Whether the providers are entitled to include all Dual Eligible (Medicare/Medicaid) days in the numerators of the Supplemental Security Income (SSI) ratios (Medicare Fractions).

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 (including those enrolled in a Medicare Advantage (Part C) plan) 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 (including those enrolled in a Medicare Advantage (Part C) plan). 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 Medicaid ratio is also a statutory formula, which appears at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).[[3]](#footnote-3)

The Supreme Court recently ruled on this very issue, where the Court sided with the Secretary. In *Empire Health Foundation v. Becerra*[[4]](#footnote-4) (*Empire*), each and every argument put forth by the Group in the instant case was addressed by the Supreme Court. See Exhibit C-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. CMS then sends the resulting percentage (SSI ratio or Medicare fraction) to each hospital’s MAC. The MACs use the SSI ratios 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.

1. 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 denominators of the Providers’ Medicare fractions should have (and did) include Medicare entitled days from PPS-included units of the Providers. To the extent, therefore, that the Providers claim that the denominators of their Medicare fractions 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.

1. 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 fractions, 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 calculations. 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).

1. **Argument**

The regulation at 42 C.F.R. § 413.20 states that the provider must permit the intermediary to examine its records and documents as necessary to ascertain information pertinent to the determination of the proper amount of program payments due. A provider claiming that days should be removed from its SSI percentage and included within its Medicaid percentage, at a minimum, should provide a listing of days. The providers have failed to identify any days at this time.

As of this writing, not a single participant within this group has identified a single day at issue. Currently, the Group’s case is a theory. Keep in mind, this group appeal was filed over seven years ago, and all the cost reporting periods at issue concluded more than ten years ago. Despite having ten years to gather evidence and support for their position, the Providers have failed to lift even a nanogram of weight in this case with respect to supporting their position.

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 which insurance the patients had, if any. The patient files would also include information on employment, income, 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 and State Medicaid data, does not allow them to create a list of patients (and the related patient days) in total they believe can or should be included in their Medicaid ratios, and removed from the SSI ratios.

The MAC contends that CMS properly accounts for dual eligible days within the DPP. 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.[[5]](#footnote-5) As found by the Supreme Court in Empire, the phrase “entitled to benefits” is used as a term of art throughout the Medicare statute. This echoes previous findings from other Courts. 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)[[6]](#footnote-6). 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.[[7]](#footnote-7) 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. The crux of the Group’s arguments in the instant case is that patients cannot be entitled to Medicare Part A benefits if Medicare does not pay. The Provider’s argument has been thwarted by multiple Courts. The Supreme Court has dealt the latest blow, which cannot be overcome by the Group here.

As previously noted, the statute at 1886(d)(5)(F)(vi)(I) defines the Medicare (SSI) fraction as:

1. 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….

The statute is unequivocally clear that days included within the Medicare fraction are those that relate to patients who are entitled to benefits under Medicare Part A. As affirmed by the Supreme Court in *Empire*, the term “entitled to benefits” has a consistent meaning throughout Medicare statute, which is qualifying for benefits. The Group’s position runs contrary to the Medicare statute and the *Empire* decision, where the Group wishes the term “entitled to benefits” means an absolute right to payment. The Supreme Court noted over and over that the reading of “entitled to Part A benefits” to mean an “absolute right to Part A payments” cannot be applied throughout the Medicare statute. The Group’s argument that was considered and dismissed by the Supreme Court would remove days from the Medicare fraction and somehow theoretically allow inclusion of days related to dually eligible patients, where Medicare Part A did not pay for certain days, within the Medicaid fraction. Based on *Hall* and *Empire*, we know the Group’s argument is verifiably false. Patients entitled to Medicare Part A remain entitled to Medicare Part A, regardless of payment status. Again, there are no actual days at issue in the instant case, but the theoretical days must be included within the Medicare fractions. Again, the Group’s entire argument was carefully considered and dismissed by the Supreme Court in *Empire*. For that reason, the MAC believes the Supreme Court has foreclosed any further proceedings on the same issue and arguments and this case should be dismissed.

The Group failed to present any evidence whatsoever that any hospital within the Group has identified a single patient it believes should be omitted from the SSI ratio and included in the Medicaid ratio. At some point, the Group must submit something to substantiate its theories. 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 their contention related to dual eligible days demonstrates that this issue has zero merit and should be dismissed.

**C. Conclusion**

In view of the foregoing, the MAC asks that the Board dismiss this case pursuant to the Supreme Court’s ruling in *Empire*. 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, and Program Instructions. Thus, the Board should refuse to disturb CMS’s calculations of the Providers’ DPPs for the cost year at issue.

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

Law: Social Security Act § 1861(v)(1)(A), 1886(d)(5)(F)

Regulations: 42 C.F.R. § 412.106

42 C.F.R. § 405.1801 and 405.1803

42 C.F.R. § 405.1885 – 405.1889

42 C.F.R. § 413.9

42 C.F.R. § 413.20, 413.24

Program Instructions: Provider Reimbursement Manual, CMS Pub. 15-I

§ 2304

Other Sources: Ruling CMS 1498-R

**V. EXHIBITS**

C-1 Schedule of Providers.

C-2 Becerra v. Empire Health Foundation, for Valley Hospital Medical Center, 20-1312, (U.S. Supreme Court, June 24, 2022)

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. [T]he fraction (expressed as a percentage), the numerator of which is the number of the hospital’s patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State [Medicaid plan], but who were not entitled to benefits under part A of [Medicare], and the denominator of which is the total number of the hospital’s patient days for such period. [↑](#footnote-ref-3)
4. *BECERRA, SECRETARY OF HEALTH AND HUMAN SERVICES v. EMPIRE HEALTH FOUNDATION, FOR VALLEY HOSPITAL MEDICAL CENTER*, U.S. Supreme Court, 2022, No. 20-1312. [↑](#footnote-ref-4)
5. 42 U.S.C. § 402 [↑](#footnote-ref-5)
6. 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-6)
7. See Medicare Claims Processing Manual Chapter 1, § 50.1.5. [↑](#footnote-ref-7)