Whether the Centers for Medicare and Medicaid Services (“CMS”) properly calculated the Provider’s Disproportionate Share Hospital (“DSH”)/ Supplemental Security Income (“SSI”) percentage.

1. **Facts**

Section 1886(d)(5)(F) of the Medicare Act provides for a DSH payment to hospitals that serve a significantly disproportionate number of low-income patients (42 U.S.C. §1395ww(d)(5)(F) (**Exhibit C-2**). A hospital typically qualifies for a DSH payment adjustment through a complex statutory formula under which the DSH payment adjustment is based on the hospital’s geographic designation, the number of beds in the hospital, and the level of the hospital’s disproportionate patient percentage (“DPP”). A hospital’s DPP is the sum of two fractions: the “Supplemental Security Income (“SSI”) fraction” and the “Medicaid fraction.” The SSI fraction (also known as the “SSI ratio” or the “Medicare fraction”) is computed by dividing the number of the hospital’s inpatient days that are furnished to patients who were entitled to both Medicare Part A (including patients who are enrolled in a Medicare Advantage (Part C) plan) and SSI benefits by the hospital’s total number of patients entitled to benefits under Medicare Part A (including patients who are enrolled in a Medicare Advantage (Part C) plan). The Medicaid fraction is computed by dividing the hospital’s number of inpatient days furnished to patients who, for such days, were eligible for Medicaid, but were not entitled to benefits under Medicare Part A, by the hospital’s total number of inpatient days in the same period. (42 C.F.R.§412.106(b)) (**Exhibit C-3**).

In the August 12, 2005 Federal Register (70 FR 47438-47441) (**Exhibit C-4**), the Centers for Medicare and Medicaid Services (CMS) explained how the Medicare fraction would be calculated and the matching process used to arrive at the SSI ratio. The Provider community believed there were errors in the matching process. In *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008), *as amended* *by* 587 F. Supp. 2d 37 (D.D.C. 2008), the District Court for the District of Columbia found that, in certain aspects, CMS’s current matching process did not use the “best available data.” Based on the decision in *Baystate,* CMS revised its process for matching Medicare and SSI eligibility data. The Secretary published the revised process in the August 16, 2010 Federal Register (75 FR 50275-50286) (**Exhibit C-5**).

This appeal stems from CMS Ruling 1498-R (See **Exhibit C-6**) issued on April 28, 2010 in response to the Baystate decision, which relates to this matching process. The August 16, 2010 Federal Register explained that CMS Ruling 1498-R provides that, for qualifying appeals of the data matching issue and for cost report not yet final settled by an initial Notice of Program Reimbursement (NPR), CMS will apply any new data matching process that is adopted in the forthcoming FY 2011 IPPS final rule for each appeal that is subject to the Ruling. CMS specified that [t]he data matching process provisions of the Ruling would apply to properly pending appeals and open cost report for cost reporting periods beginning prior to October 1, 2010 (that is, those preceding the effective date of the FY 2011 IPPS final rule). *Id*. The Ruling further states that if a new data matching process was not adopted in the FY 2011 IPPS final rule, CMS would apply the same data matching process as the agency used to implement the *Baystate* decision to claims subject to the Ruling by recalculating that Provider’s SSI fractions. *Id.* CMS adopted the proposed data matching process for FY 2011 as final (75 FR 50275-50286) (**Exhibit C-5**). The cost reporting periods for the Group are subject to the provisions of 1498-R.

In the Group issue statement, the Providers contend that the SSI percentages calculated by the CMS and used by the MAC to settle their cost reports do not address all the deficiencies identified in the Baystate decision and that CMS adopted a new methodology inconsistent with the Medicare statute. The Group believes the MAC failed to calculate its DSH SSI percentage based on the following reasons:

1. Availability of MedPAR and SSA Records,[[1]](#footnote-1)
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.

The Group issue statement further contends:

[T]hat errors and problems still exist in the data match process, as well as improper policy changes by CMS, which are resulting in understated DSH adjustments for Providers, including the failure to include all Dual Eligible (Medicare/Medicaid) patient days in the Medicare fraction numerator as intended by Congress or alternatively in the Medicaid fraction numerator. CMS asserts in Ruling 1498-R that such Dually Eligible/Crossover days, including such days that are Medicare Non-Covered days, are being included in the Medicare proxy for discharges occurring on or after October 1, 2004. Providers assert that all such days are not properly being captured in the Medicare proxy of the calculation.

In its preliminary position paper, the Group states the issue as follows:

Whether Medicare DSH reimbursement calculations for the Providers were understated due to the failure of CMS and the MAC to include in the numerator of the Medicare Fraction of the Medicare DSH percentage all of the Providers’ patients entitled to SSI, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi)?

1. **Arguments**

1. **The Providers’ SSI Ratio has been properly determined in accordance with the revised data matching process.**

Based on the decision in *Baystate*, CMS developed a revised data matching process for matching Medicare and SSI eligibility data that comports with the court’s decision. The Secretary published the revised process in the August 16, 2010 Federal Register. See 75 FR 50275-50286 (**Exhibit C-5**). CMS adopted that revised data matching process for FY 2011 and beyond. In accordance with CMS Ruling 1498-R (included as **Exhibit C-6**), the revised data matching process applied to all open cost reports for cost reporting periods beginning prior to October 1, 2010 as is the cost reporting period included in this appeal. This was explained in the August 16, 2010 Federal Register. See 75 FR 50284-50285 (**Exhibit C-5**):

On April 28, 2010, the CMS Administrator issued a CMS Ruling,

CMS–1498–R (Ruling), that addresses three Medicare DSH issues, including CMS’ process for matching Medicare and SSI eligibility data and calculating hospitals’ SSI fractions. With respect to the data matching process issue, the Ruling requires the Medicare administrative appeals tribunal (that is, the Administrator of CMS, the PRRB, the fiscal intermediary hearing officer, or the CMS reviewing official) to remand each qualifying appeal to the appropriate Medicare contractor. The Ruling also explains how, on remand, CMS and the contractor will recalculate the provider’s DSH payment adjustment and make any payment deemed owing. The Ruling further provides that CMS and the Medicare contractors will apply the provisions of the Ruling on the data matching process issue (and two other DSH issues, as applicable), in calculating the DSH payment adjustment for each hospital cost reporting period where the contractor has not yet final settled the provider’s Medicare cost report through the issuance of an initial notice of program reimbursement (NPR) (42 CFR 405.1801(a) and 405.1803).

More specifically, the Ruling provides that, for qualifying appeals of the data matching issue and for cost reports not yet final settled by an initial NPR, CMS will apply any new data matching process that is adopted in the forthcoming FY 2011 IPPS final rule for each appeal that is subject to the Ruling. The data matching process provisions of the Ruling would apply to properly pending appeals and open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is, those preceding the effective date of the FY 2011 IPPS final rule).

CMS applied this revised data matching process in the determination of the Providers’ SSI Ratios that are in contention in this case. The Providers’ SSI Ratios have been properly determined in accordance with CMS Ruling 1498-R, the revised data matching process adopted in the August 16, 2010 Federal Register, and in accordance with 42 C.F.R §412.106.

1. **CMS Properly Included All SSI Days in the SSI%**

In its preliminary position paper (page 7-8), the Group states:

[W]hile there are greater than 100 SSI payment status codes, CMS has chosen to use only three codes (CO1, M01 and M02) to identify persons entitled to SSI…The Providers challenge that CMS includes only three SSI codes (i.e., C01, M01, and M02) to define entitlement to SSI benefits for purposes of the Medicare Fraction for the Medicare DSH calculation. The Providers contend that the statute, 42 U.S.C. § 1382h(b), continues non-cash benefits (i.e., Medicaid benefits), and that SSA policy allowing the resumption of SSI cash payments without reapplying evidences a beneficiary’s continued entitlement to SSI benefits. In addition, the Providers assert that certain additional SSI codes illustrate continued SSI eligibility even when the individual’s SSI payments are suspended or placed in a stop payment status and that these individuals continue to be “entitled to” SSI benefits…the Providers respectfully submit that these additional SSI codes should be included in the data matching process used to determine the SSI ratio for the Medicare DSH calculation.

The MACs contend that CMS properly included all SSI days that have been sufficiently documented for purposes of calculating the Providers' Medicare fractions. The Providers' primary argument is that the term "entitled to SSI benefits" must be construed to include all patients who enrolled in the SSI program and were not terminated from the SSI program, even if the patients were not eligible for benefits while they were enrolled in the SSI program. What creates the controversy is that in applying the Medicare fraction, CMS does look at “entitled to Medicare Part A” and “entitled to SSI” differently. The Providers focus on patient days that were excluded because these days have been matched with SSA codes indicating that the patients had not demonstrated that they were eligible for SSI benefits on the days for which care was provided. In the August 16, 2010 Federal Register at **Exhibit C-5**, CMS explained how it interprets “entitled to SSI benefits” and why it had excluded these days in responses to comments raising complaints similar to those made by the Providers 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. 75 Fed. Reg. 50280 (August 16, 2010) (**Exhibit C-5**).

Later in CMS’ response, it addressed each code submitted in the comment and explained why these codes did not establish that the patients were entitled to SSI benefits. *Id*., at 50281. Per the SSA, codes that begin with the letter “T” represent patients whose SSI entitlement has terminated. Codes that begin with “S” represent records that are in a “suspended” status and do not represent individuals who are entitled to SSI benefits during the month. Code “P01” is obsolete and has not been used since the mid-1980’s. Codes that begin with “N” represent records on “nonpayment” and are not used for individuals who are SSI entitled. (**Note**: With one exception, recipients cannot get State benefits based on SSI, including Medicaid, when their record is in a suspension, stop payment or termination status code. The exception is code “N01” for Section 1619(b) eligibles. Reference **Exhibit C-8**.) Code “E01” represents an individual who is a resident of a medical treatment facility (MTF) and is subject to a $30 payment limit but has countable income of $30 or more and is not entitled to receive SSI payment. (See also 20 CFR §§ 416.211 - 416.212.) Those patients that are a resident of an MTF and subject to the $30 payment limit, but do not have countable income of at least $30 would be reflected in the SSI file as “C01” and included in the SSI% calculation. Finally, Code “E02” represents a person who is not entitled to SSI payments pursuant to section 1611(c)(7) of the Act, which provides that an application for SSI benefits shall be effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date the individual becomes eligible for SSI based on that application. Contrary to the Providers’ argument, such an individual is not entitled to SSI during the month that his application is filed, but the following month, regardless of the fact that he may be aged, blind, disabled and low income during the application month. This determination is made by the SSA in accordance with its regulations, not CMS. Therefore, it is proper to not include these codes / days in the calculation of the SSI%, as these patients were not SSI entitled during that given month.

In summary, CMS’ interpretation of “entitled to SSI” is that a single measure is used to determine who is in the numerator of the Medicare proxy. The reasons why someone is not paid benefits, yet not completely eliminated from the SSI roles, vary widely. A disabled qualifier who goes back to work no longer meets the income standard. A person who becomes a Medical Facility Beneficiary (MFB) now has support for the expenses of daily living and is in a better position to have health needs met on a daily basis. At the far end of the non-payment spectrum might be a person who has their SSI payment directed to satisfy a different debt. Rather than parse through and make a separate judgment on the innumerable reasons why benefits are not paid, CMS’ decision to use the payment standard has a rational basis and passes the Chevron Two test.

1. **The Burden of Proof Remains on the Provider**

The Providers complain that CMS's determination is improper because certain codes merely indicate that patients did not receive payments, even though they may, nevertheless, have been entitled to SSI benefits under the Providers' theory that patients were entitled to benefits merely because they enrolled in the SSI program, even in months where they neither received benefits nor were even eligible to receive benefits, simply because they had not yet been officially terminated from the SSI program. The Providers, however, are improperly attempting to shift the burden of proof to CMS to prove that these patients were not entitled to SSI benefits. In fact, the burden is on the Providers to demonstrate that these patients were entitled to SSI benefits. In order to establish a right to relief, it is not enough for the Providers merely to identify a possible reason why a patient might still have been entitled to SSI benefits notwithstanding a code indicating that this patient did not receive benefits.

It is reasonable for CMS to conclude — until presented with evidence to the contrary — that patients who did not receive SSI benefits were not eligible to receive SSI benefits and thus were not entitled to receive benefits, either. The Providers claim that entitlement to SSI benefits is analogous to entitlement to Medicare Part A entitlement under the statute. In fact, this is an "apples to oranges" comparison. A person becomes automatically entitled to Medicare Part A benefits merely by reaching age 65 and filing an application or becoming disabled and entitled to disability benefits before reaching retirement age. See 42 U.S.C. §402. Subsequent changes in circumstances typically cannot nullify this entitlement.

By comparison, eligibility and entitlement to SSI benefits are much less straightforward and much less static. Initially, there are multiple SSI eligibility requirements: a person must be (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits. Reference 20 C.F.R. §416.202 at **Exhibit C-9**.

In contrast to the generally, immutable and generally age-based eligibility requirements that makes most beneficiaries permanently entitled to Medicare Part A benefits once they become entitled to receive them initially, many of the conditions that make a person eligible for and entitled to SSI benefits are subject to change in a way that makes an eligible person become ineligible and not entitled to SSI benefits at a later date. The Regulations explicitly provide for redeterminations of SSI at periodic intervals to ensure continued eligibility. Reference 20 C.F.R. § 416.204 (**Exhibit C-9**). They explicitly note that SSI eligibility may be lost if a person no longer meets the basic requirements or because of one of the reasons set forth in Sections 416.207 - 416.216 (**Exhibit C-9**). Thus, a person who was eligible, but obtains more income or resources than is permitted, flees from prosecution or violates parole would no longer meet the basic requirements. See 20 C.F.R. § 416.202 (**Exhibit C-9**). People who were entitled to SSI benefits at one time, but subsequently do not give the SSA permission to contact financial institutions (20 C.F.R. § 416.207), do not apply for other benefits (20 C.F.R. § 416.210), become a resident of a public institution (such as prison or a medical treatment facility) (20 C.F.R. § 416.211), do not abide by treatment for drug addictions or alcoholism (20 C.F.R. § 416.214) or merely leave the United States for more than 30 days (20 C.F.R. § 416.215), would all lose their eligibility for, and thus entitlement to SSI benefits. There are virtually no similar events that would cause people who were initially eligible for Medicare Part A to no longer be eligible for Medicare Part A. Accordingly, it is necessary to show that patients were actually entitled to SSI benefits before including their days of care in the Medicare fraction, rather than simply including these days because patients were potentially entitled to SSI benefits, as the Providers seek to do. CMS also recognized this distinction when it discussed SSI eligibility in the August 16, 2010 Federal Register:

[U]nlike the SSI program (in which entitlement to receive SSI benefits is based on income and resources and, therefore, can vary from time to time), once a person becomes entitled to Medicare Part A, the individual does not lose such entitlement simply because there was no Medicare Part A coverage of a specific inpatient stay. Entitlement to Medicare Part A reflects an individual’s entitlement to Medicare Part A benefits, not the hospital’s entitlement or right to receive payment for services provided to such individual. Such Medicare entitlement does not cease to exist simply because Medicare payment for an individual inpatient hospital claim is not made.

Id., 75 Fed. Reg. at 50280-50281 (**Exhibit C-5**).

Because SSI entitlement is impermanent, difficult to establish and easy to lose, the Providers' complaint that CMS and the MACs excluded patient days based on codes that do not "prove" entitlement is unwarranted.

There are a variety of reasons why a person might lose entitlement to SSI benefits, and it is reasonable for CMS to conclude, for instance, that once a person's SSI benefits are suspended or the person no longer has an address on file[[2]](#footnote-2), this person may no longer be entitled to SSI benefits and may properly be excluded from the Medicare fraction, barring evidence to the contrary.

The Providers have failed to produce such evidence to the contrary. The Providers simply contend SSI unpaid days that were not included in the Medicare fraction. The Providers have failed to provide any evidence or explanation establishing that these days were for patients who were actually entitled to SSI benefits, but who were not included in the Medicare fraction. The documentation in the record does not satisfy the auditable documentation requirements of 42 C.F.R. §§ 413.20 and 413.24 necessary to award the Providers any relief.

The MAC inquired of CMS whether the Providers in this appeal availed itself of the opportunity to receive its MedPAR LDS data. Based on the CMS reports, it appears the Providers have requested the data related to their Provider numbers and cost reporting periods in disagreement. (See **Exhibit C-7**.)

According to the Group’s preliminary position paper, “based on records that the

Providers have obtained from the Social Security Administration, the Providers have determined that patient days entitled to SSI were excluded from the numerator of the DSH Medicare Fraction.” Without the Providers’ analysis of the SSI data it is impossible to determine if its claim that the SSI ratios are flawed is valid.

1. **The Board is Bound by 42 CFR §405.1867**

Per the Group’s preliminary position paper:

The Providers seek an order that CMS include all SSI codes, whether payment was or was not made during the month of hospitalization, in the computation of the numerator of the DSH Medicare Fraction.

On April 28, 2010, CMS published Ruling 1498-R (See **Exhibit C-6**) to respond to a court order in *Baystate v. Leavitt,* 545 F. Supp. 2d 20 as amended 587 F. Supp. 2d 37, 44 (D.D.C. 2008). In *Baystate*, the plaintiff alleged that the Secretary’s process to identify and gather the data necessary to calculate each hospital’s SSI ratio was deficient.

The Ruling stated that CMS had implemented the court order by recalculating the plaintiff’s SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used “updated and refined SSI eligibility data and Medicare records, and by matching individuals’ records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers.” The Ruling also stated that “in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process” for use with all hospitals and that “[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process.” Finally, CMS stated that it would “use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling.”

Even though not effective for the FYE included in this appeal, consistent with the Ruling 1498-R, CMS finalized the new data matching process in the FY 2011 final rule published on August 16, 2010. 75 FR 50280-50281 (**Exhibit C-5**). In the preamble to the FY 2011 Final Rule, CMS acknowledged a public comment related to the issue in dispute in this case regarding the SSA codes used to identify SSI patients in the numerator of the SSI percent. CMS stated that SSI codes C01, M01 and M02 “accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits.” CMS explicitly rejected the inclusion of other SSA codes because “SSI entitlement can change from time to time” and none of the other codes “would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used.”

In accordance with 42 CFR § 405.1867 (**Exhibit C-10**),

[T]he Board must comply with all provisions of Title XVIII of the Act and regulations issued thereunder as well as CMS Rulings. … The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.

Based on 42 CFR § 405.1867, the Board must comply with CMS Ruling 1498-R and as a result, the Board does not have the authority to revise the data matching process established in the FY 2011 Final Rule, including what SSI codes the Agency will and will not use in calculating the SSI fraction to be applied to all hospitals. Reference the Board’s decisions in *Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction*, 2017-D11 and *Hall Render Individual, Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction*, 2017-D12 dated March 28, 2017.

1. ***Becerra v. Empire Health***

On June 24, 2022, the U.S. Supreme Court issued an opinion in *Becerra, Secretary of Health and Human Service v. Empire Health Foundation, For Valley Hospital Medical Center,* 597 U. S. \_\_\_\_ (2022) (**Exhibit C-11**), which reversed and remanded the decision of the 9th Circuit U.S. Court of Appeals. Per the Court’s opinion (emphasis added):

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 disabled. That remains so even when Medicare is not pay­ing for part or all of his hospital stay—for example, because a private insurer is legally responsible or because he has used up his allotted coverage. Today, we approve HHS’s understanding of the Medicare fraction.

Furthermore:

HHS’s regulation correctly construes the statutory lan­guage at issue. … The text and context support the agency’s reading: HHS has interpreted the words in those provisions to mean just what they mean throughout the Medicare statute. And so too the structure of the DSH provisions supports HHS: 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. (**Exhibit C-11**)

The Group refers to this decision in their preliminary position paper [and in a supplemental paper filed in OH CDMS on September 26, 2023] to support their claim that all patient days for patients with SSI codes, regardless of the code, should be included in the Medicare fraction of the DSH calculation. CMS has clearly addressed in the FY 2011 Final Rule what SSI codes the Agency will and will not use in calculating the SSI fraction to be applied to all hospitals. The decision in fact speaks to Medicare Part A eligibility and cannot reasonably be interpreted to extend beyond the program being debated.

1. **Conclusion**

The Providers’ SSI Ratios have been properly determined in accordance with CMS Ruling 1498-R, the revised data matching process adopted in the August 16, 2010 Federal Register, and in accordance with 42 C.F.R §412.106. The MACs contend that CMS properly included all SSI days that have been sufficiently documented for purposes of calculating the Providers' Medicare fractions. The Providers have failed to show that its current SSI percentage is inaccurate.

Finally, the Board does not have the authority to revise the data matching process established in the FY 2011 Final Rule, including what SSI codes the Agency will and will not use in calculating the SSI fraction to be applied to all hospitals. The MAC’s adjustments are consistent with the regulations discussed above. The MAC requests that the Board affirm the SSI percentage included in the current Medicare cost report and dismiss this appeal.

LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

SSA:

**Title XVIII of Social Security Act;**SSA §1886 (d)(5)(F)

**United States Statues:**

42 U.S.C. §402;42 U.S.C. §1395ww(d)(5)(F)

**Code of Federal Regulations:**

20 C.F.R. §416.200-416.216;42 C.F.R. §405.1801(a);42 C.F.R. §405.1803;42 C.F.R. §405.1867;42 C.F.R. §412.106;42 C.F.R. §413.20;42 C.F.R. §413.24

**Federal Register:**

70 FR 47438-47441 (August 12, 2005);75 FR 50275-50286 (August 16, 2010)

**Case Law:**

*Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008), *as amended* *by* 587 F. Supp. 2d 37 (D.D.C. 2008);*Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction*, 2017-D11, March 28, 2017;*Hall Render Individual, Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction*, 2017-D12, March 28, 2017;*Becerra, Secretary of Health and Human Service v. Empire Health Foundation. For Valley Hospital Medical Center,* 597 U. S. \_\_\_\_(2022)

**Agency Instructions:**

CMS Ruling 1498-R (April 28, 2010)

**V. EXHIBITS**

C-1 Schedule of Providers

C-2 42 U.S.C. § 1395ww(d)(5)(F)

C-3 42 CFR §412.106

C-4 70 FR 47438-47441 (August 12, 2005)

C-5 75 FR 50275-50286 (August 16, 2010)

C-6 CMS Ruling 1498-R (April 28, 2010)

C-7 MedPAR Reports

C-8 SSI PSC Codes

C-9 20 CFR 416.200-416.216

C-10 42 CFR 405.1867

C-11 *Becerra, Secretary of Health and Human Service v. Empire Health Foundation, For Valley Hospital Medical Center*

1. See **Exhibit C-7**. [↑](#footnote-ref-1)
2. Examples of why a person may no longer have an address: death, left the country, admitted to a medical treatment facility or incarcerated. All of these examples would terminate SSI entitlement. [↑](#footnote-ref-2)