Whether the providers are entitled to additional social security income (SSI) days in the calculation of their SSI?

1. **Facts**

By way of background, hospitals are paid for services to Medicare patients under a prospective payment system (“PPS”). Under PPS, inpatient operating costs are reimbursed based on a prospectively determined formula taking into account national and regional operating costs. The PPS legislation contains a number of provisions that adjust reimbursement based on hospital-specific factors. *See* 42 U.S.C. § 1395ww(d)(5). This case involves one of the hospital-specific adjustments, the DSH adjustment. The DSH adjustment, effective in 1986, requires the Secretary to provide increased PPS reimbursement to hospitals that serve a “significantly disproportionate number of low-income patients.” 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). Whether a hospital qualifies for the DSH adjustment, and the amount of the adjustment it receives, depends on the hospital's “disproportionate patient percentage” (“DPP”). *See* 42 U.S.C. § 1395ww(d)(5)(F)(v).

A hospital’s DPP is determined by adding the results of two computations and expressing the results as a percentage. As indicated in 42 U.S.C. § 1395ww(d)(5)(F)(v) and 42 C.F.R. § 412.106, the two computations are the Medicare fraction (first computation) and the Medicaid fraction (second computation). The Medicare fraction is determined by dividing the number of days of care that are furnished to patients who were entitled to Medicare Part A (or Medicare Part C) benefits and who were “entitled to Supplemental Security Income benefits” by the number of days of care that are furnished to patients who were entitled to Medicare Part A (or Medicare Part C). The Medicaid Fraction is determined by dividing the number of hospital patient days for patients who (for such days) were eligible for medical assistance under a State Plan approved under Title XIX for such period but not entitled to benefits under Medicare Part A by the total number of the hospital's patient days for such period. A provider whose DSH percentage meets certain thresholds receives an adjustment which results in increased PPS payment for inpatient hospital services. 42 U.S.C. § 1395ww(d)(5)(F)(ii).

The SSI ratio is a statutory formula appearing at section 1886(d)(5)(F)(vi)(I)[[1]](#footnote-1), and is known as the “Medicare fraction”. Congress recognized that the Medicare fraction was only a proxy for determining the low-income patient population.[[2]](#footnote-2)

The Centers for Medicare & Medicaid Services (CMS) makes the computation noted above by electronically matching the health insurance claim number of Medicare beneficiaries from records in the national claims history database, which contains data on Medicare claims for the current and previous three years, to Title II numbers on the SSI file supplied yearly by the Social Security Administration (SSA). CMS tabulates the number of Medicare entitled/SSI days in PPS units of the hospital and the total number of Medicare entitled days in inpatient prospective payment system (IPPS) units of the hospital. It then sends the resulting percentage (SSI ratio or Medicare fraction) to each hospital’s MAC. The MACs use the SSI ratio to determine whether the hospitals should receive a DSH payment, and if so, the amount of such payment. In this case, the Group contends that the SSI ratios supplied by CMS to the MAC for the fiscal periods at issue were not correct, and thus, the Providers’ DSH payments were understated.

I. The Type of Days Included in the Denominator of the Medicare Fraction

The MAC’s position is that, for the cost year at issue in this appeal, the denominator of the Provider’s Medicare fraction should have (and did) include Medicare entitled days from PPS-included units of the Provider. To the extent, therefore, that the Provider claims that the denominator of its Medicare fraction should contain some other type of days (e.g., only paid days), such claim should be rejected. The regulation provides for the inclusion of Medicare entitled days, whether paid or not, and the Board is bound by CMS’s regulations. See 42 C.F.R. § 405.1867. To the extent the Board finds that it has the authority to decide what types of days should appear in the denominator, however, the MAC’s position is that CMS’s policy of including Medicare entitled days is reasonable and not arbitrary and capricious.

II. The Type of Days in the Numerator and the Denominator of the Medicare Fraction

The MAC’s position is that CMS’s calculations of the Providers’ Medicare fractions were fixed when performed and that no change to the Medicare fraction, either higher or lower, is appropriate based on updated or corrected data. That is, CMS’s policy is that it calculates the Medicare fractions for providers based on the best data reasonably available to it at the time of the calculation. Subsequent information relating to the SSI eligibility status of individuals, or the number of Medicare entitled days properly attributable to a provider, cannot be used as a basis for changing the calculation and raising or lowering the DSH payment adjustment (or qualifying or disqualifying a provider for a DSH adjustment).

## **Argument**

FOOTNOTE: 3 Provider position paper at 1.

END FOOTNOTE

The Group starts by confirming there are multiple issues within the instant case, based on the heading “STATEMENT OF THE ISSUES”[[3]](#footnote-3)FOOTNOTE: 3 Provider position paper at 1.

END FOOTNOTE

, and the subsequent argument that refers to the first and second issues. The MAC has confirmed with the Provider’s Representative that the Provider is pursuing the data match aspect. It is unclear why much of the Group’s paper does not focus on data matching aspects. A significant portion of the Provider’s paper relates to non-data-match aspects. In fact, very little of the Group’s paper is dedicated solely to the data match aspect. Rather, the Group focuses on a statute that does not exist, where enrollment equals SSI benefit entitlement. The evidence is quite clear that SSI benefits are cash benefits. The statute is

explicit that such entitled beneficiaries be paid benefits. Each of the arguments put forth by the Group were considered by the DC Circuit Court in *Advocate*, where such arguments were struck down. The Group ignores the *Advocate* decision by suggesting they are awaiting a decision. The Group’s position paper was filed in November 2023. The *Advocate* decision was issued September 1, 2023. It is unclear why the Group willingly forewent any means to explain how its case differs from the huge consolidation that was the *Advocate* case, which essentially foreclosed further appeal of this issue.

This case revolves around the Medicare fraction. CMS and the courts have agreed upon a definition of Medicare Part A entitlement. Both the DC Circuit Court of Appeals and the Supreme Court have made clear in separate cases that entitled to benefits under Medicare Part A means to qualify for benefits. The courts very clearly understand that Medicare Part A is an insurance benefit under Title XVIII, overseen by HHS, and that SSI is a cash benefit program under Title XVI, overseen by the SSA. In other words, Medicare Part A and SSI are very much different. Each being authorized through separate legislation, each overseen by separate agencies, and each possessing its own entitlement criteria. There is not one entitlement criteria as the Group would have the Board believe. It would be irresponsible to ignore SSI entitlement criteria, and force SSI entitlement to be determined through Medicare Part A entitlement criteria, simply because it would be financially beneficial for providers. At one point, the Group refers to SSI benefits as financial insurance, which is grossly misleading. SSI benefits are a cash payment. The Provider Community’s interpretation of various aspects of the DSH statute and regulation do not ensure consistency with the text, context, and structure of the DSH provisions. To the contrary, the Secretary’s interpretation does provide consistency as affirmed by the Supreme Court.

The Group argues that additional SSA status codes must be included in the numerator of the SSI percentage beyond the current three (C01, M01, and M02). CMS addressed the Group’s concern years ago and the Provider Community has failed to accept the explanation from CMS. In the August 16, 2010 Federal Register, CMS explained why it had excluded certain codes in responses to comments raising complaints similar to those made by the Group here:

Comment: One commenter stated that CMS uses total (that is, “paid and unpaid”) Medicare days in the denominator of the SSI fraction, but uses paid SSI days in the numerator of the SSI fraction. The commenter requested that CMS interpret the word “entitled” to mean ”paid” for both SSI-entitled days used for the numerator and Medicare-entitled days used in the denominator, or alternatively, that CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there is consistency between the numerator and the denominator of the SSI fraction. The commenter stated that there were several SSI codes that represent individuals who were eligible for SSI, but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data matching process. Specifically, the commenter stated that at least the following codes should be considered to be SSI-entitlement:

E01 and E02

N06, N10, N11, N18, N35, N39, N42, N43, N46, N50, and N54

P01

S04, S05, S06, S07, S08, S09, S10, S20, S21, S90, and S91

T01, T20, T22, and T31

CMS responded definitively to the concerns included in the comment:

In response to the comment that we are incorrectly applying a different standard in interpreting the word ”entitled” with respect to SSI entitlement versus Medicare entitlement, we disagree. The authorizing DSH statute at section 1886(d)(5)(F)(vi)(I) of the Act limits the numerator to individuals entitled to Medicare benefits who are also ”entitled to supplemental security income benefits (excluding any State supplementation)” (emphasis added). Consistent with this requirement, we have requested, and are using in the data matching process, those SSA codes that reflect ”entitlement to” receive SSI benefits. Section 1602 of the Act provides that “[e]very aged, blind, or disabled individual who is determined under Part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be paid benefits by the Commissioner of the Social Security” (emphasis added). However, eligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month. For example, section 1611(c)(7) of the Act provides that an application for SSI benefits becomes effective on the later of either the month following the filing of an application for SSI benefits or the month following eligibility for SSI benefits.[[4]](#footnote-4)

The Circuit Court in *Advocate* addressed the Group’s concern regarding additional SSA codes as well.

First, the hospitals contend that HHS arbitrarily excluded patients whose SSI benefits were withheld under the so-called “cross-program recovery” scheme. When an SSI beneficiary receives an overpayment from another SSA program, SSA may correct the mistake by reducing SSI benefits correspondingly. 42 U.S.C. § 1320b–17. The hospitals assert that SSA assigns to individuals whose benefits are so withheld the E01 code, which indicates a loss of SSI eligibility, even though these individuals receive an SSI benefit that cancels another monetary liability. This assertion is mistaken. As the government explained at oral argument, individuals whose SSI benefits are clawed back under the cross-program recovery scheme still are assigned the C01, M01, or M02 codes, and therefore remain “entitled to [SSI] benefits” in the agency’s calculation of the Medicare fraction.

Second, the hospitals contend that HHS unreasonably focused on whether patients receive SSI payments when hospitalized because the payments depend on income and resource levels from earlier months. But “eligibility” for the SSI benefit “for a month” depends on the individual’s income, resources, and other characteristics “in such month.” 42 U.S.C. § 1382(c)(1). Thus, if an individual satisfies these criteria during one month yet does not receive the payment until a later month, HHS still counts the individual as “entitled to [SSI] benefits” during the first month.

At a very basic level, the Provider falsely implies that SSI entitlement and Medicare Part A entitlement should be one in the same. In view of the *Empire[[5]](#footnote-5)* decision, the Group suggests that if Medicare Part A entitlement means to qualify for benefits, SSI entitlement must mean the same. The Provider also avoids the Advocate Christ DC District Court decision[[6]](#footnote-6) that carefully considered each of the Group’s arguments and rejected them. The *Advocate* case was appealed to the DC Circuit Court of Appeals, and the Circuit Court also rejected the Provider Community’s arguments.[[7]](#footnote-7) The idea that SSI entitlement criteria is irrelevant must be rejected. The SSI statute cannot be rejected simply because it results in an outcome the Provider Community dislikes. The SSI statute is clear that basic entitlement to SSI benefits results in paid benefits. The Provider offers no explanation for why the basic SSI entitlement definition Congress developed should be disregarded. The Court of Appeals for the DC Circuit addressed this aspect head-on.

We begin with the dispute over the phrase “entitled to supplementary security income benefits … under subchapter XVI.” 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). HHS reads it to cover only Medicare beneficiaries who are entitled to SSI cash payments at the time of their hospitalization. The hospitals read it to cover Medicare beneficiaries who are enrolled in the SSI program at the time of their hospitalization, regardless of whether they receive a cash payment at that time. To justify their position, the hospitals contend that SSI benefits under subchapter XVI include not only cash payments but also the Medicare Part D subsidy and vocational rehabilitation services.

The hospitals are mistaken. At every turn, subchapter XVI is about cash payments for needy individuals who are aged, blind, or disabled. Its title promises “supplemental security income” for those individuals. 42 U.S.C. ch. 7, subch. XVI. Its statement of purpose is “to provide supplemental security income” to those individuals. *Id.* § 1381. Its “[b]asic entitlement to benefits” is that aged, blind, or disabled individuals, once determined not to have income or resources above the statutory cutoffs, “shall, in accordance with and subject to the provisions of this subchapter, be paid benefits.” *Id.* § 1381a. Section 1382 sets forth “[t]he benefit under this subchapter”—not simply “a” benefit—in specific dollar amounts. *Id.* § 1382(b). Scores of later provisions elaborate on when and how this cash benefit is to be paid out.

The Group asserts that HHS rejects the statutory interpretation of the word entitled in the phrase “entitled to benefits under part A”. The Group goes on to repeat a failed argument that HHS interprets the word “entitled” differently within the same sentence of the statute. The statute utilizes terms or phrases, not a single word, as the Group insists. The two separate terms are:

1. entitled to benefits under part A of this subchapter
2. entitled to supplementary security income benefits (excluding any State supplementation)

The Providers’ argument is only a repackaged way of asking that SSI entitlement be determined using Medicare Part A entitlement criteria, even though the SSA possesses its own very distinct definition of entitlement and its own criteria to become entitled to SSI benefits. The Group seems to try to imply that the Provider Community is only seeking what is due to them, while HHS attempts to pay as little as possible. The Group consistently refers to reductions in payments. To be clear, ensuring the provider community is paid what is due to them per statute and regulation, is not a reduction in payments. One need only consult reality to dispel the notion. HHS, through the MACs, administer the Medicare program and seek to pay providers appropriately. In other words, what is due to providers per statute, regulation, program policy, etc. Again, the MACs administer the Medicare program. There is no reason and there are no incentives for the MACs to pay hospitals as little as possible. The MACs are audited annually by CMS contractors to ensure the MACs are auditing hospital cost reports appropriately and performing several other tasks in compliance with work requirements.[[8]](#footnote-8) CMS writes up MACs where errors are found whether correcting the MAC determination results in an overpayment or an underpayment. The goal is to get it right, not pay as little as possible. It is the Provider Community that is persistently and perpetually seeking more than what is due.

The Group lists what it purports to be non-cash SSI benefits and argues that the Board must apply the same interpretation/logic to the numerator of the SSI fraction as CMS applied to the denominator. First, the SSI fraction involves statutorily defined figures. The Group cannot wish its definition into existence. This is an attempt by the Group to suggest that SSI benefits are not a cash benefit. The SSA defines SSI benefits as a cash-benefit payable by the Commissioner of Social Security. It is unclear why the Group would possess more expertise than the Commissioner of Social Security regarding SSI benefits. Further, the benefits purported to be available SSI benefits are not actually SSI benefits. For example, the Group claims that Title XIX (Medicaid) is an SSI benefit. This is an absurd notion and should be dismissed on its face. In other cases on this issue, groups have suggested that a potential for SSI payment status to be reviewed for those in a suspension status without reapplication is a non-cash benefit. Administrative efficiencies are not non-cash SSI benefits for individuals. The Group argues that the Medicare Part D subsidy is a non-cash SSI benefit. This is not the case. Individuals can be deemed automatically eligible for the full Medicare Part D subsidy because they were enrolled and eligible for SSI benefits, or eligible for full Medicaid benefits, or eligible for a Medicare Savings Program. Again, another administrative efficiency. If not automatically deemed eligible, individuals could obtain a full subsidy through an application process. Clearly, eligibility to have one’s Part D coverage subsidized, is not indicative of being entitled to SSI benefits. Medicare Part D is a Title XVIII benefit, not a non-cash SSI benefit. Entitlement to Medicare Part D does not make an individual entitled to monthly SSI payments. The statute defines SSI benefits as a cash benefit and the Commissioner of Social Security also defines it as such, therefore, it is difficult to give the Group’s position any validity. The Group’s attempt to suggest that Title XIX, Title XVIII, and Title XI benefits are non-cash SSI benefits must be dismissed. The Circuit Court in *Advocate* addressed this as well.

The hospitals respond that the word “benefits” can include cash or non-cash benefits, tangible or intangible. True enough, but the question here turns on what counts as “income” benefits “under subchapter XVI.” Neither of the two benefits that the hospitals cite fits that description. Medicare Part D benefits are housed in subchapter XVIII. So too is the provision making individuals “who are recipients of supplemental security income benefits” also eligible for a prescription-drug subsidy. 42 U.S.C. § 1395w-114(a)(3)(B)(v)(I). The prescription-drug subsidy is thus a non-cash benefit provided under subchapter XVIII, not the monthly cash benefit provided under subchapter XVI. Likewise, the Ticket to Work benefits cited by the hospitals are provided under subchapter XI, which requires SSA to establish that program for blind and disabled individuals “to obtain employment services, vocational rehabilitation services, or other support services from an employment network.” *Id.* § 1320b-19(a). Subchapter XI sets forth the metes and bounds of that program, which SSA may run through state agencies that choose to administer approved plans, *see id.* § 1320b-19(c)(1), or through private employment networks selected by SSA, *see id.* § 1320b-19(d)(4). Subchapter XVI merely provides that, if a state chooses to participate in the Ticket to Work program, SSA may reimburse the state for the cost of providing covered vocational benefits to SSI enrollees. *Id.* § 1382d(d). That simply provides a funding mechanism for a subchapter XI benefit—and one that expressly defines the term “supplemental security income benefits under subchapter XVI” as “a cash benefit under section 1382 or 1382h(a).” *Id.* § 1320b-19(k)(5).

The CMS regulations do not allow for re-computations based on later or “corrected data.” Regulation 42 C.F.R. § 412.106(b) provides that CMS will calculate a hospital’s Medicare fraction based on its discharge data for a federal fiscal year or based on its discharge data for its cost-reporting period. There is no provision for doing re-computations based on later or corrected data, and thus one should not be implied. CMS’s establishment of the recalculation process specified in section 412.106(b)(3) gives further support to the MAC’s position. The recalculation process exists not for the purpose of simply using updated or corrected data, but, rather, to calculate a hospital’s Medicare fraction for a different time period, i.e., its cost reporting period rather than the fiscal year in which its cost reporting period began.[[9]](#footnote-9) Where a provider seeks to have its Medicare fraction recalculated on the basis of its cost reporting period, instead of on the basis of the Federal Fiscal Year (FFY), CMS will do so, but the resulting percentage, higher or lower, is the provider’s Medicare fraction. See 42 C.F.R. § 412.106(b)(3). Responding to a comment, in which the submitter suggested that hospitals that request a recalculation be “held harmless” if the resulting percentage were lower, CMS stated:

Concerning the request for a "hold harmless" provision, it has been our consistent policy that a hospital that requests a recalculation of its Medicare Part A/SSI percentage based on its cost reporting period must accept the result of that calculation in place of the Federal fiscal year calculation. We believe that this policy prevents hospitals from taking advantage of the opportunity to request this procedure merely so that they can choose the higher percentage.

60 Fed. Reg. at 45812. The policy on recalculations evinces a clear intent that the determination is final when made and not subject to change based on later data, including later data available at the time of an appeal. Thus, a provider that has a cost reporting period different from the FFY could not receive a recalculation based on its cost reporting period and then file an appeal to obtain a different Medicare fraction using later data. Similarly, a provider that has a cost reporting period that is the same as the FFY cannot obtain a different Medicare fraction using later data. This reading of the regulations is consistent with CMS’s stated goal to derive approximate, not perfect, disproportionate patient percentages.[[10]](#footnote-10) In sum, regulation 412.106(b) should be read as not allowing re-computations based on later data. Accordingly, as the Board is bound by CMS’s regulations, it must rule for the MAC on this issue.

Even if the Board could rule on the question of whether subsequent or different data could be used, however, CMS’s policy should be upheld. Courts have recognized that in implementing the inpatient hospital PPS, CMS is entitled to rely on the best data available at the time it makes a determination and is not obligated to correct its determinations based on later or corrected data. If, based on later data, the Secretary were to revise a provider’s Medicare fraction under her reopening authority at 42 C.F.R. § 405.1885-1889 (or under other authority developed especially for this purpose), it could result in increasing or decreasing a provider’s DSH payments, or awarding or denying altogether a DSH adjustment, thus leading to unexpected shifts in basic reimbursement rates, which would erode the predictability and finality that underlie the PPS scheme. Performing re-computations also would be administratively burdensome. Therefore, should the Board decide that it has the authority to address CMS’s policy of not performing re-computations, it should uphold CMS’s policy as reasonable and not arbitrary and capricious, and no adjustment to the Provider’s Medicare fractions should be made in this case. This is not the first, nor will it be the last time the Secretary’s “finality rationale” is challenged by a provider. The United States Court of Appeals for the District of Columbia has spoken on the issue of finality:

“The Secretary refers to this as the "finality" rationale, and we cannot conclude under our deferential standard of review that it is arbitrary and capricious. In addition to promoting efficiency, the Secretary’s emphasis on finality protects Medicare providers as well as the Secretary from unexpected shifts in basic reimbursement rates.” *Methodist Hospital of Sacramento v. Shalala* ***38 F.3d 1225 (D.C. Cir. 1994)***

The providers are simply arguing that there may be additional SSI days. They have not substantiated that errors exist within the Secretary’s SSI ratio, even though MEDPAR data has been available to the providers to reconcile their listings of SSI days they believe were omitted from their SSI percentages. The providers cannot claim that CMS will not provide data used to calculate their SSI percentages, where they failed to request such data, or failed to do anything with the data once they received it. Providers that have possessed MEDPAR data for years, cannot claim to have been denied access to the data. The regulation at 42 C.F.R. § 413.20 states that the provider must permit the intermediary to examine their records and documents as necessary to ascertain information pertinent to the determination of the proper amount of program payments due. The providers argue that the DSH Medicare fraction should be modified but has provided no documentation or support as to how it arrived at the modification. A provider claiming that additional SSI days should be included in its SSI percentage, at a minimum, should provide a listing of SSI days it believes should be used to calculate its SSI percentage. The providers have failed to identify SSI days they believe were omitted from their SSI percentages. For example, the Courts have confirmed that SSI payments are made to those entitled and affirmed the Secretary’s interpretation. Hospitals gather and retain enormous amounts of information about its patients. Income, bank accounts, and other financial evidence are part of the hospital’s patient account records. The hospitals would know whether patients were receiving SSI payments. Has the Group identified a single patient within any of the census reports from the hospitals that were receiving SSI payments that were not included within the MEDPAR data? No, it has not.

The Provider contends that CMS continues to use incorrect data matching methods to determine the SSI ratio. At the same time, the Provider acknowledges that CMS corrected the errors and flaws identified in the *Baystate* decision. The matching process was revised with the Ruling No. CMS-1498-R as stated “…in order to avoid, or at least minimize, the filing of new administrative appeals on the SSI fraction data matching process issue, CMS and the Medicare contractors will apply the same suitably revised data matching process in determining the SSI fraction, and calculating the DSH payment adjustment, for each "open" hospital cost reporting period where the contractor has not yet settled finally the provider’s Medicare cost report through the issuance of an initial notice of program reimbursement (NPR)…” see 42 C.F.R. § 405.1801(a), 405.1803. CMS and the Medicare contractors will also apply the provisions of this Ruling, on all three DSH issues, to each qualifying hospital cost reporting period where the contractor has not yet settled finally the provider’s Medicare cost report.

If additional SSI days exist, the group has failed to explain why, and more importantly, document that any specific days were not included in their SSI percentages. Again, years after the end of the cost reporting periods in question, the providers have failed to identify any listings of SSI days. There is no support that any effort was put forth on the part of the providers to identify what days if any should be included in their SSI percentages that were not already. Regardless of the reason the providers believe their SSI percentages may have been understated, they were required to submit a fully developed position paper including any arguments and documenting evidence necessary to support their position.[[11]](#footnote-11) Again, the providers failed to even supply a total listing of days they believe should be included in their respective SSI percentages. The providers have artfully attempted to shift the burden of proof away from themselves, even though they are the proponents of this action and owners of this appeal, and therefore, bear the burden of proving their case through adequate documentation. The providers cannot shift their burden of proof to the MAC or CMS, by claiming they do not have access to the data, when they do have access to MEDPAR data, and their own internal records. At the very least, each provider was required to submit the listing of days they believed belong in their SSI percentages and identifying within such listing those days they believe have been omitted. The Group mentions previous attempts to access SSI data but submitted no evidence the Providers within the instant case made any efforts previously, or more importantly, any efforts to obtain additional data related to the instant cost reports. Again, MEDPAR data is available to the Group. The Group possesses its own records, which would include patient account files, including State and Federal assistance information. Despite this, the Group fails to document any specific deficiencies in the SSI ratios and continues to make unsubstantiated and extraordinarily general claims. The Group actually focuses the data match issue on PSC codes that are clearly not indicative of SSI entitlement. The Group’s data match theory requires dismissal.

There are no unique facts in the instant case, as the Group has failed to substantiate any specific deficiencies, let alone provide concrete evidence of any such deficiency. CMS is not obligated to arrange to furnish necessary underlying SSI data. CMS releases MEDPAR data, yet not a single provider within the Group has shown where MEDPAR data supports its claims. The Group demands that the Board require release of specific SSA data. This same contention was considered by the Circuit Court in Advocate and dismissed.

Section 951 does not unambiguously compel release of this data. According to the hospitals, section 951 requires HHS to disclose what they describe as “input data” to help them re-do the entire determination of the Medicare and Medicaid fractions from start to finish. On the other hand, section 951 could simply mean that HHS must provide wholesale data that it uses for the actual computation. We are tempted to say that this ambiguity alone is enough to doom the claim, for mandamus is unavailable when the alleged duty depends on a statutory construction that is “not free from doubt.” *Power v. Barnhart*, 292 F.3d 781, 786 (D.C. Cir. 2002) (cleaned up). But there is a simpler ground of decision: What section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does *not* provide HHS with the specific codes assigned to individual patients. *See* 75 Fed. Reg. at 50,276.

Again, the instant Group has failed to offer a single piece of evidence related to any single patient day. As far as the MAC is aware, the providers within the Group are capable of reading their own records, knowing which patients were admitted to their hospitals and when. Patient files at the hospitals would show what insurance the patients had, if any. The patient files would also include information on employment, income, bank records, etc. Providers collect vast amounts of data on patients or have that information available to them through collection efforts for certain patients. The Group has failed to explain why the vast amounts of data they possess, coupled with MEDPAR data, does not allow them to put together a list of patients (and the related patient days) in total they believe can or should be included in their SSI ratios. The Group falls back into its failed and illogical theory that most PSC codes indicate SSI entitlement.

The MAC contends that CMS properly included all SSI days that have been sufficiently documented for purposes of calculating the providers’ Medicare fractions. The providers contend that entitlement to SSI benefits is analogous to entitlement to Medicare Part A. The MAC has previously pointed out that this is an “apples to oranges” comparison, as an individual becomes automatically entitled to Medicare Part A benefits by reaching age 65 and filing an application or becoming disabled and entitled to disability benefits before reaching retirement age.[[12]](#footnote-12) The United States Court of Appeals for the District of Columbia Circuit spoke to the question of entitlement to Part A benefits in *Hall vs. Sebelius* (Decided February 7, 2012, No. 1:08-cv-01715).[[13]](#footnote-13) In its opinion, the Court stated:

“Plaintiffs’ lawsuit faces an insurmountable problem: Citizens who receive Social Security benefits and are 65 or older are automatically entitled under federal law to Medicare Part A benefits. To be sure, no one has to take the Medicare Part A benefits. But the benefits are available if you want them. There is no statutory avenue for those who are 65 or older and receiving Social Security benefits to disclaim their legal entitlement to Medicare Part A benefits. For that reason, the District Court granted summary judgment for the Government.”

The Court’s opinion in *Hall* went on to point out that individuals may refuse to request Medicare payment for services they receive and instead pay for the services themselves or with other insurance.[[14]](#footnote-14) As the Court points out, “If you are 65 or older and sign up for Social Security, you are automatically entitled to Medicare Part A benefits. You can decline those benefits. But you still remain entitled to them under the statute.” Clearly, entitlement to part A benefits is not reliant upon payment for those services.

To the contrary, the eligibility for payment, and the payment of benefits are intrinsic to basic SSI entitlement.[[15]](#footnote-15) Statute requires the Commissioner of Social Security to pay SSI benefits to every individual who is determined to be eligible. There is no automatic entitlement to SSI. In fact, there are several requirements an individual must meet before achieving eligibility for SSI and receiving SSI benefits.[[16]](#footnote-16) Further, regulation requires redeterminations of SSI eligibility on a scheduled basis at periodic intervals.[[17]](#footnote-17) Where one is entitled to SSI benefits, payment is made; therefore, it is more than reasonable for CMS to conclude that an individual was not entitled to SSI where the individual was not paid SSI benefits.

The House and Senate agreed to define the low-income patients in both the Medicare Fraction, and the Medicaid Fraction. The agreement between the House and the Senate suggests that the SSI percentage should include the total number of inpatient days attributable to Federal Supplemental Security Income beneficiaries (FSSIBs), divided by the total number of Medicare patient days. The eventual statute defined the SSI percentage as:

the fraction (expressed as a percentage), the numerator of which is the number of such hospital’s patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital’s patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter[[18]](#footnote-18)

As previously noted, statute requires that all individuals eligible for SSI benefits must be paid those benefits by the Commissioner of Social Security. The Commissioner of Social Security provided many clues as to who is or is not eligible for SSI benefits, informing those individuals must meet all basic requirements listed in 20 CFR § 416.202.

For example, the Group argues that suspension from the SSI program, and the corresponding suspension of benefits, is in no way indicative of entitlement to SSI. As previously noted, statute dictates that basic entitlement requires eligibility for and payment of SSI benefits.[[19]](#footnote-19) Further, statute goes on to require that individuals meet several criteria to be eligible for payment of SSI benefits.[[20]](#footnote-20) The long-held contention of the provider community was that until an individual is terminated from the SSI program, all of his or her patient days must be counted in the Medicare Fraction. The providers’ contention related to suspension and termination must be rejected. The Social Security Administration Program Operations Manual System (POMS) identifies suspension and termination both as post eligibility (PE) events and found it important to note that the term eligible as it pertains to SSI, means that a recipient meets all basic SSI eligibility requirements.[[21]](#footnote-21) Like an individual who has terminated from the SSI program, an individual who has been suspended from the program is no longer eligible for SSI benefits. Whether a patient terminates from the SSI program, or is suspended from the SSI program, he or she is no longer eligible for or entitled to SSI benefits. Further, as noted in the August 16, 2010, Federal Register, the Social Security Administration (SSA) confirmed that individuals in a suspended status are not entitled to SSI benefits.[[22]](#footnote-22) Clearly, patients who are enrolled in the SSI Program, whose SSI eligibility and payments have been suspended or terminated, are not entitled to SSI benefits.

The Group goes on to insist (incorrectly) that CMS excluded many “SSI Eligible beneficiaries” because those beneficiaries did not receive payments under Title XVI. The Provider fails to acknowledge that Medicare Part A entitlement is not the same as SSI entitlement. In fact, Medicare and SSI are overseen by two separate agencies, each with its own rules, requirements, and entitlement criteria. The Group wishes to apply the Medicare entitlement criteria to SSI, which is illogical and improper. In most cases, Medicare entitlement is automatic and cannot be revoked. To the contrary, basic SSI entitlement is only obtained through meeting certain requirements and must be maintained by continuing to meet those requirements.

The Group failed to present any evidence whatsoever that any hospital within the Group has identified a single patient it believes was omitted from the SSI ratio. The phrase *the rubber must meet the road at some point*, is appropriate in this case. At some point, the Group must submit something to substantiate its theories. A general assertion, not specific to any provider or patient; that also requires the acceptance of several Group assumptions, is not evidence. It is the further avoidance by the Provider Community to substantiate its position with actual evidence. As alluded to earlier in this very paper, PRRB rule 23.3 requires fully developed position papers. The Group’s strategy of doing nothing requires dismissal. The MAC believes the providers’ failure to support its contention related to additional SSI days demonstrates that this issue has zero merit and should be dismissed.

Interestingly, the Group refers to PRRB Decision 2016-D17[[23]](#footnote-23) in which the Board determined among other things that,

*“because the unique set of facts of this case demonstrate that CMS has failed to “arrange to furnish” (i.e., make available) the necessary underlying Colorado Medicaid data needed for the HCA Hospitals to do required verification. Further, the Board finds that the HCA Hospitals have provided sufficient evidence to demonstrate that, using the best available data, they are entitled to the additional Medicaid eligible days at issue.”*

The Board’s decision goes on to cite many specific deficiencies that were substantiated by the Group with regard to the Colorado Medicaid verification process. Further, the Providers within the Group did extensive work in identifying specific days at issue and provided evidence where specific patient stays were eligible in one verification run but where later verification runs showed the same patient stays as ineligible. The Provider in PRRB Case # 2016-D17 did the work to support its allegations. Further, those allegations related to the Medicaid program. Here the Group has done nothing.

There are no unique facts in the instant case, as the Group has failed to substantiate any specific deficiencies. The cited HCA PRRB case related to Medicaid data where the Board noted that CMS has a statutory obligation to arrange to furnish necessary underlying Medicaid data so the providers could satisfy their regulatory obligation of verifying and substantiating Medicaid eligibility. CMS is not obligated to arrange to furnish necessary underlying SSI data. Despite the fact that CMS has no obligation to arrange to furnish SSI data, CMS releases MEDPAR data, yet not a single provider within the Group has shown where MEDPAR data supports its claims. The total lack of effort put forth by the instant Group plagues the Group’s citation of *Pomona Valley Hospital v. Azar*. In *Pomona*, the provider presented evidence related to its own patient days. Whether or not the evidence presented by the provider in *Pomona* was reliable was not decided by the Court, rather, the Court remanded the case back to the PRRB.

The Board reviewed an individual case on this very issue, in which the Board dismissed the issue from the appeal because the hospital failed to develop its case. In its dismissal letter, the Board noted that the Provider’s final position paper was perfunctory and failed to sufficiently set forth the merits of its claim, explain why the agency’s SSI calculation was wrong, and provide documents and analysis to support its position. The Board distinguished the Provider in the individual appeal from those in the *Baystate* case, where according to the Board, “the DSH SSI Data Match issue in this case stands in stark contrast to the significant argument, analysis and evidence that was presented in the *Baystate* case.”[[24]](#footnote-24) In those respects, this case does not differ. Not a single participant within this Group submitted evidence to support why the Secretary’s SSI calculation is wrong. The Group wishes to make generic allegations, with no references, examples, or supporting evidence; and therefore, deserves the same disposition as the hospital in PRRB case number 17-1920. For this Group, the rubber never met the road.

**C. Conclusion**

In view of the foregoing, the MAC asks that the Board dismiss the case as the providers have failed to identify any additional SSI days. Further, most of the argument put forth by the Group has been foreclosed by Supreme Court precedent Accordingly, the burden of proof, which was upon the providers, has not been met. Therefore, the Board must find that the MAC’s determination was not arbitrary or capricious and did in fact properly adhere to Medicare Law, Regulations & Program Instructions. Thus, the Board should refuse to disturb CMS’s calculations of the Providers’ Medicare fraction for the cost year at issue.

IV. LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

Law: Social Security Act

Sections 1611(c), 1815, 1833, 1861(v)(1)(A), 1886(d)(5)(F)

42 U.S.C. Sections 402, 1381a, 1382, 1395ww(d)(5)

Regulations: 20 C.F.R., Part 416, Subpart B

Sections 202 and 204

42 C.F.R., Part 405, Subpart R

Sections 405.1801-1803, 405.1867, 405.1885-1889

42 C.F.R., Part 412, Subpart G

Section 412.106

42 C.F.R., Part 412, Subpart M

Section 412.320

42 C.F.R., Part 413, Subpart B

Sections 413.20, 413.24

Program Provider Reimbursement Manual, CMS Pub. 15-1

Instructions: Section 2304

Medicare Claims Processing Manual Chapter 1, § 50.1.5

HCFA Rulings & Program Memorandums

HCFAR 97-2, Transmittal Nos. A-99-62 & A-01-13

Other Sources: Federal Register Vol. 60, No. 170, Friday, Sept. 1, 1995

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Federal Register Vol. 75, No. 157, Monday, Aug. 16, 2010

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SSA POMS SI 02301.201

V. EXHIBITS

C-1. PRRB Decision in PRRB Case # 17-1920

C-2. *Advocate Christ Medical Center, et al. v. Becerra*, No. 1:17-cv-1519 (DC Cir. 2023).

1. (I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital’s patient days for such period which were made up of patients who (for such days) were entitled to benefits under Part A of this title and were entitled to supplementary security income benefits (excluding any State supplementation) under Title XVI of the Act, and the denominator of which is the number of such hospital’s patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under Part A of this title… [↑](#footnote-ref-1)
2. See H.R. Conf. Rep. No. 99-453 at 459 (“proxy measure for low-income”); S. Rep. No. 99-146 at 291, reprinted in 1986 U.S.C.C.A.N. at 258 (“proxy measure for low-income Medicare patients”); H.R. Rep. No. 99-241 at 18, reprinted in 1986 U.S.C.C.A.N. 579 (“proxy measure of low-income status”). [↑](#footnote-ref-2)
3. Provider position paper at 1. [↑](#footnote-ref-3)
4. 75 Fed. Reg. 50,041, 50,280 (Aug. 16, 2010). [↑](#footnote-ref-4)
5. *BECERRA, SECRETARY OF HEALTH AND HUMAN SERVICES v. EMPIRE HEALTH FOUNDATION, FOR VALLEY HOSPITAL MEDICAL CENTER*, 20-1312 [↑](#footnote-ref-5)
6. *Advocate Christ Med. Ctr. v. Azar*, Civil Action 17-cv-1519 (TSC) (D.D.C. Jun. 8, 2022) [↑](#footnote-ref-6)
7. *Advocate Christ Medical Center, et al. v. Becerra*, No. 1:17-cv-1519 (DC Cir. 2023). See C-2. [↑](#footnote-ref-7)
8. Medicare QASP review including claim appeals, audit and reimbursement, beneficiary customer service, claims processing, financial management, debt management, FOIA, medical review, MSP, provider customer service, and provider enrollment. [↑](#footnote-ref-8)
9. CMS’s policy on the data that it uses for calculations based on the federal fiscal year is consistent with the data that it uses for recalculations, because, for purposes of recalculations based on the provider’s cost reporting period, CMS uses the latest update of MEDPAR existing at the time it performs the recalculation. CMS’s policy is consistent because in both situations (calculations based on the federal fiscal year and recalculations based on the provider’s cost reporting period), the latest data available at the time are used. Further, as noted below, in neither situation will CMS perform an additional calculation or recalculation based on data that is updated subsequent to the calculation or recalculation. [↑](#footnote-ref-9)
10. In the final rule implementing the DSH adjustment, CMS explained that its preferred method was to calculate Medicare fractions based on the FFY, rather than on the hospital’s cost reporting period. It stated:

    We do not believe that there are likely to be significant fluctuations from one year to the next in the percentage of patients served by the hospital who are dually entitled to Medicare Part A and SSI. Consequently, the percentage for a hospital’s own experience during the Federal fiscal year should be reasonably close to the percentage specific to the hospital’s cost reporting period. [↑](#footnote-ref-10)
11. PRRB Rule 23.3 [↑](#footnote-ref-11)
12. 42 U.S.C. § 402 [↑](#footnote-ref-12)
13. The plaintiffs (including Hall) wished to disclaim their legal entitlement to Medicare Part A benefits, because the plaintiffs preferred to receive coverage from their private insurers rather than from the government. [↑](#footnote-ref-13)
14. See Medicare Claims Processing Manual Chapter 1, § 50.1.5 [↑](#footnote-ref-14)
15. See 42 U.S. Code § 1381a [↑](#footnote-ref-15)
16. See 20 CFR § 416.202 [↑](#footnote-ref-16)
17. See 20 CFR § 416.204 [↑](#footnote-ref-17)
18. See 42 U.S.C. § 1395ww(d)(5)(F)(vi) [↑](#footnote-ref-18)
19. *Id.*at 42 U.S.C. § 1381a [↑](#footnote-ref-19)
20. 42 U.S.C. § 1382 [↑](#footnote-ref-20)
21. See SSA POMS SI 02301.201 [↑](#footnote-ref-21)
22. FR Vol. 75, No. 157, Monday August 16, 2010, at page 50281. [↑](#footnote-ref-22)
23. *HCA DSH-Colorado State Database Group v. Novitas*, PRRB Decision 2016-D17 (September 12, 2016). [↑](#footnote-ref-23)
24. See PRRB Jurisdictional Decision in Case # 17-1920 attached as Exhibit C-1 [↑](#footnote-ref-24)