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

REPLY BRIEF FOR THE PETITIONER

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The Secretary of Health and Human Services (HHS) properly interpreted "patients who * * * were entitled to benefits under [Medicare] part A" in the Medicare fraction, 42 U.S.C. 1395ww(d)(5)(F)(vi)(I), to mean patients whom Congress specified are "entitled to" those benefits, 42 U.S.C. 426(a) and (b). That approach embodies the best reading of the statutory text and context, and at a minimum constitutes a reasonable interpretation. Respondent contends (Br. 23-52) that the statute forecloses HHS's straightforward approach and that the agency's construction deserves no deference. Respondent's contentions are incorrect at every turn.

I. THE SECRETARY'S IMPLEMENTATION OF THE MEDICARE FRACTION EMBODIES THE BEST READING OF THE STATUTE

A. The Statutory Text Strongly Supports The Secretary's Approach To The Medicare Fraction

The Medicare fraction directs the Secretary to count patient days "of patients who (for such days) were entitled to benefits under [Medicare] part A." 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). HHS has properly construed that language to include persons who satisfy the requirements that Congress specified to be "entitled to" Part A benefits, and HHS correctly recognized that a person who exhausts one particular benefit under Medicare Part A, 42 U.S.C. 1395c *et seq.*, may still be entitled to others. Gov't Br. 24-37. Respondent's contrary arguments lack merit.

1. The Medicare Act's text supports the Secretary's determination of who is "entitled to" Part A benefits

a. Section 426 states unequivocally that "[e]very individual who" satisfies the criteria set forth in those provisions "shall be entitled to hospital insurance benefits under [Medicare] part A." 42 U.S.C. 426(a) and (b). Respondent acknowledges (Br. 32) that "Sections 426(a) and (b) * * * provide that individuals who satisfy [those] criteria are 'entitled to hospital insurance benefits under [Medicare] part A.'" Respondent's efforts to avoid the straightforward conclusion that follows are unavailing.

Respondent contends (Br. 32, 37) that Section 426(c)(1) and 42 U.S.C. 1395d(a) establish that, if the Medicare program did not ultimately pay for a person's inpatient care on a particular day, that person was not "entitled to" Medicare Part A benefits on that day at all. Respondent's contention has the import of Sections

426(c)(1) and 1395d(a) backwards. As we have explained (Gov't Br. 29), Sections 426(c)(1) and 1395d(a) confirm that entitlement to Medicare Part A benefits does *not* depend on whether Medicare ultimately pays for particular increments of care. Both provisions make clear that the basic underlying entitlement to Part A benefits continues even when conditions and limitations render payment for particular services unavailable. See 42 U.S.C. 426(c)(1) ("[E]ntitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, *and subject to the limitations in*, [Medicare] part A." (emphasis added)); 42 U.S.C. 1395d(a) ("The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1395f(d)(2) of this title[,] to him (*subject to the provisions of this part*) for" enumerated services. (emphasis added)). Congress thus made a person's statutory entitlement to benefits a necessary but not a sufficient condition to have Medicare pay for particular units of care. And, significantly, the reference in the Medicare fraction is "entitled to *benefits*" under Part A generally, 42 U.S.C. 1395ww(d)(5)(F)(vi)(I) (emphasis added), not "entitled to *payment*" for particular services at a particular point in time, cf., *e.g.*, 42 U.S.C. 1395ww(h)(3)(C) (referring to patient days "attributable to patients with respect to whom payment may be made under part A").

Respondent rejoins that the specific meaning of "'entitlement'" that Congress set forth conflicts with the word's "ordinary meaning," which respondent contends is an "'absolute right to . . . payment.'" Resp. Br. 30 (citation omitted). Even assuming that the "ordinary

meaning" respondent proffers (*ibid.*) is accurate, Congress is free to define terms in ways that differ from everyday usage—as when it "says something like 'a State "includes" Puerto Rico and the District of Columbia,'" *Advocate Health Care Network* v. *Stapleton*, 137 S. Ct. 1652, 1658 (2017) (citation omitted). Where, as here, Congress prescribes a statute-specific meaning, courts "'must follow that definition,' even if it varies from [the] term's ordinary meaning." *Digital Realty Trust, Inc.* v. *Somers*, 138 S. Ct. 767, 776 (2018) (citation omitted).

The examples respondent offers (Br. 31) from everyday speech to show that "entitled" invariably means "having an absolute right"—*e.g.* "[n]ot every batter is 'entitled' to hit a home run"—likewise disregard the meaning of "entitlement" that Congress prescribed. And they overlook that, even in ordinary usage, an entitlement can be subject to conditions. For example, suppose a baseball team grants season-ticket holders an entitlement to bring a guest to any game at half price, but only if unsold seats remain on game day. A season-ticket holder who brings a guest to a sold-out game has not lost her entitlement to half-priced guest tickets; that entitlement simply came subject to a condition that was not satisfied. The same is true of Medicare Part A benefits, which confer a form of health-insurance coverage subject to certain limitations. It is commonplace to describe an insured person as entitled to insurance coverage even though the policy contains conditions or exclusions for particular occurrences.

Respondent dismisses (Br. 37) as hairsplitting a distinction between the existence of an entitlement and the entitlement's effect in particular circumstances. But the flaw in respondent's argument is fundamental. Congress prescribed which persons "shall be entitled to"

Part A benefits, 42 U.S.C. 426(a) and (b), and defined that entitlement as one subject to limitations that make payment by Medicare unavailable if certain conditions are not met, 42 U.S.C. 426(c)(1), 1395d(a). Respondent urges the Court (Br. 30-31) to reason backward from the absence of a result (payment by Medicare) to negate Congress's determination of who is "entitled to" Part A benefits in the first place. The Court instead should give "entitled to" the meaning that Congress did in the statute. To the extent that applying that meaning causes payment by Medicare to be unavailable in particular circumstances, that is a consequence that Congress expressly contemplated.

b. Other provisions of the Medicare Act, 42 U.S.C. 1395 *et seq.*, refute respondent's position that a person is "entitled to" Part A benefits only if he has an "absolute right to" payment for particular patient days. Resp. Br. 30; see Gov't Br. 34-37. Respondent offers no persuasive answer to those provisions.

i. Both 42 U.S.C. 1395*l*(a)(8)(B)(i) and (t)(1)(B)(ii) refer to an individual who is "entitled to" Part A benefits "but has exhausted" them, and further distinguish such an individual from a person who "is not so entitled" at all. *Ibid.*; Gov't Br. 35-36. Respondent contends that those provisions are irrelevant because they address when covered outpatient services include certain services provided to inpatients, and the Medicare fraction "is concerned only with days in which a patient was entitled to inpatient hospital services." Resp. Br. 41 (emphasis omitted). That contention lacks merit.

As discussed below, respondent's premise that the Medicare fraction is concerned exclusively with inpatient hospital care is incorrect. See pp. 13-15, *infra*.

But even if respondent's premise were correct, its response still misses the critical point: by describing persons who are "entitled to" benefits but have "exhausted" them, the text of 42 U.S.C. 1395*l*(a)(8)(B)(i) and (t)(1)(B)(ii) confirms that entitlement to benefits and exhaustion of benefits are not mutually exclusive. The statute thus expressly posits a "categor[y]" that respondent "says does not exist." *Sanchez* v. *Mayorkas*, 141 S. Ct. 1809, 1814 (2021).

ii. Still other Medicare Act provisions make one's ability to enroll in Medicare Parts B, C, and D—and the agency's obligation to provide certain notices—contingent on whether the individual "is entitled to" Part A benefits. 42 U.S.C. 1395b-2(a)(2), 1395*o*(a)(1), 1395w-21(a)(3), 1395w-101(a)(3)(A). Construing "entitled to" as referring to a person's *status* as satisfying the statutory requirements to be entitled to Medicare Part A benefits—as HHS did in the 2004 rule, 69 Fed. Reg. 48,916, 49,099 (Aug. 11, 2004) (J.A. 173-174)—comports with those provisions. Construing the phrase to turn on whether Medicare paid for each separate unit of care would create a morass. Gov't Br. 36-37.

Respondent contends (Br. 42) that those provisions "do not specify *when* an individual must be entitled to Part A benefits" in order to trigger the consequences they prescribe, and that 42 U.S.C. 1395*o*(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." But each provision uses the present tense, referring to an individual who "is entitled to" Part A benefits. *Ibid.* Moreover, respondent does not dispute that a person's Part A entitlement must be fixed on *some* date. Yet under respondent's reading, a patient's entitlement could oscillate on a daily basis, and

his ability to enroll in other Medicare programs could fluctuate constantly based on the happenstance of whether Medicare paid for particular prior services.

Respondent additionally argues (Br. 42-43) that those other Medicare provisions predated the 2004 rule and that HHS implemented its pre-2004 interpretation of "entitled to" in the Medicare fraction "without apparent problem." But respondent misstates the change that the 2004 rule effected. HHS has for decades interpreted "entitled to" in the Medicare Part A context to refer to a status established by a person's satisfying the statutory requirements. Gov't Br. 10. Its interpretation of that phrase thus has always been compatible with the provisions prescribing who may enroll in other Medicare programs and notices the agency must provide.

HHS's prior view that Section 1395ww(d)(5)(F)(vi) called for considering only patient days actually paid for by the Medicare and Medicaid programs, respectively, rested instead on HHS's previous reading of other language specific to that provision—namely, the "(for such days)" parentheticals. Gov't Br. 32-33. In 1997, HHS acquiesced in a series of appellate decisions that had rejected its prior approach to the Medicaid fraction, and had rejected its interpretation of that fraction's "(for such days)" parenthetical specifically. *Id.* at 33. Then, in the 2004 rule, HHS carried over that revised approach to the Medicare fraction. *Ibid.* The 2004 rule thus reflected only a change in the agency's understanding of the effect of the "(for such days)" proviso, not in its understanding of "entitled to" as used in the Medicare Act more generally. In contrast, adopting respondent's view of "entitled to" would go beyond restoring HHS's pre-2004 approach to "(for such days)" and

would introduce novel difficulties in applying other Medicare provisions.

c. Respondent argues (Br. 29-30) that HHS's reading of "entitled to benefits under [Medicare] part A" conflicts with two other phrases in Section 1395ww(d)(5)(F)(vi) itself. Both asserted conflicts are illusory.

i. Like the court of appeals, Pet. App. 18a-21a, respondent contends that HHS's approach improperly accords "the same effective meaning" to "'*entitled to* benefits under [Medicare] part A'" in the Medicare fraction and "'*eligible for* [Medicaid]'" in the Medicaid fraction, Resp. Br. 29 (brackets in original). That assertion fails for two reasons. See Gov't Br. 29-30.

First, as this Court has held, the principle that Congress's use of different language in different provisions of a statute "can indicate that 'different meanings were intended' * * * is 'no more than a rule of thumb' that can tip the scales" in close cases. *Sebelius* v. *Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 156 (2013) (brackets and citations omitted). Congress, like other speakers, sometimes uses synonyms to express the same or similar concepts. Here, Congress specified who is "entitled to" benefits under Medicare Part A. 42 U.S.C. 426(a) and (b). That express determination controls and displaces any inference one might otherwise draw.

Respondent contends (Br. 36) that four courts of appeals previously rejected HHS's prior reading of the Medicaid fraction based in part on their view that "entitled" and "eligible" mean different things. But none of those courts, which were considering the Medicaid fraction, addressed Congress's specification of who is "entitled to" Medicare Part A benefits in Section 426. Cf. *Deaconess Health Servs. Corp.* v. *Shalala*, 912 F. Supp. 438, 446-447 (E.D. Mo. 1995) (construing "entitled to" in

Medicare fraction as 2004 rule does), aff'd, 83 F.3d 1041 (8th Cir. 1996) (per curiam). Those decisions supply no sound basis for invalidating the 2004 rule. Gov't Br. 11-13, 32-34.

Second, Congress's use of different terminology in referring to Medicare and Medicaid makes perfect sense because it corresponds directly to the distinct terminology that Congress has employed in connection with those programs in the Medicare and Medicaid statutes themselves. Gov't Br. 47. "Congress has, throughout the various Medicare and Medicaid statutory provisions, consistently used the words 'eligible' to refer to potential Medicaid beneficiaries and 'entitled' to refer to potential Medicare beneficiaries." *Northeast Hosp. Corp.* v. *Sebelius*, 657 F.3d 1, 12 (D.C. Cir. 2011) (citation omitted); compare, *e.g.*, 42 U.S.C. 426, 1395d ("entitled" in Medicare context), with, *e.g.*, 42 U.S.C. 1396a, 1396d ("eligible" in Medicaid context). Congress had ample reason to "borrow[] th[o]se terms" when referring to those two programs, respectively, in the disproportionate-patient percentage. *Northeast Hosp. Corp.*, 657 F.3d at 13. Indeed, departing from the established terms in referring to each program might have introduced confusion.

Despite acknowledging that argument (Br. 36), respondent does not attempt to refute Congress's vernacular conventions in the Medicare and Medicaid programs. And respondent offers no reason to suppose that Congress's use in Section 1395ww(d)(5)(F)(vi) of the same terms—"entitled" and "eligible"—that it had used in the statutes establishing those programs was a mere coincidence, or an oblique signal that Congress intended starkly different methodologies for counting Medicare and Medicaid patient days.

ii. Respondent also erroneously contends (Br. 30) that HHS's approach "interprets the word 'entitled' differently" within "a single sentence" in the Medicare fraction. Respondent notes (*ibid.*) that the Medicare fraction's numerator refers to individuals who were "entitled to supplemental security income [(SSI)] benefits," 42 U.S.C. 1395ww(d)(5)(F)(vi)(I), and that HHS includes in that numerator only Medicare beneficiaries who were entitled to SSI payments, not all individuals who would qualify for SSI benefits. As the Sixth Circuit has recognized, however, HHS's approach reflects "key distinction[s]" between the Medicare and SSI programs, and "the differences in the language used in the SSI and Medicare statutory schemes explain th[at] apparent inconsistency." *Metropolitan Hosp.* v. *United States Dep't of Health & Human Servs.*, 712 F.3d 248, 268 (2013); Gov't Cert. Reply Br. 8.

For example, unlike entitlement to Medicare Part A benefits, which arises automatically when an individual meets the statutory criteria, 42 U.S.C. 426(a) and (b), Congress has provided that an individual who is eligible for SSI benefits must apply for them to become entitled to receive them, see 42 U.S.C. 1382(c)(7); see also 75 Fed. Reg. 50,042, 50,280 (Aug. 16, 2010); cf. *Schweiker* v. *Hansen*, 450 U.S. 785, 790 (1981) (per curiam). "Such an individual is thus *eligible* for, but not *entitled* to, SSI benefits during any period in which he or she meets the criteria set forth in § 1382(a) but has no application on file." *Metropolitan Hosp.*, 712 F.3d at 269. HHS's "nuanced interpretation of the Medicare fraction's numerator appropriately reflects this difference between the two benefit programs." *Ibid.* An individual's "entitlement to receive SSI benefits" also "can vary from time to time" more readily than entitlement to Medicare Part

A benefits because it is "based on income and resources," not solely on age or disability. 75 Fed. Reg. at 50,280. In addition, HHS's approach reflects the distinct nature of Medicare Part A benefits—a form of health-insurance coverage to which a person may be entitled whether or not he uses it—and SSI benefits, which consist of cash payments.

HHS thus gives the same basic meaning to "entitled" in addressing both Medicare and SSI benefits: a person is "entitled to" benefits if the underlying statute provides that he is. The Medicare and SSI statutes simply establish different prerequisites to entitlement. To continue the season-ticket-holder analogy above, suppose that Team A provides that all season-ticket holders are entitled to purchase playoff tickets before the general public, but Team B provides that only season-ticket holders who have renewed their subscription for the following season are entitled to do so. To determine whether a season-ticket holder of either team is entitled to purchase playoff tickets, one must take account of the prerequisites to entitlement imposed by that team.

Respondent's observation (Br. 40) that the SSI statute more frequently "refers to *eligibility* for benefits, not entitlement," further reinforces HHS's approach. Precisely because the SSI statute distinguishes between eligibility for and entitlement to benefits, HHS properly construed the Medicare fraction's reference to persons "entitled to [SSI] benefits," 42 U.S.C. 1395ww(d)(5)(F)(vi)(I), to mean persons who are not only eligible for SSI benefits but actually entitled to them, which requires the additional step of applying for benefits under that cash-benefit program.

d. Finally, respondent contends (Br. 31-32, 38-39) that counting only persons with an absolute right to have payment made for particular services is necessary to avoid rendering the "(for such days)" parenthetical "surplusage." Resp. Br. 32. Every circuit to consider the issue—including the Ninth Circuit—has rejected that argument in the context of the Medicaid fraction. Gov't Br. 32-33. The same conclusion follows for the Medicare fraction.

HHS's interpretation gives full effect to the "(for such days)" qualifier. Entitlement to Medicare Part A benefits can vary, and a patient day is counted in the Medicare fraction only if that patient was entitled to Part A benefits on that day. *Northeast Hosp. Corp.*, 657 F.3d at 12. In that sense, the statute does call for "a day-by-day analysis." Resp. Br. 37. What it does not compel is a determination, potentially long after the fact, of whether Medicare ultimately was not responsible to pay for particular care for other reasons—which may be because patients "had exhausted their Part A benefits or had another insurer primary to Medicare," *id.* at 18. Indeed, respondent elsewhere recognizes (*id.* at 44-45) that the proviso applies where, for example, a person receiving hospital treatment turns 65 during a hospital stay. Regardless of how often such circumstances arise, the phrase at a minimum "does something," and neither respondent nor a court "get[s] to say that the something it does is not enough." *Sanchez*, 141 S. Ct. at 1815.

2. The Secretary's approach is sound even under respondent's narrow reading of "entitled to"

Even if respondent were correct that "entitled" in the Medicare fraction refers to an "absolute right to . . . payment," Br. 30 (citations omitted), its attack on HHS's approach still would fail. As HHS recognized, an individual whose expenses for a particular service are not paid by

Medicare Part A (for example, because the cost of the service was paid by a private insurer) may still be able to have payment made for other services under Medicare Part A. 69 Fed. Reg. at 49,098 (J.A. 173); Gov't Br. 31-32. To return again to the season-ticket-holder hypothetical, if a team offers a package of season-ticket-holder benefits that includes free parking at every game and a free hot dog at any ten games, it is natural to describe a season-ticket holder as entitled to season-ticket-holder benefits even if he has exhausted his allotment of hot dogs.

Respondent acknowledges (Br. 39) that Medicare "Part A covers more than just inpatient hospital services" but contends that other benefits "are irrelevant to the [disproportionate-share-hospital] provision, which cares only whether a patient is entitled to *inpatient* hospital services." That is incorrect. The Medicare fraction refers to "benefits under [Medicare] part A," 42 U.S.C. 1395ww(d)(5)(F)(vi)(I). Its text does not single out inpatient care. And the Medicare Act elsewhere defines Part A benefits to include inpatient care *and* other specified services. See 42 U.S.C. 426(c)(1) ("entitlement to" Part A benefits means a conditional right to have payment made "for inpatient hospital services, post-hospital extended care services, and home health services"). Respondent cites no statutory provision that supports its narrow view of the Medicare fraction's focus.

Instead, respondent relies on an HHS regulation that respondent contends shows that the agency understands the entire disproportionate-share-hospital provision as "concerned only with" inpatient services. Resp. Br. 41 (citing 42 C.F.R. 412.106(b)(4)(i)). That reliance is misplaced. The cited regulation by its terms addresses only the calculation of the Medicaid fraction—the second, sep-

arate component of the disproportionate-patient percentage. 42 C.F.R. 412.106(b)(4)(i). It provides that, "[f]or purposes of this computation," *i.e.*, the Medicaid fraction,

> a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under [42 U.S.C. 1315(a)(2)] on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

Ibid. The Medicare fraction, at issue here, is addressed by a separate provision, 42 C.F.R. 412.106(b)(2)(i), which HHS modified in the 2004 rule to implement its current interpretation, and which contains no similar limitation to inpatient services, *ibid.*

Respondent appears to assume (Br. 41) that HHS's approach to the relevant benefits in the Medicaid fraction applies equally to the Medicare fraction. That assumption is incorrect. As HHS explained 18 years ago in adopting the Medicaid regulation's relevant language, its focus on eligibility for inpatient services in that provision reflects Medicaid-specific considerations. Although many Medicaid beneficiaries receive benefits through "a traditional State Medicaid program," which is "required to offer inpatient benefits to all eligible beneficiaries," many individuals also receive Medicaid-supported benefits through Medicaid demonstration projects that Congress authorized in 42 U.S.C. 1315. 68 Fed. Reg. 45,346, 45,421 (Aug. 1, 2003). And although Medicaid demonstration projects may resemble a traditional Medicaid plan and provide access to inpatient services, some demonstration projects instead offer "a limited set of services, such as pharmaceuticals or family planning services." *Ibid.*

HHS determined that the Medicaid fraction should include patients covered by traditional Medicaid plans and those "who receive benefits under [a] demonstration project that are similar to" those received by "traditional Medicaid beneficiaries, including inpatient benefits." 68 Fed. Reg. at 45,421. HHS thus sought to ensure that the Medicaid fraction's numerator captures all persons who receive quintessential Medicaid benefits—whether through a traditional Medicaid plan or a demonstration project—but that it is not skewed by counting persons who are eligible (through a demonstration project) only for a different, more limited set of benefits that excludes inpatient care. Congress has since expressly codified HHS's discretion to include or exclude demonstration-project-only patient days as "the Secretary determines appropriate" and has "ratified" HHS's regulations. Deficit Reduction Act of 2005, Pub. L. No. 109-171, Tit. V, Subtit. A, § 5002(a) and (b)(1), 120 Stat. 31. HHS's regulations thus reasonably apply distinct approaches to the Medicare and Medicaid fractions.

B. The Statutory Structure, History, And Purpose Reinforce The Secretary's Interpretation Of The Text

The broader context of the Medicare fraction—including the statutory "structure, history, and purpose," *Abramski* v. *United States*, 573 U.S. 169, 179 (2014) (citation omitted)—powerfully supports HHS's interpretation. Gov't Br. 37-41. Respondent does not confront the core feature of the disproportionate-patient percentage's design and urges the Court (Br. 44-45) to disregard the congressional compromise that it embodies. Respondent's assertions (Br. 33-35, 45-46) that HHS's approach undermines Congress's aims lack merit.

1. The Secretary's interpretation best implements the statute's bifurcated, population-focused structure

The disproportionate-patient percentage evaluates a hospital's proportion of low-income patients by separately examining two populations: low-income patients who are entitled to Medicare Part A benefits, and those who are not. Gov't Br. 37-39. Congress chose different proxies of low-income status for each group. HHS's approach fits well within Congress's bifurcated, *population-focused* framework. Respondent's contrary, unit-of-care approach would fit poorly. *Id.* at 40-41.

Respondent never directly addresses this core feature of the statutory structure. It does not attempt to reconcile its preferred who-paid-for-which-item-of-care test with Congress's population-focused approach. Nor does respondent explain why Congress would have intended the same patient to phase in and out of the Medicare fraction—or, on respondent's reading (Br. 50-51), bounce back and forth between the Medicare and Medicaid fractions—during a single hospital stay. Respondent notes (Br. 44-45) that, under HHS's interpretation, a patient who acquires or loses Medicare Part A entitlement during a hospital stay could move from one fraction to the other. But respondent does not deny that such changes in entitlement status under the agency's approach occur much less frequently.

Respondent urges the Court (Br. 44-45) to ignore the compromise forged in Congress that produced the bifurcated structure. But this Court has held that "[c]ourts and agencies must respect and give effect to these sorts of compromises." *Ragsdale* v. *Wolverine World Wide, Inc.*, 535 U.S. 81, 94 (2002). Our submission is not that the Court should probe the subjective intentions of Members of Congress. But the Court

can and should take account of the fact that the disproportionate-patient percentage's combination of separate calculations assessing two distinct populations was deliberate. HHS's approach gives effect to that compromise, but respondent's contrary approach would distort it.

2. Respondent's assertions that the Secretary's approach undermines Congress's purposes lack merit

Respondent erroneously contends (Br. 33) that HHS's interpretation thwarts Congress's objective of "compensating hospitals that care for the indigent." See Resp. Br. 33-35. All agree that the disproportionate-share-hospital adjustment is intended to augment payments to hospitals that "serve a disproportionate share of low-income patients" because they "generally have higher per-patient costs." *Auburn Reg'l Med. Ctr.*, 568 U.S. at 150. HHS's approach indisputably does so. The dispute here is precisely how HHS should identify such hospitals and calculate the additional payments they will receive.

Respondent mistakenly assumes (Br. 33-35) that Congress simplistically sought to increase payments to hospitals serving low-income patients, full stop, and that the Court should adopt whichever reading maximizes payments. "No legislation pursues its purposes at all costs." *Cyan, Inc.* v. *Beaver Cnty. Emps. Ret. Fund*, 138 S. Ct. 1061, 1073 (2018) (citation omitted). The reticulated statutory formula for disproportionate-share-hospital adjustments embodies myriad measured policy judgments. See generally 42 U.S.C. 1395ww(d)(5)(F). The statute's purpose is thus best described as providing increased payments to hospitals that serve a disproportionate share of low-income patients, and doing so in the manner and to the extent that Congress specified. HHS's approach better accords with the choices Congress made.

Respondent's argument (Br. 13-16) that HHS's approach reduces payments to hospitals rests largely on its observation that the Medicaid fraction's numerator includes a larger proportion of a hospital's patients than the Medicare fraction's numerator, because "a patient is much more likely to be 'eligible' for Medicaid than 'entitled to' SSI." Resp. Br. 14. But to the extent that is true, it follows from Congress's selection of those different proxies. Congress could have chosen instead to adopt a single proxy based on Medicaid eligibility in the numerator of both the Medicare and Medicaid fractions, or to adopt a single fraction that used Medicaid eligibility alone as a proxy for low-income status. Such an approach might well have increased many hospitals' payments, though the precise effects are uncertain. For example, States are not required to extend Medicaid eligibility to every individual who is entitled to SSI benefits, see 42 U.S.C. 1396a(f); *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 38-39 & n.6 (1981), and HHS has informed this Office that eight States currently do not.

In any event, Congress chose to adopt two fractions and to employ different proxies in each one. Congress may have selected SSI entitlement and Medicaid eligibility for the Medicare and Medicaid fractions, respectively, because it viewed those measures as appropriate for the separate populations that the fractions address. In the Medicare fraction, it chose SSI benefits, which—like Medicare Part A benefits themselves, see 42 U.S.C. 426(a) and (b)—are limited to persons over age 65 or who have certain disabilities, 42 U.S.C. 1382(a)(1), 1382c(a)(1). In the Medicaid fraction, which focuses on patients who are *not* Medicare Part A beneficiaries (and thus who need not be aged or disabled), Congress used eligibility for Medicaid benefits, which are similarly

not generally confined to the aged or disabled. Whatever Congress's exact reason, it selected separate metrics. That Congress's choice does not maximize payments to respondent or other particular hospitals casts no doubt on HHS's 2004 rule implementing it.

Respondent's assertions (*e.g.*, Br. 13) that the 2004 rule was deliberately designed to reduce disproportionate-share-hospital payments are unfounded. As respondent acknowledges (Br. 17), HHS noted during the rulemaking that it lacked adequate data to quantify the anticipated effects of varying approaches to the Medicare fraction. 68 Fed. Reg. 27,514, 27,416 (May 19, 2003) (J.A. 52-53). Although numerous providers urged the agency to reject the approach that respondent now advocates—including because of concerns that it would result in lower payments than the approach HHS ultimately adopted—HHS expressly declined, in adopting the final rule, to base its revised approach on the potential effects of generally increasing or decreasing hospitals' payments. 69 Fed. Reg. at 49,098 (J.A. 171, 173). Instead, HHS recognized that the effects would depend on a particular hospital's patient population. *Ibid.* (J.A. 173); Gov't Br. 43-44.

To the extent respondent posits (Br. 50-51) that the 2004 rule has resulted in lower payments for most hospitals than they would have received under the decision below, HHS has informed this Office that it does not have a basis to dispute that characterization, and that in the ordinary course it does not calculate the counterfactual effects on hospitals' payments under the approach it rejected in 2004. HHS has further informed this Office, however, that it has calculated the Medicare fractions for Fiscal Year 2019 of hospitals in the Ninth Cir-

cuit applying that court's interpretation. HHS has informed this Office that, of those hospitals, approximately 97% have higher Medicare fractions for that year under the Ninth Circuit's interpretation than under the 2004 rule (the remainder are unchanged), with a median increase of approximately 2.9% and an average increase of approximately 4.3%. Those increases in Medicare fractions do not translate into one-to-one increases in disproportionate-share-hospital payments, which are determined under the statutory formula that includes other variables and requires hospital-specific computations that have not yet been performed. See 42 U.S.C. 1395ww(d)(5)(F).

Respondent and its amici point to a private consultant's report—discussed in a Provider Reimbursement Review Board decision that was addressing whether an amount-in-controversy requirement was satisfied—that analyzed the effects of HHS's approach on payments to 52 hospitals in one year (2005). Federation of Am. Hosps. Amicus Br. 6-8 (discussing *Southwest Consulting 2004 DSH Dual Eligible Days Grp.* v. *Blue Cross Blue Shield Ass'n*, No. 2010-D36, 2010 WL 4214212, at *8-*9 (P.R.R.B. June 14, 2010), vacated on other grounds, 2010 WL 11433197 (CMS Adm'r Aug. 12, 2010)); see Resp. Br. 33 (citing brief discussing same decision). But respondent and its amici offer no valid basis for extrapolating from that report to all hospitals over time.

More fundamentally, even if respondent is correct in predicting (Br. 50-51) that the court of appeals' interpretation of the Medicare fraction would increase most hospitals' payments, that would be a consequence of those hospitals' patient populations—not an inevitable result foreordained by the statute for all providers. Respond-

ent's contention that HHS's approach necessarily reduces all hospitals' payments (Br. 15-16) rests on its assumption that every dual-eligible exhausted patient day that HHS counts in the Medicare fraction would otherwise be added to the Medicaid fraction's numerator. But the court of appeals did not address that distinct issue concerning the Medicaid fraction, which is not before the Court, and it is far from clear that respondent's assumption is correct. HHS, notably, has never counted such patient days in the Medicaid fraction, including when it construed the "(for such days)" parentheticals as respondent now does. Gov't Br. 12, 16 n.4. This Court should not skew its interpretation of the provision that is at issue here based on an untested assumption about another provision that is not.

II. THE SECRETARY'S APPROACH AT A MINIMUM IS REASONABLE AND IS ENTITLED TO DEFERENCE

At the very least, the 2004 rule, adopted pursuant to HHS's statutory rulemaking authority, see 42 U.S.C. 1395hh(a), embodies a reasonable interpretation of the Medicare fraction that is entitled to deference. Gov't Br. 42-44. Respondent's contrary arguments (Br. 23-28, 46-52) lack merit.

Respondent asserts that no deference is due because the Medicare fraction "reflects no '"implicit" delegation to the agency.'" Resp. Br. 24 (brackets and citation omitted). But the central premise of *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), is that where Congress has not articulated its "specific intention" on a particular issue, it has "implicit[ly]" delegated that question to the agency that it has authorized to administer the statute, *id.* at 844-845. Respondent's argument that the Medicare fraction unambiguously forecloses HHS's approach is incorrect for the

reasons discussed above. And respondent's observation (Br. 24-26) that Congress enacted a disproportionate-share-hospital adjustment 35 years ago after HHS had failed to develop one does not demonstrate that Congress intended to withhold any deference to HHS's implementation of the adjustment Congress enacted.

Respondent further contends (Br. 26-27) that no deference is due because of alleged defects in the notice-and-comment process that was completed 17 years ago. But the court of appeals rejected respondents' procedural challenges. Pet. App. 12a-16a. As respondent acknowledges (Br. 26), it sought review of that ruling in this Court—contending that the procedural challenge would bear on the Court's analysis of the merits, 20-1486 Cross-Pet. at 15-18—but this Court denied that request. As the case comes to the Court, the procedural validity of the 2004 rule is settled.

Respondent seeks to revive its notice-and-comment argument by asserting (Br. 49-50) that public comments on which HHS relied were skewed by commenters' misunderstanding of HHS's prior policy. But as the court of appeals recognized, commenters were aware of, and their comments addressed, the substance of the alternative approaches the agency considered: excluding dual-eligible exhausted patient days from the Medicare fraction (and counting them in the Medicaid fraction), as HHS initially proposed, or counting such days only in the Medicare fraction, which HHS ultimately adopted. Pet. App. 14a-15a. "[M]any sophisticated commenters" opposed the former approach and supported the latter approach. *Id.* at 14a. HHS had misdescribed the latter approach as the agency's then-existing practice—an error it corrected before the close of the comment period. *Ibid.*

But in adopting the final rule, HHS appropriately considered comments supporting the substance of that approach. See 69 Fed. Reg. at 49,098 (J.A. 173).

Respondent asserts (Br. 27-28) that the 2004 rule was accompanied by insufficient discussion of the legal merits and policy consequences of HHS's revised approach. That argument conflates the purely legal question that the court of appeals decided and on which this Court granted review—whether HHS properly interpreted the statutory provision at issue—with a process-based arbitrary-or-capricious challenge that is not before the Court, cf. 5 U.S.C. 706(2)(A). Whether an agency's interpretation of a statute is reasonable should not turn on the length of its excursus in a regulatory preamble, but on the compatibility of its interpretation with the statutory text and context. Moreover, contrary to respondent's contention (Br. 27-28), HHS did explain why its approach is more consonant with the statute than the approach it rejected. The agency observed that it is incongruous to describe "beneficiaries who have exhausted their Medicare Part A inpatient coverage" as not entitled to Part A benefits because they may "still be entitled to other Part A benefits." 69 Fed. Reg. at 49,098 (J.A. 173). Respondent's related assertion (Br. 27, 34-35) that HHS failed to perform a robust empirical analysis of the effects of its interpretation—due to insufficient data—likewise misconceives the statutory question before the Court.

Respondent, in short, has identified no valid basis to conclude that HHS's approach exceeded the bounds of reasonable interpretation. Whether HHS's interpretation is superior or simply one of several reasonable readings, the Court should sustain the agency's approach and reverse the Ninth Circuit's decision rejecting it.

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For the foregoing reasons and those stated in our opening brief, the judgment of the court of appeals should be reversed.

Respectfully submitted.

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Solicitor General

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