No. 23-715

In the Supreme Court of the United States

ADVOCATE CHRIST MEDICAL CENTER, et al.,

v.

XAVIER BECERRA, SECRETARY OF HEALTH AND HUMAN SERVICES

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR AMERICAN HOSPITAL ASSOCIATION, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, AMERICA'S ESSENTIAL HOSPITALS, CATHOLIC HEALTH ASSOCIATION, FEDERATION OF AMERICAN HOSPITALS, AND NATIONAL RURAL HEALTH ASSOCIATION AS AMICI CURIAE SUPPORTING PETITIONERS

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INTEREST OF AMICI CURIAE[1]

The American Hospital Association represents nearly 5,000 hospitals, healthcare systems, and other healthcare organizations. Its members are committed to improving the health of the communities that they serve, and to helping ensure that care is available and affordable for all Americans.

The Association of American Medical Colleges is a nonprofit association dedicated to improving the health of people everywhere through medical education, healthcare, medical research, and community collaborations. Its members include all 158 U.S. medical schools accredited by the Liaison Committee on Medical Education; approximately 400 academic health systems and teaching hospitals; and more than 70 academic societies.

America's Essential Hospitals is dedicated to equitable, high-quality care for all people, including those who face social and financial barriers to care. Consistent with this safety-net mission, the association's more than 300 members provide a disproportionate share of the nation's uncompensated care, with three-quarters of their patients uninsured or covered by Medicare or Medicaid.

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[1] No counsel for any party authored this brief in whole or in part, and no party or counsel made a monetary contribution to the preparation or submission of this brief. No person other than amici, their members, or their counsel made a monetary contribution to the preparation or submission of this brief.

The Catholic Health Association of the United States is the national leadership organization of the Catholic health ministry, representing the nation's largest group of not-for-profit healthcare providers. CHA's Vision for U.S. Health Care calls for healthcare to be available and accessible to everyone, paying special attention to underserved populations. CHA works to advance the ministry's commitment to a just, compassionate healthcare system that protects life.

The Federation of American Hospitals is the national representative of more than 1,000 leading taxpaying hospitals and health systems throughout the United States. FAH members provide patients in urban and rural communities with access to high-quality, affordable healthcare. Its members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals. They provide a wide range of acute, post-acute, emergency, children's, cancer care, and ambulatory services.

The National Rural Health Association is a national nonprofit organization whose 21,000 members represent nearly every component of rural America's healthcare. This includes rural hospitals, critical access hospitals, doctors, nurses, and patients. NRHA provides leadership on rural health issues through advocacy, communication, education, and research.

Amici's member hospitals treat patients enrolled in public-assistance programs such as Medicare, Medicaid, and the Supplemental Security Income program. Many of those hospitals receive or, under an appropriate construction of the Medicare statute, would receive "disproportionate share hospital" (DSH) payments to offset their costs so that the hospitals are not disadvantaged by treating a large number of low-income pa-

tients. Amici have an interest in ensuring that the Department of Health and Human Services complies with its statutory mandate to fully fund DSH payments. When HHS systemically undercounts those payments—as it has by more than $1 billion per year for the relevant years—it puts hospitals and their patients at risk.

INTRODUCTION AND SUMMARY OF ARGUMENT

Medicare reimburses hospitals for the care that they provide to elderly and disabled Americans. But ordinary Medicare reimbursement rates are not always enough to cover the hospitals' true costs. In particular, hospitals incur significant uncompensated costs when treating the neediest patients. Those costs burden hospitals in poorer communities, and can force hospitals to terminate important programs or even shutter for good. Congress mandated "disproportionate share hospital" (DSH) payments to solve that problem. By offsetting a portion of hospitals' otherwise-uncompensated costs, DSH payments help hospitals stay afloat and allow them to continue offering 24/7 care to America's most vulnerable populations.

Under a formula set by Congress, a hospital's DSH payments are pegged to the size of its needy-patient population. To measure that population, the DSH formula focuses on three public-assistance programs: Medicare, Medicaid, and Supplemental Security Income (SSI). The formula includes a fraction (called the "Medicare fraction") for patients who are over 65 or disabled, with the SSI-entitled Medicare population in the numerator, and the total Medicare population in the denominator. See 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). When more patients are cat-

egorized as SSI-entitled, the numerator of the Medicare fraction increases, and so does a hospital's DSH payments.

The question here is when a patient is "entitled to supplementary security income benefits" for purposes of the Medicare fraction. And the plain text of the statute supplies a simple answer: a patient is "entitled to" SSI benefits so long as he or she is *eligible for any* SSI benefits—regardless of whether the patient *actually received cash* SSI payments during his or her stay in the hospital.

That focus on eligibility follows directly from this Court's decision in *Becerra* v. *Empire Health Foundation*, 597 U.S. 424 (2022). *Empire Health* held that patients are "'entitled to [Medicare Part A] benefits'" for purposes of the DSH formula if they are "qualifie[d] for the Medicare program," even if "Medicare is not paying" for their hospital stay. *Id.* at 428 (citation omitted). The Court's reasoning applies with full force here. The statute uses the phrase "entitled to" twice in the same sentence, once to refer to Medicare benefits (at issue in *Empire Health*) and once to refer to SSI benefits (at issue here). See 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). In each case, the meaning should be the same: a patient is "entitled to" benefits if she qualifies for the relevant category of public assistance. See, *e.g.*, *Inyo Cnty.* v. *Paiute-Shoshone Indians*, 538 U.S. 701, 710 (2003) ("[I]t would be anomalous for the Court to give the same word a different meaning when it appears later in the same sentence.") (citing *Brown* v. *Gardner*, 513 U.S. 115, 118 (1994)).

HHS has refused to adopt that straightforward reading of "entitled to" for the SSI category. A focus on eligibility for Medicare helps the agency inflate the *denominator* in the Medicare fraction (and thereby

drive down payments). But a focus on eligibility for SSI would increase the *numerator*, too (driving payments back up). So the agency has adopted the view—which the government no longer appears to defend, see Pet. Br. 33-44—that a patient is "entitled to" SSI benefits only if the patient actually received cash SSI payments for the month of her hospital stay. See Pet. App. 9-14. HHS thus excludes from the numerator both patients that are eligible for cash SSI benefits but not receiving them, and patients that are actually receiving non-cash SSI benefits.

As petitioners explain, that approach is inconsistent with the statutory text and significantly undercounts the number of needy patients included in the DSH formula. It also continues the agency's long history of undermining the DSH program. Although Congress established DSH payments to address the critical needs of hospitals serving poor communities, HHS has repeatedly interpreted the statute in the most restrictive manner possible. Consistency has been no obstacle: HHS has interpreted the text one way when that would drive down payments, and another way when that would increase them. This case is just the latest—and hopefully last—iteration of "an agency, hostile from the start to the very idea of making the payments at issue," attempting "to rewrite the will of Congress." *Cabell Huntington Hosp., Inc.* v. *Shalala*, 101 F.3d 984, 990 (4th Cir. 1996); see *Northeast Hosp. Corp.* v. *Sebelius*, 657 F.3d 1, 20 n.1 (D.C. Cir. 2011) (Kavanaugh, J., concurring in the judgment) ("The only thing that unifies the Government's inconsistent definitions . . . is its apparent policy of paying out as little money as possible.").

The correct interpretation of the DSH formula is vitally important. Although HHS has refused to share

the data that would allow hospitals to accurately count the SSI-eligible patients whom the agency's approach excludes, the available estimates suggest that hospitals will lose more than a billion dollars each year in DSH funds if the decision below stands. What's more, a hospital's eligibility for DSH payments affects its entitlement to other federal benefits designed to help hospitals "provide a wide range of medical services" to vulnerable populations. *American Hosp. Ass'n* v. *Becerra*, 596 U.S. 724, 730 (2022). HHS's error thus has far-reaching implications for hospitals, patients, and the American healthcare system.

Those harms will fall hardest on America's rural and safety-net hospitals, many of which are already in extreme financial distress. In the last 20 years, hundreds of hospitals in rural and low-income communities have closed their doors. Those closures have harmed patients, denying them access to care and forcing already-vulnerable populations to travel long distances to receive essential services. They have harmed local communities, eliminating thousands of good-paying jobs and pushing healthcare providers to move elsewhere. And they have harmed the healthcare system more broadly, causing overcrowding at nearby hospitals and discouraging hospitals from investing in programs to benefit low-income patients. By reversing the decision below, this Court can prevent further harm to hospitals and the communities they serve.

ARGUMENT

This Court should apply the logic of *Empire Health* to a different part of the same statutory formula, and reverse. In *Empire Health*, HHS successfully argued that a patient is "entitled to" Medicare Part A under the DSH formula so long as she is qualified for that program. But despite that victory, HHS has refused to

apply the same logic to determine whether a patient is "entitled to" SSI benefits—even though Congress used the same words in the same sentence. That approach is textually indefensible, and it significantly undercounts the needy patients served by America's hospitals.

I. HHS'S APPROACH TO SSI ELIGIBILITY IS WRONG.

Under the plain text of the Medicare Act, patients who are eligible for SSI benefits must be included in the DSH formula, regardless of whether they actually received a cash payment from SSI for the month of their hospital stay. That conclusion follows from the statute's command to include every patient "entitled to supplementary security income benefits." And it furthers the purpose of the DSH program by capturing all of the needy patients enrolled in the SSI program.

HHS does not interpret the statute that way. Rather than asking whether patients are *eligible for any* SSI benefits, the agency focuses solely on whether patients *actually received cash* benefits. That approach significantly undercounts the SSI-eligible population in at least two ways. First, it excludes from the DSH formula needy patients who are indisputably eligible for cash benefits but did not receive those benefits for some administrative or programmatic reason. Second, it omits patients who are eligible for, or even receiving, SSI benefits other than cash payments. Neither limitation appears in the statutory text.

A. The DSH Formula Focuses On Eligibility, Not Receipt Of Benefits.

1. When calculating hospitals' DSH payments, HHS includes only those patients who actually "receive SSI benefits for a particular month." 75 Fed. Reg.

50,042, 50,280 (2010). That focus on the actual receipt of benefits—rather than a patient's eligibility for benefits—cannot be squared with the statutory text, this Court's decision in *Empire Health*, or the structure of the DSH program.

a. *Empire Health* held that a patient must be counted in the Medicare fraction when "he qualifies for the Medicare [Part A] program," "even when Medicare is not paying for part or all of his hospital stay." 597 U.S. at 428. The Court reached that result by looking to the plain text of the Medicare statute, which consistently used the phrase "entitled to benefits" as a "term of art" to "mean qualifying . . . for benefits." *Id.* at 435. And the Court explained that Medicare beneficiaries are entitled to benefits even when there are "limitations on payment"—that is, when someone is generally eligible for Medicare but is not receiving benefits under the circumstances. *Id.* at 436.

The logic of *Empire Health* resolves the question here. The DSH formula uses the same language to describe Medicare-entitled and SSI-entitled patients. See 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) (stating that the "numerator" of the Medicare fraction is "made up of patients who . . . were *entitled to* benefits under [Medicare] and were *entitled to* supplementary security income benefits") (emphases added). Given "the normal presumption that, when Congress uses a term in multiple places within a single statute, the term bears a consistent meaning throughout," *Azar* v. *Allina Health Servs.*, 587 U.S. 566, 576 (2019), a patient should be "entitled to" SSI benefits if she is "qualified for" the SSI program, just as she is entitled to Medicare benefits if she is qualified for the Medicare program. Indeed, the

presumption of consistent usage is "at its most vigorous when a term is repeated within a given sentence." *Brown*, 513 U.S. at 118.

As with Medicare, the criteria to "qualif[y] for" SSI benefits are clear. The SSI program provides benefits to "aged, blind, and disabled individuals" who satisfy certain "income and resource[]" thresholds. 42 U.S.C. § 1381a. When an individual meets those requirements, he becomes "an eligible individual for purposes of this subchapter," *id.* § 1382(a), and subsequently receives SSI benefits according to the program's conditions, *id.* § 1382(b). And he remains enrolled in the program and eligible for benefits until either his disability status changes, see 20 C.F.R. § 416.1331, or his income exceeds the statutory threshold for 12 consecutive months, see *id.* § 416.1335.

Other parts of the SSI statute confirm that a patient is "entitled to" SSI benefits whenever she is eligible for those benefits—regardless of whether she received a benefit for a particular month. One provision states that certain individuals remain "entitled to . . . benefits" even when SSI payments have been deferred or suspended. 42 U.S.C. § 1383(a)(2)(B)(x). And another refers to individuals who are "entitled to" benefits but did not receive them because of a pending administrative review. *Id.* § 1383(a)(8)(A). In short, within the context of the SSI statute, "entitled to"—like the same term in the Medicare statute—typically means that an individual is eligible for or qualifies for a benefit.

b. HHS's approach unquestionably excludes patients who "qualify for" SSI benefits—even focusing, for the moment, only on cash payments. First, HHS does not count beneficiaries who are eligible for cash benefits but cannot receive a check because of SSI pro-

gram rules. For example, beneficiaries may not receive a check because they are staying long-term in a homeless shelter, or they live in a nursing home. See 42 U.S.C. § 1382(e)(1)(D); 20 C.F.R. § 416.211(d) (homeless-shelter rule); 42 U.S.C. 1382(e)(1)(B); 20 C.F.R. § 416.414 (nursing-home rule); see also Social Sec. Admin., *State Verification & Exchange System and State Online Query Manual* 178-181 (2013) (SSI Manual). Eligible beneficiaries also do not receive cash benefits in their first month of program eligibility. See 42 U.S.C. § 1382(c)(7); 20 C.F.R. § 416.200. All of those beneficiaries are still "qualified for" cash benefits and will receive a check as soon as other circumstances change—*i.e.*, they leave the nursing home or homeless shelter, or remain in the program for another month.

Second, HHS does not include beneficiaries who qualify for cash benefits but do not receive them because of an administrative limitation on payment. For example, a beneficiary eligible for a cash benefit will frequently not receive it for technical reasons—including because the Social Security Administration has the wrong mailing address or because the beneficiary cannot accept a direct deposit. See SSI Manual 181; see also Social Sec. Admin., *SSI Annual Statistical Report*, *2021*, at tbl. 76, https://shorturl.at/RxDCH (172,364 SSI recipients had payments suspended in 2021 due to "whereabouts unknown"). At other times, SSA may suspend payments because it cannot be sure they are reaching the beneficiary or being used properly—such as when the agency believes that the beneficiary's "representative payee" is misusing the benefits, see 42 U.S.C. § 1383(a)(2)(A)(ii)-(iii), or that issuing the payment "will cause substantial harm" to the beneficiary, see 20 C.F.R. § 416.611(a),(b) (withholding payment to entitled beneficiaries who are drug

addicts or legally incompetent). SSA also may suspend payments when an administrative review is pending, then retroactively "reinstate[]" payments "for any previous month for which they are otherwise payable." *Id.* § 416.992; see *id.* § 416.1322. As the SSI Manual makes clear, all of these beneficiaries "may still be eligible" for cash payments, SSI Manual 178; they just do not receive those payments for reasons unrelated to their eligibility.

Under the reasoning of *Empire Health*, these categories of patients are qualified for, and therefore "entitled to," SSI benefits. But HHS's narrow focus on actual receipt excludes them from the DSH formula.

c. Interpreting "entitled to" to mean "eligible for" also coheres with the structure and purpose of the statute. Congress authorized the DSH program because "[h]ospitals serving a disproportionate share of low-income patients have higher . . . costs per case." H.R. Rep. No. 99-241, pt. 1, at 16 (1985). And the statute uses SSI eligibility as a "proxy measure for low income," *id.* at 17, because *all* patients eligible for SSI benefits have satisfied the statutory income criteria to enroll in the program. See 42 U.S.C. § 1382(a). Accordingly, it makes good sense to interpret the phrase "entitled to . . . [SSI] benefits" to include all SSI-eligible patients; those patients necessarily have low income levels.

By contrast, HHS's approach leaves many needy, low-income patients out of the DSH equation. As noted above (at 9-11), SSI beneficiaries may not receive cash payments for a host of reasons that have nothing to do with their financial need or the cost of their care. Indeed, many of SSI's programmatic or administrative rules are triggered by circumstances that suggest the beneficiary is *especially* needy or vulnerable—such as

the rules barring cash payments to homeless-shelter residents or to individuals who may be exploited by the person receiving a check on their behalf. These are the people who may require the highest level of hospital care, and Congress enacted the DSH program to ensure that hospitals would not be penalized for serving their needs. By refusing to include these patients, HHS has perversely settled on an interpretation that excludes the neediest populations.

2. HHS offers two justifications for its focus on payment rather than eligibility. Neither has merit.

a. First, HHS has argued that the decision below is consistent with *Empire Health* because of differences between the Medicare and SSI programs. According to HHS, "a patient's [entitlement to SSI] is different" from his entitlement to Medicare "because [SSI] benefits consist of monetary payments to the beneficiary" and the beneficiary "must be eligible for each month's payment based on his income." Br. in Opp. 15. The premise of that argument is that for SSI—unlike for Medicare Part A—a patient is eligible for benefits only when he is actually receiving them.

That premise is wrong. An SSI beneficiary, just like a Medicare beneficiary, becomes "entitled to" benefits once he meets the program's threshold eligibility determination. Compare 42 U.S.C. § 1395c (Medicare), with *id.* § 1382(a) (SSI). And he remains enrolled in the SSI program and entitled to benefits even if those benefits are not paid for a particular period of time. Compare *id.* § 1395*l*(a)(8)(B)(i) (Medicare), with *id.* § 1383(j)(1) (SSI). Accordingly, the SSI program and Medicare Part A are similar in all the ways that matter under *Empire Health*.

b. Second, HHS has sought to defend its approach on policy grounds, arguing that, because "an individual's financial status can fluctuate over time," it "makes good sense" to ask only whether a patient received cash benefits while hospitalized. Br. in Opp. 13. That argument is wrong substantively, and any claim of administrative convenience is irrelevant.

HHS's actual-receipt rule is not a reliable "proxy to identify a hospital's low-income patients." Br. in Opp. 13. As the examples above demonstrate, HHS's approach excludes a large number of patients who are unquestionably needy and eligible for cash benefits. What's more, that approach results in "patients ping-ponging back and forth" from the Medicare fraction "based on happenstance," *Empire Health*, 597 U.S. at 443—for instance, a change in their mailing address—rather than in response to actual changes in their financial need or the costs they impose on the healthcare system. An approach that excludes the neediest patients is not a good proxy for hospitals' costs and does not comport with Congress's desire to capture "a hospital's senior (or disabled) low-income population." *Id.* at 429.

To the extent HHS's argument is that an actual-receipt rule is easier to administer than an eligibility test, that is irrelevant. "[N]o amount of policy-talk can overcome a plain statutory command." *Niz-Chavez* v. *Garland*, 593 U.S. 155, 171 (2020). This case is about the meaning of "entitled to supplementary security income benefits" in the Medicare fraction, and the agency's preference for ease of administration cannot override the language Congress chose.

B. The DSH Formula Includes All Benefits Offered Through The SSI Program.

1. HHS would not just narrow the statute from "entitled to" to "receiving." It also attempts to narrow *what* somebody must be eligible to receive (or, in its view, must actually receive). Although the statute refers to entitlement to "supplementary security income benefits," HHS would limit the DSH formula to cash SSI payments, not other SSI benefits. See 75 Fed. Reg. at 50,280.

Understanding this distinction requires a little background on the SSI program. Once individuals become eligible for SSI cash payments, they also become entitled to receive various non-cash benefits. Those benefits include state rehabilitation services and health-insurance benefits. See 42 U.S.C. § 1382d (rehabilitation services); *id.* § 1395w-114(a)(3)(B)(v) (Medicare Part D subsidies); *id.* § 1382h(b) (Medicaid extension). A beneficiary remains eligible to receive these non-cash benefits for a defined period even if she becomes ineligible for a monthly check. See *id.* § 1382d(e)(2) (entitling blind and disabled individuals to continued reimbursement of rehabilitation services for 13 months after cessation of cash payments); 20 C.F.R. § 423.773(c)(2) (entitling SSI beneficiaries to continued subsidies under Medicare Part D for at least six months after cessation of cash payments). So if somebody's income crosses the statutory threshold, cash payments stop immediately, but other SSI support winds down more slowly. And if that person's income again falls below the threshold in a subsequent month, they will resume receiving cash payments, 20 C.F.R. § 416.1100—without ever having lost access to SSI's other non-cash benefits.

The DSH formula does not distinguish between cash and non-cash SSI benefits; it simply asks whether someone is entitled to "supplementary security income benefits . . . under subchapter XVI." Beneficiaries who are eligible for non-cash SSI benefits are "entitled to" SSI benefits. And all of those benefits are made available "under subchapter XVI": an individual's entitlement turns on the threshold determination that he is eligible to enroll in the SSI program. See 42 U.S.C. § 1382(a). Once an individual enrolls, he remains enrolled and entitled to at least non-cash benefits until he exceeds the program's income threshold for 12 consecutive months. 20 C.F.R. § 416.1335.

Surrounding text in the DSH statute confirms that beneficiaries receiving non-cash SSI benefits must be counted in the Medicare fraction. In defining the SSI-eligible population, the statute directs HHS to count every patient "entitled to supplementary security income benefits (*excluding any State supplementation*)." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) (emphasis added). Congress clearly viewed the class of potential "supplementary security income benefits" as broader than just cash payments provided by the federal government—or it would have had no need to carve out state supplementation. And the fact that Congress expressly excluded state supplementation, while saying nothing to exclude non-cash SSI benefits, suggests that non-cash benefits still count. See *NLRB* v. *SW General, Inc.*, 580 U.S. 288, 302 (2017) ("[E]xpressing one item of [an] associated group or series excludes another left unmentioned.") (citation omitted).

Finally, considering eligibility for all SSI benefits conforms with the purpose of the DSH program. The mix of benefits that an SSI enrollee receives—cash, non-cash, or both—often bears no relationship to her

financial status or the costs incurred by the treating hospital. And by authorizing non-cash SSI benefits, Congress determined that the recipients of those benefits were "'especially deserving of public assistance' for medical expenses." *Atkins* v. *Rivera*, 477 U.S. 154, 157 (1986) (citation omitted). They may be working to get on their feet, but they remain an at-risk population who Congress has determined still need a hand. Excluding those patients from the DSH formula therefore undermines Congress's goal of "encourag[ing] hospitals to treat low-income patients." *Empire Health*, 597 U.S. at 429.

2. HHS's arguments for excluding patients entitled to non-cash SSI benefits are meritless.

a. HHS argues that it is appropriate to exclude patients entitled to non-cash benefits because the DSH statute refers to "income" benefits, and thus omits those who receive other benefits from the SSI program. Br. in Opp. 17. The court below adopted similar reasoning. Pet. App. 9 (suggesting that the SSI program "is about cash payments" alone because "[i]ts title promises 'supplemental security income'").

That argument conflates the substance of the SSI program with the label given to it by Congress. The DSH statute refers to "supplementary security income benefits." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The key word in the statute is "benefits"—not "income." "[I]ncome" is not a freestanding adjective; "supplementary security income" is a reference to the SSI program. See *Califano* v. *Gautier Torres*, 435 U.S. 1, 1 (1978) (per curiam) (noting that Congress "created a uniform program, known as the Supplemental Security Income (SSI) program"). Here, "supplementary security income" acts as an "attributive noun" phrase—*i.e.*,

a "noun functioning as a modifier, usu[ally] as an adjective"—that modifies the term "benefits." Bryan A. Garner, *Garner's Modern American Usage* 906 (3d ed. 2009). Grammatical niceties aside, the key is that "supplementary security income" is a phrase that "hangs together as a unified whole, referring to a single thing." *Cyan, Inc.* v. *Beaver Cnty. Emps. Ret. Fund*, 583 U.S. 416, 440 (2018). The court of appeals therefore erred by plucking the word "income" out of that "cohesive" phrase. *Facebook* v. *Duguid*, 592 U.S. 395, 403 (2021). And critically, even though it has the word "income" in the name, the SSI program includes both cash and non-cash "benefits."

b. HHS also asserts (Br. in Opp. 18-19) that, regardless of whether non-cash benefits are part of the SSI program, they are not benefits "under subchapter XVI." Pet. App. 11-12. That is not right. *All* SSI benefits—cash and noncash—are provided "under subchapter XVI." See 42 U.S.C. §§ 1381-1385 ("Supplemental Security Income For Aged, Blind, and Disabled"). Benefits are provided "under" a particular provision when that "provision . . . serve[s] as the basis" for providing them. *Harrow* v. *Department of Defense*, 601 U.S. 480, 486 (2024). To become eligible for any SSI benefits, an individual must meet the eligibility criteria of 42 U.S.C. § 1382(a)—a provision housed within subchapter XVI. Other benefits (say, Part D subsidies) may be described outside of subchapter XVI, but they are offered only to individuals who qualify under subchapter XVI. See, *e.g.*, 42 U.S.C. § 1395w-114(a)(3)(B)(v)(I) (explaining that an individual is entitled to Medicare Part D subsidies only when he is eligible for SSI benefits). That is true of the "state supplementation" payments that Congress expressly carved out of the DSH formula, 42 U.S.C.

§ 1395ww(d)(5)(F)(vi)(I)—which again, Congress would not have needed to do if HHS's reading of "under subchapter XVI" had already accomplished the same thing.

In any event, HHS's line between cash and non-cash benefits does not actually track where a benefit is described. Subchapter XVI includes provisions establishing certain non-cash benefits of the SSI program—in particular, reimbursement for rehabilitation services and an extension of Medicaid coverage. See 42 U.S.C. §§ 1382d, 1382h. And HHS excludes eligibility for those non-cash benefits anyway. So the agency cannot claim that it is relying on a strict construction of the words "under subchapter XVI" when that is not its own test.

At bottom, no one disputes that many provisions of the SSI program discuss cash benefits, and that cash benefits are a central component of the SSI program. Pet. App. 9-10. But non-cash benefits are important, express SSI benefits as well. The DSH formula does not empower HHS to distinguish among SSI benefits when calculating DSH payments to hospitals.

II. HHS'S APPROACH TO SSI ELIGIBILITY REFLECTS ITS LONGSTANDING HOSTILITY TO THE DSH PROGRAM.

HHS's refusal to reconsider its position in light of *Empire Health* is simply the latest in a long series of actions taken by the agency to drive down DSH payments for needy hospitals. In opposing certiorari, HHS objected that it has taken the same approach to SSI eligibility "since the outset of the DSH program." Br. in Opp. 11. That is no longer true. See Pet. Br. 32 (noting the government's change in position). But even if it were, the agency has changed its position on *other*

inputs into the DSH formula and thus created the inconsistency that persists today. The agency's longstanding hostility to the DSH program demonstrates that its interpretation here has less to do with a "body of experience and informed judgment," *Loper Bright* v. *Raimondo*, 603 U.S. __ (2024) (slip op. 25) (quoting *Skidmore* v. *Swift & Co*, 323 U.S. 134, 140 (1944)), than with paying as little as it can.

For over four decades, HHS has tried to squelch the DSH program. In the beginning, the dispute centered on HHS's refusal to disburse payments altogether. But after Congress and the Judiciary stepped in, the ground shifted to the agency's stingy DSH calculations. Time and again, HHS has adopted interpretations of the DSH formula that drive payments lower. When HHS interprets a category in the numerator, it counts patients as "entitled to" or "eligible for" public assistance only if the program actually made payments—at least until a court tells it otherwise. But when it interprets a category in the denominator, it takes the opposite approach, counting every patient who meets the criteria for public assistance, even if the government did not ultimately pay for the patient's care. One can "appreciate the desire for frugality, but not in derogation of law." *Northeast Hosp. Corp.*, 657 F.3d at 20 n.1 (Kavanaugh, J., concurring in the judgment).

A. HHS Initially Resisted Its Obligation To Make DSH Payments.

HHS has resisted DSH payments from the start. In 1983, Congress directed HHS to "adjust[] payments" for the Medicare program "to take into account the special needs of . . . hospitals that serve a significantly disproportionate number of patients who have low income." Pub. L. 98-21, §601(e). But HHS simply "chose

not to formulate the DSH adjustment." *Cabell Huntington Hosp.*, 101 F.3d at 986. So the following year Congress passed a law *requiring* HHS to identify hospitals eligible for DSH funds, and set a firm deadline of December 31, 1984, for the agency to complete its work. See Pub. L. 98-369, § 2315(h). When HHS blew through that deadline, a group of hospitals went to court to force the agency to act. *See Samaritan Health Ctr.* v. *Heckler*, 636 F. Supp. 503, 517 (D.D.C. 1985) ("There is no dispute that the Secretary has failed to perform this mandatory duty within the time required."). Only after losing that litigation did HHS publish its first DSH regulations. See 50 Fed. Reg. 53,398 (1985). And those regulations merely established a definition of "disproportionate share hospitals"; the agency still refused to "mak[e] adjustments to the prospective payment rates for disproportionate share hospitals." *Id.* at 53,400.

The next year, Congress responded to HHS's foot-dragging by replacing the agency's discretion over DSH payments with a detailed statutory formula—similar to the formula found in the Medicare Act today. See Pub. L. 99-272, § 9105; see also S. Rep. 146, 99th Cong. 258 (1986) (explaining that Congress created the DSH formula because the Secretary failed to carry out its obligations under the 1983 statute). Under the new legislation, HHS was no longer empowered to develop its own method for measuring a hospital's low-income population. Instead, it was tasked with implementing the formula prescribed by Congress.

B. HHS Has Repeatedly Interpreted The DSH Formula To Drive Down Payments.

Since Congress intervened, HHS has carried out its statutory duty in a way that repeatedly reduces DSH payments.

1. An early dispute concerned the Medicaid fraction, which is the other half of the DSH formula. The Medicaid fraction measures a hospital's needy-patient population under the age of 65 by dividing the number of patients "eligible for" Medicaid by the "total number" of patients treated in the hospital. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Starting in 1986, HHS counted patients as "eligible for" Medicaid assistance—which, like SSI, appears in the numerator of its respective fraction—only if a state Medicaid program actually paid for the patient's care in the hospital, even if the patient was enrolled in Medicaid. See 51 Fed. Reg. 16,772, 16,777 (1986) ("Any day of a Medicaid patient's hospital stay that is not payable by the Medicaid program will not be counted as a Medicaid patient day.").

Hospitals challenged HHS's cramped reading of the statute, leading to a string of court of appeals decisions rejecting HHS's interpretation. See *Legacy Emanuel Hosp. & Health Ctr.* v. *Shalala*, 97 F.3d 1261, 1265 (9th Cir. 1996) ("[T]he Medicaid proxy includes all patient days for which a person was eligible for Medicaid benefits, whether or not Medicaid actually paid for those days of service."); see also *Cabell Huntington Hosp.*, 101 F.3d at 991; *Deaconess Health Servs. Corp.* v. *Shalala*, 83 F.3d 1041, 1041 (8th Cir. 1996) (per curiam); *Jewish Hosp., Inc.* v. *Secretary of HHS*, 19 F.3d 270, 274 (6th Cir. 1994).[2]

2. After losing on the Medicaid fraction, HHS turned its attention to the denominator of the Medicare

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[2] Hospitals have also successfully challenged other attempts by HHS to drive down DSH payments, including by undercounting the SSI-eligible population. See, *e.g.*, *Baystate Med. Ctr.* v. *Leavitt*, 545 F. Supp. 2d 20, 48-49 (D.D.C. 2008) (holding that HHS failed to consider the "best available data" for measuring the SSI-eligible population).

fraction. In 2004, HHS published a rule stating that the agency would consider patients "entitled to" Medicare based on enrollment status alone, even if Medicare did not pay for their hospital stay. See 69 Fed. Reg. 48,916, 49,099 (2004). That position directly contradicted HHS's approach in the Medicaid litigation—where it had defined eligibility by looking only to whether Medicaid had *actually paid* for a patient's care. But the agency was content extending courts' rulings about Medicaid to the Medicare context. After all, a broader interpretation of Medicare eligibility had the effect of driving down DSH payments by expanding the number of patients counted in the Medicare fraction's denominator.

This Court agreed with HHS's revised approach to Medicare payments in *Empire Health*. In doing so, the Court acknowledged the similarities between the Medicare and Medicaid fractions, *id.* at 436 n.3, and explained that HHS had adopted its interpretation of "entitled to" to "bring its reading of the . . . Medicare fraction into line" with the earlier court of appeals decisions about the Medicaid fraction, *id.* at 441 n.4.

3. HHS's desire for consistency stopped there. Once this Court affirmed the agency's construction of Medicare eligibility, the agency made no effort to "bring its reading of" SSI eligibility "into line" as well. *Empire Health*, 597 U.S. at 441 n.4. Hospitals have thus again been forced to rely on the courts to hold HHS to a consistent administration of the DSH formula.

The upshot is that, across 30 years of litigation, this Court and courts of appeals have uniformly agreed that patients should be included in the DSH formula whenever they qualify for the relevant public-assistance program, regardless of whether that program actually

paid for the patient's hospital care. That approach led to higher payments when applied to Medicaid eligibility, see *Cabell Huntington Hosp.*, 101 F.3d at 987, and lower payments when applied to Medicare eligibility, *Empire Health*, 597 U.S. at 433. It would lead to higher payments when applied to SSI eligibility, too. So rather than adhere to the logic of those decisions, HHS has taken one last swing at constraining DSH payments.

III. UNDERFUNDING DSH PAYMENTS HARMS HOSPITALS AND PATIENTS.

The decision below will have serious repercussions for healthcare in the United States. Many hospitals around the country are operating on thin margins and teetering on the edge of survival. And many of those hospitals are concentrated in rural America and other communities with a high number of low-income patients. They are the reason Congress created DSH payments to supplement Medicare reimbursement rates, which are often well below the actual cost of care. See Alison Binkowski et al., *Assessing Payment Adequacy and Updating Payments: Hospital Inpatient and Outpatient Services*, MedPAC 7 (Jan. 11, 2024) (reporting that 2022 reimbursement rates were more than 12% below the cost of care). DSH payments are a vital lifeline for those hospitals, and can mean the difference between expanding services and shutting down. But DSH payments have steadily declined for years, with payments to DSH hospitals falling by more than $950 million from 2023 to 2024. See 88 Fed. Reg. 58,640, 59,409 (2023).[3] HHS's flawed interpretation of

[3] The Affordable Care Act amended the DSH formula to account for costs incurred by hospitals when treating uninsured patients. See Pub. L. 111-148, § 3133 (2010) (codified at 42 U.S.C.

the DSH formula is exacerbating that decline, with the costs of its policy falling hardest on the hospitals and communities that can least afford it.

A. HHS's Interpretation Of SSI Eligibility Has Serious Financial Consequences For Hospitals.

HHS's undercounting of SSI-eligible patients in the numerator of the Medicare fraction has several layers of financial consequences. It reduces the number of hospitals entitled to DSH payments, slashes the payments those hospitals receive, and cuts off other related avenues of financial support.

First, the DSH formula has a cut-off for whether hospitals are entitled to payments at all. See 42 U.S.C. § 1395ww(d). Because hospitals must treat a certain percentage of needy patients to qualify for DSH payments, HHS's undercounting means that hospitals close to the cut-off may become ineligible for DSH payments altogether.

Second, for those hospitals that remain above the cut-off, HHS's cramped view of the statute drastically reduces the size of DSH payments. Any estimates are necessarily imprecise, as HHS has never given hospitals the data needed to accurately measure their SSI-eligible population.[4] But petitioners estimate that

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§ 1395ww(r)). Under the revised formula, which went into effect in fiscal year 2014, 25% of the payments to DSH hospitals are based on the pre-existing DSH formula, while the remaining 75% are based on a new formula that measures the cost of "uncompensated care." *Ibid.*

[4] To calculate DSH payments, HHS compares hospital records with data it receives from the Social Security Administration (SSA), which assigns a particular code to each SSI beneficiary to indicate whether the patient received a cash benefit and why or why not. Pet. App. 7. Although Congress requires HHS to give hospitals "the data

HHS's interpretation of SSI eligibility is costing hospitals more than a billion dollars each year, at least for the years under review here. To calculate that shortfall, petitioners sampled hospitals and identified patients who should have been included in the DSH formula but were not. Based on that population, petitioners estimate that HHS's interpretation lowered DSH payments to the sample hospitals by 15%. Pet. 18. Extrapolated to hospitals nationwide, that 15% reduction yields approximately $1.5 billion in losses annually. *Ibid.*

Third, the financial consequences ripple outward from there because the DSH formula affects hospitals' eligibility for other federal programs and resources.

Perhaps most significantly, a hospital's DSH percentage may establish its eligibility for the 340B Drug Pricing Program, which gives hospitals access to discounted pharmaceutical drugs. See Health Resources & Services Admin., 340B Eligibility (June 2022), https://www.hrsa.gov/opa/eligibility-and-registration. The 340B Program both helps control hospitals' drug costs and enables hospitals to "provide a wide range of medical services in low-income and rural communities." *American Hosp. Ass'n*, 596 U.S. at 730-731. When a hospital loses its DSH qualification for the 340B Program, the repercussions can be staggering. Currently, there are about 250 to 300 hospitals across

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necessary" to check its work, see 42 U.S.C. § 1395ww note, HHS provides hospitals only a "binary yes-or-no marker indicating whether the patient . . . was counted as being entitled to SSI benefits" under HHS's approach, Pet. App. 7. Hospitals do not receive any information indicating which patients would be included if HHS had properly focused on eligibility, nor can hospitals otherwise get that information from the SSA. *Id.* at 6-7.

the country that are on the cusp of the minimum required DSH threshold for 340B eligibility. That represents about 8% of all 340B hospitals.

If these hospitals lose 340B eligibility, it will decimate access to care for patients who rely on the program. One of amici's members, a Northeastern academic medical center, reports that it is very close to the cut-off for DSH payments and that it stands to lose more than $100 million in 340B Program benefits if it falls short of the DSH threshold. Another member hospital in Idaho is at risk of losing nearly $25 million next year because its SSI percentage has dropped by less than 1%. And a third member, located in a rural county in the mid-Atlantic, is in a similar position: it has lost millions in 340B benefits and estimates that even a modest 1% increase in the qualifying SSI days in the DSH formula would put it back over the threshold.

Similarly, under the Affordable Care Act, hospitals can receive funds to offset uncompensated care—*i.e.*, care for "patients who have no means to pay"—only if they also receive DSH payments. *Florida Health Sci. Ctr., Inc.* v. *Secretary of HHS*, 830 F.3d 515, 517 (D.C. Cir. 2016) (citing 42 U.S.C. § 1395ww(r)). And some federal grant programs, such as a program administered by the Substance Abuse and Mental Health Services Organization, prioritize federal funds for hospitals that receive DSH payments. As a result, hospitals that miss out under HHS's stingy view of the DSH formula miss out on other funding programs as well.

B. HHS's Interpretation Of SSI Eligibility Harms Patients, Communities, And The Healthcare System.

1. These financial losses will have severe consequences for hospitals that treat the most vulnerable patients, including rural and safety-net hospitals that are already confronting serious financial challenges. "[R]ural hospitals often treat patient populations that are older, sicker and poorer compared to the national average." American Hosp. Ass'n, *Rural Hospital Closures Threaten Patient Access to Care* 5 (2022). Those hospitals came under intense pressure during the Covid-19 pandemic, "which hit rural areas especially hard." *Id.* at 3. Since 2010, more than 130 rural hospitals have closed or discontinued inpatient services, with a record 19 closures in 2020 alone. *Id.* at 4.

Outside of rural America, safety-net hospitals located in major urban areas are also struggling to stay afloat. Those facilities face "financial headwinds" caused by low reimbursement rates, uncompensated care for patients who lack adequate health insurance, and "high labor costs from worker shortages." David Kendall et al., *Revitalizing Safety Net Hospitals: Protecting Low-Income Americans From Losing Access to Care*, Third Way 2 (2023). These forces have led many safety-net hospitals to close in recent years, leaving some communities without access to essential services. *Ibid.* To give a few examples, Hahnemann Hospital in downtown Philadelphia closed its doors in 2019, depriving the community of "500 [hospital] beds" and "600 medical professionals." *Ibid.* And last year, the Kingsbrook Jewish Medical Center in Brooklyn, which "predominantly serves low-income patients," announced that it was halting emergency services. See

Maya Kaufman, *Brooklyn Safety-Net Hospital Slated For More Cuts*, Politico (Aug. 7, 2023).

Short of closure, the loss of DSH funding can also make it difficult for hospitals to make long-term capital investments and to maintain or expand needed services—particularly those like behavioral health that tend to lose significant amounts of money. This is especially true for hospitals that serve low-income communities, including large populations of unhoused individuals, and that are already operating at thin or negative margins. Members of amicus America's Essential Hospitals, for example, had an average aggregate margin of -8.6% in 2021, and provide close to $9 billion in uncompensated care annually. For these and other safety-net hospitals, every dollar matters.

Congress designed DSH payments to help hospitals like these survive. But HHS's failure to fully fund the DSH program puts these hospitals at risk and makes it more likely that the trend of closures or service cuts will accelerate.

2. The most obvious victims of hospital closures or cuts are patients, who may have to travel long distances or forgo necessary treatment after losing access to a community hospital. See Melissa Gomez & Hannah Fry, *This Rural County Lost Its Only Hospital, Leaving Residents With Dire Healthcare Choices*, LA Times (June 6, 2023) (reporting that hospital closure in rural county forced residents to drive more than 45 minutes to reach another facility); Jane Wishner et al., *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies*, Kaiser Family Foundation 7 (July 7, 2016) (finding that hospital closures prevented patients from accessing emergency care and made it more challenging to "transport[] patients back home after they are taken by ambulance to

another community for care"). The risk of closures also drives talented healthcare professionals to seek jobs elsewhere, which both deprives patients of care now and makes it more difficult to open a new hospital in the future. See Wishner et al., *A Look at Rural Hospital Closures*, at 7-8.

Closures also put significant pressure on the broader healthcare system. Patients who can no longer access their local hospital may seek care from the nearest alternative. See Shayann Ramedani et al., *The Bystander Effect: Impact of Rural Hospital Closures on the Operations and Financial Well-being of Surrounding Healthcare Institutions,* 17 J. Hosp. Med. 901, 902 (2022). That can lead to significant overcrowding and a deterioration in the quality of care, even if the neighboring hospital is on strong financial footing and does not rely on DSH payments. For example, one recent study found that hospital closures had spillover effects for emergency care in nearby hospitals, leading to a significant increase in mortality rates. See Renee Y. Hsia & Yu-Chu Shen, *Emergency Department Closures and Openings: Spillover Effects on Patient Outcomes in Bystander Hospitals*, 38 Health Affairs 1496, 1499 (2019).

The loss of a hospital can even cripple a local economy. "A hospital closure can eliminate a hundred or more jobs immediately," and "can make it more challenging for rural communities to attract employers." Wishner et al., *supra*, at 9. And those impacts are felt for years, with "annual county income and county population size . . . decreas[ing] steadily several years after the closures." Richard Payerchin, *Rural Hospital Closures Affect More Than Health Outcomes*, Med. Econ. (Mar. 22, 2022), https://www.medicaleconomics.com/view/rural-hospital-closures-affect-more-than-

health-outcomes. The economic harms for communities affected by hospital closures may be difficult to reverse, as worsening economic conditions make it challenging to attract new hospitals and medical professionals.

* * *

Congress created the DSH program because it recognized the unique burdens faced by hospitals that treat America's most vulnerable patients. Yet HHS has settled on an atextual interpretation of the DSH formula that excludes significant swaths of low-income, SSI-eligible patients. If allowed to stand, the decision below will have lasting consequences throughout the healthcare system and will exacerbate the very problem that Congress has long tried to solve.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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