No. 20-1312

In the Supreme Court of the United States

XAVIER BECERRA, SECRETARY
OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

EMPIRE HEALTH FOUNDATION,
FOR VALLEY HOSPITAL MEDICAL CENTER

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

REPLY BRIEF FOR THE PETITIONER

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The Ninth Circuit rejected the interpretation by the Secretary of Health and Human Services (HHS), codified in a notice-and-comment rule, of a provision of the Medicare Act, 42 U.S.C. 1395ww(d)(5)(F)(vi)(I)—and acknowledged that its decision conflicts with decisions of the D.C. and Sixth Circuits upholding that same interpretation. Pet. App. 19a-21a; see Pet. 30-32. The court of appeals' conclusion that the text of Section 1395ww(d)(5)(F)(vi)(I) unambiguously forecloses the Secretary's interpretation of that intricate provision is deeply flawed. Pet. 18-30. This Court's review is warranted to resolve the circuit conflict, to correct the Ninth Circuit's errors, and to restore clarity on this important and recurring question.

Respondent fails to grapple with multiple aspects of the statutory text and context that support the Secretary's interpretation. Respondent instead largely repeats the Ninth Circuit's errors in reading Section 1395ww(d)(5)(F)(vi)(I) to preclude the approach that two other circuits have upheld. And respondent's effort to downplay the recognized circuit conflict, entrenched by the court's denial of the government's petition for rehearing en banc, does nothing to diminish the divide. That the decision below rejected "at *Chevron* step one" the agency's interpretation that the D.C. and Sixth Circuits upheld at "*Chevron* step two," Br. in Opp. 3 (citing *Chevron U.S.A. Inc.* v. *Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984)), simply underscores the courts' disagreement over what approaches the statute permits. See *Entergy Corp.* v. *Riverkeeper, Inc.*, 556 U.S. 208, 218 n.4 (2009). And respondent's assertion (Br. in Opp. 25) that the lower courts—including the Ninth Circuit in the decision below—devoted inadequate attention to how to "interpret the Medicare statute" and focused instead on "their own precedent" if anything provides more reason for this Court's intervention, not less. The petition for a writ of certiorari should be granted.

I. THE DECISION BELOW IS INCORRECT

The Secretary properly determined that Section 1395ww(d)(5)(F)(vi)(I) permits the inclusion in a hospital's Medicare fraction of all of the patient days of individuals who satisfy the requirements to be entitled to Medicare Part A benefits—regardless of whether Medicare ultimately paid for those particular days. Pet. 18-27. The Ninth Circuit erred in concluding that the statutory text unambiguously bars that approach. Pet. 27-30. Respondent fails in attempting to defend the court of appeals' conclusion.

A. Respondent agrees (*e.g.*, Br. in Opp. 1) that the case turns on the meaning of "entitled to benefits under [Medicare] part A" in the Medicare fraction, 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). As we explained in the petition (Pet. 20-21), the Secretary's approach of including in that fraction all of a hospital's patient days of patients who meet the statutory criteria for entitlement to Medicare Part A benefits is supported by 42 U.S.C. 426. Section 426 identifies who is "entitled" to Medicare Part A benefits. 42 U.S.C. 426(a) and (b). Subsections (a) and (b) expressly provide that individuals who satisfy specified criteria—*e.g.*, individuals over age 65 who are entitled to traditional Social Security benefits—"shall be entitled to hospital insurance benefits under part A of subchapter XVIII," *i.e.*, Medicare Part A. *Ibid.* HHS properly determined that individuals who satisfy those criteria are "entitled to benefits under [Medicare] part A" within the meaning of Section 1395ww(d)(5)(F)(vi)(I).

Respondent offers no answer to Section 426's text. Instead, respondent dismisses that provision in a footnote (Br. in Opp. 18 n.3), on the ground that it is "contained in Title II" of the Social Security Act, 42 U.S.C. 401 *et seq.*, rather than in Title XVIII, 42 U.S.C. 1395 *et seq.*, where most of the Medicare Act is codified. But the provision's placement is irrelevant in light of its plain language, which expressly states that individuals who satisfy the specified criteria are "entitled to benefits under part A of subchapter XVIII," *i.e.*, Title XVIII. 42 U.S.C. 426(a) and (b). Moreover, Congress enacted Section 426 in the same 1965 law that, in its very next section, added Title XVIII to the Social Security Act and thereby established Medicare Part A. Health Insurance for the Aged Act, Pub. L. No. 89-97, Tit. I, Pt. 1, sec. 101, § 226, 79 Stat. 290-291 (42 U.S.C. 426);

id. sec. 102, §§ 1801-1875, 79 Stat. 291-332 (42 U.S.C. 1395 *et seq.*). Respondent identifies no basis for a court, in reviewing the Secretary's determination of who is "entitled to benefits under [Medicare] part A," 42 U.S.C. 1395ww(d)(5)(F)(vi)(I), to ignore Congress's specification of which persons are "entitled to * * * benefits under part A," 42 U.S.C. 426(a) and (b), in an adjacent provision of the law that created Part A itself.

Echoing the court of appeals, see Pet. App. 18a, respondent suggests (Br. in Opp. 19-21) that a patient is not entitled to Medicare Part A benefits unless he or she is "entitled to payment under Part A," thus excluding "those who had exhausted their Medicare Part A benefits" at the time of treatment. *Id.* at 19. But respondent does not confront the text of Section 426(c), which provides that "entitlement" to Part A benefits "consist[s] of entitlement to have payment made under, *and subject to the limitations in*, [Medicare] part A." 42 U.S.C. 426(c)(1) (emphasis added). The statute's text thus supports the Secretary's determination that an individual's entitlement to Medicare Part A benefits is a legal status under the Act that, in turn, triggers both the individual's right to have Medicare make payment for particular services and the limitations on that right. The same is true of another provision respondent cites, which states that "[t]he benefits provided to an individual . . . under Part A shall consist of entitlement to have payment made on his behalf." Br. in Opp. 18 (quoting 42 U.S.C. 1395d(a)) (brackets and emphasis omitted). That provision similarly qualifies its definition of "benefits" by stating that the entitlement is "subject to the provisions of this part [*i.e.*, Medicare Part A]." 42 U.S.C. 1395d(a).

Respondent also offers no answer to multiple other aspects of the statutory context that further support the Secretary's interpretation—including provisions of the Medicare Act that confirm that an individual may be entitled to Medicare Part A benefits even if he or she has exhausted some or all such benefits for a given period. Pet. 23-25. For example, respondent does not address provisions that expressly refer to an individual who "is entitled to benefits under Part A but has exhausted benefits for inpatient hospital services." 42 U.S.C. 1395*l*(a)(8)(B)(i) and (t)(1)(B)(ii)(I). Nor does respondent attempt to refute the Secretary's recognition in adopting the 2004 rule that a Medicare Part A beneficiary who has exhausted one type of benefit may still remain eligible for other benefits. See 69 Fed. Reg. 48,916, 49,098 (Aug. 11, 2004); Pet. 25. And respondent disregards the incongruity that its interpretation creates with still other provisions of the Medicare Act that link an individual's eligibility for benefits under other parts of the Medicare program, as well as HHS's obligation to provide benefit information, to an individual's entitlement to benefits under Part A. Pet. 24.

B. Respondent contends (Br. in Opp. 1-3, 16-19) that the Secretary's interpretation improperly equates the term "entitled" in the Medicare and Medicaid fractions (in the phrase "entitled to benefits under [Medicare] part A") with the term "eligible" in the Medicaid fraction (in the phrase "eligible for medical assistance under a State [Medicaid] plan"). 42 U.S.C. 1395ww(d)(5)(F)(vi). Respondent asserts (Br. in Opp. 16-19) that those terms must be accorded different meanings at all costs and that the interpretation set forth in the petition for a writ of certiorari is inconsistent with the government's position in the courts below. Respondent is incorrect on all counts.

The government has not argued, in the court of appeals or in this Court, that the words "entitled" and "eligible" in Section 1395ww(d)(5)(F)(vi) must be interpreted identically in every respect. In the court of appeals, the government explained that being "entitled" to Medicare Part A benefits is distinct from being "eligible" to enroll in Part A. C.A. Doc. 30, at 31 (Aug. 9, 2019). The government observed that "individuals who are 'entitled to benefits under part A' have met the statutory prerequisites in Section 426 and are thereby automatically entitled to Medicare benefits." *Ibid.* (citation omitted). "By contrast," the government noted, "under Sections 1395i-2 and 1395i-2a(a) of the Medicare statute, certain individuals are 'eligible to enroll' in Medicare Part A, but are not 'entitled' to benefits unless they actually enroll." *Ibid.* (citations omitted); see *Northeast Hosp. Corp.* v. *Sebelius*, 657 F.3d 1, 12 (D.C. Cir. 2011). In this Court, the government likewise has not contended that "entitled" and "eligible" in this context are synonyms that must be construed in lockstep. Instead, the government has explained (Pet. 29-30) that the Ninth Circuit—relying on its earlier decision in *Legacy Emanuel Hospital & Health Center* v. *Shalala*, 97 F.3d 1261 (1996)—erred in inferring from Congress's use of those two adjectives when referring to the Medicare and Medicaid programs, respectively, that Congress clearly intended to impose starkly different standards for counting patient days of individuals covered by those two separate programs.

Respondent repeats the court of appeals' error (Br. in Opp. 16-19) in contending that statutory-interpretation principles categorically preclude construing "entitled" and "eligible" in the same or similar ways. As the petition explains (Pet. 30), and as this Court has recognized,

the interpretive "rule" respondent invokes (Br. in Opp. 16 (citation omitted)) that different terms in a statute must mean different things is "'no more than a rule of thumb' that can tip the scales" if they are otherwise closely balanced. *Sebelius* v. *Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 156 (2013) (citation omitted). That interpretive guide is particularly unilluminating here because Congress's choice of different terms, in referring to different statutory programs, is explained by the terminology that the statutes governing those programs employ. Pet. 30; see *Northeast Hosp. Corp.*, 657 F.3d at 12.

Respondent fails to refute that general pattern of usage in the Medicare and Medicaid programs. Its contention (Br. in Opp. 18 n.3) that Section 426's placement renders the provision irrelevant, and its reliance on Section 1395d(a) (*id.* at 18), are mistaken as explained above. See pp. 3-4, *supra*. And respondent's assertion (Br. in Opp. 18-19) that other provisions do not duplicate Section 1395ww(d)(5)(F)(vi)'s "(for such days)" parentheticals misses the point: the different terminology that Congress generally employed in describing the criteria for participating in the Medicare and Medicaid programs, respectively, provides a more than adequate explanation for its use in the provision at issue here of different terms when discussing those distinct programs. To the extent respondent contends (*id.* at 19) that those "(for such days)" parentheticals independently require counting only patient days for which the identified benefits program actually paid, the courts of appeals—including the Ninth Circuit in *Legacy Emanuel*—have repeatedly rejected that view, which underlay HHS's previous approaches to the Medicaid and Medicare fractions. See, *e.g.*, *Northeast Hosp. Corp.*, 657 F.3d at 11-12; *Legacy*

Emanuel, 97 F.3d at 1266; *Jewish Hosp., Inc.* v. *Secretary of HHS*, 19 F.3d 270 (6th Cir. 1994); see also Pet. 8-9.

Respondent instead points (Br. in Opp. 18, 20, 28) to a different asserted inconsistency concerning the terminology Congress has used in referring to supplemental-security-income (SSI) benefits. Respondent notes that, although Congress often refers to "eligibility" for SSI benefits, *id.* at 18 (emphasis omitted), the Medicare fraction refers to individuals who were "entitled to [SSI] benefits," 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). And respondent notes (Br. in Opp. 20) that HHS includes in the Medicare fraction's numerator only Medicare beneficiaries who were entitled to SSI payments. As the government explained below, however, and as the Sixth Circuit has recognized, "the differences in the language used in the SSI and Medicare statutory schemes explain this apparent inconsistency." *Metropolitan Hosp.* v. *United States Dep't of Health & Human Servs.*, 712 F.3d 248, 268 (2013); see C.A. Doc. 30, at 31-32. Unlike entitlement to Medicare Part A benefits, which arises automatically when an individual meets the statutory criteria—for example, when a "person reaches age 65 and is entitled to Social Security benefits"—an individual eligible for SSI benefits must apply for those benefits to become entitled to receive them. 75 Fed. Reg. 50,042, 50,280 (Aug. 16, 2010). Moreover, "entitlement to receive SSI benefits * * * can vary from time to time" because it is "based on income and resources." *Ibid.* The Secretary's approach to determining whether an individual is "entitled to" Medicare benefits, SSI benefits, or both on particular days thus reflects differences in those distinct benefits regimes.

C. Respondent does not directly address the additional aspects of the statutory structure, history, and purpose set forth in the petition that further support the Secretary's interpretation. Pet. 25-27. Instead, respondent suggests (Br. in Opp. 10-11) that the agency's approach embodies unwise policy, and reflects supposed "hostility" to making disproportionate-share-hospital adjustments, based on respondent's prediction that the approach will "decrease the number of hospitals receiving [such] payments and the amount of those payments." As the agency observed during the rulemaking, however, whether a provider's payments would increase or decrease depends on the composition of its patient population. See 69 Fed. Reg. at 49,098. And "[n]umerous commenters opposed" HHS's original proposal to adopt a policy in line with respondent's reading of the statute, contending that it would reduce their payments. *Ibid.* Instead, in two rounds of public comment, many sophisticated providers and other organizations urged HHS to adopt the approach reflected in the 2004 rule—to include in the Medicare fraction all patient days of individuals entitled to Medicare Part A benefits, regardless of whether Medicare ultimately paid for those days. See, *e.g.*, C.A. E.R. 69-70, 71-73, 79, 81, 83, 85, 87-88, 90, 92-94, 96-97, 99-100, 106-108, 110-111, 113, 115, 118-119, 124, 131, 133, 137, 139-140, 142-143, 147-148.

Respondent disagrees with the policy determination the agency ultimately made. But Congress entrusted to the agency's expert judgment the determination of which approach to Medicare patient days better effectuates Congress's overarching policy objectives. See *Chevron*, 467 U.S. at 843-844. Absent any "unambiguously expressed intent of Congress" to bar the approach the Secretary selected, that approach should control. *Id.* at 843.

D. Respondent errs in asserting (Br. in Opp. 3, 14, 23) that the government has not contended in this Court that the Secretary's reasonable interpretation is entitled to judicial deference under the *Chevron* framework. The petition invoked that framework by expressly contending that the agency's interpretation "represents a reasonable reading that the court of appeals was obligated to uphold." Pet. 27 (citing *Entergy*, 556 U.S. at 218, in turn citing *Chevron*, 467 U.S. at 843-844); see Pet. 30 (similar). Under that framework, this Court may uphold the Secretary's "reasonable construction" of the statute without first determining whether it "is the only possible interpretation or even the one a court might think best," *Holder* v. *Martinez Gutierrez*, 566 U.S. 583, 591 (2012); see *Entergy*, 556 U.S. at 218 & n.4. As the petition explains (Pet. 18-30), however, the Court also may uphold the agency's interpretation simply because it is the better one, without addressing the additional weight due to that interpretation under *Chevron*. Whichever path the Court might choose to uphold the Secretary's sound, reasonable reading of the statute, the Ninth Circuit's decision *rejecting* that reading is unsound and warrants this Court's review.

II. THE DECISION BELOW WARRANTS REVIEW

As the petition explains and the decision below acknowledges, the court of appeals' decision that the statute forecloses the Secretary's interpretation of Section 1395ww(d)(5)(F)(vi)(I) conflicts with the D.C. Circuit's decision in *Catholic Health Initiatives Iowa Corp.* v. *Sebelius*, 718 F.3d 914 (2013), and the Sixth Circuit's decision in *Metropolitan Hospital*, *supra*; see Pet. 30-32; Pet. App. 19a-21a. Respondent's attempts to reconcile the decisions lack merit.

Respondent principally contends (Br. in Opp. 21-25) that no conflict exists because the decision below resolved the statutory-interpretation question presented in all three cases at "*Chevron* step 1," concluding that the statute unambiguously bars HHS's approach, "while the other circuits reached step 2." *Id.* at 22. That contention misapprehends the *Chevron* framework.

The Ninth Circuit's holding that "Congress 'has directly spoken to the precise question at issue' in the statutory text" and that the text "unambiguous[ly]" forecloses the interpretation codified in the 2004 regulation, Pet. App. 17a, 19a (quoting *Chevron*, 467 U.S. at 842), necessarily conflicts with the D.C. and Sixth Circuits' decisions upholding that interpretation as reasonable under *Chevron*. As this Court has observed, "surely if Congress has directly spoken to an issue then any agency interpretation contradicting what Congress has said would be unreasonable." *Entergy*, 556 U.S. at 218 n.4. For that reason, the Court has rejected the argument that a "supposedly prior inquiry of 'whether Congress has directly spoken to the precise question at issue'" is invariably necessary. *Ibid.* (citation omitted); see *Martinez Gutierrez*, 566 U.S. at 591.

Respondent's contention (Br. in Opp. 25-27) that the circuit conflict should be left to persist because (respondent asserts) all three courts—including the Ninth Circuit in this case—conducted scant "independent statutory analysis" (*id.* at 27) is doubly flawed. To the extent the decision below rests on the court of appeals' reading of its own case law addressing a different question, rather than an analysis of the statutory text and context at issue here, that provides only added reason for this Court to intervene. And to the extent the

courts' earlier decisions shed light on the relevant statutory question, the courts had no reason to repeat their earlier reasoning. See, *e.g.*, *Catholic Health Initiatives*, 718 F.3d at 919-920 (relying on *Northeast Hosp.*, *supra*).

Moreover, whatever analytical path each circuit followed to its respective conclusion, the governing interpretation of Section 1395ww(d)(5)(F)(vi)(I) in the Ninth Circuit now differs from that in the D.C. and Sixth Circuits, where the courts upheld the agency's interpretation. That disparity in the operative meaning of a federal statute, particularly one addressing a nationwide benefits program of the scale and complexity of Medicare, warrants review.

* * * * *

For the foregoing reasons and those stated in the petition for a writ of certiorari, the petition should be granted.

Respectfully submitted.

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