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

BRIEF FOR RESPONDENT

Anne M. Voigts
Matthew V.H. Noller
KING & SPALDING LLP
601 S. California Ave.
Suite 100
Palo Alto, CA 94304
(650) 422-6700

Daniel J. Hettich
Counsel of Record
Ashley C. Parrish
Jeffrey S. Bucholtz
Alek Pivec
KING & SPALDING LLP
1700 Pennsylvania Ave. NW
Washington, DC 20006
(202) 626-9128
dhettich@kslaw.com

Counsel for Respondent

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RULE 29.6 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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INTRODUCTION

Indigent patients tend to be sicker and need more medical care for many reasons, including lack of access to primary care. Hospitals provide a vital safety net for those patients by treating them regardless of ability to pay. Hospitals that serve more indigent patients therefore bear a bigger financial burden.

Congress thus instructed the Department of Health and Human Services to make additional payments to hospitals that serve a disproportionate share of indigent patients. HHS repeatedly refused to implement Congress's commands. So Congress intervened, amending the Medicare statute in 1986 to cabin HHS's discretion by ordering HHS to adjust payments based on two complementary measures of indigency that, when combined, estimate how much indigent care a hospital provides: the Medicare and the Medicaid fractions.

The Medicare fraction's measure of indigency is stricter than the Medicaid fraction's. The Medicare fraction measures indigency within the Medicare population by asking whether Medicare-entitled patients are also "entitled" to supplemental-security-income ("SSI") benefits. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Medicaid fraction measures indigency among a hospital's non-Medicare population by asking whether patients are "eligible" for Medicaid. Because the Medicare fraction requires "entitlement" to SSI—rather than mere "eligibility"—many indigent patients do not meet that standard. In fact, some common categories of SSI-eligible patients do not have a right to receive SSI benefits while hospitalized and

are therefore not considered “entitled to” SSI under the Medicare fraction.

To ensure that hospitals nonetheless receive appropriate reimbursement for indigent care, Congress narrowly defined the universe of patients encompassed by the Medicare fraction and thereby subject to the stricter SSI “entitlement” standard. The Medicare fraction does not encompass patients who were merely “eligible” for Medicare. Instead, Congress included only patients “entitled to” Medicare Part A benefits (*i.e.*, inpatient hospital benefits) on the specific days of their inpatient stay. Patients who were not “entitled” to Part A benefits because, for example, they had exhausted the number of inpatient days for which Medicare would pay, would be included in the *Medicaid* fraction’s broader definition of indigency.

HHS’s behavior has been at cross-purposes with the statute’s core purpose from the outset. HHS first refused to implement the statute at all. Then HHS attempted to constrict the Medicaid fraction’s measure of indigency (Medicaid “eligibility”), asserting that only patients for whom Medicaid actually made payment were “eligible.” Since many state Medicaid programs limit the number of hospital days for which Medicaid will pay, patients who had exhausted their right to Medicaid payment were not considered Medicaid-“eligible” under HHS’s standard and thus fell outside of the Medicaid fraction.

The courts saw through HHS’s effort. Four circuits held that HHS’s rule improperly equated “eligible,” which means capable of receiving, with “entitled,” which means an actual right to receive, and excluded clearly indigent patients, contrary to

congressional intent. HHS then threw in the towel and recognized that patients are Medicaid-"eligible" if they were qualified for Medicaid on the day at issue, regardless of whether Medicaid actually paid for that care.

Having failed to reduce payments by treating Medicaid *eligibility* as if it meant entitlement to payment, HHS turned its attention to Medicare *entitlement*—and decided to treat it as if it meant mere eligibility. Through flawed rulemaking—where HHS didn't justify its actions under the statute's purpose, mischaracterized its current policy and its proposal, and provided no economic analysis of the rule's impact—HHS abandoned a policy it had held for decades. HHS simply changed its mind, "decid[ing]" that now even patients with no right to Medicare payment would be considered "entitled" to Medicare benefits.

By expanding the universe of patients deemed "entitled to benefits under [Medicare] Part A," HHS shrank the Medicaid fraction: the more patients "entitled to benefits under [Medicare] Part A," the fewer "not entitled to" Medicare—and thus the more patients excluded from the Medicaid fraction, even if they were "eligible for" Medicaid. At the same time, HHS retained its narrow interpretation of "entitled to [SSI]" as requiring actual receipt of SSI payments. Few of the patients now excluded from the Medicaid fraction qualify under the Medicare fraction's stricter standard of indigency.

The net result was that disproportionate share hospitals ("DSH") across the country suddenly saw both their Medicare and Medicaid fractions decrease

even if they treated the same number of indigent patients as they did before.

HHS's approach cannot be reconciled with the statute's text. The term "entitled" refers only to those with a *right* to certain benefits, not more broadly to anyone merely qualified (*i.e.*, "eligible") to *seek* those benefits. The basic distinction between entitlement and eligibility is commonly understood: while every U.S.-born citizen of a certain age is *eligible* to be President, only the individual elected is *entitled* to serve.

Conflating different words with different definitions is not the only problem with HHS's position. HHS also interprets two instances of "entitled" differently in the same sentence. The Medicare fraction's numerator includes patients who are both "entitled to benefits under [Medicare] part A" *and* "entitled to [SSI] benefits." 42 U.S.C. § 1395ww(d)(5)(F)(vi). HHS argues that a patient is "entitled to" Medicare benefits even if the patient had no right to payment. But HHS interprets "entitled to [SSI] benefits" as requiring not only the right to payment, but also *receipt* of that payment. HHS thus interprets "entitled" more narrowly for SSI than for Medicare, even though Congress used the same word in both contexts.

There is yet another problem. By requiring HHS to include "patients who (*for such days*) were entitled to [Medicare]," 42 U.S.C. § 1395ww(d)(5)(F)(vi) (emphasis added), the statute contemplates day-to-day variability: a patient may be entitled to Medicare Part A benefits for some days of her stay, but not others. The statute's recognition of day-to-day

variability in patient entitlement is entirely at odds with HHS's position that Part A entitlement must be generally static throughout a patient's hospital stay.

HHS offered virtually no justification for adopting these strained interpretations in the single-paragraph explanation accompanying its final rule. J.A. 169-73 (69 Fed. Reg. 48,916, 49,098 (Aug. 11, 2004)). HHS did not claim the statute compelled its interpretation. Nor did HHS disclose any assessment of its decision's financial consequences for hospitals, even though the statute's whole point is to provide hospitals additional compensation. HHS's silence on this critical issue is surely no accident: by broadly defining which patients belong within the Medicare fraction's denominator, while narrowly defining which patients are indigent (*i.e.*, "entitled to [SSI] benefits") for purposes of the Medicare fraction's numerator, HHS's approach systematically reduces DSH payments.

This Court should affirm the Ninth Circuit's judgment vacating HHS's rule, for at least three reasons.

First, the Court should reject HHS's request for deference. Far from intending HHS to exercise discretion, Congress enacted a specific calculation method because HHS had shown it could not be trusted to carry out Congress's commands. Moreover, HHS failed to comply with proper procedures, justify its position by reference to the statute's purpose, or provide any meaningful analysis of the rule's financial impact. There is thus no proper exercise of agency discretion to defer to. *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016).

Second, even if HHS had not forfeited any claim to deference, its rule conflicts with the statute's plain text. The DSH provision unambiguously prohibits HHS from treating patients with no right to Medicare Part A benefits as being "entitled to" them. That is not just the best reading of the statute, but the only reasonable one. HHS's contrary approach cannot be squared with the statutory text, structure, or purpose.

Third, HHS's interpretation is unreasonable because it systematically reduces payments to DSH hospitals by imputing the same meaning to two different words (and two different meanings to the same word) in the same statutory sentence. HHS's attempts to defend its rule rely on *post hoc* rationales that this Court should not consider and that fail on their merits.

STATEMENT

A. Statutory and Regulatory Background

1. At its inception, Medicare Part A reimbursed hospitals for "reasonable costs" incurred providing covered services to Medicare beneficiaries. *Methodist Hosp. of Sacramento v. Shalala*, 38 F.3d 1225, 1227 (D.C. Cir. 1994). That changed in 1983, when Congress established the Inpatient Prospective Payment System, under which "hospitals are paid a fixed amount for each beneficiary treated, regardless of their actual costs." *Saint Francis Med. Ctr. v. Azar*, 894 F.3d 290, 291 (D.C. Cir. 2018).

Medicare payments to hospitals are subject to adjustments "to account for hospital-specific factors that may make a provider's costs higher than average." *Univ. of Wash. Med. Ctr. v. Sebelius*, 634

F.3d 1029, 1030 (9th Cir. 2011). One such adjustment is the "disproportionate share hospital" ("DSH") adjustment for hospitals that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). That adjustment is based on Congress's recognition that the more low-income patients a hospital treats, the higher its costs. *Adena Reg'l Med. Ctr. v. Leavitt*, 527 F.3d 176, 177-78 (D.C. Cir. 2008). Congress emphasized that "such patients may be more severely ill than average" and that the "payment system may not adequately take into account such factors." S. Rep. No. 98-23, at 54 (1983), *reprinted in* 1983 U.S.C.C.A.N. 143, 194; H.R. Rep. No. 98-25, at 141-42 (1983), *reprinted in* 1983 U.S.C.C.A.N. 219, 360-61.

Congress first ordered HHS to create a payment adjustment for "hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A" in 1982 and again in 1983. Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 101(a)(1), 96 Stat. 324, 332; Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e), 97 Stat. 65, 157. HHS refused, announcing that "[no] adjustment [was] warranted." J.A. 39 (49 Fed. Reg. 234, 276 (Jan. 3, 1984)). A court ordered HHS to implement a DSH adjustment, finding that Congress had not granted HHS discretion to ignore its mandate. *Redbud Hosp. Dist. v. Heckler,* No. C-84-4382-MHP, 1984 WL 2857 (N.D. Cal. July 30, 1984). This Court stayed the order pending HHS's appeal. *Heckler v. Redbud Hosp. Dist.,* 473 U.S. 1308 (1985).

While that litigation was pending, Congress responded to HHS's intransigence in the Deficit Reduction Act of 1984 by commanding HHS to "develop and publish a definition of 'hospitals that serve a significantly disproportionate number of patients who have low income.'" Pub. L. No. 98-369, § 2315(h), 98 Stat. 494, 1080 (1984). HHS again refused, and a court again ordered HHS to comply. *Samaritan Health Ctr. v. Heckler*, 636 F. Supp. 503, 517-19 (D.D.C. 1985). Nonetheless, HHS continued to insist no DSH adjustment was warranted, forcing the court "to remind" HHS of its "continuing obligation to carry out congressional mandates and court orders." *Samaritan Health Ctr. v. Bowen*, 646 F. Supp. 343, 347 (D.D.C. 1986).

Because HHS had repeatedly refused to implement the DSH provision, Congress was forced to fill in the blanks itself by establishing specific statutory calculations. Consolidated Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9105, 100 Stat. 82, 158-60 (1986) (codified at 42 U.S.C. § 1395ww(d)(5)(F)(vi)). The House Ways and Means Committee chastised HHS for its "total lack of responsiveness" to "implement a disproportionate share adjustment in any meaningful way," "[d]espite several mandates in the law." H.R. Rep. No. 99-241, Pt. 1, at 16 (1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 594. The Committee explained that HHS had "forced the Committee to go to the considerable length of mandating a specific adjustment . . . to provide additional payments to disproportionate share hospitals." *Id*. Members of the Senate expressed similar frustration with HHS "wast[ing] the better part of 3 years in formulating the answers they are

much better staffed to research and decide." *Economic Problems Facing Hospitals Serving the Poor and Elderly: Hearing Before the Subcomm. on Health of the S. Comm. on Fin.*, S. Hrg. 99-342, at 44 (1985) (opening statement of Sen. Durenberger)).

2. The core of Congress's mandated DSH payment formula is the "disproportionate patient percentage." 42 U.S.C. § 1395ww(d)(5)(F)(v)-(vi). That percentage is the "sum of" two fractions: the "Medicare fraction" and the "Medicaid fraction," which capture the percentage of a hospital's patient days attributable to two different groups of low-income patients. *Id.* § 1395ww(d)(5)(F)(vi). To qualify for a DSH adjustment, a hospital must have a disproportionate patient percentage of at least 15 percent. 42 U.S.C. § 1395ww(d)(5)(F)(v). Once qualified, a hospital's DSH payment increases consistent with that percentage. *Ne. Hosp. Corp. v. Sebelius*, 657 F.3d 1, 3 (D.C. Cir. 2011).

The Medicare Fraction. The Medicare fraction focuses on a hospital's patient days attributable to patients who, "for such days," were "entitled to" Medicare Part A benefits and asks what percentage of those days were for individuals who were also "entitled to" SSI benefits. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The fraction is designed to capture the percentage of a hospital's Medicare patient days attributable to indigent patients, with indigency measured by SSI entitlement. If a patient is "entitled to benefits under Part A," those inpatient days will be included in the Medicare fraction's denominator. If that patient is also "entitled to [SSI]

benefits," those inpatient days will also be included in the Medicare fraction's numerator.

The calculation can be depicted as follows:

$$\text{Medicare Fraction} = \frac{\text{Patient days for patients “entitled to” Medicare } \textit{and} \text{ “entitled to” SSI}}{\text{Patient days for patients “entitled to” Medicare}}$$

The Medicaid Fraction. The Medicaid fraction captures the percentage of *all* patient days attributable to individuals "eligible for" Medicaid coverage but *not* "entitled to" Medicare Part A benefits. *Id.* § 1395ww(d)(5)(F)(vi)(II). The Medicaid fraction thus treats "eligibility for Medicaid as the indicator of low income." *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1266 (9th Cir. 1996). By excluding patients "entitled to" Medicare Part A benefits, the statute "prevent[s] Medicaid-eligible patients from being counted" in both fractions. *Id.*

The Medicaid fraction's "numerator" is "the number of the hospital's patient days for [a cost reporting] period which consist of patients who (for such days) were *eligible for* medical assistance under a State [Medicaid] plan," but "not *entitled to* benefits under [Medicare] Part A." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (emphasis added). Its "denominator" is "the total number of the hospital's patient days for such period." *Id.*

The calculation can be depicted as follows:

$$\text{Medicaid Fraction} = \frac{\text{Patient days for patients “eligible for” Medicaid but not “entitled to” Medicare}}{\text{Total number of patient days}}$$

Congress used two different words, “entitled” and “eligible,” to define the patients included in the Medicare and Medicaid fractions. To be included in the Medicare fraction’s numerator, patients must be *“entitled to”* Medicare and SSI benefits. To be included in the Medicaid fraction’s numerator, patients must be “*eligible for*” Medicaid but *not* “*entitled to*” Medicare. The difference between “entitled to” and “eligible for” has significant real-world consequences. Whether a patient is “entitled to” Medicare Part A benefits, “entitled to” SSI benefits, or “eligible for” Medicaid benefits determines how many indigent patients the DSH calculation captures.

3. Over the years, both Congress and the courts have denounced HHS’s “hostility” to the DSH adjustment Congress mandated. *Jewish Hosp., Inc. v. Sec’y of Health & Human Servs.*, 19 F.3d 270, 276 (6th Cir. 1994); *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).

HHS’s miserly approach, driven by an “apparent policy of paying out as little money as possible,” *Ne. Hosp.*, 657 F.3d at 20 n.1 (Kavanaugh, J., concurring),

has led HHS to adopt varying interpretations of what it means to be "entitled to" Medicare Part A, "entitled to" SSI, and "eligible for" Medicaid. Although HHS's interpretations have changed (and are internally inconsistent), they have consistently decreased the overall DSH adjustments paid to hospitals by undercounting the indigent patients served.

HHS initially undercounted indigent patients by interpreting "eligible for [Medicaid]" narrowly, thereby reducing the Medicaid fraction's numerator. When HHS first implemented the DSH adjustment, it interpreted "eligible for [Medicaid]" as referring only to patients with an absolute right to have Medicaid pay for their services. 51 Fed. Reg. 31,454, 31,460-61 (Sept. 3, 1986). Under that approach, patients who were eligible for Medicaid but had, for example, exhausted their benefits, were excluded from the Medicaid fraction's numerator. That reduced both the number of hospitals qualifying for DSH and their payments.

Every appellate court to consider HHS's interpretation rejected it. *Legacy Emanuel*, 97 F.3d at 1266; *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); *Jewish Hosp.*, 19 F.3d at 275. The courts contrasted Congress's use of "entitled" in the Medicare context with "eligible" in the Medicaid context and held that HHS could not treat different words in the same statutory provision as if they were the same. To the contrary, "the use of the broader word 'eligible' indicates a meaning different from 'entitlement,' which means 'the absolute right to . . . payment.'"

Legacy Emanuel, 97 F.3d at 1265 (quoting *Jewish Hosp.,* 19 F.3d at 275). Following these decisions, HHS revised its interpretation of "eligible for" in the Medicaid fraction to match that language's plain meaning—namely, that all patients who meet Medicaid's eligibility criteria are "eligible for" Medicaid, whether or not they have an absolute right to payment. HCFA Ruling 97-2 (Feb. 27, 1997), https://go.usa.gov/xsn8W.

B. The 2005 Rule

1. Having lost its bid to dilute the Medicaid fraction, HHS tried another way to reduce DSH payments. This time, in the "2005 rule" at issue, HHS turned its attention to the meaning of "entitled to benefits under part A" in the *Medicare* fraction. Previously, HHS had interpreted that language to denote an absolute right to payment, meaning the individual not only was eligible for Part A benefits but had a right to receive them for the inpatient days at issue. Beginning in 2005, however, HHS tried to reduce DSH adjustments by interpreting "entitled" as functionally identical to "eligible" for purposes of the Medicare fraction. J.A. 169-73 (69 Fed. Reg. at 49,098). That is, HHS adopted the same definition of "*entitled* to [Medicare Part A]" benefits as it did for "*eligible* for [Medicaid]" in the same statutory provision: counting patients even if they have no right to receive benefits on the days they receive inpatient services.

That approach dilutes the Medi*caid* fraction by expanding the population of patients who are excluded from it as "entitled to" benefits under Medicare Part A. Although patients excluded from the Medicaid

fraction may instead be included in the Medicare fraction's numerator, they often are not. That is because to count in the Medicare fraction's numerator, a patient must also be "entitled to" SSI benefits. And as Congress understood when it adopted the stricter requirement of SSI *entitlement*, a patient is much more likely to be "eligible for" Medicaid than "entitled to" SSI. Only 2.3 million SSI recipients are 65 years or older—just 6 percent of the Medicare Part A population. SSA, *Monthly Statistical Snapshot, August 2021*, https://biturl.top/VJRbe2; CMS, Original Medicare Enrollment: Calendar Years 2014-2019, https://biturl.top/7BRFBn. In contrast, *75 million* Americans—22 percent of the entire U.S. population—are enrolled in Medicaid. CMS, April 2021 Medicaid and CHIP Enrollment Trends Snapshot, https://biturl.top/miaemu; U.S. Census Bureau, 2020 Census: U.S. Population as of April 1, 2020, https://biturl.top/EFFJVj.

There are several reasons why many more patients are eligible for Medicaid than entitled to SSI.

First, in most states, any individual enrolled in SSI is categorically "eligible for" Medicaid. Kalman Rupp & Gerald F. Riley, *State Medicaid Eligibility and Enrollment Policies and Rates of Medicaid Participation Among Disabled Supplemental Security Income Recipients*, 76 Soc. Sec. Bull. 3, 18 (2016). No reciprocal rule grants automatic SSI entitlement to Medicaid-eligible individuals.

Second, Medicaid's financial benefits far outstrip SSI's. Because of the high cost of medical services (particularly inpatient services), the incentive to enroll in Medicaid is powerful. In contrast, SSI

benefits consist primarily of a modest monthly stipend offset by the patient's income. 42 U.S.C. § 1382(b).

Third, because SSI entitlement requires the right to be paid benefits, two common categories of patients are excluded from the Medicare fraction's numerator. Specifically, patients who were nursing-home residents in the month preceding their hospital admission and patients who have long-term hospital stays are not entitled to receive SSI benefits if Medicaid pays for their care and they earn more than $30 a month. *Id.* § 1382(e)(1)(B); 20 C.F.R. § 416.414; J.A. 176-83 (75 Fed. Reg. 50,042, 50,281 (Aug. 16, 2010)). This rule excludes many Medicaid-eligible patients from the SSI numerator simply by virtue of their Medicaid eligibility.

Fourth, HHS construes "entitled to [SSI]" as requiring not just the *right* to SSI payments, but actual *receipt* of those payments. (That is, of course, a vastly different definition of "entitled" than HHS adopted for Medicare Part A benefits in the same fraction.) HHS therefore excludes patients who qualify for SSI benefits if they did not receive their benefits for reasons unrelated to indigency or their right to payment, such as patients whose SSI checks are returned as undeliverable, whose SSI benefits were used to offset outstanding debts, or who refuse direct deposit. J.A. 176-83 (75 Fed. Reg. at 50,280-81).

Because a patient is far less likely to be counted as indigent in the Medicare fraction than the Medicaid fraction, HHS's rule decreases the Medicaid fraction's numerator far more than it increases the Medicare fraction's numerator. And even if HHS's rule adds a few SSI patient days to the Medicare fraction's

numerator, the net result is almost always a *decrease* to the Medicare fraction overall. That is because HHS's rule tends to add far more patients to the Medicare fraction's denominator as "entitled to [Medicare] part A benefits" than it adds to the numerator, which is limited to patients who are "entitled to" both Medicare *and* SSI benefits.

In short, HHS's rule necessarily reduces hospitals' Medicaid fractions and nearly always reduces their Medicare fractions too. (That is what happened here, where respondent's Medicare and Medicaid fractions both decreased. Pl.'s Opp. to Def.'s Mot. to Clarify, *Empire Health Found. v. Becerra*, No. 16-00209-RMP (E.D. Wash. Oct. 12, 2021), ECF No. 87). That systematic exclusion of indigent patients from both fractions reduces DSH payments to hospitals, despite Congress's desire to increase them.

2. Given the tension between the 2005 rule's effect and the statute's purpose, it is perhaps no accident that the rule resulted from flawed rulemaking proceedings. In those proceedings, HHS repeatedly and mistakenly claimed that its then-current policy was to *include* patients who had exhausted their Part A benefits in the Medicare fraction and announced that it proposed to *exclude* those patients from the Medicare fraction going forward. J.A. 45-50 (68 Fed. Reg. 27,154, 27,207-08 (May 19, 2003)).

HHS claimed its proposed change would "facilitate consistent handling of these days across all hospitals." J.A. 47. But HHS did not explain how. While HHS acknowledged that it was "decid[ing]" between policies, it did not evaluate the economic

impact of its proposed change or any alternatives. Instead, citing "the administrative difficulty [of] separately identifying these days," it claimed it did "not have data available to allow us to quantify the impact of this proposed change precisely." J.A. 52-53 (68 Fed. Reg. at 27,416).

HHS misstated both its then-current policy and its proposed change. Before 2005, HHS's codified policy was that "only covered patient days"—meaning days for which Medicare Part A made payment—"are included in the Medicare fraction." J.A. 170 (69 Fed. Reg. at 49,098); 42 C.F.R. § 412.106(b)(2)(i) (2003). Its proposal to "begin" excluding patients who had exhausted their Part A benefits from the Medicare fraction was actually a proposal to maintain its existing policy.

Nearly all commenters took HHS's misstatement at face value. Only two detected HHS's mistake. J.A. 61-63, 83-85. One of those commenters urged HHS to correct its misstatement or risk "squander[ing] its credibility with the courts." J.A. 63. Nevertheless, when HHS issued information about its rulemaking on two subsequent occasions, it did not correct its misstatement. J.A. 86 (68 Fed. Reg. 45,346, 45,421 (Aug. 1, 2003)); J.A. 87-88 (69 Fed. Reg. 28,196, 28,286 (May 18, 2004)). Instead, HHS waited until July 7, 2004—over a year after being notified of its error and less than a week before the close of the final comment period—to post a website notice admitting that its policy was the opposite of what it had said. J.A. 93-94.

Not surprisingly, even after HHS's website posting, the vast majority of comments still labored

under the false premise that current DSH payments included exhausted days in the Medicare fraction. J.A. 55, 68, 71, 77, 90-91, 98-99, 102-03, 106-07, 109-10, 113, 121-22, 125, 128-29, 132, 134, 137-38, 141-42, 145, 148, 159-60; Excerpts of Record ("C.A. E.R.") 92, 106. It was not until the final rule's publication that HHS acknowledged for the first time in the Federal Register that it had "misstated [its] current policy." J.A. 169-70 (69 Fed. Reg. at 49,098). HHS admitted that its "policy has been that only covered patient days are included in the Medicare fraction." *Id.*

HHS acknowledged that "numerous" commenters "were disturbed and confused" and had asked for the "opportunity for providers to comment." *Id.* Nonetheless, HHS did not extend the time for comments. J.A. 153-56, 113-19; J.A. 171 (69 Fed. Reg. at 49,098). Instead, HHS issued a final rule that was the opposite of what it had proposed and that reversed its decades-old rule. J.A. 171 (69 Fed. Reg. at 49,098). To add insult to injury, HHS cited comments based on the false factual premise caused by its misstatement as its only reason for adopting the opposite of its original proposal. *Id.*

In the final rule, HHS changed the regulatory definition of the statutory phrase "entitled to benefits under [Medicare]" from having the right to payment under Part A to merely meeting the statutory criteria to qualify as a Part A beneficiary, regardless of whether the patient has a right to payment. Under that rule, patients who were not entitled to Part A payments for the days at issue—because, for example, they had exhausted their Part A benefits or had another insurer primary to Medicare—were

categorically excluded from the Medicaid fraction's numerator and only potentially included in the Medicare fraction's numerator. HHS did not, however, relax its interpretation of "entitled to [SSI] benefits." Instead, HHS still maintains that only patients who actually receive SSI benefits are "entitled to [SSI] benefits."

C. The Proceedings Below

As part of the DSH reimbursement process, the Medicare contractor auditing Valley Hospital Medical Center's cost report applied the amended policy from HHS's 2005 final rule to the hospital's cost reporting period for the 2008 fiscal year. ECF No. 34 at 14-15. After the Provider Reimbursement Review Board granted the hospital's request for expedited judicial review, ECF No. 11-2, the district court vacated the 2005 rule because HHS's rulemaking process was procedurally unreasonable. *Empire Health Found. for Valley Hosp. Med. Ctr. v. Price*, 334 F. Supp. 3d 1134, 1161-62 (E.D. Wash. 2018). The court concluded that HHS's numerous procedural failures deprived the public of appropriate notice and HHS of useful comments. *Id.*

While acknowledging that HHS's notice-and-comment process was "certainly not perfect," the Ninth Circuit found it sufficient under the Administrative Procedure Act. App.14a. The Circuit nevertheless upheld vacatur of the 2005 rule because it "violated the unambiguous text of 42 U.S.C. § 1395ww(d)(5)(F)(vi)" and the Ninth Circuit's earlier "ruling in *Legacy Emanuel.*" App.22a. Because *Legacy Emanuel* held that "eligible" could not mean "entitled," the Court held, HHS could not treat

"entitled" as meaning "eligible" in the same statutory provision. App.18a-21a.

In so doing, the Ninth Circuit declined to follow two previous decisions upholding the rule. In *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914, 920 (D.C. Cir. 2013), the D.C. Circuit had found the statute ambiguous and deferred to HHS's interpretation, although it acknowledged that the contrary interpretation of "entitled" was also "permissible." But it assumed deference was obligatory and did not consider the underlying procedural flaws, the conflict between the rule and the statutory purpose, or HHS's long history of refusing to follow Congress's directions. The court also did not discuss how to square HHS's internally inconsistent readings of "eligible" and "entitled" or how to reconcile the language "for such days" with HHS's theory of static entitlement. The split decision in *Metropolitan Hospital v. HHS*, 712 F.3d 248 (6th Cir. 2013), had also concluded that HHS's rule reflected a permissible construction of the DSH provision, although it found HHS's position was not compelled by the statute. But that court did not realize that HHS excludes from SSI entitlement even patients who qualify and apply for SSI benefits if they do not receive their payments. *See id.* at 269. Nor did the court consider (or seem to know about) the flaws in HHS's rulemaking process. *See id.* at 268.

SUMMARY OF ARGUMENT

Congress enacted the DSH adjustment because it recognized that hospitals with an unusually high percentage of low-income patients generally have higher per-patient costs and therefore deserve

increased payment. Courts and Congress have repeatedly called HHS on the carpet for subverting Congress's purpose and ignoring Congress's clear instructions. This case is simply more of the same. The Court should set aside the 2005 rule.

1. The only consistency to HHS's fundamentally inconsistent approaches has been its intransigence in the face of Congress's clear directions. Although HHS's brief omits that problematic history, that intransigence is well-documented, with both Congress and the courts repeatedly directing HHS to provide a DSH adjustment consistent with the statutory commands and HHS repeatedly refusing. The reason the original DSH adjustment mandated by Congress did "not come to fruition," as HHS delicately puts it, HHS Br. 5, was that HHS took an axe to its roots.

HHS does not claim the statutory interpretation it decided to adopt is the only permissible one. Instead, HHS's brief argues that the issue here is complicated and the Court should just trust it. But no deference is warranted when Congress did not intend it or when an agency has a history of deviating from statutory requirements or has violated the procedural requirements of reasoned decisionmaking. HHS's recalcitrance forced Congress to specify detailed calculations in the statute precisely because Congress could not rely on HHS's discretion. It is for good reason that HHS's brief does not claim HHS was exercising any particular expertise in adopting this rule: HHS cast aside its previous interpretation in a single paragraph that offered literally no analysis of the impact the change would have on payments to hospitals. Rather than defer to HHS under these

unusual circumstances, the Court should interpret the statute with no bias in favor of either side and determine the statute's best meaning in light of its text, structure, and purpose.

2. Whether the Court's task is to give the statute its best meaning or its unambiguous meaning is ultimately beside the point, because HHS's position conflicts with the plain statutory text. This case involves applying the principles that the same words in a single statutory provision mean the same thing—and different words different things. HHS's rule accomplishes the remarkable feat of violating both principles by ignoring the plain-meaning distinction between "eligible" and "entitled."

HHS contends that *entitlement* to SSI benefits requires actual receipt of payment, but *entitlement* to Medicare benefits does not even require the right to receive payment. Instead, according to HHS, satisfying Medicare's statutory eligibility criteria makes a patient "entitled to benefits under part A" even if Part A will not pay a dime for the inpatient days at issue because, for example, the patient has exhausted her Part A inpatient benefit. The proof that HHS has misinterpreted "entitled" to mean "eligible" is that it applies the same interpretation to the statutory phrase "*eligible* for [Medicaid]," thus including patients who meet statutory requirements regardless of whether they have a right to payment. Moreover, HHS's interpretation renders the day-by-day analysis required by the statutory phrase "for such days" meaningless in all but the rarest of cases.

3. Even if the statute were ambiguous, HHS's interpretation is unreasonable. It assigns different

statutory words the same meaning and the same statutory word different meanings, all in a single provision. It renders the statutory phrase "for such days" superfluous; ignores other statutory provisions equating entitlement to a right to payment; reverses HHS's decades-long policy treating "entitled to benefits under part A" as requiring Medicare payment; and was adopted without reasoned explanation, any real analysis of its economic impact, or the benefit of meaningful public comments.

ARGUMENT

I. The 2005 Rule Is Not a Legitimate Exercise of Agency Expertise That Could Trigger Deference.

HHS does not contend that the statute compels its interpretation. Instead, HHS's defense of the 2005 rule relies on a full-throated plea for deference. But agencies receive deference only when they exercise their expertise to resolve questions Congress assigned them discretion to answer. That is not what happened here.

1. Although courts often defer to an agency's interpretation of a statutory provision, deference is neither automatic nor absolute. *United States v. Mead Corp.*, 533 U.S. 218, 236-37 (2001); *see Kisor v. Wilkie*, 139 S. Ct. 2400, 2416 (2019) (citing *Mead*). When interpreting a statute, courts must "make an independent inquiry into whether the character and context of the agency interpretation entitles it to controlling weight." *Kisor*, 139 S. Ct. at 2416. That context-specific inquiry depends on the statute's purposes and "the degree of the agency's care, its

consistency, formality, and relative expertness, and [on] the persuasiveness of the agency's position." *Mead*, 533 U.S. at 228; *see City of Arlington v. FCC*, 569 U.S. 290, 309-10 (2013) (Breyer, J., concurring).

In this case, the "essential premises" for deference are "simply missing" because the DSH provision reflects no "'implicit' delegation to [the] agency to interpret" it. *Epic Sys. Corp. v. Lewis*, 138 S. Ct. 1612, 1629 (2018). As explained above, Congress repeatedly amended the DSH provision in response to HHS's recurring attempts to sabotage it. Each time, Congress specified more and more precisely what HHS had to do, and each time it allowed the agency less and less discretion in carrying out its mandates. The current Medicare and Medicaid fractions were designed to *displace* HHS's discretion, not enable it. That history renders unreasonable any assumption that Congress wanted "the agency to fill in the statutory gaps." *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 159 (2000). As a result, this Court must exercise its own "independent interpretive judgment," with no thumb on the scale in HHS's favor. *Epic Sys.*, 138 S. Ct. at 1629.

The need for independent interpretive judgment is particularly important where, as here, the statute establishes an entitlements regime conferring government benefits on a carefully defined set of beneficiaries. While Congress may grant an agency discretion to *administer* such a statutory regime, *see Gundy v. United States*, 139 S. Ct. 2116 (2019), the initial status determination—that is, which subset of citizens may receive benefits in the first place—entails a quintessential legislative judgment that agencies

must respect, lest they rewrite the law by creating different status distinctions than Congress did. *Cf. Kisor*, 139 S. Ct. at 2421-22 (deference to agencies does not violate separation of powers as long as agency "execute[s] a statutory plan" and "courts retain a firm grip on the interpretive function"); *Int'l Harvester Co. v. Missouri*, 234 U.S. 199, 215 (1914) ("determin[ing] upon what differences a distinction may be made for the purpose of statutory classification" is "a matter for legislative judgment").

Congress exercised its legislative judgment in the DSH provision by setting forth the precise equation for determining which hospitals should receive DSH payments and how much they should be paid. Congress explicitly did so because HHS's "total lack of responsiveness" to earlier commands had forced legislators "to go to the considerable length of mandating a specific adjustment . . . to provide additional payments to disproportionate share hospitals." H.R. Rep. No. 99-241, Pt. 1, at 16. The purpose of that "specific" DSH provision was to "require" HHS to do what it had "fail[ed]" to: "implement a disproportionate share adjustment in a[] meaningful way." *Id.*

Congress thus intended HHS to apply the DSH calculation that Congress set forth in the Medicare statute, not to "interpret" its way around it. It is unreasonable to assume that Congress would have expected or intended courts to defer to HHS's interpretation. *See Cabell Huntington*, 101 F.3d at 990 ("We cannot . . . allow an agency, hostile from the start to the very idea of making the [DSH] payments at issue, to rewrite the will of Congress."); *accord Jewish*

Hosp., 129 F.3d at 275-76. The only reasonable conclusion is that Congress wanted courts to "exercise independent interpretive judgment," *Epic Sys.*, 138 S. Ct. at 1629, to ensure HHS would finally follow the statute as written.

2. HHS's rulemaking process here proves Congress was right to doubt HHS's ability to follow its instructions. That process, which played out like a parody of inept bureaucracy, further confirms the 2005 rule was not a legitimate exercise of agency expertise to which courts should defer.

Although this Court denied respondent's conditional cross-petition challenging the 2005 rule's procedural reasonableness, those procedural flaws also undercut the deference that otherwise might be due when assessing the rule's substantive reasonableness. This Court need not and should not defer to an agency when the regulation setting forth its interpretation "is 'procedurally defective'—that is, where the agency errs by failing to follow the correct procedures in issuing the regulation." *Encino Motorcars*, 136 S. Ct. at 2125 (quoting *Mead*, 533 U.S. at 227).

HHS's process started unraveling on day one, when it misstated both its current and its proposed policies. Despite knowing about that misstatement, HHS took no steps to correct it until days before the comment period closed, and it did so only in the agency equivalent of a blog post. Then it cited comments supporting the policy it claimed it was considering as support for the diametrically opposed policy it was *actually* considering. *Cf. Caring Hearts Pers. Home Servs., Inc. v. Burwell*, 824 F.3d 968, 976 (10th Cir.

2016) (Gorsuch, J.) ("This case has taken us to a strange world where the government itself—the very 'expert' agency responsible for promulgating the 'law' no less—seems unable to keep pace with its own frenetic lawmaking.").

That is "notice and comment" in name only. HHS's process deprived "affected parties [of] fair warning of potential changes in the law" and "an opportunity to be heard on those [potential] changes," and robbed HHS of "a chance to avoid errors and make a more informed decision." *Azar v. Allina Health Servs.,* 139 S. Ct. 1804, 1816 (2019) (citing 1 K. Hickman & R. Pierce, Administrative Law § 4.8 (6th ed. 2019)). In the context of the DSH program, "where even minor changes to the agency's approach can impact millions of people and billions of dollars in ways that are not always easy for regulators to anticipate," those harms are especially severe. *Id.*

HHS exacerbated the arbitrariness by barely bothering to defend its chosen policy on the merits. It did not engage with the history of the DSH provision. It did not claim its policy reflected the best reading of the provision's text (to the contrary, it acknowledged its interpretation was at best one of a range of plausible ones). It did not contend its policy served the DSH provision's purposes better than other alternatives. And perhaps most remarkably, it provided no economic analysis of how its reading of the provision—the whole point of which, HHS concedes, is to increase compensation for disproportionate-share hospitals—would affect that compensation. Far from employing any expertise in assessing the impact its rule would have on safety-net hospitals and the

indigent patients they serve, HHS punted, claiming that such an analysis was too "difficult[]." J.A. 52 (68 Fed. Reg. at 27,416). This lack of explanation is particularly unjustifiable given that the 2005 rule represents a complete about-face from HHS's pre-2005 policy of *excluding* from the Medicare fraction patients who were not entitled to part A payment. *Encino Motorcars*, 136 S. Ct. at 2126 (holding an agency must provide "good reasons" for "changing position" (cleaned up)).

HHS's fundamentally flawed rulemaking process sends a clear message: it has not taken its obligations under the DSH provision seriously, and it does not care about the hospitals Congress ordered it to compensate. That was true when Congress first created the DSH program, and it remains true today. By abdicating its responsibility to carry out Congress's directives, HHS has relinquished any claim to deference.

II. The Statutory Text Precludes the 2005 Rule.

Even when an agency properly exercises its expertise to interpret a statute, a reviewing court's first task is to independently use "traditional tools of construction" to decide what the statute means. *SAS Inst., Inc. v. Iancu*, 138 S. Ct. 1348, 1358 (2018). Only if the court "find[s] [itself] unable to discern Congress's meaning" will it defer to the agency's reading. *Id.*

Here, the "traditional tools of construction" leave "no uncertainty that could warrant deference." *Id.* Under all the relevant canons of interpretation, the DSH provision unambiguously prohibits HHS from treating patients with no right to Medicare Part A

benefits as being "entitled to" those benefits. *Ne. Hosp.*, 657 F.3d at 19-20 (Kavanaugh, J., concurring).

A. HHS's Interpretation Defies Statutory Text, Context, and Purpose.

1. When Congress uses different words in the same provision, those words should carry different meanings. *Sosa v. Alvarez-Machain*, 542 U.S. 692, 711 n.9 (2004). The corollary is that when Congress uses the same "term in multiple places within a single statute, the term bears a consistent meaning throughout." *Allina*, 139 S. Ct. at 1812. And all statutory terms, same or different, should be "interpreted in accordance with their ordinary meaning." *BP Am. Prod. Co. v. Burton*, 549 U.S. 84, 91 (2006). The 2005 rule's interpretation of "entitled to [Medicare]" manages to violate each of these principles.

First, HHS gives the phrase "*entitled to* benefits under [Medicare] part A" the same effective meaning as the quite different phrase "*eligible for* [Medicaid]." HHS interprets "entitled to benefits under [Medicare] part A" to encompass all patients who satisfy the baseline statutory criteria for Medicare benefits, even if they have no right to actually *receive* those benefits for the hospital stay at issue. But that is also how HHS interprets "eligible for [Medicaid]"—as requiring only satisfaction of Medicaid's eligibility requirements. So, under HHS's reading, the different words "entitled" and "eligible" carry the same meaning: satisfying the statutory eligibility criteria is sufficient, regardless of whether a patient has a right to be paid those benefits.

Second, HHS interprets the word "entitled" differently twice in a single sentence. The Medicare fraction's numerator covers patients who are "entitled to benefits under part A" and "entitled to [SSI]." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). HHS interprets "entitled to benefits under part A" to include patients "regardless of whether Medicare makes payment," but "entitled to [SSI]" to *exclude* patients without an absolute right to payment (indeed, to exclude patients who have a right to payment but do not *receive* it). HHS cannot justify that disparity.

Third, HHS's interpretation of "entitled" departs from the word's "common meaning[]." *Cabell Huntington*, 101 F.3d at 988. The ordinary meaning of "entitlement" is an "absolute right to . . . payment." *Jewish Hosp.*, 19 F.3d at 275; *Legacy Emanuel*, 97 F.3d at 1265; *Ne. Hosp.*, 657 F.3d at 20 (Kavanaugh, J., concurring); *see* Collins Dictionary of the English Language 488 (1985 ed.) (defining "entitle" as "to give (a person) the right to do or have something"); Funk & Wagnalls Standard Desk Dictionary 212 (1983 ed.) (defining "entitle" as "[t]o give (a person or thing) the right to receive . . . something"); Webster's Third New International Dictionary 758 (1981) (defining "entitle" as "to give a right or legal title to" and "entitlement" as "the right to benefits"); Black's Law Dictionary 477 (6th ed. 1979) (defining "entitlement" as "[r]ight to benefits, income or property which may not be abridged without due process").

Before the 2005 rule, HHS followed that ordinary meaning by holding that only patients who had a right to payment under Medicare Part A were "entitled to benefits under [Medicare] part A." J.A. 169-73 (69 Fed.

Reg. at 49,098). Indeed, when HHS tried to impose a right to payment within the Medicaid fraction, HHS used the word "entitled." 42 C.F.R. § 412.106(a)(1)(ii) (1994).

But now, HHS interprets "entitled to [Medicare]" contrary to its ordinary meaning, as requiring far less than an "absolute right to . . . payment." *Jewish Hosp.*, 19 F.3d at 275. Instead, the rule provides that patients are "entitled to benefits under [Medicare] part A" if they merely satisfy Medicare's eligibility criteria, even if they have no right to payment. But it is obvious from common usage that a person can satisfy the eligibility criteria for a benefit without being "entitled to"—that is, having an absolute right to receive—it. *Cabell Huntington*, 101 F.3d at 988; *Jewish Hosp.*, 19 F.3d at 275; *Legacy Emanuel*, 97 F.3d at 1265. Not every U.S.-born 35-year-old is "entitled" to be President of the United States. Not every batter is "entitled" to hit a home run. And not everyone who buys a lottery ticket is "entitled" to a jackpot.

Fourth, HHS's position is at odds with the plain meaning of the statutory phrase "for such days." The Medicare fraction's numerator and denominator both include the "patient days . . . which were made up of patients who (*for such days*) were entitled to [Medicare]." 42 U.S.C. § 1395ww(d)(5)(F)(vi) (emphasis added). The phrase "for such days" makes clear that a patient's entitlement to Medicare can change on a day-to-day basis. *Ne. Hosp.*, 657 F.3d at 19 (Kavanaugh, J., concurring). HHS's contrary interpretation treats entitlement to Medicare as a permanent, largely unchanging status. But if "Medicare beneficiaries are *always* 'entitled to benefits under [Medicare] part A,'"

as HHS has claimed, J.A. 221 (emphasis added), a patient will be "entitled to [Medicare]" either for every day of her hospital stay or for none of them, making the statutory phrase "for such days" surplusage. *E.g., TRW Inc. v. Andrews*, 534 U.S. 19, 29-31 (2001) (rejecting interpretation that would render statutory language "superfluous in all but the most unusual circumstances").

2. What the plain text says, context and legislative history confirm: Congress used "entitlement" to refer "not just [to] an abstract ability to sign up for [Medicare]" but to an "entitlement *to have payment made*." *Ne. Hosp.,* 657 F.3d at 20 (Kavanaugh, J., concurring).

Other statutory provisions make clear that entitlement does not mean the same thing as mere eligibility. For instance, section 1395d(a) of the Medicare statute specifies that "[t]he benefits provided to an individual . . . under [Part A] shall consist of *entitlement to have payment made* on his behalf." 42 U.S.C. § 1395d(a) (emphasis added). Sections 426(a) and 426(b) of the Social Security statute provide that individuals who satisfy certain criteria are "entitled to hospital insurance benefits under part A." *Id.* § 426(a)-(b). Section 426(c) then explains that entitlement "consist[s] of" "*entitlement to have payment made*." *Id.* § 426(c)(1) (emphasis added).

The Medicare statute's legislative history further supports the link between entitlement to benefits and the right to payment. The House and Senate reports for the legislation originally enacting the Medicare statute both defined "entitlement to hospital insurance benefits" as "*entitlement to have payment of*

benefits made under part A." H.R. Rep. No. 89-213, at 140 (1965) (emphasis added); S. Rep. No. 89-404, at 157 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 2096-97.

3. HHS's rule also conflicts with the statutory purpose—compensating hospitals that care for the indigent. As HHS admits, HHS Br. 4, the DSH provision exists to *increase* "payments [for] hospitals serving 'low income' persons," *Legacy Emanuel*, 97 F.3d at 1265. Relentlessly "restricting the available subsidy," as HHS has done, "runs counter to this clear intent." *Jewish Hosp.*, 19 F.3d at 275; *see Portland Adventist*, 399 F.3d at 1099 (bemoaning the "series of cases in which [HHS] has refused to implement the DSH provision in conformity with the intent behind the statute").

As noted above, the DSH fractions' structure guarantees that treating patients with no right to Part A payment, such as patients who have exhausted their benefits, as nonetheless "entitled to benefits under Part A" will decrease DSH payments overall. And sure enough, HHS's interpretation has done so in over 90% of cases by an average of almost $150,000 per hospital per year. *See* Pls.' Opp. to Def's. Cross-Motion for S.J. 41-42, *Catholic Health Initiatives Iowa, Corp. v. Sebelius*, 841 F. Supp. 2d 270 (D.D.C. 2012) (No. 10-0411), 2010 WL 11685305.

HHS has never asserted otherwise or advanced any evidence that the 2005 rule furthers the statute's purpose. Indeed, HHS apparently has never even *tried* to figure out how its reading will affect reimbursements—because it thought doing so would be too hard. In its first notice of proposed rulemaking,

HHS provided detailed economic analyses of other proposed changes. But when it came to this one, HHS threw up its hands, citing "the administrative difficulty [of] separately identifying these days" and concluding that it did "not have data available to allow [it] to quantify the impact of this proposed change precisely." J.A. 52-53 (68 Fed. Reg. at 27,416).

Unwilling to do the work of actual analysis, HHS resorted to speculation. In the final 2005 rule, HHS asserted that, had it chosen to interpret "entitled to" as requiring a right to payment—that is, had it adopted the policy it proposed—it would not have necessarily *reduced* DSH payments. J.A. 173 (69 Fed. Reg. 49,098) (disagreeing "that including days in the Medicaid fraction instead of the Medicare fraction always results in a reduction in DSH payments"). That pushes the art of understatement to its limits, since interpreting "entitled to" that way would almost universally *increase* payments. As explained above, the structure of the DSH fractions and the categories of patients at issue ensure that a reversal of HHS's policy would increase DSH payments in the overwhelming majority of instances. HHS has never presented any countervailing evidence.

Even HHS's new claims regarding the economic effect of its policy are remarkably tepid. HHS asserts that it "did not adopt the 200[5] rule with a view to decreasing or increasing hospitals' payments across the board." HHS Br. 44. Notably, HHS does not deny that its policy *in fact* "decreas[es] . . . payments across the board," only that doing so was not HHS's goal. Indeed, HHS does not even say that it did not adopt the rule with a view to decreasing payments *on*

balance even if not quite "across the board." Given the complete disregard HHS exhibited for its policy's effect on DSH payments when adopting the 2005 rule, even this half-hearted statement is an improper *post hoc* rationalization. *Encino Motorcars*, 136 S. Ct. at 2127; *Michigan v. EPA*, 576 U.S. 743, 758 (2015). Moreover, even taking HHS's statement at face value, it just underscores HHS's failure to do any analysis of how its reversal of position would affect the statute's core goal—ensuring that hospitals aren't effectively penalized for caring for the poor. HHS's disregard for the economic effect of its policy is consistent with its hostility to the DSH program, but not the statute's purpose.

B. HHS's Arguments Conflict with the Statute's Text and Purposes.

1. HHS's brief in this Court marks the first time it has tried to reconcile its interpretation of "entitled to [Medicare] part A benefits" with the rest of the statute's text. In its initial notice of proposed rulemaking, HHS merely asserted that there are multiple "plausible interpretations" of the text, J.A. 46 (68 Fed. Reg. at 27,208), and when HHS issued the final 2005 rule, it offered little textual defense for its new interpretation of "entitled to [Medicare] part A benefits." J.A. 169-75 (69 Fed. Reg. at 49,098-99). HHS did not explain why its interpretation was consistent with the full statutory text, let alone "more consistent . . . than alternative policies," or "analyze or explain why the statute should be interpreted" that way. *Encino Motorcars*, 136 S. Ct. at 2127 (cleaned up).

HHS cannot do now what it should have done then. It cannot belatedly fill the gaps in its rulemaking

in its brief to this Court. A "foundational principle of administrative law [is] that a court may uphold agency action only on the grounds that the agency invoked when it took the action." *Michigan*, 576 U.S. at 758 (citing *SEC v. Chenery Corp.*, 318 U.S. 80, 87 (1943)). Because HHS did not "invoke[]" any of the textual arguments it makes to this Court when it adopted the 2005 rule, those arguments cannot be raised for the first time now. *Id.*; *see Encino Motorcars*, 136 S. Ct. at 2127.

2. Even if HHS could raise its new textual arguments, they are hopeless. HHS has argued that it can interpret "entitled" and "eligible" as having the same effective meaning, claiming the canon that different words have different meanings "has little weight" in "this particular context." HHS Cert. Pet. 30 (cleaned up). But four different appellate courts held otherwise with respect to the Medicaid fraction in the same statutory provision. *Cabell Huntington*, 101 F.3d 987-88; *Legacy Emanuel*, 97 F.3d at 1265-66; *Deaconess Health*, 83 F.3d at 1041; *Jewish Hosp.*, 19 F.3d at 274-75. There is no reason to reach a different conclusion for the Medicare fraction. The reasons HHS gives for disregarding such a longstanding canon of interpretation and reaching a different result cannot withstand scrutiny.

a. HHS's primary argument is that when Congress used the terms "entitled" and "eligible" in the DSH provision, it deliberately borrowed them from other statutes, where they are used differently, and that those different meanings should be imported into this provision. HHS Br. 47. HHS's statutory references do not support its point.

HHS first cites sections 426(a) and 426(b) of the Social Security statute and section 1395d(a) of the Medicare statute, HHS Br. 27-30, but all of those define entitlement as "entitlement *to have payment made*," 42 U.S.C. §§ 426(c)(1), 1395d(a).

HHS then tries to distinguish "the principal consequence of being 'entitled to' Part A benefits—a right to have the Medicare program make payment"—from "the category of 'patients who . . . [a]re entitled to' such benefits." HHS Br. 47. Few hairs have ever been split more finely. And it is unclear where HHS derived its empty distinction between the consequences of an entitlement and the entitlement itself, but it is certainly not from the statute. Nothing in the DSH provision (or the English language) suggests that patients could somehow be "entitled to" benefits and yet have no right to the "principal consequence" of that entitlement. *Id.* An entitlement to benefits can mean nothing other than an entitlement to what the benefits "consist of"—namely, a right "to have payment made." 42 U.S.C. §§ 426(c)(1), 1395d(a).

HHS's contention that entitlement to Part A benefits must be "binary" and "stable," HHS Br. 23, is belied by the statutory text. Contrary to HHS's suggestion, the DSH provision does not ask whether a patient is entitled to Medicare Part A benefits "at all," HHS Br. 17—it asks whether a patient *was* entitled to Part A benefits on individual "hospital[] patient days," 42 U.S.C. § 1395ww(d)(5)(F)(vi). By asking whether a patient was entitled to Part A benefits "for such days," *id.*, the statute unambiguously requires a day-by-day analysis under which entitlement can vary from day

to day. *Ne. Hosp.*, 657 F.3d at 20 n.1 (Kavanaugh, J., concurring).

HHS's interpretation, on the other hand, robs "for such days" of nearly all meaning because it ensures Medicare beneficiaries will almost "always [be] 'entitled to benefits under [Medicare] part A.'" J.A. 221. Only in exceedingly rare cases—when a patient turns sixty-five and becomes entitled to Medicare in the middle of his hospital stay, 42 U.S.C. § 426(a), or reaches his twenty-fifth month of entitlement to disability benefits, *id.* § 426(b)—will a patient's entitlement to Medicare differ on any two days. HHS Br. 34. By arguing that its interpretation gives meaning to "for such days" only in these situations, HHS tacitly admits its interpretation renders the phrase superfluous 99 times out of 100. Congress did not intend the phrase "for such days" to do so little work. *TRW*, 534 U.S. at 29-31 (rejecting interpretation that would render statutory language "superfluous in all but the most unusual circumstances").

Indeed, when it comes to the Medicaid fraction, HHS recognizes that "for such days" requires a day-by-day review. In calculating the number "of patients who (for such days) were eligible for Medicaid," HHS appropriately demands that hospitals prove "that a patient was eligible for Medicaid (for some covered services) *during each day* of the patient's inpatient hospital stay." HCFA Ruling No. 97-2, at 4 (emphasis added). Likewise, in interpreting the phrase "for such days" in the context of assessing "entitlement to [SSI] benefits," HHS also performs a day-by-day analysis under which a patient may be deemed entitled to SSI

benefits on September 30 but not October 1. 75 Fed. Reg. at 50,276-78. Because the Medicare fraction uses the same "for such days" language, it requires the same day-by-day analysis.

HHS's treatment of the Medicaid fraction likewise rebuts its argument that patients who have exhausted their Medicare benefits for inpatient hospital services can still be "entitled to" Part A benefits for purposes of the DSH provision. HHS Br. 31. It is true Part A covers more than just inpatient hospital services. 42 U.S.C. § 1395d(a)(2)-(5). But those outpatient services are irrelevant to the DSH provision, which cares only whether a patient is entitled to *inpatient* hospital services.

When HHS interpreted "eligible for [Medicaid]" as requiring an absolute right to Medicaid payment, it believed that only coverage for inpatient hospital services mattered. *Cabell Huntington*, 101 F.3d at 989 ("The Secretary reasons that . . . an otherwise Medicaid-eligible patient who has exhausted his coverage *for inpatient hospital care* is no longer 'eligible for medical assistance' because he can no longer receive payment *for inpatient services*" (emphasis added)). To this day, HHS's own DSH regulation says that "eligible for [Medicaid]" in the Medicaid fraction means "eligible for *inpatient hospital services* under an approved State Medicaid plan." 42 C.F.R. § 412.106(b)(4)(i) (emphasis added). Even though Medicaid includes benefits other than inpatient benefits, such as outpatient hospital services, nursing facility services, and dental services, 42 U.S.C. § 1396d(a), HHS treats those other benefits as irrelevant to the Medicaid fraction. Likewise, the

outpatient benefits available after a patient with exhausted Part A benefits leaves the hospital are irrelevant to whether a patient is "entitled to" the *inpatient* benefits covered by the Medicare fraction.

b. As for SSI benefits, HHS is just plain wrong to suggest that Congress borrowed "entitled" from the SSI statute. The SSI statute overwhelmingly refers to *eligibility* for benefits, not entitlement. *E.g.*, 42 U.S.C. §§ 1381a, 1382, 1382a(b)(2), 1382a(b)(10), 1382b(b)-(d), 1382c(a)(3)(G)-(H), 1382c(f), 1382e(a)-(d), 1382h(a)-(b), 1382j(a), 1383(e)-(k), 1383(p), 1383c(a)-(d), 1383d(a). But the DSH provision refers to *entitlement* to SSI benefits. *Id.* § 1395ww(d)(5)(F)(vi)(I). That is not what Congress would have done if it was deliberately borrowing words from other statutes.

And HHS cannot offer any remotely plausible explanation for its decision to interpret "entitled to [SSI]" differently than "entitled to [Medicare]" in the same statutory sentence. In the past, HHS has tried to justify its disparate definitions by claiming that (1) patients must apply for SSI benefits but are automatically entitled to Medicare benefits, and (2) Part A benefits encompass more than inpatient benefits, while SSI entitlement consists solely of a cash payment. J.A. 176-80 (75 Fed. Reg. at 50,280).

Neither makes sense. The fact that SSI benefits require an application just means that only patients who have filed an application (and satisfy the other requirements) are "entitled to SSI benefits." It does not justify interpreting "entitled to" more narrowly in the SSI context than in the Medicare context. Neither does any difference in the kinds of benefits available under Medicare Part A and SSI. Nor is it true that SSI

benefits consist solely of cash benefits. SSI also provides ancillary benefits, such as automatic qualification for Part D drug discounts and, in most states, Medicaid. 42 C.F.R. § 423.773(c)(1)(ii); 42 U.S.C. § 1382.

c. So HHS moves on to a series of other provisions in the Medicare statute, none of which helps it either. HHS's "bank shot approach" to statutory interpretation should be rejected. *Ne. Hosp.,* 657 F.3d at 21 (Kavanaugh, J., concurring).

HHS first tries one provision defining outpatient services as including inpatient services furnished 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*(t)(1)(B)(ii) (emphasis added), and another saying Medicare will pay for certain therapy services for a person "who is entitled to benefits under part A but has exhausted benefits for *inpatient hospital services*," *id.* § 1395*l*(a)(8)(B)(i) (emphasis added). These provisions, HHS contends, "confirm[] that entitlement to and exhaustion of benefits can coexist." HHS Br. 35.

HHS draws the wrong conclusion. While patients who have exhausted their benefits for inpatient hospital services may be entitled to other, outpatient benefits under Part A after they leave the hospital, *see* 42 U.S.C. § 1395d(a)(2)-(5), the DSH provision is concerned only with days in which a patient was entitled to *inpatient hospital services*. This is shown by the statute's use of "for such days," and it is how HHS has consistently interpreted the provision. 42 C.F.R. § 412.106(b)(4)(i); *Cabell Huntington*, 101 F.3d at 989.

HHS then turns to provisions requiring it to mail benefit information to "individuals entitled to benefits under Part A or Part B," 42 U.S.C. § 1395b-2(a), and tying an individual's eligibility to enroll in Medicare Parts B, C and D to the individual being "entitled" to part A benefits, *id.* §§ 1395o(a)(1), 1395w-21(a)(3), 1395w-101(a)(3)(A). These provisions, HHS says, cannot be followed unless "entitle[ment] to" Part A benefits only means mere eligibility for those benefits. HHS Br. 36-37.

None of these other provisions helps HHS because they are all missing an important qualifier: they do not specify *when* an individual must be entitled to Part A benefits. Section 1395b-2(a)(2) does not say an individual must be entitled to Part A benefits *on the day* the Secretary mails him benefit information. And sections 1395o(a)(1), 1395w-21(a)(3), and 1395w-101(a)(3)(A) do not provide that an individual must be entitled to Part A benefits *on the day* she enrolls in Parts B, C, or D. In contrast, the DSH provision requires that a patient be entitled to Part A benefits "for such days" when the patient is at the hospital receiving inpatient services. 42 U.S.C. § 1395ww(d)(5)(F)(vi). The "words 'for such days' in the statute make clear that HHS must count specific hospital days for patients who, on those specific days, were entitled to Part A benefits." *Ne. Hosp.*, 657 F.3d at 19 (Kavanaugh, J., concurring).

Furthermore, HHS's concerns about incongruity ignore that before the 2005 rule, HHS correctly interpreted "entitled to benefits under [Medicare] part A" in the DSH provision as requiring an absolute right to payment but managed to implement sections

1395b-2(a)(2), 1395o(a)(1), 1395w-21(a)(3), and 1395w-101(a)(3)(A) without apparent problem. This historical record demonstrates that HHS's predictions that the sky will fall are unfounded. *Ne. Hosp.,* 657 F.3d at 24 (Kavanaugh, J., concurring).

d. Abandoning the statute, HHS next cites a regulation that it contends supports its reading. HHS Br. 32 (citing 42 C.F.R. § 400.202). Of course, no regulation can override a statute; regulations must be consistent with statutes, not the other way around. And all the regulation says is that "[e]ntitled means that an individual meets all the requirements for Medicare benefits." 42 C.F.R. § 400.202. It thus does not answer the question whether a patient continues to "meet[] all the requirements for Medicare benefits," *id.*, after exhausting them.

But the *statute* does answer that question, and the answer is no. The Medicare statute provides that "benefits . . . under [Part A] . . . consist of *entitlement to have payment made . . . for up to 150 days*." 42 U.S.C. § 1395d(a). Once those 150 days are up, an individual can no longer "meet[] all the requirements for Medicare benefits." 42 C.F.R. § 400.202. Perhaps that is why HHS never before thought 42 C.F.R. § 400.202 required interpreting "entitled to benefits under [Medicare] part A" as meaning mere eligibility for Medicare. That regulation was adopted in 1983, but until 2005 HHS treated only patients with an absolute right to Medicare payments as "entitled to [Medicare]." J.A. 169-75 (69 Fed. Reg. at 49,098). The regulation thus provides no support for HHS's new position.

3. With no foothold in the text, HHS "invit[es]" this Court "to follow it into the legislative history lurking behind the Medicare Act." *Allina*, 139 S. Ct. at 1814. As with its textual arguments, HHS's legislative-history argument appeared nowhere in its contemporaneous justification for the 2005 rule. J.A. 169-75 (69 Fed. Reg. 49,098–99). HHS cannot raise that argument for the first time now. *Chenery*, 318 U.S. at 87.

Setting that aside, HHS's argument fails on its own terms. HHS claims the legislative history shows that Congress intended the Medicare and Medicaid fractions to be entirely distinct and that patients should not move from the Medicare fraction to the Medicaid fraction merely because they cease to qualify for Medicare Part A payments. HHS Br. 40. The statute unambiguously provides otherwise.

As this Court concluded in *Allina,* "murky legislative history . . . can't overcome a statute's clear text and structure." 139 S. Ct. at 1815. Here, the statute's use of "for such days" unambiguously contemplates that a patient's status may change from one day to the next. HHS may think that is "an unusual choice," HHS Br. 40, but it is the choice Congress made and that HHS must honor. And even HHS's position does not stop patients from moving from one fraction to the other. Under HHS's interpretation, patients with exhausted Part A benefits are always included in both the Medicaid fraction's denominator (which covers all patients) *and* the Medicare fraction. And a Medicaid patient who becomes eligible for Medicare while in the hospital (for example, by turning 65 during the patient's stay)

would move from the Medicaid fraction's numerator to the Medicare fraction.

Regardless, that legislative history establishes two things, neither of which helps HHS: (1) Congress's intent that hospitals be compensated for serving a disproportionate share of indigent patients, and (2) Congress's frustration with HHS's repeated refusals to honor that intent. The purported legislative compromise on which HHS relies does not support its suggestion that the Senate was focused solely on Medicare patients (to the exclusion of Medicaid patients) and the House solely on Medicaid patients (to the exclusion of Medicare patients). HHS Br. 38-40. At different points in the legislative process, the Senate contemplated including non-elderly *Medicaid* patients in the DSH provision, and the House contemplated including *Medicare* patients who were also Medicaid-eligible. 131 Cong. Rec. S10,928-30 (daily ed. Aug. 1, 1985) (requiring a DSH calculation based on both a Medicare fraction and a Medicaid fraction); H.R. Rep. No. 99-453, at 459 (1985) (defining the low-income proxy as "a hospital's total inpatient days attributable to [M]edicaid patients (including [M]edicaid-eligible [M]edicare beneficiaries—[M]edicare/[M]edicaid crossovers)"). That history belies HHS's claim that Congress combined each Chamber's preferred fraction but kept them hermetically sealed to ensure no indigent patient would ever move from one fraction to the other.

In any event, far more important than whether an indigent patient may move from one fraction to the other is whether the indigent patient is counted *at all* in the DSH adjustment's measure of indigency. HHS's

interpretation categorically excludes many poor patients from the DSH provision's measure of indigency, as proven by the fact that HHS's policy often results in reductions to *both* a hospital's Medicare fraction and its Medicaid fraction. The true anomaly, therefore, is not that low-income patients may move from one fraction to another, but that HHS's rule excludes many low-income patients from both fractions.

III. The 2005 Rule Is Not a Reasonable Interpretation of the DSH Provision.

Even if the DSH provision did not unambiguously foreclose the 2005 rule, the rule remains unreasonable.

1. HHS's rule is unreasonable for the same reasons it violates the statutory text. An agency interpretation that conflicts with the statutory text cannot be reasonable. *United States v. Vogel Fertilizer Co.*, 455 U.S. 16, 26 (1982); *United States v. Cartwright*, 411 U.S. 546, 557 (1973). And even if the DSH provision were ambiguous, that ambiguity cannot reasonably be resolved by interpreting the different statutory terms "eligible" and "entitled" to mean the same thing, reading "entitled" to mean two different things, and construing the phrase "for such days" right out of the statute.

"The only thing that unifies the government's inconsistent definitions . . . is its apparent policy of paying out as little money as possible." *Ne. Hosp.*, 657 F.3d at 20 n.1 (Kavanaugh, J., concurring). Rulemaking is not a game of three-card monte where the house always wins and never has to show its cards,

and the "statute does not permit HHS to pursue fiscal balance on the backs of Medicare providers and beneficiaries in this way." *Id.* at 21; *see Walter O. Boswell Mem'l Hosp. v. Heckler*, 749 F.2d 788, 799 (D.C. Cir. 1984) ("It would be arbitrary and capricious for HHS to bring varying interpretations of the statute to bear, depending upon whether the result helps or hurts Medicare's balance sheets . . . .").

2. An agency's interpretation of an ambiguous statute is unreasonable if "procedurally defective." *Mead*, 533 U.S. at 227. The procedural flaws underlying the 2005 rule render it unreasonable even apart from the textual conflicts discussed above.

So does HHS's failure to provide any meaningful substantive justification for the 2005 rule. This Court rejects agency interpretations that are "arbitrary and capricious in substance." *Id.*; *Judulang v. Holder*, 565 U.S. 42, 52 n.7 (2011). A regulation is arbitrary and capricious "if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

The 2005 rule fails these fundamental requirements for reasoned decisionmaking. The entire purpose of the DSH provision is to provide additional payments to hospitals treating a disproportionate number of indigent patients. For that reason, the most obvious consideration in interpreting the provision

should be how it affects DSH payments. Even if the economic impact was not the reason for the proposed change, assessing that impact is nonetheless essential to reasoned and reasonable rulemaking. That is particularly true where, as here, the rule itself is specifically and only about payment and was promulgated under a statute intended to *increase* those payments. Despite that, HHS provided no economic analysis of how including patients with exhausted Part A benefits in the Medicare fraction would affect DSH payments. By not "paying attention" to the economic "advantages *and* the disadvantages" of its chosen policy, HHS violated one of the most basic requirements of "reasonable regulation." *Michigan*, 576 U.S. at 753.

HHS's failure to "articulate a satisfactory explanation for its action" is especially troubling given that the 2005 rule reversed HHS's previous interpretation. Courts grant "considerably less deference" when an agency's interpretation "conflicts with the agency's earlier interpretation." *INS v. Cardoza-Fonseca*, 480 U.S. 421, 446 n.30 (1987) (cleaned up). So "[w]hen an agency changes its existing position," it "must at least display awareness that it is changing position and show that there are good reasons for the new policy." *Encino Motorcars*, 136 S. Ct. at 2125-26 (cleaned up). HHS did not do that in the 2005 rule, and the procedural history behind the rule suggests HHS couldn't even correctly explain its own position, let alone show good reasons for changing it.

Before adopting the 2005 rule, HHS interpreted "entitled to [Medicare]" to require payment of benefits,

so it *excluded* patients with exhausted benefits from the Medicare fraction. 51 Fed. Reg. at 31,461. But HHS did not acknowledge that to be its policy until a few days before closing the final comment period. And then it adopted the opposite position, electing to *include* patients with exhausted benefits in the Medicare fraction. But it gave no "good reasons for the new policy." *Encino Motorcars*, 136 S. Ct. at 2126 (cleaned up). Indeed, it "gave almost no reasons at all." *Id.* at 2127. It provided no "reasoned explanation . . . for disregarding facts and circumstances that underlay or were engendered by the prior policy." *Id.* at 2126 (cleaned up). And it never explained why its new policy was "more consistent with [the] statutory language." *Id.* at 2127 (cleaned up). This "unexplained inconsistency in agency policy" renders the 2005 rule unreasonable. *Id.* at 2126 (cleaned up).

In an attempt to justify the 2005 rule, HHS now cites twenty-five comment letters it claims supported a significant change to its prior policy. HHS Br. 15. But twenty-two of those commenters explicitly urged HHS *not to change its existing policy*. *E.g.*, J.A. 55, 68, 71, 77, 90, 98-99, 102, 106, 109, 113, 121, 125, 128, 132, 134, 137, 141, 145, 148-49, 159; C.A. E.R. 92, 106. Fifteen of those concluded their discussion by urging that the DSH calculation "*not be changed*," J.A. 69 (emphasis added), or some similar plea to maintain the status quo, J.A. 92, 99, 104, 107, 110, 119, 122, 126, 130, 135, 138-39, 143, 146, 160. Another nineteen urged HHS not to adopt a policy that would decrease DSH payments. J.A. 55, 69, 77, 91, 99, 103, 107, 110, 122, 126, 129, 134-35, 138, 142, 145, 150, 160; C.A. E.R. 94, 107.

Far from supporting HHS's about-face, therefore, these comments proved that its previous interpretation of "entitled to [Medicare]" had "engendered serious reliance interests that must be taken into account." *Encino Motorcars*, 136 S. Ct. at 2126 (cleaned up). HHS not only ignored those reliance interests, it used comments strongly urging *no* change in policy and *no* reduction in DSH payments to defend a *radical* change in policy that *significantly* reduced DSH payments. "This lack of reasoned explication for a regulation that is inconsistent with the [agency's] longstanding earlier position results in a rule that cannot carry the force of law." *Id.* at 2127.

3. Finally, when HHS adopted the 2005 rule, it made no attempt to "show a 'rational connection' between the regulations and the statute's purposes." *Verizon Commc'ns Inc. v. FCC*, 535 U.S. 467, 542 (2002) (Breyer, J., concurring in part). HHS's brief newly argues that the rule is consistent with Congress's intent to keep the Medicare and Medicaid fractions unbreachably separate, but it did not make that argument during the rulemaking process and may not do so now. *Chenery*, 318 U.S. at 87. And, as already explained, those arguments are wrong.

The 2005 rule undermines the statute's purposes by systematically reducing the number of indigent patients included in the DSH adjustment. This Court has recognized (and HHS concedes, HHS Br. 24) that the DSH provision's purpose is "[t]o ensure hospitals have the resources and incentive to serve low-income patients" by "offer[ing] additional payments to institutions that serve a 'disproportionate number' of such persons." *Allina*, 139 S. Ct. at 1809. But HHS's

unduly broad interpretation of "entitled to benefits under Part A" as encompassing even patients with no right to Part A payments and its crabbed view of "entitled to [SSI] benefits" as requiring physical *receipt* of payment unreasonably reduce the "low-income patients" captured by the provision and thus the "additional payments" Congress deemed necessary to encourage hospitals to do the essential but expensive work of treating indigent patients. *Id.*; *see Jewish Hosp.*, 19 F.3d at 275-76. An interpretation that so guts the "statutory provision's basic purposes is neither persuasive nor reasonable." *Cnty. of Maui v. Haw. Wildlife Fund*, 140 S. Ct. 1462, 1474 (2020).

The 2005 rule upsets Congress's plan by entirely excluding many low-income patients from the DSH calculation's measure of indigency. In particular, HHS's interpretation of "entitled to [Medicare] part A benefits" removes all indigent Medicaid patients with exhausted Medicare benefits from the numerator of the Medicaid fraction, but adds only a small portion of those indigent patients back to the numerator of the Medicare fraction. Even worse, any indigent patients who *are* added to the Medicare numerator tend to be offset by the many more patients added to the Medicare *denominator*. Having all but assured a reduction to *both* DSH fractions, HHS went a step further and entirely excluded the poorest of the poor—low-income patients who are both eligible for Medicaid *and* entitled to SSI—from the DSH calculation's measure of indigency if, for any reason, those patients did not receive the SSI benefits to which they were entitled. No rule that systematically reduces *both* proxies of indigency by excluding clearly indigent

patients can be reasonable in light of the statute's clear contrary purpose.

CONCLUSION

The Court should affirm the judgment of the court of appeals.

Respectfully submitted,

Anne M. Voigts
Matthew V.H. Noller
KING & SPALDING LLP
601 S. California Ave.
Suite 100
Palo Alto, CA 94304
(650) 422-6700

Daniel J. Hettich
Counsel of Record
Ashley C. Parrish
Jeffrey S. Bucholtz
Alek Pivec
KING & SPALDING LLP
1700 Pennsylvania Ave. NW
Washington, DC 20006
(202) 626-9128
dhettich@kslaw.com

Counsel for Respondent

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