Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States* v. *Detroit Timber & Lumber Co.,* 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

BECERRA, SECRETARY OF HEALTH AND HUMAN SERVICES *v.* EMPIRE HEALTH FOUNDATION, FOR VALLEY HOSPITAL MEDICAL CENTER

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

No. 20–1312. Argued November 29, 2021—Decided June 24, 2022

Once a person turns 65 or has received federal disability benefits for 24 months, he becomes "entitled" to benefits under Part A of Medicare. 42 U. S. C. §§426(a)–(b). Part A provides coverage for, among other things, inpatient hospital treatment. See §1395d(a). Medicare pays hospitals a fixed rate for such treatment based on the patient's diagnosis, regardless of the hospital's actual cost and subject to certain adjustments. §§1395ww(d)(1)–(5). One such adjustment is the "disproportionate share hospital" (DSH) adjustment, which provides higher-than-usual rates to hospitals that serve a higher-than-usual percentage of low-income patients. To calculate the DSH adjustment, the Department of Health and Human Services (HHS) adds together two statutorily described fractions: the Medicare fraction—which represents the proportion of a hospital's Medicare patients who have low incomes—and the Medicaid fraction—which represents the proportion of a hospital's total patients who are not entitled to Medicare and have low incomes. Together those fractions produce the "disproportionate-patient percentage," which determines whether a hospital will receive a DSH adjustment, and how large it will be.

Not all patients who qualify for Medicare Part A have their hospital treatment paid for by the program. Non-payment may occur, for example, if a patient's stay exceeds Medicare's 90-day cap per spell of illness, see §1395d, or if a patient is covered by a private insurance plan, see §1395y(b)(2)(A). Such limits on Medicare's coverage prompt the question raised here: whether patients whom Medicare insures but does not pay for on a given day are patients "who (for such days) were

entitled to [Medicare Part A] benefits" for purposes of computing a hospital's disproportionate-patient percentage. §1395ww(d)(5)(F)(vi)(I).

A 2004 HHS regulation says yes: If the patient meets the basic statutory criteria for Medicare (*i.e.*, is over 65 or disabled), then the patient counts in the denominator and, if poor, in the numerator of the Medicare fraction. See 69 Fed. Reg. 49098–49099. Respondent Empire Health Foundation challenged that regulation as inconsistent with the statute. The Ninth Circuit agreed. That court focused on the statute's use of two different phrases: "entitled to [Medicare Part A] benefits" and "eligible for [Medicaid] assistance." The Ninth Circuit read the latter phrase to mean that a patient qualifies for Medicaid and the former phrase to mean that a patient has an absolute right to payment from Medicare. The Court granted certiorari to resolve a conflict between the Ninth Circuit and two other Circuit Courts, which had approved of HHS's regulation.

Held: In calculating the Medicare fraction, individuals "entitled to [Medicare Part A] benefits" are all those qualifying for the program, regardless of whether they receive Medicare payments for part or all of a hospital stay. Pp. 7–19.

HHS's regulation is consistent with the text, context, and structure of the DSH provisions. The agency has interpreted the phrase "entitled to benefits" in those provisions to mean just what it means throughout the Medicare statute: qualifying for benefits. And counting everyone who qualifies for Medicare benefits in the Medicare fraction—and no one who qualifies for those benefits in the Medicaid fraction—accords with the statute's attempt to capture, through two separate measurements, two different segments of a hospital's low-income patient population.

(a) Empire's textual argument has a two-part structure. Echoing the Ninth Circuit, Empire primarily contends that the words "entitled" and "eligible" have different meanings. According to Empire, to be "eligible" for a benefit is to be "qualified" to seek it; to be "entitled" to a benefit means instead to have an "absolute right" to its payment. But throughout the Medicare statute, "entitled to benefits" is essentially a term of art meaning "qualifying for benefits," *i.e.*, being over 65 or disabled. And in the end, Empire basically concedes that point. It must devise a way to give "entitled to benefits" a different meaning in the fraction descriptions than everywhere else in the Medicare statute. So Empire shifts gears, relying now on the parenthetical phrase "(for such days)" to transform the usual statutory meaning of "entitled to benefits" to something different and novel. But those three little words do not accomplish what Empire would like, having the much less radical function of excluding days of a patient's hospital stay before he qualifies for Medicare (*e.g.*, turns 65). Pp. 8–15.

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(1) The Medicare statute explicitly states that "[e]very individual" who "has attained age 65" and is entitled to ordinary social security payments and "every individual" under age 65 who has been entitled to federal disability benefits for at least 24 months "shall be entitled to" Medicare Part A benefits. §§426(a)–(b). This broad meaning of "entitlement" coexists with limitations on payment. The entitlement to benefits, the statute repeatedly says, is an entitlement to payment under specified conditions. So a person remains entitled to benefits even if he has run into one of the statute's conditions, such as the 90-day cap on inpatient hospital services. For example, the statute twice refers to patients who are "entitled to benefits under part A but ha[ve] exhausted benefits for inpatient hospital services." §§1395*l*(a)(8)(B)(i), 1395*l*(t)(1)(B)(ii). In thus describing the Part A entitlement, the statute reflects the complexity of health insurance: An insured who hits some limit on coverage for, say, eye care is still insured. His policy will pay for more eye care in the next coverage period and meanwhile will pay for his knee replacement.

If "entitled to benefits" instead bore Empire's meaning, Medicare beneficiaries would lose important rights and protections, such as the ability to enroll in other Medicare programs. See §§1395*o*(a), 1395w-21(a)(3), 1395w–101(a)(3)(A). Empire's interpretation would also make a hash of provisions designed to inform Medicare beneficiaries of their benefits, see §1395b–2(a), and to protect beneficiaries from misleading marketing materials, see §1395w–21(a)(3). Congress could not have intended to write a statute whose safeguards would apply or not apply, or fluctuate constantly, based on the happenstance of whether Medicare paid for hospital care on a given day. Pp. 9–13.

(2) Empire concedes that its interpretation cannot be applied throughout the Medicare statute. To get around this, Empire claims that the parenthetical in "patients who (for such days) were entitled to [Part A] benefits," §1395ww(d)(5)(F)(vi)(I), converts the usual statutory meaning of "entitled to benefits" to something different: actually receiving payment. That slight phrase, however, cannot bear so much interpretive weight. Instead, the parenthetical works as HHS says: hand in hand with the ordinary statutory meaning of "entitled to benefits." It directs HHS to count only those individuals who qualify for Medicare on a particular day. So if a patient turns 65 on the 15th day of a 30-day hospital stay, HHS will count only 15 days. Pp. 13–15.

(b) The structure of the relevant statutory provisions reinforces the conclusion that "entitled to benefits" means qualifying for benefits. The statute recompenses hospitals for serving two different low-income populations: low-income Medicare patients and low-income non-Medicare patients. HHS's reading of "entitled" comports with this

structure: a low-income Medicare patient always count in the Medicare fraction. That is so regardless of whether the Medicare program is actually paying for a day of his care—because that fact has no relationship to his financial status. Empire's interpretation, by contrast, fits poorly with the statutory structure. Its who-paid-for-a-day-of-care test has no relationship to a patient's financial status. So on Empire's view, a patient could phase in and out of the Medicare fraction regardless of income. Empire responds by asserting that any low-income person excluded from the Medicare fraction (say, because of exhaustion of benefits) would get counted instead in the Medicaid fraction. But even if that is true, Empire's scheme would result in patients ping-ponging back and forth between the two fractions based on the happenstance of actual Medicare payments. In any event, Empire is too quick to claim that those who (on its view) are tossed from the Medicare fraction for non-income-based reasons like exhaustion of benefits would still wind up in the Medicaid fraction. Applying Empire's reading of "for such days," a low-income patient who has exhausted his coverage would not get counted at all, in either fraction, but he would remain just as low-income and impose just as high costs on the hospital treating him. Empire's only response is to insist that its interpretation must be right because it usually (though not always) leads to higher DSH payments. But the point of the statute is not to pay hospitals the most money possible; it is to compensate them for serving a disproportionate share of low-income patients. Pp. 15–18.

958 F. 3d 873, reversed and remanded.

KAGAN, J., delivered the opinion of the Court, in which THOMAS, BREYER, SOTOMAYOR, and BARRETT, JJ., joined. KAVANAUGH, J., filed a dissenting opinion, in which ROBERTS, C. J., and ALITO and GORSUCH, JJ., joined.

SUPREME COURT OF THE UNITED STATES

No. 20–1312

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

[June 24, 2022]

JUSTICE KAGAN delivered the opinion of the Court.

The Medicare program reimburses hospitals at higher-than-usual rates when they serve a higher-than-usual percentage of low-income patients. The enhanced rates are calculated by adding together two fractions, called the Medicare fraction and the Medicaid fraction. Roughly speaking, the former measures the hospital's low-income senior-citizen population, and the latter the hospital's low-income non-senior population.

This case raises a technical but important question about the Medicare fraction. The statutory description of that fraction refers to "the number of [a] hospital's patient days" attributable to low-income patients "who (for such days) were entitled to benefits under part A of [Medicare]." 42 U. S. C. §1395ww(d)(5)(F)(vi)(I). According to the Department of Health and Human Services (HHS), a person is "entitled to [Part A] benefits" under the statute if he qualifies for the Medicare program—essentially, if he is over 65 or

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