429. But Congress recognized that "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). That is because low-income patients are at "increased risk for mental illness, chronic disease, higher mortality, and lower life expectancy." U.S. Dep't of Health & Hum. Servs.,

Off. of Disease Prevention & Health Promotion, *Poverty: Literature Summary*, https://tinyurl.com/yc8xzbm3 (last visited Aug. 7, 2024) ("*Literature Summary*"). So Congress created the disproportionate share hospital (DSH) program—under which a hospital's "reimbursement amount is adjusted upward" when it "serve[s] a disproportionate share of low-income patients." *Auburn Reg'l*, 568 U.S. at 149-50; *see* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9105, 100 Stat. 82, 159 (1986).

To "calculate a hospital's DSH adjustment, [CMS] adds together" the Medicare and Medicaid fractions, which are "designed to capture two different low-income populations." *Empire*, 597 U.S. at 429. The DSH fractions' key inputs include the number of days the hospital provided inpatient care to patients who participated in three different entitlement programs: Medicare part A, SSI, and Medicaid.

The Medicare fraction is at issue here. It "represents the proportion of a hospital's Medicare patients"—*i.e.*, "senior (or disabled)" patients—"who have low incomes, as identified by their entitlement to [SSI] benefits." *Id.* at 429-30. In simple terms, the fraction can be expressed as follows:

$$\frac{\text{Patient days for patients "entitled to" both Medicare part A and SSI}}{\text{Patient days for patients "entitled to" Medicare part A}}$$

Id. In the statute's (less simple) terms, the Medicare fraction's numerator is "the number of [a] hospital's patient days . . . [for] patients who (for such days) were entitled to benefits under part A of [Medicare] and were entitled to [SSI] benefits (excluding any

State supplementation) under [title] XVI" of the Social Security Act. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). Its denominator is the number of patient days for "patients who (for such days) were entitled to benefits under part A of [Medicare]." *Id.*

The Medicaid fraction reflects the share of a hospital's non-Medicare patients who "have low incomes, as identified by their eligibility for Medicaid." *Empire*, 597 U.S. at 429-30. In the statute's terms, the Medicaid fraction's numerator is "the number of [a] hospital's patient days . . . [for] patients who (for such days) were eligible for medical assistance under [a state Medicaid plan], but who were not entitled to benefits under part A of [Medicare]." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Its denominator is a hospital's total patient days. *Id.*

2. SSI, for its part, is "a 'welfare program' providing benefits to 'financially needy individuals' who (like Medicare patients generally) are over 65 or disabled." *Empire*, 597 U.S. at 430 (citation omitted). 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) (alteration in original) (citation omitted); *see* Social Security Amendments of 1972, Pub. L. No. 92-603, § 301, 86 Stat. 1329, 1465-78 (rewriting title XVI of the Social Security Act).

a. *Program Eligibility*. SSI's "[b]asic eligibility for benefits" under title XVI includes "[e]very aged, blind, or disabled individual who is determined under part A [of title XVI] to be eligible on the basis of his income and resources." Social Security Amendments of 1972 § 301, 86 Stat. at 1465 (capitalization normalized) (codified at 42 U.S.C. § 1381a with the title "Basic entitlement to benefits"). Part A of title XVI, in turn,

defines an "eligible individual" using the individual's "income" for the "calendar year," resources, and status as "aged, blind, or disabled." 42 U.S.C. § 1382(a); *see* 20 C.F.R. § 416.120(c)(13).[1] A person seeking SSI benefits must file an application with Social Security and be determined eligible based on those qualifying criteria. *See* 42 U.S.C. §§ 1381a, 1382(c)(2).

After an individual qualifies, SSI program eligibility lasts until "termination." *Id.* § 1383(e)(1)(A). "[T]ermination" occurs when the individual (i) medically recovers, (ii) earns a full year's worth of income establishing that support is no longer necessary, or (iii) some other disqualifying event occurs. *Id.*; *see id.* § 1383(e)(7)(C), (j)(1); 20 C.F.R. §§ 416.1331-416.1335. Until then, the individual "shall, in accordance with and subject to the provisions of this [title], be paid benefits." 42 U.S.C. § 1381a.

Upon qualification for the SSI program, an individual is eligible for a suite of benefits. These benefits include monthly cash payments that may vary depending on an individual's circumstances. *See, e.g.*, *id.* §§ 1382(a)-(c), 1382h(a)(1). They may also include other cash benefits, as well as non-cash benefits like vocational-rehabilitation services and medical coverage. *See, e.g.*, *id.* §§ 1382d, 1382h(b).

b. *Basic Monthly Cash Benefit*. Section 1382 provides for a monthly cash payment. The amount of that payment starts with an annual dollar amount set by statute, which is adjusted for inflation and reduced

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[1] In 2024, the countable-income limit for a single individual is $11,316. *See* 42 U.S.C. § 1382(a)-(b); Soc. Sec. Admin., *Fact Sheet: 2024 Social Security Changes* 2 (2023), https://tinyurl.com/35fcb7ya (2024 inflation adjustments). Countable resources (like bank accounts) cannot exceed $2,000. 42 U.S.C. § 1382(a)(3)(B).

by the beneficiary's income. *Id.* § 1382(b) (setting the benefit "for the calendar year"); *see* Soc. Sec. Admin., *Understanding Supplemental Security Income* (2024 ed.), https://tinyurl.com/bddkxrpf. Even though the statutory amount of benefits is annual, the "period for determination of benefits" is monthly. 42 U.S.C. § 1382(c); *see id.* § 1382(a)-(b). As such, a beneficiary's actual payment amount is determined each month.

i. Payment of SSI benefits is "subject to the provisions of [title XVI]," and a host of complex rules govern whether an "eligible individual" will receive a cash payment in any given month—and, if so, how large that payment will be. *Id.* §§ 1381a, 1382(a).

"An individual's eligibility" for a cash payment "for a month" is generally based on her "income, resources, and other relevant characteristics in such month." *Id.* § 1382(c)(1). But the *amount* of the payment for any given month is based on "income and other characteristics" in "the first or . . . second" prior month. *Id.*; *see* Soc. Sec. Admin., *What You Need to Know When You Get Supplemental Security Income* 2 (Mar. 2024), https://tinyurl.com/264ay6fc. As a result, cash payments vary monthly. And because of how income is defined, cash payments can fluctuate based on in-kind contributions too, such as a relative paying an SSI beneficiary's electric bill or giving her a place to live rent-free. 42 U.S.C. §§ 1382(c)(1), 1382a(a)(2)(A); *see* 88 Fed. Reg. 9779, 9780 (Feb. 15, 2023).

If an SSI beneficiary becomes ineligible for a cash payment in one month, she must "request[] reinstatement" of benefits—which triggers Social Security's obligation to review the record and evaluate the request. 20 C.F.R. § 416.1320(b); *see* Program Operations Manual Systems (POMS) SI 02301.210(B) (2024), https://tinyurl.com/uy2manyw. But so long as

the individual was eligible for a cash payment within the prior year, no renewed application is needed. 42 U.S.C. § 1383(j).

To allow Social Security to track monthly income fluctuations, SSI beneficiaries must report changes in their circumstances. *Id.* § 1383(e)(1)(A); 20 C.F.R. § 416.704. They must also authorize Social Security to access their financial records, allowing the agency to adjust payments automatically. 42 U.S.C. § 1383(e)(1)(B)(ii)(I), (ii)(II), (iii)(I); 20 C.F.R. § 416.207(a). Such authorizations generally "remain effective until . . . the cessation of the recipient's eligibility for benefits under [title XVI]"—meaning the point at which "a terminating event," like a year of suspended payments, "occurs." 42 U.S.C. § 1383(e)(1)(B)(ii)(II)(bb); 20 C.F.R. §§ 416.207(f), 416.1335.

ii. In some months, eligible individuals may not receive a section 1382 basic monthly payment. These individuals fall into three basic categories: (1) those who are payment-ineligible for a month; (2) those who are payment-eligible for that month but for whom no payment is due; and (3) those who are both payment-eligible and due a payment but who nonetheless do not receive a payment.

First, an individual may be payment-ineligible for a particular month. That may be because of excess income in that month, because she is institutionalized, because she failed to respond to a request for information, or because of another specified reason. *E.g.*, 42 U.S.C. § 1382(c)(1), (e)(1)(A), (f)(1); 20 C.F.R. § 416.1322. That individual's payment will be "suspended" for the relevant month. 20 C.F.R. § 416.1320(a)-(b). When her income drops again, or when the other condition no longer exists, her

payments are reinstated upon request. 42 U.S.C. § 1382(c)(2); 20 C.F.R. § 416.1320(b).

Second, an individual may be payment-eligible for a month but have no payment due. *See* 20 C.F.R. § 416.203(b) (individuals may "meet the [payment] eligibility requirements in a given month but receive no benefit payment for that month"); POMS SI 02005.020(D)(2) (describing "eligible but not payable" population). That can occur for several reasons.

For one thing, SSI payment is a lagging indicator—the payment amount for a given month turns on an individual's income in a prior month. 42 U.S.C. § 1382 (c)(1). So someone in the hospital during one month may meet all eligibility requirements for a cash payment that month, but still have no payment due because she had too much income a month or two before. *Id.* For another, Social Security can recover overpayments by withholding payment during an otherwise payment-eligible month, resulting in no payment being due. *Id.* § 1383(b)(1)(B).

Nursing home patients are another important example. An "eligible individual" who spends a month in a Medicaid-paid medical-treatment facility, such as a nursing home, generally has no payment due if her countable income exceeds $30 (on the theory that the facility will meet her basic needs). *Id.* § 1382(e)(1)(B); *see* S. Rep. No. 92-1230, at 386 (1972). And most SSI beneficiaries, including those who are Medicare-eligible, are also Medicaid-eligible due to their SSI status. *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(II). So when a Medicaid-paid nursing-home patient is transferred to a hospital for care, she will not receive SSI payments during her hospitalization month because she resided in a Medicaid-paid nursing home in a prior month. *See* 20 C.F.R. § 416.203(b).

Third, an individual may be both eligible for and due a payment but have payment stopped or deferred for administrative reasons. If, for example, paying an individual directly "would cause substantial harm," Social Security may "defer (in the case of initial entitlement) or suspend (in the case of existing entitlement) 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.[2] *See* 20 C.F.R. § 416.1320(a); *see also* Soc. Sec. Admin., *State Verification and Exchange System (SVES) and State Online Query (SOLQ) Manual* 181 (July 2023), https://tinyurl.com/32ezntsa (returned checks or refusal to accept direct deposit).

c. *Additional SSI Benefits*. SSI provides more than a single monthly cash benefit. The SSI program also includes other cash and non-cash benefits, such as: (i) cash payments for certain individuals who perform substantial gainful activity despite severe medical impairment, 42 U.S.C. § 1382h(a); (ii) continued Medicaid coverage, *id.* § 1382h(b); (iii) state supplementation payments, *id.* § 1382e; (iv) vocational-rehabilitation services, *id.* § 1382d; and (v) cash payments for those whose disability has ceased but who are receiving vocational-rehabilitation services, *id.* § 1383(a)(6).

i. An individual may qualify for SSI based on disability if she is unable to earn income at a level

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[2] "Whereabouts unknown" ranked as the second most common reason for suspension of SSI payments in 2022. Soc. Sec. Admin., *Annual Statistical Report, 2022*, at 167 (Dec. 2023), https://tinyurl.com/5d6es8d6 ("*2022 Statistical Report*").

called "substantial gainful activity." *Id.* § 1382c(a)(3)(A). If she later earns income above that level "despite severe medical impairment," she may still receive cash payments, but under section 1382h(a) instead of section 1382. *Id.* § 1382h (title).

ii. Even if a beneficiary's income grows beyond the income limit for any cash payment, the SSI statute confers continued eligibility for Medicaid health coverage—which otherwise hinges on payment of SSI cash benefits. *Id.* §§ 1382h(b), 1396a(a)(10)(A)(i)(II).

iii. State supplementation benefits may also be available. States may provide "further assistance to needy residents," in the form of either additional cash payments on top of federal SSI payments or payments to those whose incomes exceed the federal threshold. *Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252, 1254 (D.C. Cir. 2023); *see* 42 U.S.C. § 1382e.

iv. To further support beneficiaries under age 65 who want to work, SSI has always included a vocational "rehabilitation program under title XVI." POMS DI 13501.005(A); *see* 42 U.S.C. § 1382d. Vocational-rehabilitation services include physical rehabilitation, assistive technology, vocational training, and a variety of other "goods and services" that assist with employment. *See* 20 C.F.R. § 416.2214(b). For fiscal year 2023, eligible SSI beneficiaries meeting employment objectives received over $13,000, on average, in goods and services. *See* Soc. Sec. Admin., *VR Reimbursement Claims Processing*, https://tinyurl.com/mryr45e7 (last visited Aug. 7, 2024).

Vocational-rehabilitation services are provided to SSI beneficiaries by state agencies or private organizations. 42 U.S.C. §§ 1320b-19(a), 1382d(a).

Those providers are reimbursed through the Ticket to Work model, which involves fixed payments based on certain milestones, or a cost-reimbursement model. *See id.* §§ 1320b-19(b)(4), (c)(1), 1382d(d)-(e). Under either model, blind or disabled SSI beneficiaries remain eligible for vocational-rehabilitation services even when monthly cash payments under sections 1382 and 1382h(a) are suspended. *Id.* § 1382d(e)(2); *see* 20 C.F.R. §§ 411.155, 416.2215.

v. Beyond those services, participation in vocational rehabilitation may extend access to certain cash benefits that otherwise would be suspended or terminated. 42 U.S.C. § 1383(a)(6).

3. Returning to the DSH formula, a key (and oft-litigated) question has been who counts as "entitled" to or "eligible" for the three different benefit programs in the formula: Medicare part A, SSI, and Medicaid. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I)-(II).

When first implementing the DSH provision, the administering agency (what is now CMS) applied the same methodology for all three programs and counted days only when the relevant program actually paid benefits. 51 Fed. Reg. 31454, 31459-61 (Sept. 3, 1986). By 1997, four courts of appeals had invalidated this rule for the Medicaid fraction, holding that the phrase "'eligible for medical assistance under [Medicaid]' refers to patients who meet the . . . qualifications specified by a particular state's Medicaid plan, whether or not they are actually receiving payment." *Cabell*, 101 F.3d at 989; *see Empire*, 597 U.S. at 441 n.4. The agency eventually acquiesced in that holding nationwide. U.S. Dep't of Health & Hum. Servs., Health Care Fin. Admin., *HCFA Ruling No. 97-2* (Feb. 27, 1997), https://tinyurl.com/2x9rp3xu.

CMS later aligned its policy on the Medicare part A component of the Medicare fraction to match the eligibility-focused Medicaid fraction. That is, CMS specified that a patient is "entitled to benefits" under Medicare part A when "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 (citation omitted). This change generally reduced DSH payments to hospitals (by increasing the population included in the denominator relative to the population included in the numerator). *Id.* at 433. And in *Empire*, the Court upheld CMS's interpretation of the Medicare component of the Medicare fraction. *Id.* at 445.

But CMS declined to conform its methodology for the SSI component of the Medicare fraction—which would have increased DSH payments to hospitals (by increasing the SSI population included in the numerator while not changing the denominator). *See* Pet. App. 2, 81, 119. SSI is now the lone program within the DSH formula where CMS counts only paid days. To justify the disparity, CMS explained that "eligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month." 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010).

B. Factual and Procedural Background

1. Petitioners are 209 hospitals located across the country, including safety-net hospitals providing care in historically underserved areas. They challenged the calculation of their Medicare fractions for 2006 to 2009 with the Provider Reimbursement Review Board. Pet. App. 18, 26. Petitioners argued that CMS violated the DSH provision by limiting the count of

SSI-entitled patients to those who actually received SSI cash payments for the month of their hospital stay. *Id.* at 113, 121-22. The correct approach, petitioners argued, was to include all patients who qualified for the SSI program during their hospital stay. *Id.* at 122.

The Board agreed that CMS "interprets SSI entitlement to correspond with any month for which an individual receives payment of SSI benefits." *Id.* at 119 (emphasis omitted). But it concluded it lacked authority to grant relief on a challenge to that rule. *Id.* at 110, 126-27.

The CMS Administrator reviewed the Board's decision and rejected petitioners' challenge. *Id.* at 46-93. The Administrator held that "only a person who is actually paid [monthly] benefits can be considered 'entitled'" to SSI benefits, and that a person who "is eligible for SSI but is not actually receiving SSI payments" is therefore "not 'entitled' to SSI benefits." *Id.* at 81-82.

2. Petitioners sought review in district court. The court found the phrase "entitled to [SSI] benefits" ambiguous and deferred to CMS's interpretation. *Id.* at 32-40 (relying on *Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984), *overruled by Loper Bright Enters. v. Raimondo*, 144 S. Ct. 2244 (2024)).

3. The D.C. Circuit affirmed. The court of appeals started from the premise that the only SSI benefits under title XVI are "cash payments." *Id.* at 9. The court then held that CMS correctly limited the SSI-entitled category to patients who received those cash payments. *Id.* at 9-10. The court deemed non-cash benefits for SSI beneficiaries (like vocational

rehabilitation) irrelevant because they were "housed" outside of title XVI (at least in part). *Id.* at 10-11.

The court of appeals discounted the relevance of this Court's *Empire* decision based on two purported distinctions between Medicare part A and SSI. *First*, the court asserted that Medicare part A benefits "extend well beyond payment for specific services at specific times" to provide an overarching insurance program, whereas SSI is a cash-only benefit. *Id.* at 13. *Second*, the court noted that individuals gain and lose SSI eligibility more readily than they do Medicare eligibility. *Id.* The court ultimately "agree[d] that [CMS] offered the correct interpretation of the Medicare fraction, . . . without considering any question of *Chevron* deference." *Id.* at 14.

SUMMARY OF ARGUMENT

I. In the DSH provision, "entitled to benefits" means being eligible or qualifying for the relevant entitlement program—whether that program is Medicare part A, SSI, or Medicaid.

A. The presumption that the same words in the same sentence have the same meaning is well-settled. In *Empire*, this Court held that a patient is "entitled to" Medicare part A benefits when she "qualif[ies] for the [Medicare] program." *Empire*, 597 U.S. at 445. The courts of appeals have held the same when interpreting analogous language in the neighboring Medicaid fraction. Only an infinitesimal, additional step is needed to conclude that a patient is likewise "entitled to" SSI benefits in the DSH provision when she is eligible for the SSI program.

The DSH provision's "entitled to [SSI] benefits" phrase further confirms that reading. Entitled and eligible are interchangeable terms in this context. The

statute refers to SSI "benefits," plural—reflecting the reality that SSI benefits are many. Congress expressly excluded only one SSI benefit (state supplementation) for DSH purposes. And the legislative history corroborates what the text makes clear: program eligibility is the chosen metric.

B. A person qualifies for the SSI program when she applies and is determined eligible by Social Security based on her status as aged or disabled and satisfaction of an annual-income standard. An SSI beneficiary is entitled to a suite of benefits that adjusts monthly to meet financial need. But only when a year's worth of income (or medical recovery) eliminates that need does eligibility terminate. Before termination, monthly payments and payment eligibility may vary; program eligibility does not.

C. A program-eligibility reading best effectuates the DSH provision's purpose. The DSH formula is designed to measure the low-income population that is in poorer health and is costlier to treat. Individuals who initially qualify for and have not been terminated from the SSI program exemplify that low-income patient population. These individuals do not suddenly become healthier or less costly to treat because they were ineligible for, were not due, or did not receive a cash payment in a given month—especially when the reason had nothing to do with income. And a program-eligibility approach has the added benefit of being easy to administer.

II. The government's contrary interpretations contravene the statutory text, context, and structure and are incompatible with the statutory purpose.

A. CMS's "actual receipt" rule is indefensible and the government does not defend it. That rule turns on

whether a patient has actually received an SSI payment for the month of her hospitalization. But the statute looks to entitlement, not receipt, of benefits, and the two terms are hardly interchangeable. The government's effort to reimagine the CMS rule is impossible to square with what the agency has said and done. That itself is reason why the decisions below cannot stand.

B. The government's "payment due" litigating position fares no better. Under that approach, a patient is "entitled to [SSI] benefits" if she is due a cash payment for a given hospitalization month. That this would give "entitled to benefits" a different meaning in the same sentence of the same statute is beyond dispute. The government and the court of appeals justified that anomalous result based on distinctions between Medicare part A and SSI. Those distinctions are overblown and woefully insufficient.

The first distinction rests on the premise that Medicare part A is an insurance program, whereas SSI is just a singular cash benefit. That is wrong twice over. The SSI program provides beneficiaries with a suite of cash and non-cash benefits. It is not all about a singular monthly cash payment; it is an income-insurance program, which adjusts to match financial need from the time someone is determined to be eligible for SSI until such eligibility terminates. In practice, a one-step forward, two-steps backward experience is common for SSI beneficiaries working to generate adequate income over time. Congress designed the program as an annualized safety net to accommodate this reality.

The second distinction focuses on perceived stability in Medicare eligibility compared to instability in SSI eligibility. But that conflates payment

eligibility and program eligibility and ignores the reality that beneficiaries do not "routinely ping-pong in and out" of SSI program eligibility. Pet. App. 13.

There are of course differences between the two entitlement programs, but none significant enough to support reading "entitled to benefits" to mean two different things in the same sentence.

C. The government's interpretations are also fundamentally incompatible with the statutory purpose. The government's preferred metrics do not measure the low-income patient population DSH was intended to capture. It is not just a less-than-perfect proxy; it is no proxy at all. And to make matters worse, it is administratively unworkable. There is a simple alternative, and it is the one Congress chose: all patients who qualify for the SSI program.

ARGUMENT

I. "Entitled to SSI Benefits" Means Qualifying for the SSI Program

When Congress decided to measure a hospital's low-income Medicare population by counting all Medicare part A patients "entitled to [SSI] benefits under [title] XVI," it included all patients who qualify for the SSI program and its suite of benefits. That reading follows from the statute's text, structure, and purpose—as interpreted by this Court in *Becerra v. Empire Health Foundation*, 597 U.S. 424, 445 (2022). Individuals qualify for the SSI program when they first apply and are deemed eligible and continue to qualify until their eligibility is terminated.

A. In the DSH Provision, "Entitled to Benefits" Means Eligible for the Benefits Program

The Medicare fraction's numerator counts a hospital's patient days for "patients who (for such days) were entitled to benefits under [Medicare part A] . . . and were entitled to [SSI] benefits (excluding any State supplementation) under [title] XVI." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). In *Empire*, this Court held that "entitled to [Medicare part A] benefits" means "qualifying for the [Medicare] program." 597 U.S. at 445. The same words should have the same meaning for the SSI program.

1. 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) (citation omitted). 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). And that presumption is stronger still when the identical phrase is a term of art within the same act. *See Empire*, 597 U.S. at 435; *T-Mobile S., LLC v. City of Roswell*, 574 U.S. 293, 301 (2015). "[W]hen Congress employs a term of art, it presumably knows and adopts the cluster of ideas that were attached to each borrowed word in the body of learning from which it was taken." *T-Mobile S.*, 574 U.S. at 301 (alteration in original) (quoting *FAA v. Cooper*, 566 U.S. 284, 292 (2012)).

Applying these principles, the phrase "entitled to benefits," used twice in the same sentence of the Medicare fraction, should be read the same way both

times. And this Court already decided how to read "entitled to benefits" in the first half of the sentence.

In *Empire*, the Court addressed the meaning of the phrase "entitled to benefits under part A of [Medicare]." 597 U.S. at 428. The government argued that someone is "entitled to" such benefits if she "qualifies for the Medicare program," and that "for such days" counts the days after a patient so qualifies. *Id.* at 428, 440. The hospitals conversely argued that an entitlement to benefits requires "an 'absolute right' to . . . payment," and that "for such days" counts only the days the patient actually receives Medicare payments. *Id.* at 435, 439-40 (citation omitted). The Court agreed with the government. The Court held that "individuals 'entitled to [Medicare Part A] benefits' are all those qualifying for the program regardless of whether they are receiving Medicare payments." *Id.* at 445 (alteration in original). And it agreed that "for such days" "count[s] the days after [a patient] qualifies for" the Medicare program, not the days she is "actually receiving Medicare payments." *Id.* at 440-41.

Just as someone is "entitled to" Medicare benefits if she is eligible for or "qualifies for the Medicare program," *id.* at 428; *see id.* at 445, that same someone is "entitled to [SSI] benefits" as long as she is eligible for or qualifies for the SSI program. And just as "for such days" in the first half of the sentence counts the days after a patient qualifies for the Medicare program, "for such days" in the second half counts the days a patient qualifies for the SSI program. *Empire* also establishes that, in "the Medicare statute . . . 'entitled to benefits' is essentially a term of art . . . mean[ing] 'qualifying (or . . . being eligible) for benefits.'" *Id.* at 435 (citation omitted). Because the

DSH provision is housed in the Medicare statute, this meaning should carry over to the SSI component. *See T-Mobile S.*, 574 U.S. at 301.

That interpretation is reinforced by the neighboring Medicaid fraction. The Medicaid fraction measures a hospital's "patients who (for such days) were eligible for medical assistance under [Medicaid]" as a portion of its overall patients. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). The courts of appeals (and now CMS) read "'eligible for medical assistance under [Medicaid]'" to mean qualifying for the Medicaid program—not due a Medicaid payment at a given time. *Empire*, 597 U.S. at 431, 441 n.4. And agree that "for such days" counts the days after a patient qualifies for the Medicaid program. *Cabell Huntington Hosp., Inc. v. Shalala*, 101 F.3d 984, 990 (4th Cir. 1996).

Throughout the DSH provision, then, Congress referred to program eligibility. It would be anomalous for the third component of the DSH formula—SSI—to be measured any differently. Construing "entitled to [SSI] benefits" to refer to program eligibility harmonizes the DSH provision and ensures textual and structural consistency across the three relevant entitlement programs.

2. There are other textual indications that the DSH term "entitled to [SSI] benefits" means eligible for the SSI program.

Starting with "entitled," the terms "entitle" and "eligible" are often interchangeable.[3] That holds true

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[3] *See, e.g.*, *Webster's Third New International Dictionary* 736 (1993) (listing "fitted or qualified to be chosen or used : entitled to something" as the first definition of "eligible"); *id.* at 758 (listing "qualify (one) for something" in the definitions of

within the DSH provision—where the Medicare fraction uses "entitled to" the same way the Medicaid fraction uses "eligible for." *See Empire*, 597 U.S. at 436 n.3. And that is reflected by the codification of a key SSI benefits provision itself: Congress titled what is now section 1381a "[b]asic *eligibility* for benefits," but, from the beginning, the provision was codified with the title "[b]asic *entitlement* to benefits." *Compare* Social Security Amendments of 1972, Pub. L. No. 92-603, § 301, 86 Stat. 1329, 1465 (emphasis added) (capitalization normalized), *with* 42 U.S.C. § 1381a (1970 Supp. II) (emphasis added).

Moving on to "[SSI] *benefits*," that is naturally read to refer to the SSI program as a whole. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) (emphasis added). In plain usage, "benefit" is a broad term, including anything "that guards, aids, or promotes well-being: advantage, good." *Fischer v. United States*, 529 U.S. 667, 677-78 (2000) (citation omitted). And the plural "benefits" denotes "'more than one matter or thing.'" *Metro. Stevedore Co. v. Rambo*, 515 U.S. 291, 296 (1995) (citation omitted).

Which makes sense because SSI benefits are many. The SSI statute makes several different kinds of cash and non-cash benefits available to eligible individuals, including (a) basic cash payments, 42 U.S.C. § 1382(b); (b) cash payments for certain individuals who perform substantial gainful activity despite severe medical impairment, *id.* § 1382h(a); (c) Medicaid continuation, *id.* § 1382h(b); (d) state

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"entitle"); *Black's Law Dictionary* (12th ed. 2024, Westlaw) (defining "entitle" as to "qualify for" and "eligible" as "[f]it and proper to be selected or to receive a benefit; legally qualified for an office, privilege, or status").

supplementation payments, *id.* § 1382e; (e) vocational-rehabilitation services, *id.* § 1382d; and (f) cash payments for those whose disability has ceased but who are receiving vocational-rehabilitation services, *id.* § 1383(a)(6).

That the DSH provision incorporates SSI benefits, plural—or, put another way, the SSI program—is made explicit by the statutory text. The DSH provision expressly carves out one of these benefits: "State supplementation" payments. *Id.* § 1395ww(d)(5)(F)(vi)(I). All other SSI benefits must, then, be included when considering SSI eligibility. *See Hillman v. Maretta*, 569 U.S. 483, 496 (2013) ("[W]here Congress explicitly enumerates [an] exception[] to a general [rule], additional exceptions are not to be implied, in the absence of evidence of a contrary legislative intent." (citation omitted)).

3. The available legislative history supports the same conclusion. The Conference Report and the report from the Senate Committee on the Budget (which accompanied a bill that was materially identical to the ultimate Medicare fraction) described the DSH provision as requiring the Medicare fraction to count "Medicare patients who are also *enrolled in the federal Supplemental Security Income (SSI) program*." S. Rep. No. 99-146, at 291 (1985) (emphasis added); *accord* H.R. Rep. No. 99-453, at 460 (1985) (Conf. Rep.).

* * *

Putting it together, under the DSH provision, "entitled to benefits" and "eligible for" benefits mean qualifying for the relevant benefits program—whether that is Medicare part A, SSI, or Medicaid.

B. A Person Qualifies for the SSI Program Based on an Initial Application and Until Termination

An individual qualifies for the SSI program when she applies and is deemed eligible for that program, and she continues to qualify until her eligibility has been terminated.

1. To qualify for the SSI program, an individual must apply and show "[e]ligibility for benefits." 42 U.S.C. § 1382 (title); *see id.* § 1381a. In general, basic "eligib[ility]" is determined "on the basis of" an "aged, blind, or disabled individual['s] . . . income and resources." *Id.* § 1381a. To qualify as an "[e]ligible individual," an individual must be "aged, blind, or disabled" and meet (very low) statutory income and resource thresholds. *Id.* § 1382(a). For purposes of an initial application, the SSI statute measures income based on long-term financial need, specifying an income threshold for a "calendar year." *Id.* § 1382(a)(1)(A), (2)(A); *see supra* at 6 n.1.

An eligible individual is entitled to certain benefits. "Every aged, blind, or disabled individual who is determined . . . to be eligible on the basis of his income and resources shall, *in accordance with and subject to the provisions of this [title]*, be paid benefits." 42 U.S.C. § 1381a (emphasis added). The SSI statute thus provides a benefits entitlement qualified by other provisions of title XVI.

That is comparable to how Medicare part A works. *See, e.g.*, *id.* § 426(c)(1) ("[E]ntitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, [Medicare] part A . . . ."). As the Court explained in *Empire*, this means

Medicare part A benefits consist of an "entitlement to have payment made under, and subject to the limitations in, part A." *Empire*, 597 U.S. at 436 (citation omitted). In other words, "[t]he entitlement to *benefits* . . . is an entitlement to *payment under specified conditions*." *Id.* And that "'entitlement' coexists with limitations on payment." *Id.* Or, as the government put it, "entitlement to Part A benefits is a legal status that, in turn, triggers both the individual's right to have Medicare make payment for particular services and the limitations on that right." *Empire* Pet'r Br. 30 (No. 20-1312).

So too here. Once qualified for the SSI program, a beneficiary may receive any of the cash and non-cash benefits available under title XVI, subject to the conditions thereof. *See supra* at 10-12, 22-23; *infra* at 34-35. During that time, payments and the availability of other SSI benefits may fluctuate. But just as a person who has exhausted Medicare inpatient coverage for a year remains "entitled to [Medicare part A] benefits," a person who is not owed or does not receive certain SSI benefits in a given month still remains "entitled to [SSI] benefits." *See Empire*, 597 U.S. at 437 ("[T]he stoppage of payment for any given service cannot be thought to affect the broader statutory entitlement . . . ."); *infra* at 34-44.

And an individual continues to be eligible for the SSI program until termination. As noted, payment may stop in any given month. But that "suspension" of eligibility is distinct from "termination" of eligibility. *See, e.g.*, 42 U.S.C. § 1383(e)(1)(A) (making this distinction); 20 C.F.R. §§ 416.1320-416.1330. Unless someone's circumstances have changed enough that her ineligibility for payment persists for "12 consecutive months," she need not "reappl[y]" for

benefits for payment to resume. 42 U.S.C. § 1383(j)(1); 20 C.F.R. § 416.1335. Until a full year of ineligibility elapses, that is, a beneficiary remains qualified for the SSI program.

In sum, eligibility for the SSI program is based on long-term need and continues (subject to conditions) until there is a demonstrated lack of such need.

2. Other provisions confirm Congress understood the concept of long-term, program eligibility.

The SSI statute, for example, authorizes Social Security to access a beneficiary's financial records in order to monitor income and resources monthly. 42 U.S.C. § 1383(e)(1)(B)(ii)(I). An authorization lasts until "the cessation of the recipient's eligibility for benefits under [title XVI]." *Id.* § 1383(e)(1)(B)(ii)(II)(bb); *see* 20 C.F.R. § 416.207(f). The government would presumably agree that, under this provision, Social Security can access those records so long as program eligibility has not terminated—and need not obtain reauthorization every time a beneficiary becomes ineligible to receive a specific monthly cash payment. *See* POMS SI 00515.001(B)(1).

The SSI statute utilizes the same program-eligibility concept elsewhere too. For example, Social Security must conduct periodic reviews of certain disability determinations to ensure "continued eligibility for benefits under [title XVI]." 42 U.S.C. § 1382c(a)(3)(H)(ii)(I). This eligibility is reassessed on one- or multi-year timeframes—not as to eligibility for a particular benefit at a particular time. *E.g.*, *id.* (requiring review at least "every 3 years"). And other provisions show that someone may have a benefits

"entitlement" even when payment is "suspend[ed]" or "defer[red]." *Id.* § 1383(a)(2)(B)(viii).[4]

The SSI statute thus embraces the same program-eligibility concept that characterizes Medicare part A and Medicaid. That is the concept to which the DSH provision refers when it speaks of SSI entitlement.

C. A Program-Eligibility Reading Furthers the Purpose of the DSH Adjustment

Recognizing that entitlement to SSI benefits means program eligibility—and that an individual remains eligible until termination—also best serves the purpose of the DSH adjustment. The DSH adjustment is designed to "compensate hospitals for serving a disproportionate share of low-income patients" because they "are often more expensive to treat than higher income ones, even for the same medical conditions." *Empire*, 597 U.S. at 429, 444. Those higher costs stem from characteristics of the low-income population that persist over time.

Congress identified "two categories of reasons for these increased costs." H.R. Rep. No. 99-241, pt. I, at 16 (1985). *First*, "low-income [M]edicare patients are in poorer health." *Id.* They are "more severely ill than [the] average [patient]," even for the same diagnosis, and "tend to have more complications." *Id. Second*, hospitals that serve a "large share of low-income patients" typically have "extra overhead costs and higher staffing ratios." *Id.* These higher costs reflect,

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[4] CMS likewise recognizes that SSI eligibility is programmatic, not month-to-month. *See* Ctrs. for Medicare & Medicaid Servs., *Medicare Prescription Drug Benefit Manual* ch. 13, § 70.5.2 (Rev. 14, Oct. 1, 2018), https://tinyurl.com/y3wtzr9y ("*Drug Benefit Manual*") (accepting initial SSI award letter as proof of SSI eligibility).

among other things, "the special need for such personnel as medical social workers, translators, nutritional and health education workers." *Id.*

These reasons support counting SSI beneficiaries as low-income as long as they qualify for the SSI program. Program eligibility is a stable—and accurate—indicator of low-income status. Nearly 80% of beneficiaries remain program eligible for five years or more, measured from the date of application to a termination event requiring re-application. *See 2022 Statistical Report*, *supra*, at 170. This is the low-income population—subject to years of poverty, and likely experiencing the adverse and costly health consequences that result from such poverty—that was front of mind for the Congress that enacted the DSH provision. *See, e.g.*, H.R. Rep. No. 99-241, pt. I, at 16; *see also Empire*, 597 U.S. at 429, 444.

A patient may be program-eligible but not due a payment for many reasons that have nothing to do with her low-income status. Take SSI-eligible patients in Medicaid-paid nursing homes. They are undoubtedly low-income and especially costly for hospitals to treat. *See infra* at 45. It would be senseless not to count their hospitalization days.

Similarly, short-term changes in circumstances may make someone ineligible for a cash payment in a given month but do not alleviate the characteristics that make this population less healthy and costlier for hospitals to treat. Program-eligible individuals may be ineligible to receive a monthly cash payment for reasons unrelated to income, like being institutionalized or failing to comply with a request for information. 42 U.S.C. § 1382(e)(1)(A); 20 C.F.R. § 416.1322. Such individuals have not stopped being

low-income, in poorer health on average, or otherwise more expensive to care for.

The same is true of individuals whose incomes briefly pop above the limit for certain SSI cash payments. A month of extra income here or there over a years-long span of poverty hardly eliminates the poorer health that contributes to the higher costs compensated by the DSH adjustment. And the need for special services to properly care for this vulnerable population likewise remains. Nor is there even a temporal correlation between any momentary increase in income and the month of a patient's hospitalization. *See* 42 U.S.C. § 1382(c)(1) (amount of payment due for a month depends on income one or two months prior). Simply put, a patient's health does not improve overnight—and a hospital's costs do not decrease overnight—because the patient made $1,100, rather than $1,000, for a single month (which pre-dated her hospitalization in any event).

Measuring a low-income population using SSI program eligibility recognizes this reality. It captures those whom Congress has defined as "eligible individual[s]" based on their durable low income and age or disability. *Id.* § 1382(a). It continues to count these people until they have achieved some semblance of a steady, above-threshold income. And, since it does not turn on the complexity of month-to-month payment status, it has the added benefit of being straightforward to administer. In short, the program-eligibility measure "better captures low-income" Medicare patients and so sharpens the calculation of "what the Medicare fraction is designed to measure—the share of low-income Medicare patients relative to the total." *Empire*, 597 U.S. at 444-45.

II. The Alternative Interpretations Offered by the Government Do Not Hold Up

The government argues against a program-eligibility approach for SSI (only). CMS applies an "actual receipt" rule, counting only patients who actually receive cash payments for a given hospitalization month by the time it calculates the Medicare fraction. The government abandons that rule in favor of a "payment due" litigating position. That approach appears to count patients due an SSI payment for the hospitalization month (even if they had not received payment by the time CMS does its count), but would continue to exclude patients who are payment-ineligible for a hospitalization month or payment-eligible but with no payment due for that month. Neither rule is consistent with the statutory text; neither serves the population-counting purpose of the DSH provision; and both should be rejected.

A. CMS's "Actual Receipt" Rule Is Indefensible, and the Government Does Not Defend It

CMS counts an individual as "entitled to [SSI] benefits" only when she actually receives a cash payment for a given month. Pet. App. 6 & n.1 (CMS counts patients who "receive[d] an automated cash payment" or whose payments were "manage[d] manually"). This cannot be squared with the DSH provision—which counts individuals "entitled to [SSI] benefits," not those paid cash benefits.

As a textual matter, entitlement and receipt are different. This Court recognized as much in *Empire*: being "entitled" is different from "actually receiving payment." 597 U.S. at 435. To take just one obvious example, a beneficiary is *entitled* to a cash payment

for a month even if Social Security did not send it (and so she did not receive it) because it did not have her current address. *See* 20 C.F.R. § 416.1320(a).

And when Congress wants to refer to receipt or payment of SSI benefits, it says so explicitly. That is true in the SSI statute itself.[5] It is true in the Medicare statute.[6] And that convention carries over to the Medicaid statute too.[7] Congress's decision not to use similar terms in the DSH provision when referring to SSI entitlement strongly counsels against using actual receipt as the relevant rule. *See Azar v. Allina Health Servs.*, 587 U.S. 566, 577 (2019) ("When [Congress] did not adopt 'obvious alternative' language, 'the natural implication is that [it] did not intend' the alternative." (citation omitted)).

Somewhat puzzlingly, in other contexts, CMS has rejected an actual-receipt approach in favor of program eligibility—even when faced with a statute turning on receipt. In Medicare part D, Congress referred to "*recipients* of [SSI] benefits under [title] XVI" when discussing entitlement to prescription-drug subsidies. 42 U.S.C. § 1395w-114(a)(3)(B)(v)(I) (emphasis added). Even so, the agency applies the part D subsidy based on SSI program eligibility. An

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[5] *E.g.*, 42 U.S.C. § 1382(c)(3) (discussing increases in the "benefit amount payable . . . to an individual receiving benefits under this [title]"); *id.* § 1382d(d) (discussing individuals who "receive benefits" under section 1383(a)(6)).

[6] *E.g.*, 42 U.S.C. § 1395w-114(e)(3)(B) (including "recipient[s] of [SSI] benefits under [title] XVI" in a definition).

[7] *E.g.*, 42 U.S.C. § 1396a(a)(10)(A)(i)(II)(aa) (providing Medicaid eligibility for individuals "to whom [SSI] benefits are being paid under [title] XVI"); *id.* § 1396d(a) (referring to an individual "with respect to whom [SSI] benefits are not being paid under [title] XVI").

"individual needs to be reported eligible by [Social Security] for only 1 month in a calendar year to be deemed eligible from that month through the end of the year." *Drug Benefit Manual*, *supra*, ch. 13, § 40.2.1. And CMS accepts the initial SSI award letter—reflecting Social Security's determination of program eligibility, not monthly payments—as conclusive proof of eligibility for the part D subsidy. *Id.* § 70.5.2; *see also supra* at 27 n.4.

In this Court, the government has not defended CMS's actual-receipt rule. The government instead denies that CMS applies that rule at all. *See* BIO 16. That is impossible to square with the agency's own pronouncements in this case. *See* Pet. App. 119; *id.* at 81 ("[O]nly a person who is actually paid these benefits can be considered 'entitled.'"); *id.* at 82 ("[A] person [who] is eligible for SSI but is not actually receiving SSI payments . . . is not 'entitled' to SSI benefits."). It is hard to reconcile with the court of appeals' understanding of the agency's position. Pet. App. 2 ("[CMS] understands this population to include only patients receiving cash payments during the month in question."). And in the underlying rulemaking, CMS rejected commenters' suggestion that patients should count as "entitled to [SSI] benefits" when payment is due but has been delayed for administrative reasons and instead adopted a rule that counts them only if payment is received by the time CMS runs its count of SSI-entitled patients. 75 Fed. Reg. 50042, 50280, 50282 (Aug. 16, 2010). The government's abandonment of CMS's actual-receipt rule shows that the decisions below cannot stand and is reason enough to reverse.

B. The Government's "Payment Due" Rule Fares No Better

In lieu of the actual-receipt rule, the government now posits that patients are not "entitled to [SSI] benefits" unless they are due a cash payment greater than $0 for their hospitalization month. The drumbeat of the court of appeals' decision and the government's defense of this payment-due rule (so far) is that the SSI program is all about cash payments. *See* Pet. App. 9-11; BIO 12-14, 17-19. Based on that premise, the government has argued that SSI "benefits consist [only] of monetary payments . . . [of] 'income,'" such that entitlement to "[SSI] benefits" under the DSH provision turns solely on entitlement to a cash payment for a particular month. BIO 15; *see* Pet. App. 11-13. This feature, the argument goes, distinguishes SSI from the Medicare part A health-insurance program in *Empire*.

The government's position is flawed twice over—each flaw independently sufficient to reject the government's rule. First of all, the premise is wrong. SSI entitlement is not all about cash. But even if it were, the government's conclusion does not follow: an individual is "entitled" to cash benefits regardless whether payment is due for a given hospitalization month. Properly understood, the SSI program functions much like an income-insurance program, akin to Medicare part A health insurance. And, like Medicare part A, qualifying for SSI provides a right to payment of certain benefits at certain times, subject to specified limitations. Whatever differences exist, they are not enough to give "entitled to" two opposing meanings in the same sentence.

1. First, the premise. The government has argued, and the court of appeals held, that the entitlement at issue here "is different" from the entitlement at issue in *Empire* "because [SSI] benefits consist of monetary payments," whereas the Medicare part A entitlement in *Empire* was "'hospital insurance.'" BIO 15 (citation omitted); *see* Pet. App. 13. That is wrong.

Cash payments are a central pillar of the SSI program, yes. But they are not the only SSI benefit under title XVI; individuals remain eligible for non-cash SSI benefits, including in months when they are not eligible for a monthly cash payment. The SSI program provides a comprehensive and continuing set of supports, designed to meet low-income beneficiaries' needs until they secure enough income, for long enough, to ensure that income support is no longer necessary. When the DSH provision refers to "[SSI] benefits under [title] XVI," it refers to all SSI benefits, not just cash benefits.

a. SSI benefits include non-cash benefits, including vocational-rehabilitation services and continued Medicaid coverage.

Start with vocational rehabilitation. SSI has always included "[r]ehabilitation services for blind and disabled individuals." POMS DI 13501.005(A); *see* Social Security Amendments of 1972 § 301, 86 Stat. at 1474; 42 U.S.C. § 1382d; 20 C.F.R. § 416.2214(b). By statute, SSI-eligible individuals remain eligible for vocational-rehabilitation benefits even in months when cash payments are suspended. 42 U.S.C. § 1382d(e)(2); *see* 20 C.F.R. §§ 411.155, 416.2215.

So too for continued Medicaid coverage. In most states, receipt of SSI cash payments qualifies a person for Medicaid health coverage. 42 U.S.C. § 1396a(a)

(10)(A)(i)(II). But even when cash payments are paused due to a blind or disabled beneficiary's income, the beneficiary remains eligible for continued Medicaid benefits. *Id.* § 1382h(b)(1).

b. The court of appeals and the government contend that these non-cash benefits are not "[SSI] benefits *under [title] XVI*," 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) (emphasis added), because they are "housed" outside of title XVI, *see* Pet. App. 11-12; BIO 18-19. That argument does not withstand scrutiny.

i. Starting, again, with vocational-rehabilitation benefits. The court of appeals focused on the Ticket to Work program. It believed that, because that program appears, in part, in title XI, the reference in title XVI to vocational rehabilitation provides "a funding mechanism for a [title] XI benefit," as opposed to a benefit "under [title] XVI." Pet. App. 10-12. But Ticket to Work is not the only (or even the most common) vocational-rehabilitation program, and the primary program is still housed in title XVI. And even Ticket to Work is, fundamentally, a title XVI benefit.

To understand why, some background helps. As initially enacted, blind or disabled SSI beneficiaries were referred to state agencies for free vocational-rehabilitation services, which the federal government reimbursed at cost. *See* Social Security Amendments of 1972 § 301, 86 Stat. at 1474. That provision was added as section 1615 of the Social Security Act—*i.e.*, it was housed in title XVI when Congress enacted the DSH provision, and remains in title XVI today. *Id.*; *see* 42 U.S.C. § 1382d (1970 Supp. II); 42 U.S.C. § 1382d (1982 Supp. IV); 42 U.S.C. § 1382d (current). Congress also established a similar benefit for Social Security Disability Insurance (SSDI) beneficiaries. 42 U.S.C. § 422.

In 1999—after enactment of the DSH provision (in 1986)—Congress enacted the Ticket to Work Act. *See* Ticket to Work and Work Incentives Improvement Act of 1999, Pub. L. No. 106-170, § 101(a), 113 Stat. 1860, 1863-81 (codified at 42 U.S.C. § 1320b-19). The Act combined some provisions governing both SSI and SSDI vocational-rehabilitation programs into a single statutory section housed in title XI's "General Provisions." The Act expanded vocational-rehabilitation services and provided beneficiaries with alternatives for those services. *See id.* As a result, beneficiaries now have greater choice of where to obtain vocational-rehabilitation services. 42 U.S.C. § 1320b-19(a), (b)(2). And if they choose a state agency, that agency has the option of providing those services under the Ticket to Work milestone-based model (set forth in title XI) or under the traditional cost-reimbursement model (which remains in title XVI). *See id.* §§ 1320b-19(c)(1), 1382d(d)-(e).

So understood, vocational-rehabilitation services are and have always been a title XVI benefit.

First, historically *all* SSI vocational-rehabilitation services were provided under title XVI; and even today *most* SSI vocational-rehabilitation services are provided under title XVI. States have overwhelmingly opted to provide these benefits under the traditional, pre–Ticket to Work option that has always been located in title XVI. *See id.* § 1382d(d)-(e); Gina A. Livermore et al., Ctr. for Studying Disability Pol'y, *Ticket to Work Participant Characteristics and Outcomes Under the Revised Regulations* 17 (Sept. 24, 2012), http://tinyurl.com/mr2d37cz. When they do so, they are electing to have an SSI beneficiary not "participate in the [Ticket to Work] Program."

42 U.S.C. § 1320b-19(c)(1). So that program's placement outside of title XVI is beside the point.

Second, even Ticket to Work is not a distinct "title XI" benefit. Pet. App. 12. The only way to receive Ticket to Work services is to qualify for a benefit program outside of title XI (SSI or SSDI); there are no eligibility criteria within Ticket to Work itself. *See* 42 U.S.C. § 1320b-19(k)(4) (defining "title XVI disability beneficiary" by reference to "eligib[ility] for [SSI] benefits under [title] XVI on the basis of blindness . . . or disability"). Funding, too, comes from SSI or SSDI. *See id.* § 1320b-19(j)(1). This means that, for SSI beneficiaries, funding comes from title XVI. *See id.* § 1320b-19(j)(1)(B) (drawing funding from the appropriation "under section 1381," in title XVI).

Whether or not Ticket to Work is involved, vocational-rehabilitation services are, in every relevant sense, benefits "under [title] XVI."

ii. Medicaid continuation is similar in this respect. Even though Medicaid is governed by title XIX, the continuation benefit arises solely out of section 1382h(b). And the SSI statute itself refers to continued Medicaid coverage as a "benefit[] pursuant to section 1382h(b)," *id.* § 1383(j), and "assistance under section 1382h(b)," *id.* § 1382d(e)(1)(B). As section 1382h(b) is a title XVI provision, Congress plainly understood Medicaid continuation to be an "[SSI] benefit under [title] XVI."

c. The court of appeals and the government also suggest that, notwithstanding these other SSI benefits under title XVI, Congress understands SSI benefits to reduce to cash benefits alone. *See* Pet. App. 9-11; BIO 12, 17-18. For support, they point to

the word "income" and some scattered statutory references to a singular SSI benefit. Neither works.

First, both the court of appeals and the government have emphasized that the DSH provision (like the SSI statute itself) refers to "supplementary security *income* benefits," seeming to equate "income" with "cash payment." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) (emphasis added); *see* Pet. App. 9-10; BIO 12. But the word "income"—both ordinarily and especially in this context—does not stop at cash. Federal law routinely counts in-kind benefits as "income." For SSI itself, Congress defined income to include "support and maintenance furnished in cash or kind." 42 U.S.C. § 1382a(a)(2)(A). And the many in-kind benefits that SSI provides would count as "income" if provided to an employee—including a transit pass, job-related courses, and job-placement services. *See* 26 U.S.C. § 61(a)(1); Internal Revenue Serv., Publication 15-B, *Employer's Tax Guide to Fringe Benefits* (2024), https://tinyurl.com/ymph8j4p.

Second, the government and the court of appeals rely on cherrypicked statutory provisions to suggest that SSI is all about a singular cash benefit. They start with an anodyne provision setting an annual benefit payment amount under SSI: "[t]he benefit under [title XVI] for an individual . . . shall be payable at the rate of $1,752" per year (adjusted for inflation and reduced by the beneficiary's income). 42 U.S.C. § 1382(b)(1). The court of appeals reasoned that, by using the definitive article "*the* benefit" instead of "*a* benefit," and setting out "specific dollar amounts," Congress limited SSI benefits to "the" cash payment. Pet. App. 10; *see* BIO 12.

That choice of article cannot do nearly this much work. For one thing, the DSH provision refers to

benefits in the plural, and says nothing about payment due. *See supra* at 22. Indeed, by expressly "excluding any State supplementation," 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the DSH provision acknowledges that "[t]he benefit" under section 1382 is not the only benefit under title XVI, *see id.* § 1382e. Congress's decision, when talking about the amount of one cash benefit in one SSI provision, to refer to *that* benefit cannot support any broader conclusion about the nature of SSI benefits more broadly. And there are also scores of SSI provisions referring to "*a* benefit under [title XVI]," or (like DSH) "benefits" plural—further undermining the suggestion that intermittent use of the definitive article should be given such conclusive weight.[8]

The court of appeals also focused on the statute governing procedures for Ticket to Work. Pet. App. 10-11. In crafting that program, Congress defined "[t]he term '[SSI] benefit under [title] XVI' [to] mean[] a cash benefit under section 1382 or 1382h(a) of this title." 42 U.S.C. § 1320b-19(k)(5). But that definition applies only "[i]n this section," *id.* § 1320b-19(k), which is over 1,000 pages away from the DSH provision in the U.S. Code. It does not purport to define "[SSI] benefits under [title] XVI" for purposes of the DSH provision.

If anything, the Ticket to Work definition shows that Congress understood SSI benefits under title XVI to sweep in a range of cash *and* non-cash benefits broader than the section 1382 monthly payment. The

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[8] *See, e.g.*, 42 U.S.C. § 1382(c)(7) ("application . . . for benefits under [title XVI]"); *id.* § 1382(f)(2)(A) ("eligible to receive a benefit under [title XVI]"); *id.* § 1382b(c) ("ineligible for benefits under [title XVI]"); *id.* § 1383(p)(1)(C)(i) ("eligible for a benefit under [title XVI]").

definition explicitly includes another cash payment, under section 1382h(a). Congress would not have had to adopt any curated definition of "[SSI] benefit[] under [title] XVI" for Ticket to Work if those two cash payments were the sum total of SSI benefits under title XVI. *Id.* § 1320b-19(k)(5). By excluding some SSI benefits and not others, the definition—like the DSH formula itself—takes as a given that the phrase "[SSI] benefits under [title] XVI" encompasses many different benefits—not just a single cash benefit. *See id.* § 1395ww(d)(5)(F)(vi)(I).

* * *

In sum, "[SSI] benefits under [title] XVI" go far beyond monthly cash payments. There is accordingly no textual justification for excluding patients who are entitled to, eligible for, and due non-cash SSI benefits simply because they are not due a cash payment in a given month. Those patients remain "entitled to [SSI] benefits under [title] XVI" in every way that matters.

2. There is an even bigger problem with the government's reading. Even if "[SSI] benefits under [title] XVI" somehow refers only to cash, that still would not justify reading the phrase "entitled to benefits" to require that payment be due. That is of course not what it means for Medicare part A (in the same sentence) or for Medicaid (in the neighboring fraction). The government has argued, and the court of appeals believed, that differences between the entitlement programs compel the anomalous result of reading the same phrase differently. They point specifically to two differences: (a) the scope of the entitlement, and (b) fluctuations in eligibility. These distinctions neither exist nor change the outcome.

a. Starting with the scope of the respective entitlements. According to the government, the SSI

entitlement is a narrow one to "'be paid benefits,'" whereas the Medicare entitlement is a broader right to "insurance" that persists even without a right to payment at any given time. *See* BIO 12-15 (emphasis omitted) (citation omitted). The court of appeals similarly distinguished SSI from Medicare part A on the basis that SSI benefits do not "extend well beyond payment . . . at specific times." Pet. App. 13. Neither characterization is accurate.

SSI operates as an income-insurance program even as to cash benefits. Much of that follows from what has already been said. To refresh: "[e]very aged, blind, or disabled individual who is determined . . . to be eligible on the basis of his income and resources" secures "[b]asic eligibility for benefits." Social Security Amendments of 1972 § 301, 86 Stat. at 1465 (capitalization normalized); *see* 42 U.S.C. § 1382(a) (defining "eligible individual" by reference to annual income and resources). And this "[b]asic eligibility" for SSI confers a right to "be paid benefits" "in accordance with and subject to the provisions of [title XVI]." Social Security Amendments of 1972 § 301, 86 Stat. at 1465 (capitalization normalized); *see* 42 U.S.C. § 1381a. This payment right "is an entitlement to *payment under specified conditions*" that remains even when those conditions are not met at a particular time. *Empire*, 597 U.S. at 436. Or as *Empire* explained, "entitlement" or "eligibility" "coexists with limitations on payment." *Id.*; *see id.* at 435, 438.

Once eligible, SSI supplements a beneficiary's income in months when needed, while limiting payments (and sometimes reducing them to $0) in months when the need is less. Such payment adjustments occur for all "eligible individual[s]." 42 U.S.C. § 1382(a), (b)(1). As the government has

acknowledged, a person may be *eligible* for benefits under title XVI even if the cash payment *due* for a given month is $0. *See* 75 Fed. Reg. at 50280. And a beneficiary remains eligible until she has "medically improve[d]" or has been "ineligible for any SSI benefit . . . for 12 consecutive months." POMS SI 02302.006(B)(2)(f); *see* 42 U.S.C. § 1383(j); 20 C.F.R. § 416.1335. Until then, a host of statutory provisions, aimed at preserving income stability for SSI beneficiaries, are available as needed.

That is by design. In 1986, the same Congress that enacted the DSH provision "recognize[d] the reality that severely impaired individuals who attempt to work may not be able to follow a steady progression" to self-sufficiency, and may often face "setbacks." H.R. Rep. No. 99-893, at 14 (1986). That is why Congress established "a relatively simple transition, in either direction, among the various categories of benefits." *Id.*; *see supra* at 10-12, 22-23, 34-37 (collecting categories of SSI benefits). The upshot is income-insurance coverage that confers income stability for at least a year.

In sum, Congress enacted a continuing safety net, comprising a suite of benefits that extends to SSI beneficiaries throughout their period of program eligibility, even in months when cash payments are not due because the payment amount is set at $0. That income support—a continuing entitlement to payment subject to the conditions and limitations in title XVI—makes SSI much more analogous to Medicare part A's insurance program than the court of appeals and the government acknowledge.

b. The court of appeals also relied on what it viewed as stability in Medicare eligibility compared to instability in SSI eligibility. According to the court,

Medicare beneficiaries rarely lose eligibility, whereas SSI beneficiaries "routinely ping-pong in and out . . . depending on fluctuations in their income or wealth from one month to another." Pet. App. 13. That conflates payment eligibility and program eligibility, and the reality is that beneficiaries do not "routinely ping-pong in and out" of SSI program eligibility. *Id.*

The court of appeals' reasoning on this point fails first and foremost because it simply assumes that SSI eligibility is a purely monthly inquiry. That is wrong, for reasons that have already been discussed. In short: payment eligibility is not the same thing as program eligibility; as to Medicare part A and Medicaid, we already know that the DSH provision is concerned with the latter, not the former; and SSI itself clearly contemplates program eligibility beyond monthly payments. *See supra* at 24-27. Because SSI eligibility means program eligibility—and is broader than monthly payment eligibility—the court of appeals' concern about monthly fluctuations in income provides no basis for distinguishing SSI from Medicare part A or Medicaid.

That matches the reality (which Congress anticipated) that, for SSI beneficiaries, progress toward self-sufficiency is not always steady. As noted above, nearly 80% of beneficiaries remain eligible for SSI benefits for five years or more, regardless of episodic changes in intervening payment status. *2022 Statistical Report*, *supra*, at 170. What's more, it is difficult for SSI beneficiaries to transition out of the SSI program by earning income. Only about 8% to 12% of SSI beneficiaries work in a year. Jack Smalligan & Chantel Boyens, *Raising the Alarm on the Unintended Consequences of Social Security's Return to Work Policies* 6 (Mar. 2023), https://tinyurl.com/3ktkm6xc.

And most beneficiaries who see their cash payments suspended due to a month or two of higher earned income are not able to sustain those earnings. A study that examined the work activity for people who became eligible for the SSI program in 2001 found that in the following 15 years, about 22% of them had some earnings, about 12% had sufficient earnings to suspend cash benefits at some point, but less than 0.5% had sufficient earnings for benefits to be terminated—over a decade and a half. *Id.* at 6-7.

c. That is not to say that the three entitlement programs are all the same. Of course they are not. Medicare part A eligibility, for example, *is* more stable than SSI eligibility (because age moves in only one direction). But they are not different in any way that matters. And they are not different enough to overcome the presumption that "entitled to benefits" in the DSH provision should have the same meaning both times it is used in the numerator of the Medicare fraction—and the same meaning as the analogous phrase in the nearby Medicaid fraction.

C. The "Actual Receipt" and "Payment Due" Rules Both Fail to Capture the DSH-Relevant Population and Are Unworkable

CMS's actual-receipt rule and the government's payment-due rule have plenty of problems as a matter of text, context, and structure. They also fail miserably at doing what "the Medicare fraction is designed to" do: "measure . . . the share of low-income Medicare patients" in a hospital's patient population. *Empire*, 597 U.S. at 445. And they create instability and arbitrariness in the DSH formula—all of which makes the DSH program "harder," if not impossible, "to administer." *Id.* at 443.

1. The actual-receipt and payment-due rules all but guarantee that significant numbers of low-income individuals—the "patients the DSH provisions care about"—will be omitted from the DSH formula entirely. *Id.* at 444.

Most egregiously, many SSI-eligible, low-income patients will be excluded *because* they need extensive medical care. For SSI-eligible patients in Medicaid-paid medical facilities, including nursing homes, SSI payments are reduced to $0 if countable income exceeds $30—which it almost always does by virtue of Social Security retirement or disability benefits. 42 U.S.C. § 1382(e)(1)(B); *id.* § 426(a)-(b). When these patients are transferred to a hospital for inpatient care (a common occurrence), they will not count in the Medicare fraction numerator because their SSI payments are $0. *See* 75 Fed. Reg. at 50281. But because they are eligible for Medicare part A, they also will be excluded from the Medicaid fraction—meaning they are not counted as low-income at all. That is so even though, as patients eligible for both Medicaid and Medicare part A, they "are generally poorer," "have worse health status," and have higher hospitalization rates than other Medicare beneficiaries. *See* Misha Segal, Ctrs. for Medicare & Medicaid Servs., *Dual Eligible Beneficiaries and Potentially Avoidable Hospitalizations* 1 (Sept. 2011), https://tinyurl.com/m8a22yra.

The rules applied by CMS and advanced by the government commit another sin that disqualified the payment-focused reading in *Empire*: they turn on facts bearing "no relationship to [a patient's] financial status." 597 U.S. at 442. By focusing on whether a patient receives or is due a payment for a particular month, they exclude patients who meet *all* SSI criteria

for a cash payment during their hospital stay. As noted above, eligibility for a cash payment is based on income and other characteristics for the *payment* month, but the amount of the payment is based on income and other characteristics for a *prior* month. *See* 42 U.S.C. § 1382(c)(1). The actual-receipt and payment-due rules thus drop 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. This may happen because a patient pulled an extra shift a month or two before, when her health was better. *See* 20 C.F.R. § 416.203(b). Or because a patient's family member chipped in for rent the prior month.

CMS's actual-receipt rule is especially flawed in this respect. That rule excludes patients from the DSH formula who are undoubtedly low-income—patients actually *due* SSI payments because they are low-income—simply because SSI has not made payment for administrative reasons like undeliverable mail. *See* 20 C.F.R. § 416.1320(a) (distinguishing suspension of payments for administrative reasons from other suspensions).

None of this "better captures low-income" patients. *Empire*, 597 U.S. at 445. Like the "actual-payment test" rejected in *Empire*, the actual-receipt and payment-due rules "count[] fewer, not more, of the low-income patients the DSH provisions care about." *Id.* at 444.

2. The actual-receipt and payment-due rules are also exceedingly difficult to administer. Unlike SSI program eligibility, SSI payment status can vary significantly each month—resulting in a constant month-by-month churn that has little to do with financial status or the cost of care.

What's worse, monthly payment determinations are often wrong. SSI payment rules are so complicated that Social Security frequently misapplies them. In a recent year, nearly 10% of SSI payments were incorrect. Soc. Sec. Admin., *FY2019 Agency Financial Report* 172 (Nov. 12, 2019), https://tinyurl.com/2ur5e5mf. Zeroing in on minuscule month-to-month changes, from an array of possible income sources, would unnecessarily repeat and import these errors in the DSH formula.

The way CMS implements its rule only amplifies that senselessness. According to CMS, for a patient to count as "entitled to [SSI] benefits," payment must be made at some point before the Medicare fraction is calculated. 75 Fed. Reg. at 50282. Yet besides being prone to error, Social Security is also often very slow to process and complete payment. *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* 4, 6 (June 20, 2011), https://tinyurl.com/4fcpc2dh (noting that "past-due benefits [in the audit sample] occurred over an average of 30 months, ranging from 1 to 229 months"). So CMS's actual-receipt approach builds a complicated calculation—which itself generates extensive errors—on top of a foundation made of sand. *See, e.g.*, *Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252, 1259 (D.C. Cir. 2023) (describing evidence "that the . . . matching process missed thousands of Medicare patient days attributable to patients who qualified for SSI benefits"); Pet. 19-23.

3. The government does not defend the CMS actual-receipt rule and concedes (in a gross understatement) that its payment-due rule is not a "perfect" proxy for low-income patients. BIO 16-17.

But the payment-due rule is still superior, the government says, because it avoids counting "an individual whose income dramatically increased." BIO 15-16. That concern is misplaced.

For one thing, it isn't realistic. SSI beneficiaries rarely move from suspension to full termination, suggesting that those with "dramatically increased" income within months of receiving an SSI payment are few and far between. *See supra* at 28, 43-44. Regardless, Congress understood that for SSI beneficiaries, income increases can be erratic and financial gains fragile. That is why the SSI program continues to support SSI beneficiaries even in months when they are due no cash payment, for at least a year. Congress made the judgment that such beneficiaries are financially insecure, even if less strapped for cash in some months than in others, and placed them comfortably within the DSH low-income population.

The DSH adjustment's purpose also undercuts any concern about chimerical, suddenly wealthy SSI beneficiaries. Congress required CMS to measure a hospital's treatment of low-income patients because "low-income patients tend to be in worse health and therefore costlier to treat." Pet. App. 3; *see Empire*, 597 U.S. at 429. To meet initial eligibility standards, an SSI applicant must have great financial need. *See supra* at 6, 24. An abrupt (and improbable) windfall within a year of such great financial need would not erase the health effects of living in the impoverished conditions that generate the higher healthcare costs the DSH adjustment is designed to address. *See Literature Summary*, *supra* (describing research on the "increased risk for mental illness, chronic disease, higher mortality, and lower life expectancy" for "residents of impoverished communities").

In one respect, the government is correct: no low-income proxy is perfect. But to be a proxy at all, the focus has to be on measuring the low-income population that Congress was targeting: patients with a tendency to be in worse health and to be more costly for hospitals to treat. Eligibility for SSI benefits—*i.e.*, qualifying for the SSI program—better approximates that population. The negligible risk of sweeping in a high-income patient is far outweighed by the certainty of excluding low-income patients based on the vagaries of receiving or being due a cash payment for a specific month.

The government's approach may "save money" by "significantly reducing [CMS's] reimbursements to hospitals that serve low-income patients." *Empire*, 597 U.S. at 446 (Kavanaugh, J., dissenting). But it does so at great cost to hospitals and the patients they serve. Such "frugality" cannot be pursued "in derogation of law." *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 20 n.1 (D.C. Cir. 2011) (Kavanaugh, J., concurring in the judgment). And it cannot justify reading the DSH provision to defeat its own purpose of counting low-income patients.

* * *

Hospitals that care for low-income patients depend on the extra compensation that Congress mandated to keep their doors open. Congress used the same words in the same sentence to ensure that hospitals' low-income Medicare population would be measured by a stable SSI-eligibility proxy that fully captures this financially fragile population. The claimed differences between the entitlement programs do not justify defying Congress's textual command and cannot countenance the government's destructive and counterintuitive approach.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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ADDENDUM

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42 U.S.C. § 1320b-19

§ 1320b-19. 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.

* * *

(c) State participation

(1) In general

Each State agency administering or supervising the administration of the State plan approved under title I of the Rehabilitation Act of 1973 (29 U.S.C. 720 et seq.) may elect to participate in the Program as an employment network with respect to a disabled beneficiary. If the State agency does elect to participate in the Program, the State agency also shall elect to be paid under the outcome payment system or the outcome-milestone payment system in accordance with subsection (h)(1). With respect to a disabled beneficiary that the State agency does not elect to have participate in the Program, the State agency shall be paid for services provided to that beneficiary under the system for payment

applicable under section 422(d) of this title and subsections (d) and (e) of section 1382d of this title. The Commissioner shall provide for periodic opportunities for exercising such elections.

* * *

(j) Authorizations

(1) Payments to employment networks

(A) Title II disability beneficiaries

There are authorized to be transferred from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund each fiscal year such sums as may be necessary to make payments to employment networks under this section. Money paid from the Trust Funds under this section with respect to title II disability beneficiaries who are entitled to benefits under section 423 of this title or who are entitled to benefits under section 402(d) of this title on the basis of the wages and self-employment income of such beneficiaries, shall be charged to the Federal Disability Insurance Trust Fund, and all other money paid from the Trust Funds under this section shall be charged to the Federal Old-Age and Survivors Insurance Trust Fund.

(B) Title XVI disability beneficiaries

Amounts authorized to be appropriated to the Social Security Administration under section 1381 of this title shall include amounts necessary to carry out the provisions of this section with respect to title XVI disability beneficiaries.

* * *

(k) Definitions

In this section:

* * *

(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.

* * *

42 U.S.C. § 1381a

§ 1381a. 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.

42 U.S.C. § 1382

§ 1382. Basic entitlement to 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 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.

(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 income 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 individual) 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 certified 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 comprising 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 confinement 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 periodic 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 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.

* * *

42 U.S.C. § 1382d

§ 1382d. 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.

(b) Repealed. Pub. L. 97-35, title XXI, §2193(c)(8)(B), Aug. 13, 1981, 95 Stat. 828

(c) Repealed. Pub. L. 106-170, title I, §101(b)(2)(B), Dec. 17, 1999, 113 Stat. 1874

(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, 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.

42 U.S.C. § 1382e

§ 1382e. 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 excluded 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 receiving benefits determined under section 1382(e)(1)(B) of this title.

* * *

42 U.S.C. § 1382h

§ 1382h. 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 under 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.

42 U.S.C. § 1383

§ 1383. Procedure for payment of benefits

* * *

(e) Administrative requirements prescribed by Commissioner; criteria; reduction of benefits to individual for noncompliance with requirements; payment to homeless

(1)(A) The Commissioner of Social Security shall, subject to subparagraph (B) and subsection (j), prescribe such requirements with respect to the filing of applications, the suspension or termination of assistance, the furnishing of other data and material, and the reporting of events and changes in circumstances, as may be necessary for the effective and efficient administration of this subchapter.

(B)(i) The requirements prescribed by the Commissioner of Social Security pursuant to subparagraph (A) shall require that eligibility for benefits under this subchapter will not be determined solely on the basis of declarations by the applicant concerning eligibility factors or other relevant facts, and that relevant information will be verified from independent or collateral sources and additional information obtained as necessary in order to assure that such benefits are only provided to eligible individuals (or eligible spouses) and that the amounts of such benefits are correct. For this purpose and for purposes of federally administered supplementary payments of the type described in section 1382e(a) of this title (including payments pursuant to an agreement entered into under section 212(a) of Public

Law 93-66), the Commissioner of Social Security shall, as may be necessary, request and utilize information available pursuant to section 6103(l)(7) of the Internal Revenue Code of 1986, and any information which may be available from State systems under section 1320b-7 of this title, and shall comply with the requirements applicable to States (with respect to information available pursuant to section 6103(l)(7)(B) of such Code) under subsections (a)(6) and (c) of such section 1320b-7 of this title.

(ii)(I) The Commissioner of Social Security may require each applicant for, or recipient of, benefits under this subchapter to provide authorization by the applicant or recipient (or by any other person whose income or resources are material to the determination of the eligibility of the applicant or recipient for such benefits) for the Commissioner to obtain (subject to the cost reimbursement requirements of section 1115(a) of the Right to Financial Privacy Act [12 U.S.C. 3415]) from any financial institution (within the meaning of section 1101(1) of such Act [12 U.S.C. 3401(1)]) any financial record (within the meaning of section 1101(2) of such Act [12 U.S.C. 3401(2)]) held by the institution with respect to the applicant or recipient (or any such other person) whenever the Commissioner determines the record is needed in connection with a determination with respect to such eligibility or the amount of such benefits.

(II) Notwithstanding section 1104(a)(1) of the Right to Financial Privacy Act [12 U.S.C. 3404(a)(1)], an authorization provided by an applicant or recipient (or any other person whose income or resources are

material to the determination of the eligibility of the applicant or recipient) pursuant to subclause (I) of this clause shall remain effective until the earliest of—

(aa) the rendering of a final adverse decision on the applicant's application for eligibility for benefits under this subchapter;

(bb) the cessation of the recipient's eligibility for benefits under this subchapter; or

(cc) the express revocation by the applicant or recipient (or such other person referred to in subclause (I)) of the authorization, in a written notification to the Commissioner.

(III)(aa) An authorization obtained by the Commissioner of Social Security pursuant to this clause shall be considered to meet the requirements of the Right to Financial Privacy Act [12 U.S.C. 3401 et seq.] for purposes of section 1103(a) of such Act [12 U.S.C. 3403(a)], and need not be furnished to the financial institution, notwithstanding section 1104(a) of such Act [12 U.S.C. 3404(a)].

(bb) The certification requirements of section 1103(b) of the Right to Financial Privacy Act [12 U.S.C. 3403(b)] shall not apply to requests by the Commissioner of Social Security pursuant to an authorization provided under this clause.

(cc) A request by the Commissioner pursuant to an authorization provided under this clause is deemed to meet the requirements of section 1104(a)(3) of the Right to Financial Privacy Act [12 U.S.C. 3404(a)(3)]

and the flush language of section 1102 of such Act [12 U.S.C. 3402].

(IV) The Commissioner shall inform any person who provides authorization pursuant to this clause of the duration and scope of the authorization.

(V) If an applicant for, or recipient of, benefits under this subchapter (or any such other person referred to in subclause (I)) refuses to provide, or revokes, any authorization made by the applicant or recipient for the Commissioner of Social Security to obtain from any financial institution any financial record, the Commissioner may, on that basis, determine that the applicant or recipient is ineligible for benefits under this subchapter, determine that adjustment or recovery on account of an overpayment with respect to the applicant or recipient would not defeat the purpose of this subchapter, or both.

(iii)(I) The Commissioner of Social Security may require each applicant for, or recipient of, benefits under this subchapter to provide authorization by the applicant, recipient or legal guardian (or by any other person whose income or resources are material to the determination of the eligibility of the applicant or recipient for such benefits) for the Commissioner to obtain from any payroll data provider (as defined in section 1320e-3(c)(1) of this title) any record held by the payroll data provider with respect to the applicant or recipient (or any such other person) whenever the Commissioner determines the record is needed in connection with a determination of initial or ongoing eligibility or the amount of such benefits.

(II) An authorization provided by an applicant, recipient or legal guardian (or any other person whose income or resources are material to the determination of the eligibility of the applicant or recipient) under this clause shall remain effective until the earliest of—

(aa) the rendering of a final adverse decision on the applicant's application for eligibility for benefits under this subchapter;

(bb) the cessation of the recipient's eligibility for benefits under this subchapter;

(cc) the express revocation by the applicant, or recipient (or such other person referred to in subclause (I)) of the authorization, in a written notification to the Commissioner; or

(dd) the termination of the basis upon which the Commissioner considers another person's income and resources available to the applicant or recipient.

(III) The Commissioner of Social Security is not required to furnish any authorization obtained pursuant to this clause to the payroll data provider.

(IV) The Commissioner shall inform any person who provides authorization pursuant to this clause of the duration and scope of the authorization.

(V) If an applicant for, or recipient of, benefits under this subchapter (or any such other person referred to in subclause (I)) refuses to provide, or revokes, any authorization required by subclause (I), paragraph (2)(B) and paragraph (10) shall not apply to such applicant or recipient beginning with the first day of

the first month in which he or she refuses or revokes such authorization.

* * *

(j) Application and review requirements for certain individuals

(1) Notwithstanding any provision of section 1382 or 1382h of this title, any individual who—

(A) was an eligible individual (or eligible spouse) under section 1382 of this title or was eligible for benefits under or pursuant to section 1382h of this title, and

(B) who, after such eligibility, is ineligible for benefits under or pursuant to both such sections for a period of 12 consecutive months (or 24 consecutive months, in the case of such an individual whose ineligibility for benefits under or pursuant to both such sections is a result of being called to active duty pursuant to section 12301(d) or 12302 of title 10 or section 502(f) of title 32),

may not thereafter become eligible for benefits under or pursuant to either such section until the individual has reapplied for benefits under section 1382 of this title and been determined to be eligible for benefits under such section, or has filed a request for reinstatement of eligibility under subsection (p)(2) and been determined to be eligible for reinstatement.

(2)(A) Notwithstanding any provision of section 1382 of this title or section 1382h of this title (other than subsection (c) thereof), any individual who was eligible for benefits pursuant to section 1382h(b) of this title, and who—

(i)(I) on the basis of the same impairment on which his or her eligibility under such section 1382h(b) of this title was based becomes eligible (other than pursuant to a request for reinstatement under subsection (p)) for benefits under section 1382 or 1382h(a) of this title for a month that follows a period during which the individual was ineligible for benefits under sections 1382 and 1382h(a) of this title, and

(II) has earned income (other than income excluded pursuant to section 1382a(b) of this title) for any month in the 12-month period preceding such month that is equal to or in excess of the amount that would cause him or her to be ineligible for payments under section 1382(b) of this title for that month (if he or she were otherwise eligible for such payments); or

(ii)(I) on the basis of the same impairment on which his or her eligibility under such section 1382h(b) of this title was based becomes eligible under section 1382h(b) of this title for a month that follows a period during which the individual was ineligible under section 1382 of this title and section 1382h of this title, and

(II) has earned income (other than income excluded pursuant to section 1382a(b) of this title) for such month or for any month in the 12-month period preceding such month that is equal to or in excess of the amount that would cause him or her to be ineligible for payments under section 1382(b) of this title for that month (if he or she were otherwise eligible for such payments);

shall, upon becoming eligible (as described in clause (i)(I) or (ii)(I)), be subject to a prompt review of the type described in section 1382c(a)(4) of this title.

(B) If the Commissioner of Social Security determines pursuant to a review required by subparagraph (A) that the impairment upon which the eligibility of an individual is based has ceased, does not exist, or is not disabling, such individual may not thereafter become eligible for a benefit under or pursuant to section 1382 of this title or section 1382h of this title until the individual has reapplied for benefits under section 1382 of this title and been determined to be eligible for benefits under such section.

* * *

42 U.S.C. § 1395ww

§ 1395ww. Payments to hospitals for inpatient hospital services

* * *

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

* * *

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

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

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

* * *

(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.

* * *

Social Security Amendments of 1972,
Pub. L. No. 92-603, 86 Stat. 1329

AN ACT

To amend the Social Security Act, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act, with the following table of contents, may be cited as the "Social Security Amendments of 1972".

* * *

SEC. 301. Effective January 1, 1974, title XVI of the Social Security Act is amended to read as follows:

* * *

"BASIC ELIGIBILITY FOR BENEFITS

"SEC. 1602. 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 title, be paid benefits by the Secretary of Health, Education, and Welfare.

* * *

20 C.F.R. § 416.1320

§ 416.1320 Suspensions; general.

(a) *When suspension is proper.* Suspension of benefit payments is required when a recipient is alive but no longer meets the requirements of eligibility under title XVI of the Act (see subpart B of this part) and termination in accordance with §§ 416.1331 through 416.1335 does not apply. (This subpart does not cover suspension of payments for administrative reasons, as, for example, when mail is returned as undeliverable by the Postal Service and the Administration does not have a valid mailing address for a recipient or when the representative payee dies and a search is underway for a substitute representative payee.)

(b) *Effect of suspension.* (1) When payments are correctly suspended due to the ineligibility of a recipient, payments shall not be resumed until the individual again meets all requirements for eligibility except the filing of a new application. Such recipient, upon requesting reinstatement, shall be required to submit such evidence as may be necessary (except evidence of age, disability, or blindness) to establish that he or she again meets all requirements for eligibility under this part. Payments to such recipient shall be reinstated effective with the first day such recipient meets all requirements for eligibility except the filing of a new application.

(2) A month of ineligibility for purposes of determining when to prorate the SSI benefit payment for a subsequent month, is a month for which the

individual is ineligible for any Federal SSI benefit and any federally administered State supplementation.

* * *

20 C.F.R. § 416.1335

§ 416.1335 Termination due to continuous suspension.

We will terminate your eligibility for benefits following 12 consecutive months of benefit suspension for any reason beginning with the first month you were no longer eligible for regular SSI cash benefits, federally-administered State supplementation, special SSI cash benefits described in § 416.262, or special SSI eligibility status described in § 416.265. We will count the 12-month suspension period from the start of the first month that you are no longer eligible for SSI benefits (see § 416.1320(a)) or the start of the month after the month your special SSI eligibility status described in § 416.265 ended. This termination is effective with the start of the 13th month after the suspension began.