**A. Facts**

Pursuant to the audit adjustment numbers noted on the Schedule of Providers (Exhibit C-1), the MAC adjusted the Providers’ SSI Ratios and protested amounts. The Providers included the estimated reimbursement effect for including the Medicare/Medicaid dual eligible Part A unpaid days in the calculation of the SSI Ratios in their filed Protested Amounts on their cost reports.

This issue is whether the Medicare (SSI) fraction of the Providers’ disproportionate share hospital (“DSH”) adjustment should include inpatient days where the patient was eligible for Medicaid and Medicare was the secondary payer or where Medicare benefits were exhausted.

Acute care 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 those 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.” *See* 42 U.S.C. § 1395ww(d)(5)(F)(v).

A hospital’s disproportionate patient percentage (“DPP”) is the sum of two fractions expressed as a percentage. The two fractions are referred to as the Medicare Low-Income Proxy (“Medicare fraction”) and the Medicaid Low-Income Proxy (“Medicaid fraction”). 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 (including Medicare Advantage (Part C)) benefits and Supplemental Security Income (“SSI”) by the number of days of care that are furnished to patients who were entitled to Medicare Part A (including Medicare Advantage (Part C)) (42 C.F.R. § 412.106(b)(2)) (Exhibit C-2). 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 (42 C.F.R. § 412.106(b)(4)) (Exhibit C-2). 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).

This appeal concerns a dispute involving dual eligible days. The term dual-eligible refers to patients who are eligible to receive benefits under both Medicare Part A and a state Medicaid program, generally the elderly poor. *See* *Allina Health System v. Sebelius*, CA No. 09-cv-1889, 2013 (D.D.C. Oct. 8, 2013) (Exhibit C-3) (citing *McCreary v. Offner*, 172 F.3d 76, 78 (D.C. Cir. 1999)). Dual-eligible exhausted days are patient days for individuals who are eligible for both Medicare and Medicaid, but who have exhausted their Medicare benefits for the days at issue. *Allina*, 2013 (citing *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914, 917 (D.C. Cir. 2013)). Medicare secondary payer (“MSP”) days are patient days for Medicare beneficiaries for which a party other than Medicare – such as an employer-sponsored health plan – has paid for patient services in full, and for which Medicare makes no payment by statute. *Allina*, 2013; 42 U.S.C. § 1395y(b)(2).

There are no material facts in dispute. The parties agree that the SSI or Medicare fraction used by the MAC included inpatient days where the patient was eligible for Medicaid and Medicare was the secondary payer (“dual eligible MSP days”) and where Medicare benefits were exhausted (“dual eligible exhausted days”).

The Providers contend that the Medicare (SSI) fraction of the Providers’ DSH adjustment should not include dual eligible MSP days and dual eligible exhausted days. The MAC contends that these days should be included in the Medicare (SSI) fraction, as these patients are entitled to Medicare Part A benefits. Conversely, these days are excluded from the Medicaid fraction.

**B. Argument**

**1. The Providers’ SSI Ratios have been properly determined as they relate to Exhausted Benefits (EB) and Medicare Secondary Payor (MSP) days.**

A recent Judicial Decision bears on the controversy, *Becerra v. Empire Health Foundation, for Valley Hospital Medical Center*, No. 20-1312, (U.S. Supreme Court, June 24, 2022). The controversy will first be analyzed without regard to this Decision, then its impact will be evaluated.

The issue raised by the Providers was specifically addressed by the Court of Appeals for the District of Columbia in *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914, 917 (D.C. Cir. 2013) (Exhibit C-4) and by the District Court of the District of Columbia in *Allina Health System v. Sebelius*, CA No. 09-cv-1889 (D.D.C. Oct. 8, 2013) (Exhibit C-3). In *Catholic Health Initiatives*, the provider contended that dual eligible exhausted days must be included in the Medicaid fraction of the DSH adjustment because the phrase “entitled to benefits under part A of Medicare” meant the right to have payments made on the patient’s behalf – so for days where a patient had exhausted his right to payment, he was not “entitled to benefits,” and such days should be counted in the Medicaid fraction. *Id.*, 718 F.3d at 920. The Secretary contended, however, that the word “entitled” in the Medicare statute “is not in reference to the right of payment of a benefit, but rather the legal status of the individual as a Medicare beneficiary under the law.” *Id.*, at 919. Thus, entitlement to benefits under Part A is determined by 42 U.S.C. § 426(a), which states that “[e]very individual who…has attained age 65, and … is entitled to monthly [Social Security benefits] … shall be entitled to hospital insurance benefits under Part A of [Medicare].”

The Court held that the Secretary’s interpretation that entitlement to Medicare benefits was simply a matter of meeting the statutory criteria, not a matter of receiving payment, was reasonable and entitled to deference under *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-3 (1984). See *Catholic Health Initiatives,* 718 F.3d at 920 (Exhibit C-4). In fact, the Court noted that this interpretation was actually a better interpretation than that advanced by the providers in that case and by the Provider here. *Id.* Therefore, both patients who have exhausted their Medicare Part A benefits, or for whom Medicare is the secondary payer were, nevertheless, entitled to benefits to Medicare Part A, having met the statutory criteria for eligibility. For this reason, days of care furnished to those patients must be excluded from the Medicaid fraction.

The decision by the Court of Appeals in *Catholic Health Initiatives* was followed and endorsed by the District Court of the District of Columbia in *Allina Health System v. Sebelius*, CA No. 09-cv-1889 (D.D.C. Oct. 8, 2013) (Exhibit C-3). In *Allina*, the fiscal intermediary excluded dual eligible MSP days and dual eligible exhausted days from the Medicaid fraction when it calculated the provider’s DSH adjustment. The Board reversed that determination. *See* *Allina Health System 1995-2003 DSH Dual Eligible Day Group v. BCBSA/Noridian Admin. Serv’s*, PRRB Dec. No. 2009-D35 (July 30, 2009) (Exhibit C-5). The Administrator subsequently reversed the Board’s decision. *See Allina Health System 1995-2003 DSH Dual Eligible Day Group v. BCBSA/Noridian Admin. Serv’s*, Adm. Review of PRRB Dec. No. 2009-D35 (September 21, 2009) (Exhibit C-6). On appeal, the District Court granted the Secretary’s Motion for Summary Judgment, finding in favor of the Secretary.

The District Court first held that the Secretary’s interpretation of the statute did not violate the plain language of the Medicare statute, finding that the Court of Appeals’ decision in *Catholic Health Initiatives* controlled the result.

The Court also rejected *Allina’s* argument that dual eligible MSP days and dual eligible exhausted days had to be included somewhere in the DSH adjustment formula. The Court held that because *Allina* – like the Provider here - had never advanced an alternative claim that the Secretary wrongly construed the Medicare fraction of the DSH formula and should have counted the dual eligible days in the Medicare fraction even if these days were properly excluded from the Medicaid fraction, this theory could not be considered.

The Court also rejected *Allina’s* contention that the terms “eligible” and “entitled” had different meanings in the DSH adjustment formula based on prior appellate court decisions. The Court found this argument “unpersuasive” because these cases had not dealt with the precise issue before the Court, and the Court of Appeals had declined to follow these cases in *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 398 U.S. App. D.C. 43 (D.C. Cir. 2011) (Exhibit C-7). The Court also rejected *Allina’s* contention that the Secretary’s interpretation amounted to impermissible retroactive rulemaking, since the Court of Appeals in *Catholic Health Initiatives* had rejected this same contention.

The Court thus disagreed that the interpretation pressed by *Allina* was compelled by the plain language of the Medicare statute, otherwise found that the Secretary’s interpretation was permissible and reasonable, and concluded that *Allina’s* attacks against the Secretary’s decision were without merit.

In this case, the Providers rely on the same arguments and claims that *Allina* made. Since all of *Allina’s* arguments and claims have already been rejected by the District Court and the Court of Appeals for the District of Columbia, the Board should likewise reject these arguments and claims here.

In their Preliminary Position Paper, the Providers do not discuss the adverse impact of Catholic Health Initiatives; they make only a passing reference to that case in their background discussion. Instead, the Providers rely entirely on Empire for support for their position, citing that case extensively. The Providers summarize their position, on pages 15-16 of their Position Paper, as:

In *Empire Health Found. V. Price*, 334 F. Supp. 3d 1134 (E.D. Wash. 2018), in the United States District Court of Eastern Washington, Providers challenged the Department of Health and Human Services (“HHS”) 2005 change to the DSH payment formula. The HHS changed the Medicare fraction to include the patient days for patients who exhausted their Medicare Part A (hospital) coverage. The Empire court held interested parties didn’t have a “meaningful opportunity to comment” because the clarification came just three days before the comment period was to close and because the 2005 rule was not a logical outgrowth of the 2003 proposed rule. The court ruled Court ruled for the Providers regarding the procedural invalidity of the 2005 DSH rule, thus vacating the 2005 DSH rule.

*Empire* created a dilemma for all entities involved in the dispute. At page 6 (see Exhibit C-8), the *Empire* decision stated:

**We hold that the 2005 Rule’s rulemaking process, while not perfect, satisfied the APA’s notice-and-comment requirements. However, we also hold that the 2005 Rule is substantively invalid, and must be vacated, because it directly conflicts with our interpretation of 42 U.S.C. § 1395ww(d)(5)(F)(vi) in *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261, 1265-66 (9th Cir. 1996).**

In *Becerra v. Empire Health Foundation, for Valley Hospital Medical Center*, No. 20-1312, (U.S. Supreme Court, June 24, 2022), the Court ruled that:

**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.**

(See Exhibit C-9, page 2.)

**2. Some of the Providers’ arguments in this appeal are duplicative of issues in other Group Appeals involving these same Providers.**

The Providers’ Preliminary Position Paper for this appeal contains additional arguments regarding the calculation of the SSI ratio. The MAC notes that the individual Providers in this Group appeal have other appeal issues dealing specifically with the impact of these types of days on the SSI ratio. The Providers in this Group Appeal (CN 21-1451G – HRS CY 2016 DSH SSI Fraction Dual Eligible Days 2 Group) are also participants in the following group appeals:

* CN 20-1449G – HRS CY 2016 DSH/SSI Percentage 2 Group
* CN 21-1450G – HRS CY 2016 DSH SSI/Medicaid Medicare Managed Care Part C Days 2 Group
* CN 21-1452G – HRS CY 2016 DSH Medicaid Fraction Dual Eligible Days 2 Group

Thus, the Providers in this Group Appeal have other pending appeals that addresss the other aspects of the issue that the Providers are including in their Preliminary Position Paper discussion of this group appeal issue. It appears this may violate Board Rule 4.6, No Duplicate Filings. However, the MAC will address these aspects of the issue as the Providers’ Preliminary Position Paper addressed these aspects.

**3. The Providers’ “Apples to Oranges” argument is not persuasive.**

The Providers’ Preliminary Position Paper states on page 10:

… CMS adds exhausted days to the denominator and refuses to recognize SSI related days in the numerator. This is an example of CMS comparing ‘apples to oranges.’

In short, when Medicare Part A stops paying Title XVIII benefits, and Medicaid starts paying Title XIX benefits, CMS counts the days (paid for by Title XIX) in the denominator of the SSI percentage. When SSI stops paying Title XVI benefits, and Medicaid starts paying Title XIX benefits, CMS refuses to count the days (paid for by Title XIX) in the numerator of the SSI percentage.

On page 12 of the Providers’ Preliminary Position Paper, it states:

… CMS includes MSP days of care in the denominator of the SSI fraction and refuses to include SSI related days in the numerator of the SSI fraction. Thus, another example of CMS comparing ‘apples to oranges.’

On page 21 of the Providers’ Preliminary Position Paper, it states:

CMS stated that she intends no different meaning between the phrases “SSI-eligible” and “SSI-entitled”. However the Providers concern is that CMS is using “SSI-entitled” patient days in the numerator of the SSI fraction and “Part A-eligible” days in the denominator (i.e. *‘apples vs. oranges’*). CMS also stated in her response that “…*unlike 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* [payment] *of an inpatient stay*.”

The above CMS’ statement brings the “***apples to oranges***” comparison a bit more into focus. CMS seems to be saying that for the numerator, SSI individuals must be “entitled to payment” whereas for the denominator, individuals enrolled in Part A need only be “entitled to benefits” – they don’t have to be “entitled to payment”.

Although the Providers’ Preliminary Position Paper discusses this argument of “apples to oranges” and the interpretation of the term ‘entitled’ at length, its assertions are not persuasive.

The Providers’ statement that the numerator was left unchanged is not correct. The MAC’s position is there is no inconsistency between the numerator and the denominator as the Providers claim. The change to the regulation removing the word “covered” was meant to allow non-covered, but Medicare entitled, days to be included in both the numerator and denominator of the Medicare fraction. Specifically, the August 11, 2004 Federal Register stated with respect to dual eligible, Part A exhausted days:

…we are adopting a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage. **If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction.** This policy will be effective for discharges occurring on or after October 1, 2004. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual-eligible beneficiaries in the Medicare fraction of the DSH calculation.

(Emphasis added.) (69 FR 49,099) (Exhibit C-10)

With respect to Medicare Part C days, CMS stated:

…we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction. As noted previously, **if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction**. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation. (Emphasis added.) (69 FR 49,099)(Exhibit C-10)

Clearly the changes with respect to entitlement were applied to both the numerator and denominator.

CMS has previously addressed concerns regarding the interpretation of ‘entitled’. Specifically, in the August 16, 2010 (Exhibit C-11) Federal Register, it was explained:

*Response:* 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).19 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.

19 As a side note, we have used the phrase "SSI-eligible" interchangeably with the term "SSI-entitled" in the FY 2011 proposed rule as well as prior proposed and final rules, but the statute requires that we include individuals who were entitled to SSI benefits in the SSI fractions. Although we have used these terms interchangeably, we intended no different meaning, and our policy has always been to include only Medicare beneficiaries who are entitled to receive SSI benefits in the numerator of the SSI fraction.

On the other hand, section 226 of the Act provides that an individual is automatically ‘‘entitled’’ to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits under section 202 of the Act (42 U.S.C. 402) or becomes disabled and has been entitled to disability benefits under section 223 of the Act (42 U.S.C. 423) for 24 calendar months. Section 226A of the Act provides that qualifying individuals with end-stage renal disease shall be entitled to Medicare Part A. In addition, section 1818(a)(4) of the Act provides that, ‘‘unless otherwise provided, any reference to an individual entitled to benefits under [Part A] includes an individual entitled to benefits under [Part A] pursuant to enrollment under [section 1818] or section 1818A.’’ We believe that Congress used the phrase ‘‘entitled to benefits under part A’’ in section 1886(d)(5)(F)(vi) of the Act to refer individuals who meet the criteria for entitlement under these sections.

Moreover, unlike 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. Again, we are bound by section 1886(d)(5)(F)(vi)(I) of the Act, which defines the SSI fraction numerator as the number of SSI-entitled inpatient days for persons who were "entitled to benefits under [P]art A," and the denominator as the total number of inpatient days for individuals who were "entitled" to Medicare Part A benefits. 75 FR 50,280

These issues raised by the Providers were considered in the determination of the revised data matching process adopted by CMS as explained in the August 16, 2010 Federal Register. These issues have been properly addressed in the determination of the Providers’ SSI Ratios.

In *Metropolitan Hospital v. U.S. Dep’t of Health and Human Services*, 712 F.3d 248, 268-69 (6th Cir. 2013) (Exhibit C-12), the U.S. Court of Appeals for the Sixth Circuit upheld the Secretary’s interpretation in the 2010 final rule of the references in the numerator of the SSI fraction (also known as the “Medicare fraction”) to “entitled to SSI benefits” and “entitled to Medicare Part A benefits.” The court concluded that “[a]lthough seemingly in tension” with each other, the Secretary’s differential interpretation of the two references to “entitled” in the SSI fraction rest on “differences in the language used in the SSI and Medicare statutory schemes [that] explain this apparent inconsistency.” *Id.* at 268. Entitlement to Medicare Part A benefits is a permanent status that obtains “automatically” when one first becomes entitled to social security benefits under Title II of the Act, and one cannot “lose” entitlement to Medicare Part A benefits due to happenstance developments such as exhaustion of the individual’s available coverage of hospital services. By contrast, one must apply for SSI benefits, and thus an individual who is “eligible” for SSI is not “entitled” to SSI benefits until the person actually submits an SSI application, the Social Security Administration (SSA) approves the application, and the statutory delayed effective date for SSI payments comes about. Thus, the Sixth Circuit held that “[t]he Secretary’s nuanced interpretation of the Medicare fraction’s numerator appropriately reflects this difference between the two benefit programs” of Medicare and SSI. *Id.* at 269.

Put simply, SSI is a cash benefit program, so a person is entitled to SSI benefits only if the individual is actually receiving SSI payments. By contrast, Medicare Part A is an insurance program, so a person does not lose entitlement to Part A benefits because the individual happens to not use this insurance or because specific services are not covered or certain coverage has been exhausted. Given the fundamental differences between the SSI cash benefit program and the Medicare Part A insurance program, the Secretary has reasonably interpreted the SSI fraction’s reference to “entitled” differently for purposes of SSI entitlement versus Medicare Part A entitlement. *Metropolitan Hospital*, 712 F.3d at 268-69.

**4. The Providers’ argument that to eliminate the “Apples to Oranges” inequity, additional SSA Status codes must be included in the SSI ratio, is not persuasive.**

The Providers’ Preliminary Position Paper states on page 26:

To eliminate the *"apples to oranges"* inequity, additional SSA Status codes must be included in the numerator of the SSI percentage beyond the current three (i.e. C01, M0l and M02). Some of the codes that have been left out indicate the individual was entitled to have a SSI payment made. Other codes that have been left out indicate the individual was eligible for SSI benefits, however did not receive a SSI payment. And yet another code indicates the individual was entitled to SSI payments before being institutionalized, however no longer receives SSI payments because Medicaid is paying for over 50% of the cost of their care.

The Providers’ Preliminary Position Paper discusses specific SSI status codes that it asserts should be handled differently in the determination of the SSI ratios. The Providers challenge the use, in the revised data matching process, of only three of SSA’s computer codes to identify entitlement to SSI benefits. The Providers maintain that the revised data matching process should make use of additional computer codes from SSA.

SSA computer codes that indicate a person may be eligible for SSI, but is not actually receiving SSI payments, do not belong in the revised data matching process, because the Secretary reasonably interprets “entitled to SSI benefits” to mean that the individual is actually receiving SSI payments. As the Sixth Circuit concluded, an individual who is “eligible” for SSI is not “entitled” to SSI benefits until the person submits an SSI application, SSA approves the application, and the statutory delayed effective date for SSI payments comes about. *Metropolitan Hospital*, 712 F.3d at 268-69 (Exhibit C-12). Given the Secretary’s reasonable interpretation of “entitled to SSI benefits” in the 2010 final rule, 75 Fed. Reg. at 50,280-81 (Exhibit C-11), it was entirely reasonable for the agency to exclude from the revised data matching process any computer codes that SSA may use to indicate that a person is eligible for SSI but is not actually receiving SSI payments and so is not entitled to SSI benefits.

In responding to public comments on the computer coding issue, the Secretary explained that SSA had informed CMS that all but three of the SSI status codes in question indicated that the person was not entitled to SSI payments at the time. 75 Fed. Reg. at 50,280-81. Many of the codes discussed in the Providers’ Preliminary Position Paper were addressed in the August 16, 2010 Federal Register (Exhibit C-11) in response to comments, where it stated:

In response to the comment about specific SSI status codes, SSA has provided information regarding all of the SSI status codes mentioned by the commenter to assist in the determination of whether any of these codes represent individuals who were entitled to SSI benefits for the purposes of calculating the SSI fraction for Medicare DSH. With respect to the codes that begin with the letter "T," SSA informed us that all of the codes represent individuals whose SSI entitlement was terminated. Code "T01" represents records that were terminated because of the death of the individual, but we confirmed that this code would not be used until the first full month after the death of the individual. That is, for example, if a Medicare individual was entitled to SSI during the month of October, was admitted to the hospital on October 1 and died in the hospital on October 15, the individual would show up as entitled to SSI for the entire month of October on the SSI file (code T01 would not be used on the SSI file until November) and 15 Medicare/SSI inpatient hospital days for that individual would be counted in the numerator and the denominator of the SSI fraction for that hospital.

Codes beginning with the letter "S" reflect records that are in a "suspended" status and, according to SSA, do not represent individuals who are entitled to SSI benefits.

SSA maintains that code "P01" is obsolete and has not been used since the mid-1980s. Therefore, it would not be used on any SSI files reflecting SSI entitlement for FY 2011 and beyond.

Codes that begin with the letter "N" represent records on "nonpayment" and are not used for individuals who are entitled to SSI benefits.

Code "E01" represents an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but has countable income of $30 or more. Such an individual is not entitled to receive SSI payment. Alternatively, an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but does not have countable income of at least $30, would be reflected on the SSI file as a "C01" (which denotes SSI entitlement) for any month in which the requirements described in this sentence are met. Code "E02" is used to identify a person who is not entitled to SSI payments in the month in which that code is used 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. Such an individual is not entitled to SSI benefits during the month that his or her application is filed or is determined to be eligible for SSI, but, for the following month, would be coded as a "C01" because he or she would then be entitled to SSI benefits.

Therefore, both codes E01 and E02 represent individuals who are not entitled to SSI benefits and are reflected accordingly on the SSI file. If the individual's entitlement to SSI benefits is initiated the ensuing month, that individual would then be coded as a "C01" on the SSI file and would be included as SSI-entitled for purposes of the data matching process.

As we have described above, none of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used. SSI entitlement can change from time to time, and we believe that including SSI codes of C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits. (Emphasis added.) 75 FR 50,281

The issues raised by the Providers were considered in the determination of the revised data matching process adopted by CMS as explained in the August 16, 2010 Federal Register. These issues have been properly addressed in the determination of the Providers’ SSI Ratios.

CMS’s 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 rolls vary widely. Rather than parse through and make a separate judgment on the innumerable reasons why benefits are not paid, CMS’s decision to use the payment standard has a rational basis. The policy line drawn by CMS based on the actual benefit payment requirement as the criteria for inclusion in the fraction does not produce an irrational or illogical result.

**5.** **The Providers’ SSI Ratios have been properly determined in accordance with the revised data matching process.**

Beginning on page 17 of the Providers’ Preliminary Position Paper, it discusses *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) (Exhibit C-13). In *Baystate* 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. *See* 75 FR 50,275-50,286 (Aug. 16, 2010) (Exhibit C-11).

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 50,275-50,286 (Exhibit C-11). CMS adopted that revised data matching process for FY 2011 and beyond. In accordance with CMS Ruling 1498-R (Exhibit C-6), the revised data matching process applied to all open cost reports for cost reporting periods beginning prior to October 1, 2010. This was explained in the August 16, 2010 Federal Register. See 75 FR 50,284 (Exhibit C-11):

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 Ruling 1498-R (Exhibit C-14) relates to this matching process and provides 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. *See* CMS Ruling 1498-R, pp. 4-7. 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 Ruling1498-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 Providers assert in the Preliminary Position Paper that CMS incorrectly computed the SSI ratios for the fiscal year at issue. Although the Providers’ Preliminary Position Paper discusses its various arguments at length, their assertions are not persuasive. The MAC contends that although the Providers’ Paper has outlined their contentions in detail, it has not provided any documentation to support that the SSI Ratios computed by CMS are not in accordance with CMS Ruling1498-R, the revised data matching process adopted in the August 16, 2010 Federal Register, and 42 C.F.R. § 412.106. The MAC asserts that the Providers’ SSI Ratios were properly determined in accordance with these requirements.

**C. Conclusion**

For the foregoing reasons, the Board should affirm the MACs’ adjustments to use the CMS issued SSI ratios, which properly include these dual eligible MSP days and dual eligible exhausted days in the Medicare fraction. Further, the Board should confirm the exclusion of these dual eligible MSP days and dual eligible exhausted days from the Medicaid fraction of the Providers’ DSH adjustments calculation as proper. The MAC’s position is in accordance with 42 C.F.R. § 412.106.

**IV. LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS**

**Law:**

**Title XVIII of the Social Security Act;**SSA § 1886(d)(5)(F)(vi);SSA § 1886(d)(5)(F)(vi)(I);SSA § 202;SSA § 223;SSA § 226**;**SSA § 226A**;**SSA § 1602**;**SSA § 1611(c)(7)**;**SSA § 1818**;**SSA § 1818A**;**SSA § 1818(a)(4)

**United States Statutes:**

42 U.S.C. § 402;42 U.S.C. § 423;42 U.S.C. § 426(a);42 U.S.C. § 1395y(b)(2);42 U.S.C. § 1395ww(d)(5);42 U.S.C. § 1395ww(d)(5)(F)(i)(I);42 U.S.C. § 1395ww(d)(5)(F)(ii);42 U.S.C. § 1395ww(d)(5)(F)(v)

**Regulations:**

42 C.F.R. § 405.1801(a);42 C.F.R. § 405.1803;42 C.F.R. § 412.106

**Federal Register:**

69 FR 49,093-49,099 (August 11, 2004);75 FR 50,275-50,286 (August 16, 2010)

**Judicial Decisions:**

*Allina Health System v. Sebelius*, CA No. 09-cv-1889, (D.D.C. Oct. 8, 2013);*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);*Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013);*Chevron U.S.A.*, Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837 (1984);*Empire Health Foundation v. Azar*, Nos.18-35845 and 18-35872 (9th Cir. May 5, 2020);*Becerra v. Empire Health Foundation, for Valley Hospital Medical Center*, No. 20-1312, (U.S. Supreme Court, June 24, 2022);*Metropolitan Hospital v. U.S. Dep’t of Health and Human Services*, 712 F.3d 248, 268-69 (6th Cir. 2013);*McCreary v. Offner*, 172 F.3d 76 (D.C. Cir. 1999);*Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 398 U.S. App. D.C. 43 (D.C. Cir. 2011)

**Agency Decisions:**

*Allina Health System 1995-2003 DSH Dual Eligible Day Group v. BCBSA/Noridian Admin. Serv’s*, PRRB Dec. No. 2009-D35 (July 30, 2009);*Allina Health System 1995-2003 DSH Dual Eligible Day Group v. BCBSA/Noridian Admin. Serv’s*, Adm. Review of PRRB Dec. No. 2009-D35 (September 21, 2009)

**Agency Instructions:**

CMS Ruling 1498-R (April 28, 2010);PRRB Rule 4.6

**V. EXHIBITS**

C-1. Schedule of Providers

C-2. 42 C.F.R. § 412.106

C-3. *Allina Health System v. Sebelius*, CA No. 09-cv-1889, (D.D.C. Oct. 8, 2013)

C-4. *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013)

C-5. *Allina Health System 1995-2003 DSH Dual Eligible Day Group v. BCBSA/Noridian Admin. Serv’s*, PRRB Dec. No. 2009-D35 (July 30, 2009)

C-6. *Allina Health System 1995-2003 DSH Dual Eligible Day Group v. BCBSA/Noridian Admin. Serv’s*, Adm. Review of PRRB Dec. No. 2009-D35 (September 21, 2009)

C-7. *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 398 U.S. App. D.C. 43 (2011)

*C-8. Empire Health Foundation v. Azar*, Nos.18-35845 and 18-35872 (9th Cir. May 5, 2020)

C-9. *Becerra v. Empire Health Foundation, for Valley Hospital Medical Center*, No. 20-1312, (U.S. Supreme Court, June 24, 2022)

C-10. 69 FR 49,093-49,099 (August 11, 2004)

C-11. 75 FR 50,275-50,286 (August 16, 2010)

C-12. *Metropolitan Hospital v. U.S. Dep’t of Health and Human Services*, 712 F.3d 248, 268-69 (6th Cir. 2013)

C-13. *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)

C-14. CMS Ruling 1498-R (April 28, 2010)