NO. 20-1312

In the
Supreme Court of the United States

XAVIER BECERRA,
SECRETARY OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

EMPIRE HEALTH FOUNDATION, FOR VALLEY HOSPITAL MEDICAL CENTER,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Congress mandated in the Medicare statute that any hospital serving a "significantly disproportionate number of low-income patients" is entitled to additional payments for treating them. Accordingly, Congress directed the Secretary of Health and Human Services to calculate a disproportionate share hospital adjustment by using two fractions: (1) the percentage of a hospital's patient days attributable to individuals "entitled to benefits under [Medicare] part A" and "entitled to supplemental-security-income benefits" (the "Medicare fraction"); and (2) the percentage of a hospital's patient days attributable to individuals "eligible" for Medicaid coverage but *not* "entitled to benefits under [Medicare] part A" (the "Medicaid fraction"). 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I)-(II).

After HHS promulgated a prior rule narrowly defining who was "eligible for Medicaid" under the Medicaid fraction, four circuit courts concluded that rule conflicted with the statute because it improperly equated being merely "eligible" for benefits with being "entitled" to them. HHS then promulgated a new rule addressing the Medicare fraction set forth in the same statutory provision. That new rule equated "entitled" with "eligible."

The question presented is:

Does 42 U.S.C. § 1395ww(d)(5)(F) preclude HHS from equating being "eligible" for benefits with being "entitled" to such benefits?

CORPORATE DISCLOSURE STATEMENT

Empire Health Foundation Medical Center is not a publicly traded company. It has no parent company and no company owns 10% or more its stock.

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BRIEF IN OPPOSITION

This Court should deny HHS's petition for certiorari contesting the Ninth Circuit's unanimous decision upholding Respondent Empire Health's challenge to the rule governing how HHS does its annual calculation of the disproportionate share hospital ("DSH") adjustment. HHS contends that review is warranted because the Ninth Circuit's decision was incorrect, there is a split between that Circuit and two others, and allowing the Ninth Circuit's decision to stand will create a "balkanized" approach to DSH calculations. None of those reasons warrant review here.

First, the Ninth Circuit got it right: because the statute precludes equating "eligible" with "entitled," it also precludes equating "entitled" with "eligible." The HHS rule at issue violates that obvious rule of statutory interpretation.

The DSH adjustment increases a hospital's annual Medicare inpatient services reimbursement based on how many low-income patients the hospital serves. In determining which hospitals qualified for this adjustment and how much the adjustment would be, Congress ordered HHS to calculate: (1) what proportion of the hospital's "patients who (for such days) were entitled to benefits under [Medicare] part A" were also "entitled" to Supplemental Security Income ("SSI") (the Medicare fraction), and (2) what proportion of the hospital's non-Medicare patients were "eligible for [Medicaid]" (the Medicaid fraction). The purpose of this provision was to ensure that those hospitals that served a disproportionately large

number of indigent patients got a corresponding increase in reimbursement for doing so.

Congress's purpose, however, has not been reflected in HHS's practices. To the contrary, HHS's rules have consistently (and impermissibly) sought to reduce the payments to which such hospitals are entitled. First, HHS took on the Medicaid fraction, contending that only patients with an absolute right to have their services paid for by Medicare or Medicaid would be considered "entitled to [Medicare]" or "eligible for [Medicaid]" respectively. This reduced the number of patients who would be considered "eligible for [Medicaid]" and, as a result, reduced the DSH reimbursement to which hospitals were entitled. But four circuit courts held that HHS's position that only those with a right to Medicaid payment were "eligible for [Medicaid]" violated the DSH statute because HHS was assigning the more restrictive meaning of the word "entitled" to the word "eligible."

HHS then sought to reach the same result by a slightly different route. This time, it promulgated a rule that addressed the Medicare fraction. Again disregarding Congress's deliberate choice of two different words to reflect two different concepts, the new rule concluded that "entitled" in the phrase "entitled to benefits under part A" meant the same thing as "eligible"—thus not requiring a right to payment. At the same time, HHS continued to interpret the word "entitled" in the phrase "entitled to [SSI]" in the same statutory sentence to require actual receipt of payment. Put differently, after courts ruled that, under the statute, "eligible" and "entitled" were not the same for purposes of the Medicaid fraction,

HHS promulgated a rule that "entitled" and "eligible" were the same—but in only one of the two places the word "entitled" appears in the Medicare fraction. That makes no sense: if X does not equal Y, Y cannot equal X.

Faced with that illogic, the Ninth Circuit correctly vacated a portion of 69 Fed. Reg. 48,916, 49,098-99 (Aug. 11, 2004) (the "2005 Rule") because it conflicted with 42 U.S.C. § 1395ww(d)(5)(F)(vi)'s unambiguous text. That was the right result. To uphold the 2005 Rule would require treating different words in the same statutory provision as if they are the same—and the same words as if they are different. Nothing in the statutory text supports such a result—in fact, Congress's deliberate use of different words to mean different things precludes it.

Second, while both the Ninth Circuit's opinion and the decisions on which HHS relies in asserting a circuit split turned on the application of *Chevron U.S.A. Inc. v. Natural Resources Defense Council*, 467 U.S. 837 (1984), HHS doesn't so much as cite *Chevron* in its argument for review here. And while HHS implicitly frames the Question Presented in terms of *Chevron* step two by asking whether it "permissibly" interpreted the DSH statute, this case never got to that step. In short, HHS is asking this Court to decide a *Chevron* step two question in a case decided at *Chevron* step one, all without actually relying on *Chevron*. Perhaps HHS is wary of putting the continuing vitality or contours of *Chevron* before the Court. But HHS can hardly expect the Court to grant certiorari to decide a *Chevron* step two question without considering whether *Chevron* even applies.

Certiorari is all the more unwarranted because the argument HHS presents before this Court—namely, that it is appropriate to equate "entitled" to "eligible" because the canon that different words carry different meanings is just a "rule of thumb" that "has little weight" here, Pet.30—is the opposite of what it argued before the Ninth Circuit. *See, e.g.,* USA Resp.-Reply Br. at 31 (9th Cir. Dkt. No. 30) ("[t]he Secretary … does *not* conflate the terms 'entitled' and 'eligible' in the Medicare DSH provision") (emphasis added). Indeed, *no* court has explicitly endorsed HHS's current argument that "entitled" means the same thing as "eligible."

An additional reason to deny HHS's petition is that endorsing HHS's new and untenable argument would not even necessarily change the outcome of this case. As the district court below held, there is an independent reason to invalidate HHS's 2005 Rule: it was adopted through inadequate notice and comment rulemaking. The Ninth Circuit reversed that holding, but the procedural invalidity of the rule is bound up with the question on which HHS seeks certiorari, so the Court should grant Empire Health's conditional cross-petition if it grants HHS's petition.

Finally, HHS's petition is conspicuously light on why this Court's review is needed: it devotes only a single page to the supposed consequences of allowing the Ninth Circuit's decision to stand. And the primary concern HHS raises in its brief discussion, namely, potential "balkaniz[ation]" of how the DSH adjustment is calculated, rings hollow. Having different Medicare reimbursement rules apply in different jurisdictions is hardly unprecedented and,

indeed, is the logical outcome of a congressional scheme that expressly allows hospitals to bring Medicare reimbursement appeals in different venues.

For all these reasons, the Court should deny the petition for certiorari.

STATEMENT

A. Statutory and Regulatory Background

Because hospitals that treat a disproportionate share of indigent patients incur higher costs, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) requires HHS to provide an upward adjustment to the routine Medicare payments made to those hospitals. HHS's practices have historically been at odds with that legislative mandate and purpose.

1. Both courts and Congress have noted HHS's "hostility" toward the congressionally mandated DSH payments, and yet, despite repeated correction by both Congress and federal courts, that hostility has continued largely unabated from the enactment of the DSH adjustment until today. *Alhambra Hosp. v. Thompson*, 259 F.3d 1071, 1076 n.4 (9th Cir. 2001); *Portland Adventist Med. Ctr. v. Thompson*, 399 F.3d 1091, 1099 (9th Cir. 2005) ("This appears to be the latest in a series of cases in which the Secretary has refused to implement the DSH provision in conformity with the intent behind the statute").

In 1983, when Congress first implemented the prospective payment system, it commanded HHS to include a DSH adjustment but left it to HHS's discretion to determine how that adjustment would be calculated. *See* former Section 1886(d)(5)(C)(i) of the Social Security Act, formerly codified at 42 U.S.C.

§ 1395ww(d)(5)(C)(1). HHS, however, determined that "[no] adjustment [was] warranted." 48 Fed. Reg. 234, 276 (Jan. 3, 1984). In response, Congress intervened a second time, commanding HHS to "develop and publish a definition of 'hospitals that serve a significantly disproportionate number of patients who have low income'" by December 31, 1984. Deficit Reduction Act of 1984, Pub. Law No. 98-369, § 2315(h), 98 Stat. 494, 1080. After that deadline came and went with no action from HHS, a court ordered the Secretary to comply with the congressional mandate. *Samaritan Health Ctr. v. Heckler*, 636 F. Supp. 503 (D.D.C. 1985).

Adding a court order to the congressional mandate had little effect. Faced with HHS's continued argument that no DSH adjustment was required, despite the plain language of the statute and its own order, the *Samaritan* court found it necessary "to remind [HHS's] responsible associates of their continuing obligation to carry out congressional mandates and court orders." *Samaritan Health Ctr. v. Heckler*, No. 85-0464, Medicare and Medicaid Guide (CCH) ¶ 35,853 (Sept. 26, 1986). Meanwhile, the House Ways and Means Committee issued a report explaining that HHS's "total lack of responsiveness" to "implement a disproportionate share adjustment in any meaningful way," "[d]espite several mandates in the law," had "forced the Committee to go to the considerable length of mandating a specific adjustment to the PPS System to provide additional payments to disproportionate share hospitals." H.R. Rep. No. 99-241, Pt. 1, at 16 (1985), *as reprinted in* 1986 U.S.C.C.A.N. 579, 594.

2. In direct response to HHS's refusal to develop a methodology for calculating DSH adjustments, Congress enacted Section 1395ww(d)(5)(F)(vi)(II). *See id.* That section commands HHS to calculate two factors to determine which hospitals will receive DSH adjustments and what those adjustments will be: (1) what proportion of the hospital's "patients who (for such days) were entitled to benefits under [Medicare] part A" were also "entitled" to SSI (the Medicare fraction), and (2) what proportion of a hospital's non-Medicare patients, i.e., patients who are *not* "entitled to benefits under [Medicare] part A," were "eligible for [Medicaid]" (the Medicaid fraction). *Id.*

a. HHS's obstructionism continued unabated. HHS initially contended that only patients with an absolute right to have their services paid for by Medicare or Medicaid would be considered "entitled to [Medicare]" or "eligible for [Medicaid]," respectively. This reduced the number of patients who would be considered "eligible for [Medicaid]" and, as a result, reduced the DSH reimbursement to which hospitals were entitled. But four different circuit courts, including the Ninth Circuit, rejected HHS's position that only those with a right to Medicaid payment during their inpatient stay are "eligible for [Medicaid]," finding that the statute precluded such a reading. *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1266 (9th Cir. 1996); *see also Cabell Huntington Hosp., Inc. v. Shalala*, 101 F.3d 984, 987-88 (4th Cir. 1996); *Deaconess Health Servs. Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996) (per curiam), *aff'g*, 912 F. Supp 438, 447 (E.D. Mo. 1995); *Jewish Hosp., Inc. v. HHS*, 19 F.3d 270, 275 (6th Cir. 1994).

In so doing, all four circuits contrasted Congress's use of "entitled" in the Medicare context with "eligible" in the Medicaid context. As *Legacy Emanuel* explained, "the use of the broader word 'eligible' indicates a meaning different from 'entitlement,' which means 'the absolute right to … payment.'" 97 F.3d at 1265 (quoting *Jewish Hosp.*, 19 F.3d at 275); *see also Cabell Huntington*, 101 F.3d at 987-88 ("the Secretary would have us read the word 'eligible' in the Medicaid proxy to mean exactly the same thing as the word 'entitled' .... To do so, we would have to violate both a clear canon of statutory construction, and the plain meaning of the two terms.").

After four losses, HHS capitulated, recognizing, consistent with the statute, that patients meeting Medicaid eligibility criteria are "eligible for Medicaid" whether or not Medicaid actually made payments on their behalf for their inpatient stay. HHS, HCFA Ruling No. 97-2, at 3-4 (Feb. 27, 1997).

b. Having been told that the statute precluded interpreting "eligible" to mean "entitled" in the context of the Medicaid fraction, HHS then tried to interpret "entitled" to mean "eligible" in the context of the *Medicare* fraction. In a Notice of Proposed Rulemaking for Federal Fiscal Year 2004, HHS addressed the meaning of the statutory phrase "entitled to benefits under [Medicare] part A." 68 Fed. Reg. 27,154, 27,154 (May 19, 2003); 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).

As set forth in Empire Health's conditional cross-petition for certiorari, that notice had a problem. Cross-Pet.7. It claimed that HHS's current policy was to include patients who had exhausted their Medicare

Part A benefits in the Medicare fraction, when in fact its current policy was to *exclude* such days from the Medicare fraction. *Id.* HHS proposed to "begin" to exclude exhausted benefit days from the Medicare fraction, but it miscategorized this proposal as a change in policy when it was actually a continuation of existing policy. *Id.*

Although HHS had been informed of its errors and formally addressed the public on two subsequent occasions regarding its proposal, it did not correct those misstatements until a few days before the end of the second and final notice-and-comment period, when it issued a correction on its website. Cross-Pet.8-10. Despite widespread confusion among commenters (nearly all of whom took HHS's statement regarding the status quo at face value in the submission of their comments) and requests for additional time to comment, HHS did not extend the time for comments. *Id.* at 10. Instead, HHS issued a final rule that was radically different from its current policy—the opposite of what it had proposed—and that decreased the amount of DSH payments for most hospitals. *Id.* at 11.

Under this 2005 Rule,[1] HHS deemed patients "entitled to benefits under [Medicare]" regardless of a right to Medicare payments on their behalf. In other words, patients would be considered "entitled to benefits under part A" even after having exhausted

[1] HHS sometimes refers to this as the "2004 regulation," *e.g.*, Pet.9 & n.3, 10, 11, presumably because it was finalized on August 11, 2004. But because it was effective for federal fiscal year 2005, Empire Health calls it the "2005 Rule," as did the Ninth Circuit below.

their part A benefits. 69 Fed. Reg. at 49,098. In equating "entitled" with "eligible," HHS once again sought to treat those two different words as if they were the same.

The effect of this amended rule, like HHS's prior DSH policies that courts and Congress rejected, is to once again significantly decrease the number of hospitals receiving DSH payments and the amount of those payments by undercounting the indigent patients those hospitals serve. That is because the Medicaid fraction encompasses only non-Medicare patients who are eligible for Medicaid. The broader the pool of those "entitled to [Medicare]," the fewer those "eligible for [Medicaid]." Meanwhile, HHS defined those who are considered indigent for purposes of the Medicare fraction, that is, those who are "entitled to [SSI] benefits," extremely narrowly—encompassing only those who both have an absolute right to SSI benefits and *actually receive* those benefits. For example, HHS's policy excludes from the definition of "entitled to [SSI] benefits" patients who have their SSI benefits applied to offset other debts, patients whose SSI checks are returned as undeliverable, and patients who decline direct deposit of their SSI benefits. Empire Reply Br. at 16 (9th Cir. Dkt. No. 40)

In short, HHS's 2005 Rule required all indigent patients with exhausted Medicare benefits to be removed from the Medicaid fraction and added only a small portion of them back to the Medicare fraction.[2]

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[2] There are other reasons, besides HHS's remarkably narrow definition of SSI entitlement, that hospitals tend to have many more patients that are "eligible for Medicaid" than are "entitled

That 2005 Rule (and the policy underlying it) are part and parcel of HHS's ongoing hostility to the congressionally-mandated DSH adjustment. *See, e.g., Jewish Hosp.,* 19 F.3d at 276 (finding "credible and compelling" evidence of HHS "hostil[ity] to the concept of the disproportionate share adjustment"); *see also Alhambra Hosp.*, 259 F.3d at 1076 n.4 (noting "Secretarial 'hostility to [DSH]'"); *Portland Adventist Med. Ctr.*, 399 F.3d at 1099 ; *Legacy Emanuel*, 97 F.3d at 1265-66; *Azar v. Allina Health Servs.,* 139 S. Ct. 1804 (2019); *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1106 (D.C. Cir. 2014).

B. The Sixth and D.C. Circuit Decisions

Before this case, two other circuits rejected challenges to the 2005 Rule. In those decisions, the Sixth and D.C. Circuits applied the two-step framework from *Chevron U.S.A. Inc. v. Natural Resources Defense Council*, 467 U.S. 837 (1984), to hold that the 2005 Rule was a reasonable interpretation of Section 1395ww(d)(5)(F)(vi). *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013); *Metro. Hosp. v. HHS*, 712 F.3d 248 (6th Cir. 2013).

In both cases, HHS defended the 2005 Rule under *Chevron*, something it does not do in this petition. Specifically, HHS argued that the text of Section 1395ww(d)(5)(F)(vi) either required the 2005 Rule's interpretation of "entitled to benefits under

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to SSI." For example, the majority of states grant automatic Medicaid eligibility to patients enrolled for SSI benefits, *see, e.g.*, Wash. Admin. Code § 182-510-0001; Cal. Code Regs. tit. 22, § 50179.7(a), but there is no automatic SSI entitlement for Medicaid recipients.

Part A" or was, at a minimum, ambiguous. Final Brief for Appellant Kathleen Sebelius at 20-30, *Catholic Health*, 718 F.3d 914 (No. 12-5092), 2012 WL 4849174; Brief for Appellants Cross-Appellees at 19-24, *Metro. Hosp.*, 712 F.3d 248 (Nos. 11-2465, 11-2466), 2012 WL 988895. And, HHS argued, if the statute was ambiguous, the 2005 Rule's interpretation was reasonable. Final Brief for Appellant Kathleen Sebelius at 20-30, *Catholic Health*; Brief for Appellants Cross-Appellees at 23-24, *Metro. Hosp.*

The Sixth and D.C. Circuits both rejected HHS's argument that the DSH statute unambiguously requires the 2005 Rule, concluding that "entitled to benefits under part A" is ambiguous. *Catholic Health*, 718 F.3d at 920; *Metro. Hosp.*, 712 F.3d at 261-62. In reaching this conclusion, both courts heavily engaged with their own earlier precedent interpreting the statute.

Having concluded that the DSH statute was ambiguous, the Sixth and D.C. Circuits then found that the 2005 Rule's interpretation of "entitled to benefits under part A" was reasonable under *Chevron*. *Catholic Health*, 718 F.3d at 920; *Metro. Hosp.*, 712 F.3d at 265-70. Neither court considered whether the 2005 Rule satisfied notice-and-comment requirements or whether the irregularities in HHS's rulemaking process rendered its interpretation of the DSH statute unreasonable. *See Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 52, 55 (1983) (holding that an agency policy will be considered "arbitrary and capricious," and not "reasonable," if the agency failed to engage in "reasoned decisionmaking").

C. The Ninth Circuit Decision

Empire Health brought a procedural and substantive challenge to the 2005 Rule's change to the regulatory definition of the statutory phrase "entitled to benefits under [Medicare]" from the right to receive Medicare payment to simply "me[eting] the statutory criteria to qualify as Medicare beneficiaries regardless of whether Medicare paid the hospital." USA Resp.-Reply Br. at 8 (9th Cir. Dkt. No. 30). The district court struck down the rule on procedural grounds, finding that HHS's misstatement regarding the status quo deprived parties of a meaningful opportunity to comment. *See* ER 50 (9th Cir. Dkt. No. 16) (explaining that it was unclear "[w]hich policy [commenters were] advocating, the policy that the Secretary actually maintained at the time or the policy that the Secretary inaccurately stated that it maintained"). While acknowledging HHS's notice and comment process was "certainly not perfect," the Ninth Circuit disagreed with the district court, holding it sufficient under the Administrative Procedure Act ("APA"). App.14a.

Because, however, the Ninth Circuit found that "the 2005 Rule violated the unambiguous text of 42 U.S.C. § 1395ww(d)(5)(F)(vi) and our court's ruling in *Legacy Emanuel*," it upheld the district court's vacatur of the 2005 Rule. App.22a. Since *Legacy Emanuel* held that "eligible" cannot mean "entitled," the panel held, "entitled" cannot mean "eligible." App.18a-21a. The panel's decision, therefore, stands for the irrefutable truth that if X does not equal Y, Y cannot equal X.

The Ninth Circuit denied HHS's petition for rehearing en banc, with "no judge … request[ing] a vote on whether to rehear the matter." App.84a-85a.

REASONS FOR DENYING HHS'S PETITION

HHS contends that this Court should grant certiorari because the Ninth Circuit's decision was wrong, there is a direct conflict with the decisions of two other courts of appeals, and the decision, if left unreviewed, could result in balkanization. Not so.

First, the Ninth Circuit got it right. This case involved the straightforward application of the principle that the same words in a single statutory provision mean the same thing—and that different words mean different things. These principles of statutory interpretation are well understood, were correctly applied, and do not need further clarification from this Court. Indeed, in its briefing before the Ninth Circuit, HHS explicitly disavowed the argument it advances here that "entitled" and "eligible" should be given the same meaning. *Compare* Pet.30 *with* USA Resp.-Reply Br. at 30-31 (9th Cir. Dkt. No. 30).

Second, the decision below and the two other decisions HHS relies upon in asserting a circuit split all turned on the application of *Chevron*, yet HHS doesn't so much as cite *Chevron* in arguing for review. Furthermore, HHS asks this court to decide whether HHS's interpretation of "entitled" is "permissib[e]," an implicit *Chevron* step two question, in a case that decided the issue at *Chevron* step one (and, as noted above, all without explicitly arguing that *Chevron* applies).

This case (and the underlying split) also don't warrant review because the courts all relied heavily on interpretations of their own prior precedents rather than performing independent and in-depth statutory analysis (and none of them were faced with the argument that HHS now advances before this Court). Given HHS's contention that the Ninth Circuit's decision is geographically limited, it would therefore be prudent for the Court to wait for another circuit, without complicating prior precedent, to provide a thorough statutory analysis and to address the novel position HHS now takes before deciding this question of statutory interpretation.

Third, deciding HHS's question presented may have no practical effect because there are alternative grounds for invalidating HHS's 2005 Rule. HHS's 2005 Rule should be invalidated in any event because it was not promulgated through proper and notice and comment rulemaking. *See* Cross-Pet.

For all these reasons, HHS's petition should be denied.

I. The Decision Below Is Correct Because HHS's Interpretation Conflicts With the Plain Language of the Statute

HHS dedicates most of its argument in favor of granting certiorari to contending that the "decision below is incorrect." Pet.18-33. The primary question at the certiorari stage, however, is not whether the lower court got it wrong, but whether there is a compelling need for this Court's intervention. A brief in opposition is not, therefore, the place for a full defense of the merits of the decision below. But even a distilled version of that merits defense makes it clear

that even if error correction could be a sufficient reason for certiorari in some circumstances, there was no error here.

1. As a threshold matter, the argument HHS makes now that "entitled" should be interpreted to mean "eligible" is not the argument HHS made below. Indeed, HHS explicitly *denied* that its position equated the word "entitled" with the word "eligible." *See* USA Reply Br. at 30-31 (9th Cir. Dkt. No. 30) ("Contrary to plaintiff's contention[] …, under the Secretary's interpretation, the phrase 'entitled to benefits under part A' in the DSH provision does not mean the same thing as "eligible for benefits under part A"); *see also id.* at 31 ("[t]he Secretary … does not conflate the terms "entitled" and "eligible" in the Medicare DSH provision"). Surely before asking this Court to consider its arguments in favor of equating "entitled" with "eligible," HHS should have first presented that argument to the Ninth Circuit instead of erroneously arguing that its policy still drew some distinction between the two terms.

2. Even if this Court overlooks this significant procedural flaw, HHS's argument fares no better when considered on the merits. HHS's contention that the Ninth Circuit's straightforward application of a basic canon of statutory interpretation—that different words have different meanings (especially when, as here, used within the same statutory provision)—requires this Court's clarification is implausible on its face. *See Sosa v. Alvarez-Machain*, 542 U.S. 692, 711 n.9 (2004) (citing the "rule that 'when the legislature uses certain language in one part of the statute and different language in another, the court assumes

different meanings were intended'") (quoting 2A N. Singer, Statutes and Statutory Construction § 46:06, p. 194 (6th rev. ed. 2000)). This Court recently emphasized the corollary of this canon in considering, and rejecting, HHS's attempt to interpret "entitled to benefits under part A" as encompassing patients who had enrolled in a Medicare managed care plan under Medicare Part C without proper notice and comment rulemaking. *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1812 (2019) ("the government fails to offer any good reason or evidence to unseat our normal presumption that, when Congress uses a term in multiple places within a single statute, the term bears a consistent meaning throughout"); *Mohasca Corp. v. Silver*, 447 U.S. 807, 826 (1980) (explaining that adhering to the canon—that the same words bear the same meaning—"is the best guarantee of evenhanded administration of the law").

HHS tries to get around this by contending that when Congress used the terms "entitled" and "eligible" in the DSH provision, it was merely "borrowing these terms from elsewhere in the statute," where they are used differently, and that those different meanings should be imported into this particular provision. Pet.30 (quoting *Ne. Hosp. Corp. v. Sebelius*, 657 F.3d 1, 13 (D.C. Cir. 2011) and citing *Cabell Huntington*, 101 F.3d at 992 (Luttig, J., dissenting)). But four different circuit courts rejected similar arguments that the statute allowed HHS to equate "eligible" and "entitled," citing the canon that different words have different meanings. *See, e.g., Cabell Huntington*, 101 F.3d 987-88 (refusing to "violate … a clear canon of statutory construction, and the plain meaning of the two terms" by equating eligible and entitled).

In any event, HHS's argument that these purportedly borrowed terms have clear and consistent meanings throughout the statute as a whole doesn't hold up. As an initial matter, HHS cites ambiguous statutory provisions that aren't even in the Medicare statute.[3] Provisions that *are* in the Medicare statute don't support HHS's argument. For example, HHS ignores a statutory provision in the Medicare statute that links "entitlement" to "payment": "The benefits provided to an individual ... under [Part A] shall consist of *entitlement to have payment made on his behalf*." *See* 42 U.S.C. § 1395d(a) (emphasis added).

And notwithstanding HHS's claim that Congress consistently distinguished between eligibility and entitlement and that this warrants attributing different meanings to the same words in the same statutory provision, Congress often refers to SSI *eligibility*, *e.g.,* 42 U.S.C. § 1396u-2(a)(2)(A)(i) (a "[s]tate may not require … the enrollment in a managed care entity of an individual under 19 years of age who … is *eligible* for supplemental security income"), yet referred to SSI *entitlement* in the DSH statute. This indicates that Congress did not merely "borrow" words from other places in the statute but consciously chose them.

Finally, none of the statutory or regulatory provisions HHS cites include the phrase "for such days" or use the terms "entitled" in contrast to "eligible," even though both of those features of the DSH statutory language are essential to

[3] Sections 426(a) and (b) (*see* Pet.21) are contained in Title II, pertaining to social security disability benefits. The Medicare statute is found in Title XVIII.

understanding what "entitled" means in the DSH context and differentiate the DSH provision from others. By using both "entitled" and "eligible" in the same provision, Congress made it clear that "entitled" can't mean merely "eligible." And by using the phrase "for such days," *see* 42 U.S.C. § 1395ww(d)(5)(F)(vi) (stating that the Medicare fraction includes "patients who (*for such days*) were entitled to benefits under part A"), Congress also made it clear that "entitlement" cannot be some unchanging or abstract characteristic. *Cf.* SER 6-7 (9th Cir. Dkt. No. 24) (HHS arguing that "Medicare beneficiaries are *always* 'entitled to benefits under [Medicare] part A'" (emphasis added)).

3. HHS also contends that its current policy reflects its "longstanding interpretation" of "entitled" that was simply "*codified* in the 2004 regulation at issue here." Pet.15, 20 (emphasis added). Not so. That wasn't HHS's long-standing policy, and it is inconsistent with HHS's interpretation of other parts of the underlying statutory provision.

a. HHS's policy clearly wasn't "long-standing" because for the decades preceding the 2005 Rule, HHS's codified policy explicitly *excluded* patients who were not entitled to payment under Part A, such as those who had exhausted their Medicare Part A benefits, from the Medicare fraction. Pet.7 ("Prior to 2004 … HHS … included in the Medicare fraction only 'covered' Medicare patient days, 42 C.F.R. § 412.106(b)(2) (2003)—i.e., days for which payment from the Medicare program was available to the hospital"). HHS's 2005 rule, therefore, was not a "codification" of longstanding policy, but a 180-degree

rejection of it. HHS even relied upon its interpretation that "entitlement" meant "entitled to payment" in arguing before multiple circuits that the Medicaid fraction should *also* be limited to patients who are entitled to Medicaid payment. *See supra* at 7-8.

Finally, HHS maintains to this day a diametrically opposed interpretation of the same word "entitled" in the same statutory sentence. That is, when it comes to determining who is "*entitled* to [SSI] benefits," HHS interprets the word "entitled" as meaning the absolute right to receive SSI payments. USA Resp.-Reply Br. at 32 (9th Cir. Dkt. No. 30) (quoting 75 Fed. Reg. at 50,042, 50,280 (Aug. 16, 2010) (emphasis added)). (Indeed, HHS takes this a step further by requiring *actual* receipt of SSI payments. *See* Empire Reply Br. at 16 (9th Cir. Dkt. No. 40)). But when it comes to determining who is "entitled to benefits under part A," HHS holds that whether the patient is entitled to payment under Part A doesn't matter as long as the patient meets the statutory criteria for Medicare coverage.

Simply put, HHS maintained for decades a policy that is the opposite of the one it is defending now. HHS's current policy that "entitlement" doesn't require "entitlement to payment," is not, therefore, "longstanding," and is not even consistent with HHS's current interpretation of the word "entitled" in the phrase "entitled to [SSI] benefits" found in the same statutory sentence.

b. HHS's more programmatic concerns also don't withstand scrutiny. For example, HHS claims that it would be "unusual" for "each unit of treatment—each patient day—to be classified individually and

incorporated into one fraction or the other based on whether it was paid for by Medicare." Pet.27. But the statute's focus on patient *days* and, in particular, its use of the phrase "for such days," specifically requires a day-by-day analysis, necessarily suggesting that some days may be included while others are excluded. Furthermore, even under HHS's interpretation, some days of a patient's stay could be included in the Medicare fraction while other days would be excluded—if, for example, the patient turned 65 during the stay.

In any event, the true anomaly is not that low-income patients may move from the Medicare fraction to the Medicaid fraction. It's that under HHS's policy, low-income patients who are both eligible for Medicaid *and* entitled to SSI—the poorest of the poor—are entirely *excluded* from a hospital's DSH calculation if those patients did not receive the SSI benefits to which they were entitled. *See supra* at 10. That's not what Congress intended, and it's not what the statute's plain language permits.

II. There Is No Clean Circuit Split on the Question Presented

HHS's petition claims a "direct and acknowledged conflict" with respect to the question presented. But the actual question that HHS presents is one the Ninth Circuit didn't answer. The three decisions on which HHS relies—the Ninth Circuit's decision below, D.C. Circuit's decision in *Catholic Health*, and the Sixth Circuit's decision in *Metropolitan Hospital*—did not all address the same question, and none addressed HHS's arguments here. Moreover, any conflict that does exist is muddied by the fact that the primary

disagreement between these decisions is over how the Ninth, Sixth, and D.C. Circuits interpreted their own precedent, not over how best to read the Medicare statute in the first instance. That complication renders any circuit split messy and unsuited for review now. Instead, because HHS contends the Ninth Circuit's decision is geographically limited, this Court can await further development in the lower courts.

A. HHS's Position Before This Court Is Not the One It Advanced Before the Ninth, D.C., and Sixth Circuits

HHS asks this Court to decide the question whether it "permissibly" interpreted 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) to "include[] in a hospital's Medicare fraction all of the hospital's patient days of individuals who satisfy the requirements to be entitled to Medicare Part A benefits, regardless of whether Medicare paid the hospital for those particular days." Pet.i. But that question, which implicitly invokes *Chevron* step 2, isn't what the Ninth Circuit, which ruled on *Chevron* step 1, actually decided.

1. The Ninth Circuit's decision below, the D.C. Circuit's decision in *Catholic Health*, and the Sixth Circuit's decision in *Metropolitan Hospital* all addressed the 2005 Rule's legality under *Chevron*'s two-step framework. *See* App.17a-19a; *Catholic Health*, 718 F.3d at 919-20; *Metro. Hosp.*, 712 F.3d at 265-70. The question answered in those cases, therefore, was whether the 2005 Rule survived *Chevron* review. The Ninth Circuit only reached step 1, while the other circuits reached step 2.

HHS's petition, in contrast, doesn't argue under the *Chevron* framework. The petition never even *cites Chevron* in its argument, mentioning the case only in its description of the decision below. Pet.14. And the arguments that HHS does advance are different than the ones it raised below. Accordingly, this petition doesn't raise the same issues decided either by the Ninth Circuit or in *Catholic Health* or *Metropolitan Hospital*. *See, e.g.*, Brief for Appellants Cross-Appellees at 18-35, *Metro. Hosp.* (HHS defending its 2005 Rule under *Chevron*); Final Brief for Appellant Kathleen Sebelius at 18-36, *Catholic Health* (same). HHS certainly knows how to present a *Chevron* argument when it wants to, but it chose not to in its petition.

2. Making matters worse, HHS's petition asks the Court to decide a *Chevron* step two question, despite HHS's choice not to invoke the *Chevron* framework in its argument and the fact that the Ninth Circuit did not address any step two issue.

HHS's question presented asks whether its interpretation of Section 1395ww(d)(5)(F)(vi)(I) is "*permissibl[e]*"—inherently a *Chevron* step two question. Step one of *Chevron*'s "two-step framework" asks "whether Congress 'has directly spoken to the precise question at issue' in the statutory text." App.17a (quoting *Chevron,* 467 U.S. at 842). Only if the answer to that question is *no*—only "[i]f the statute is silent or ambiguous"—does a court "proceed to *Chevron* step two." *Id.* And it is only at step two that the court asks whether the agency's interpretation of the statute is "permissible." *Chevron*, 467 U.S. at 843. By asking this Court to

decide whether its interpretation of the statute is "permissibl[e]," HHS skips step one—the issue the Ninth Circuit actually decided—in favor of step two. This case is a poor vehicle to address that question because the Ninth Circuit didn't address it, let alone decide it. App.18a; *see* Pet.14 ("the court of appeals ... resolved the meaning of 'entitled' when referring to Medicare at 'step one' of the inquiry under *Chevron*").

Moreover, while *Catholic Health* did address *Chevron* step two, its analysis was cursory at best. The D.C. Circuit simply asserted in one sentence that because it found the Medicare statute ambiguous, it "of course defer[s] to the [HHS's] construction." 718 F.3d at 920. But an agency's interpretation of a statute is not automatically permissible just because the statute is ambiguous. *Chevron*, 467 U.S. at 843. And the D.C. Circuit didn't provide any rationale for *why* HHS's interpretation was permissible under *Chevron* step two.

A shallow 2-1 split scarcely warrants certiorari where, as to the question presented, one decision provides no explanation for why it decided the issue the way it did, and the decision from which certiorari is sought didn't decide the issue at all. And granting certiorari to decide HHS's step two question would be all the more inappropriate given HHS's failure to make any argument in its petition under the *Chevron* framework. *Chevron*'s continued vitality and proper contours have generated extensive controversy of late, so it is no wonder that HHS would rather not have the Court directly consider those issues. But it is incoherent and unfair for HHS to ask the Court to decide a question that is inherently tied to the

Chevron framework while studiously avoiding invoking that framework. HHS's effort to have it both ways is reason enough to deny certiorari.

Furthermore, neither the D.C. Circuit nor the Sixth Circuit addressed the significant rulemaking irregularities infecting HHS's final rule even though those irregularities are highly relevant in assessing the reasonableness of HHS's rule under a *Chevron* step two analysis. *See Motor Vehicle Mfrs.*, 463 U.S. at 52, 55 (1983) (holding that an agency policy will not be considered "reasonable" if the agency failed to engage in "reasoned decisionmaking").

B. Even if Review Could Be Warranted at Some Point, It Isn't Warranted Now

For the reasons just given, the conflict between the decision below and the D.C. and Sixth Circuit's decisions is limited to whether the DSH statute is ambiguous under *Chevron* step one. But, as explained, that's not the question that HHS's petition presents. And the conflict is both too messy and too undeveloped to justify this Court's review now.

1. The *Chevron* step one disagreement between the decision below, *Catholic Hospital*, and *Metropolitan Hospital* doesn't turn primarily on how the courts at issue interpret the Medicare statute, but rather on how those courts should interpret their own precedent. App.19a-21a (discussing the Sixth and D.C. Circuit decisions and the role of precedent). Because all three of the decisions at issue relied heavily on prior circuit precedent, this case presents a poor vehicle for deciding this question of statutory interpretation now. It would be prudent, therefore, for this Court to wait for a decision that delves into the

statutory analysis directly, before deciding this case of statutory interpretation.[4]

Take, for example, the D.C. Circuit's analysis of *Chevron* step one in *Catholic Health* which relied on its "recent decision in *Northeast Hospital*" in finding the statute ambiguous. *Catholic Health*, 718 F.3d at 920. That analysis was short-circuited by the court's reliance on earlier precedent. But that earlier precedent, *Northeast Hospital*, did not address whether Section 1395ww(d)(5)(F)(vi)(I) is ambiguous with respect to dual eligible exhausted coverage patient days. Instead, it addressed whether patients enrolled in Medicare Part C could also be "entitled" to Part A benefits, relying on numerous provisions of the Medicare statute specific to Part C enrollees. *Ne. Hosp.*, 657 F.3d at 5-13.[5] HHS even argued in *Catholic Health* that "[t]he ambiguity identified by the Court in *Northeast* ... simply does not apply to the patients at issue [in *Catholic Health*]" because *Northeast Hospital* "was limited to the specific question presented—whether a Medicare Part A

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[4] To be sure, HHS's petition argues that the Ninth Circuit incorrectly interpreted *Legacy Emanuel*. Pet.27-28. But not only is HHS wrong on this point, *see* App.19a, whether the Ninth Circuit correctly interpreted its own precedent isn't a cert-worthy question. And because HHS opted not to petition for certiorari in *Legacy Emanuel*, it is difficult for HHS now to complain about the Ninth Circuit's adherence to *Legacy Emanuel* in the decision below.

[5] Now-Justice Kavanaugh disagreed with the court's reasoning, concluding that the meaning of "entitled" in the Medicare fraction is unambiguous and requires "entitlement to have payment made." *Ne. Hosp.*, 657 F.3d at 19-21 (Kavanaugh, J., concurring in the judgment); App.20a n.16.

beneficiary who has enrolled ... under Medicare Part C remains 'entitled to benefits under part A' within the meaning of the DSH provision." Final Reply Brief for Appellant Kathleen Sebelius at 5, *Catholic Health*, 718 F.3d 914 (No. 12-5092), 2012 WL 4849175. *Catholic Health*'s uncritical extension of that *Chevron* step one analysis to the different context of dual eligible exhausted coverage patient days does not present a clean, cert-worthy conflict with the Ninth Circuit's reasoned step one analysis in *Legacy Emanuel*.

2. The paucity of independent statutory analysis and complicated, case-specific questions concerning whether the Ninth, D.C., and Sixth Circuits properly weighed and interpreted their own precedent render any conflict between those courts' *Chevron* step one analyses too muddled to support certiorari at this time.

Instead, this Court should await further development in the courts of appeals, either from circuits that can consider it as an issue of first impression, or from the two other Circuits that share the Ninth Circuit's interpretation of "entitled," but that have not yet had the chance to decide whether that interpretation forecloses the 2005 Rule. *Cabell Huntington*, 101 F.3d at 988-89; *Deaconess Health*, 83 F.3d at 1041.

III. Additional Reasons Warrant Denial of HHS's Petition

This Court should also deny HHS's petition because resolving HHS's question presented may have no practical effect on the outcome of this case. As set forth in Empire Health's conditional cross-petition for

certiorari, the APA requires federal agencies engaged in rulemaking to comply with notice-and-comment procedures. *See* 5 U.S.C. § 553(b). Those procedures require fair notice and a meaningful opportunity to comment. *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158, 174 (2007). That fair notice requirement isn't satisfied where, as here, an agency misstates key information, such as the policy upon which current payments are based and how its proposal would affect that status quo, and thereby deprives interested parties of a meaningful opportunity to comment. That problem was only compounded here by the fact that the rule ultimately adopted by HHS was the opposite of what HHS had proposed and therefore not a logical outgrowth of HHS's proposal. Because HHS's procedural failings are bound up with the unreasonableness of the 2005 Rule, the Court should grant Empire Health's cross-petition if it grants HHS's petition. *See* Cross-Pet.8.

Furthermore, there is still another reason why the 2005 Rule is invalid. Even if HHS's broad interpretation of the word "entitled" in the phrase "entitled to benefits under part A" were to be upheld, its narrow interpretation of the word "entitled" in the phrase "entitled to [SSI] benefits" would then have to fall. Empire Reply Br. at 24-26 (9th Cir. Dkt. No. 40). This alternative argument, which neither the district court nor the Ninth Circuit considered because they agreed with Empire Health's primary argument regarding "entitled to benefits under part A,"[6] is yet

[6] The district court did comment, however, that HHS's contradictory definition of "entitled" in the SSI context "d[id] not appear entirely reasonable." ER 32 (9th Cir. Dkt. No. 16-1).

another reason why this case is not a good candidate for certiorari.

IV. HHS's Concerns About the Administration of Medicare Are Unfounded

Normally, a petition for certiorari focuses on why there is an urgent need for the Court's intervention. HHS's petition strikingly fails to make any such case. HHS suggests in less than a page that the decision below could create a "balkanized" approach to Medicare reimbursement. But that concern is misplaced. This case does not implicate how HHS administers Medicare; it is only about which hospitals get reimbursed and how much, and HHS doesn't even tell the Court how much is at stake. In short, the sky is not falling and the Court's limited resources would be better devoted to other cases.

A comparison between HHS's petition here and one of its prior unsuccessful petitions is telling. In *Leavitt v. Baystate Health Systems*, 547 U.S. 1054 (2006) (mem.), HHS also asked this Court to resolve a circuit split. In that case, the question was whether HHS's acquiescence to the four circuit court decisions discussed above invalidating HHS's narrow interpretation of "eligible for Medicaid" required HHS to *reopen* settled cost reports to reflect HHS's updated policy. The D.C. Circuit held that reopening was required, *In Re Medicare Reimbursement Litig.*, 414 F.3d 7 (D.C. Cir. 2005), after the Tenth Circuit had held the opposite, *Bartlett Mem'l Med. Ctr., Inc. v. Thompson,* 347 F.3d 828 (10th Cir. 2003).

In sharp contrast to its petition here, HHS explained in detail "the staggering and immediate financial and administrative burdens imposed by the

decision below." Pet. for Writ of Cert. at 27, *Baystate Health Sys.*, 547 U.S. 1054 (No. 05-936). HHS pointed out, for example, that it would have to "review ... 2,306 cost reports for … 639 hospitals" and—apart from that enormous administrative burden—that the financial impact could be "*as much as $2.8 billion* ... owed to providers." *Id.* Despite these weighty concerns and high stakes, this Court denied HHS's petition.

By contrast, here HHS has only pointed to the potential need to calculate the DSH adjustment one way for hospitals located within the Ninth Circuit and another way for other hospitals. It has made no attempt to suggest that doing so would be administratively problematic or even to quantify the financial impact of doing so.

That failure is not surprising. Having different Medicare reimbursement rules apply in different jurisdictions is hardly unprecedented. *See, e.g.*, *Grant Med. Ctr. v. Hargan*, 875 F.3d 701, 703 (D.C. Cir. 2017) (explaining that after the Sixth Circuit ruled that HHS's "method for counting hospital beds conflicted with the plain language of the applicable regulation," HHS "amended the regulation to … appl[y] the Sixth Circuit's interpretation to hospitals located within that circuit"). Indeed, having rules that may vary between jurisdictions is the natural outcome of Congress's decision to allow hospitals to bring their Medicare reimbursement appeals before either the district courts where they are located or the D.C. district court. 42 U.S.C. § 1395oo(f)(1). Moreover, variations in coverage are routine and specifically contemplated by HHS's rules allowing regional Medicare contractors, in the absence of a national

coverage determination, to make regional determinations regarding Medicare's coverage of certain treatments or devices. *See* 42 U.S.C. § 1395ff(f)(2)(B) ("the term 'local coverage determination' means a determination by a fiscal intermediary or a carrier ... respecting whether or not a particular item or service is covered on an intermediary- or carrier-wide basis").

Nevertheless, HHS suggests that the decision below is "fraught" because Ninth Circuit hospitals that prefer HHS's current policy could "seek review in the D.C. Circuit, which has upheld the agency's position." Pet.18. HHS's concern is again overstated. As an initial matter, the D.C. Circuit would likely apply Ninth Circuit precedent in the circumstances HHS describes. *See Grant Med. Ctr.*, 875 F.3d at 703, 708 (applying Sixth Circuit precedent regarding the treatment of "swing beds" to hospitals located in the Sixth Circuit). Furthermore, HHS has on other occasions given hospitals a choice of different DSH calculation methodologies when faced with agency policy of questionable validity, and it could easily do the same here. *See* HHS, CMS Ruling No. 1498-R2, at 8 (Apr. 22, 2015) ("we are allowing providers to elect whether to receive suitably revised Medicare-SSI fractions on the basis of 'covered days' or 'total days' for [FFY] 2004 and earlier"). Finally, because HHS's current policy all but guarantees a reduced DSH payment for hospitals as described above, *supra* at 10, there is unlikely to be an influx of hospitals to the D.C. Circuit seeking application of HHS's current policy.

CONCLUSION

Since the DSH adjustment was enacted, it has taken repeated intervention by Congress and the courts to get HHS to simply follow the statute as written. Accordingly, four different circuit courts invalidated HHS's policy of equating "eligible" with "entitled" because it was inconsistent with that statute. HHS doesn't challenge those decisions now. Instead, it argues for a different result, despite the fact that it is the same statutory provision at play. That only compounds the problems with HHS's interpretation. The Ninth Circuit here did nothing different by holding that if under the statute, "eligible" cannot mean "entitled," "entitled" cannot mean "eligible." This Court should deny the petition for certiorari.

Respectfully submitted,

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