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|  | Whether the SSI percentage as calculated by CMS and used by the lead MAC to calculate the Providers’ Disproportionate Share Hospital (“DSH”) payment is understated due to fundamental flaws in the methodology used by CMS to identify patient days in the numerator and denominator. |

**A. Facts**

The Providers in this appeal contend that the Medicare Part A/SSI fraction is understated due to the employment of incorrect raw data by the Social Security Administration (“SSA”). Specifically, that there were fundamental problems with the development of the Medicare fraction, that the match process between Centers for Medicare and Medicaid Services’ (“CMS”) Medicare Provider Analysis and Review (“MedPAR”) and the SSI data file is flawed, and that the Medicare fraction is incomplete in that it omits certain SSI eligible beneficiary records.[[1]](#footnote-1)

The Providers expand the issue in the Group’s preliminary position paper stating that the disproportionate share hospital (“DSH”) reimbursement calculation is understated due to the CMS and the Medicare Administrative Contractor’s (“MAC’s”) failure to include all patient days for patients who were eligible for and enrolled in the SSI program but may not have received a Supplemental Security Income (“SSI”) payment for the month in which they received services from the Provider (“SSI Eligible days”) in the numerator of the Medicare fraction of the DSH Percentage.[[2]](#footnote-2) The MAC contends that this expanded issue of SSI Eligible Days is a separate issue and has been untimely added to the appeal. In accordance with 42 C.F.R. § 405.1837(a)(2), the issue in a group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Rulings. Board Rule 8 states that each contested component of an issue must be appealed as a separate issue and lists several distinct components of the DSH payment issue, including SSI data matching and SSI eligible days. The MAC plans to file a jurisdictional challenge for the SSI Eligible Days issue in this appeal but will address both the SSI data matching and SSI Eligible Days issues in this position paper.

Hospitals are paid for services to Medicare patients through 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.” *See* 42 U.S.C. § 1395ww(d)(5)(F)(v).

A hospital’s disproportionate patient percentage (“DPP”) is determined by adding the results of two computations and expressing the result as a percentage. As indicated in 42 U.S.C. § 1395ww(d)(5)(F)(vi) 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 (“SSI”) 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 that results in increased PPS payment for inpatient hospital services. 42 U.S.C. § 1395ww(d)(5)(F)(ii).

In the August 12, 2005, Federal Register (70 FR 47438-47441), CMS explained how the Medicare fraction would be calculated and the matching process used to arrive at the Medicare fraction (**Exhibit C-3**). 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* 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 50277-50279) (**Exhibit C-4**).

This appeal stems from CMS Ruling 1498-R, which relates to this matching process. CMS Ruling 1498-R provides that, for qualifying appeals of the data matching issue and for cost reports 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 FY 2011 Inpatient Prospective Payment System (“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 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).” *Id.*, at p. 28. 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.* In the Ruling, CMS also adopted the proposed data matching process for FY 2011 as final.

The process that CMS used to compute the Medicare fraction involved electronically matching the health insurance claim number of Medicare beneficiaries from records in the national claims history database, which contained 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"). *See* 75 FR 50275-50278 (August 16, 2010) at **Exhibit C-4**. CMS tabulated the number of Medicare entitled/SSI days in IPPS units of the hospitals (i.e., the numerator) and also the total number of Medicare entitled days in IPPS units of the hospitals (i.e., the denominator). *Id*. The resulting percentage (SSI fraction or Medicare fraction) for each hospital was then published on the CMS website. The MACs used the published SSI fractions in the calculation of the hospitals’ DPP to determine whether the hospitals qualified for DSH payments and, if so, the amount of such payments.

The MAC reviewed the Group’s Schedule of Providers at **Exhibit C-1** and supporting documentation and noted no jurisdictional impediments. The two participants each appealed final Notices of Program Reimbursement (“NPR”) for their respective FYE 2007 and 2008 cost reports. The NPRs were issued after the issuance of CMS Ruling 1498-R and the MAC used an SSI fraction calculated in accordance with the Ruling in the determination of the Providers’ DSH payments. The Providers in the appeal assert “[t]he data related to the number of individuals whose SSI payments were withheld and were, thus, excluded from the numerator of the Medicare Fraction for the Providers must ultimately be provided by the Social Security Administration and CMS. Consequently, at the hearing, the Providers will provide data that illustrate the extent of the financial harm resulting from CMS’s systematic exclusion of these individuals from the DSH calculation that was applied to the Providers. However, without access to the data maintained by the Social Security Administration and CMS, the Providers will be unable to demonstrate with certainty the full extent of the harm that CMS’s flawed calculations have caused.”[[3]](#footnote-3) The Providers further claim that the burden of production of the SSI eligibility data lies with CMS and the MACs to establish patients’ SSI eligibility status.[[4]](#footnote-4) The Providers in this appeal note that “the Provider in this Appeal has obtained MedPar data from CMS[.] However, the information critical to these appeals, the SSI PSC Codes, is omitted.”[[5]](#footnote-5)

The MAC received confirmation that CMS processed requests for the Medicare Provider Analysis and Review (“MedPAR”) data for all Providers in the Group (**Exhibit C-5**). However, the Providers have not identified any errors in the MedPAR data obtained from CMS. Documentation that the data has been reviewed by the Providers and found to be flawed has not been submitted to the MAC to support that an adjustment of the SSI fraction is warranted.

This appeal also concerns a dispute involving “dual eligible” days and whether or not these days are properly included in the published SSI fraction. 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*, 982 F. Supp. 2d, CA No. 09-cv-1889, 2013 WL 5530609, \*1, \* 2 (D.D.C. 2013) (citing *McCreary v. Offner*, 172 F.3d 76, 78 (D.C. Cir. 1999)). There are multiple types of dual eligible days including, for instance, days for individuals who are eligible for both Medicare and Medicaid, but who have exhausted their Medicare benefits for the days at issue (“dual eligible exhausted benefit days”) and days for which a party other than Medicare –such as a state Medicaid program or an employer-sponsored health plan – has paid for patient services in full and for which Medicare makes no payment by statute (“dual eligible Medicare Secondary Payor days”). The dispute in this appeal is whether CMS included all days of care furnished to dual eligible patients who were entitled to Medicare Part A and SSI benefits ("SSI eligible days") in the Medicare fraction.

The Providers contend that the SSI fractions published by CMS and used by the MAC for the cost reporting years at issue did not include all SSI eligible days and therefore, are not correct. As a result, the Providers assert that the DSH payments are understated.

**B. Arguments**

**i. CMS Has Produced the Data That It Is Required to Produce to the Providers**

The Providers contend that they have been prevented from obtaining the necessary data from the SSA to verify the accuracy of CMS’s calculation of the SSI fraction. Whether and to what extent this contention is accurate is irrelevant. CMS does not have any authority over the SSA and the Board may not award any relief to the Providers based on its purported inability to obtain documentation from a party that is not before the Board.

The Providers’ appeal is based on the claim that CMS incorrectly computed the SSI fractions for the fiscal years at issue because it failed to include all patients that were entitled to SSI benefits in its calculation. The Providers believe that the SSI fractions issued by CMS remain flawed and the resulting DSH payments issued by the MAC are understated. The Providers claim that they have been unable to analyze Medicare Part A/SSI data because CMS and the SSA have not provided the data that is necessary to analyze.

The statutory basis for the Providers to obtain the data relating to the SSI fraction is the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-173) (the “MMA”). Section 951 of the MMA directed the Secretary to begin providing hospitals the information necessary to “compute the number of patient days used in computing the disproportionate patient percentage” no later than December 8, 2004.

The Secretary published her method for complying with the MMA in the August 12, 2005, Federal Register. Reference 70 FR 47438-47439 (August 12, 2005) at **Exhibit C-3**. CMS explained that:

We interpret section 951 to require the Secretary to arrange to furnish to hospitals the data necessary to calculate both the Medicare and Medicaid fractions. With respect to both the Medicare and Medicaid fractions, we interpret section 951 to require CMS to arrange to furnish the personally identifiable information that would enable a hospital to compare and verify its records, in the case of the Medicare fraction, against the [sic] CMS’ records, and in the case of the Medicaid fraction, against the State Medicaid agency’s records.

*Id.*, at 47438.

Specifically, CMS stated that it calculated the Medicare fraction using data from the “MedPAR LDS,” which was established in a notice published in the August 18, 2000, Federal Register (65 FR 50548). *Id.*, at 47439. The notice explained that “MedPAR LDS contains a summary of all services furnished to a Medicare beneficiary, from the time of admission through discharge, for a stay in an inpatient hospital or skilled nursing facility, or both; SSI eligibility information; and enrollment data on Medicare beneficiaries.” *Id.* CMS determined that it would comply with Section 951 of the MMA by releasing the MedPAR LDS data to providers. *See* 70 FR 47438-47441 (**Exhibit C-3**):

Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108-173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital’s patients eligible for both SSI and Medicare at the hospital’s request, regardless of whether there is a properly pending appeal relating to DSH payments. We will make the information available for either the Federal fiscal year or, if the hospital’s fiscal year differs from the Federal fiscal year, for the months included in the Federal fiscal years that encompass the hospital’s cost reporting period. Under this provision, the hospital will be able to use these [this] data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year. The data set made available to hospitals will be the same data set CMS uses to calculate the Medicare fractions for the Federal fiscal year.

*Id.*, at 47439.

CMS has arranged to comply with Section 951 by releasing the MedPAR LDS data to providers. In fact, CMS’ records show that the Providers have requested and received the MedPAR LDS data from CMS for all Providers and FYE’s in the group. Reference **Exhibit C-5**. CMS has therefore complied with the statutory and regulatory requirements compelling it to provide the data necessary for the Providers to confirm that the SSI fractions were properly computed. Consistent with the requirements of Section 951 of the Medicare Modernization Act and the requirements of *Baystate*, great strides have been made in improving the data match. However, the data match is limited to capturing the patient days for Medicare Part A patients whom CMS has determined to belong in the Medicare proxy (those who received payment of the SSI benefit). As CMS has determined and is defending the position that this group of patients meets the test for inclusion in the proxy, there is not an obligation to do more. The required data has been furnished to the Providers to review and identify any of the purported inaccuracies.

Although CMS has complied with its statutory obligations, the Providers claim that the data received is insufficient to identify any patients missing from the published SSI fraction. The Providers only received the detailed patient data that CMS used to calculate the published SSI fractions, but the Providers are looking for data from the SSA, so that the Providers can match the data against its own records in order to identify additional days related to Medicare/SSI patients that should be included in the SSI fraction.

Section 951 does not state that CMS must arrange to release SSA data or data in excess of what CMS used to compute the SSI fraction to the Provider. CMS does not have the authority over the SSA to require this data to be furnished and this data is protected by the Federal Privacy Act (5 U.S.C. § 552a). In *Advocate Christ Medical Center v. Azar*, Civil Action 17-cv-1519, (D.D.C. 2022) (**Exhibit C-6**), the plaintiffs were seeking a writ of mandamus compelling the Secretary to give them the SSA’s payment status codes for all persons enrolled in the SSI program. The District Court denied the request stating that “[b]ecause Plaintiffs have not shown that there is a ‘clear and compelling duty under the [Act] as interpreted’ for the Secretary to provide them with SSA payment status codes, Plaintiffs’ mandamus claim fails, and the court need not consider whether there are alternative remedies available or any equitable considerations that dictate a different result.” This decision was affirmed in *Advocate Christ Medical Center v. Becerra*, No. 22-5214 (D.C. Cir. 2023) **(Exhibit C-7)**. The United States Court of Appeals decision stated “[w]hat 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.”

The Providers contend that “CMS has suppressed their DSH adjustments by contorting the

language of the DSH statute to exclude SSI Eligible patient days that should rightly be

included in the numerator of the Medicare Fraction of the DSH Formula.”[[6]](#footnote-6) The Providers further contend that the SSI calculations omit from the numerator of the SSI fraction, the patient days for individuals whose SSI benefits were temporarily on hold or in suspense or were otherwise entitled to benefits under the SSI statute.[[7]](#footnote-7)

The Providers should have the ability to identify their own Medicare/SSI patients, including those in hold or suspense statuses, and should be able to match that data set against the CMS MedPAR data set used to compute the SSI fraction and should be able to identify if any additional days exist that should have been included in the SSI fraction. The Providers have failed to identify any discrepancies in the MedPAR data and have failed to carry their burden of proof and persuasion.

The Providers argue that they have exhausted all avenues for obtaining the information they need. Specifically, the Providers submitted as Exhibit P-14with its preliminary position paper an email exchange between the Providers’ counsel and the State of Indiana Medicaid. This email states that Indiana Medicaid[[8]](#footnote-8) cannot release the information the Providers’ representative is requesting for the same reasons that CMS cannot release the information; it is bound by the Privacy Act and its data use agreement with the SSA. Per the SSA website’s data exchange instruction at **Exhibit C-8**, all states, all prisons, foreign governments and private sectors can complete a data use agreement with the SSA to obtain information it may need. The Providers here (as private sectors) have failed to submit any documentation to show that they completed said data use agreements and tried to obtain the data they needed to show whether or not there are any true errors in the CMS calculated SSI fractions.

Other Providers have used their State Medicaid eligibility documentation to perform a match against their MedPAR data and, using the Medicaid program eligibility codes, identify days for patients which they believe are entitled to SSI, but not included in the published SSI fractions. When providers have submitted this data, the MACs have forwarded this data to CMS for further analysis. The Providers here have not even attempted to show that errors remain in their published SSI fractions. Therefore, the burden of proof remains on the Providers and the Providers cannot recover in this appeal when they failed to take the actions available to them that would allow them to potentially identify remaining errors.

**ii. CMS Properly Included All SSI Eligible Days in the SSI Fraction**

The MAC contends that CMS properly included all SSI eligible days that have been sufficiently documented for purposes of calculating the Providers' Medicare fractions. The Provider contends that there are patient days for patients who were eligible for and enrolled in the SSI program, but who may not have received an SSI payment for the month in which they received services from the Provider, that are excluded from the SSI fraction.[[9]](#footnote-9)

In the August 16, 2010, Federal Register (75 FR 50280 at **Exhibit C-4, p. 7**), CMS explained why it had excluded these days in responses to comments which raised 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:

*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). 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 FR 50280

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 entitled to SSI benefits. (**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-9**.) 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 C.F.R. §§ 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 fraction 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 benefits 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’s. Therefore, it is proper to exclude these codes/days from the calculation of the SSI fraction, as these patients were not entitled to SSI benefits 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. In *Empire Health Foundation v. Price*, the U.S. District Court, Eastern District of Washington, Doc. No. 2:16-CV-209-RMP (August 13, 2018) agreed. It stated, “[t]his inconsistent application of the word ‘entitled’ does not appear entirely reasonable; however, nothing in the language of 42 U.S.C. § 1395ww precludes the Secretary's interpretations in relation to Medicare Part A and SSI benefits. … Therefore, the Secretary's interpretation is not ’manifestly contrary to the statute’.” The District Court also “finds permissible the Secretary's interpretation of ‘entitled to benefits under [Medicare] part A' in § 1395ww, and, under *Chevron*, the Court defers to the Secretary's construction. *See Chevron*, 467 U.S. at 843.” [[10]](#footnote-10)

The Providers also contend that CMS’s policy of excluding all but a few categories of SSI patient days must be rejected as arbitrary and capricious under the second step of the *Chevron* test, which asks whether an agency’s interpretation of a statute is reasonable and not arbitrary and capricious.[[11]](#footnote-11) On June 24, 2022, the Supreme Court ruled in *Becerra v. Empire Health Foundation*, 597 U.S. \_\_\_\_ (2022), 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.” The Court ruled that throughout the Medicare statute, “entitled to benefits” is essentially a term of art meaning “qualifying for benefits”, i.e., being over 65 or disabled and that if “entitled to benefits” instead bore *Empire’s* meaning, Medicare beneficiaries would lose important rights and protections, such as the ability to enroll in other Medicare programs. It ruled that the Department of Health and Human Services (“HHS”) regulation correctly construes the statutory language at issue and that Congress could not have intended to write a statute whose safeguards would apply or not apply, or fluctuate constantly, based on the happenstance of whether Medicare paid for hospital care on a given day. The Court reversed the judgment of the Court of Appeals and remanded the case for further proceedings consistent with its opinion. *Empire* did not raise the question of whether HHS has properly interpreted the phrase “entitled to [SSI] benefits” in the Medicare fraction, which is the issue in dispute in this case. Accordingly, the Supreme Court did not express a view on this issue. Reference **Exhibit C-10.**

In *Advocate Christ Medical Center v. Azar*, Civil Action 17-cv-1519, (D.D.C. 2022), **(Exhibit C-6)**,the plaintiffs challenged CMS’ interpretation of the phrase “entitled to [SSI] benefits” and argued that CMS violated the Medicare statute by treating only three payment codes – C01, M01, and M02 – as indicators of SSI entitlement. The District Court ruled that the Secretary’s interpretation of “entitled to [SSI] benefits” was reasonable stating that:

The Secretary adequately explained that the perceived inconsistency arises from the two distinct types of statutory entitlements at issue – SSI cash benefits versus Part A insurance benefits. SSI cash benefits are an entitlement that depends on a right to be paid, while one’s insured status is a continuous entitlement that is not contingent on certain payments being made each month.

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By contrast, Plaintiffs’ interpretation would encompass numerous persons who are not eligible for SSI benefits, let alone “entitled to” them. Of the 74 SSA payment status codes that Plaintiffs say should be treated as indicators that a person is “entitled” to SSI benefits, at least fifty are used to identify persons who, for various reasons, are not eligible for SSI benefits....Counting those individuals as “entitled to [SSI] benefits” seems squarely at odds with the statute.

The Court’s decision also stated that “[t]he burden rests with the plaintiff to show that an agency’s decision is arbitrary,…and Plaintiffs have failed to meet that burden.” The Court proceeded to deny the Plaintiffs’ Motion for Summary Judgment and grant the Secretary’s Cross-Motion for Summary Judgment.

On September 1, 2023, the United States Court of Appeals for the District of Columbia Circuit affirmed the district court’s decision. *Advocate Christ Medical Center v. Becerra*, No. 22-5214 (D.C. Cir. 2023) **(Exhibit C-7)**. In addressing the hospitals’ contention that SSI benefits under subchapter XVI include not only cash benefits but also non-cash benefits such as the Medicare Part D subsidy and vocational rehabilitation services, the Court’s decision stated:

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 Court ruled that "the phrase 'supplemental security income benefits under subchapter XVI'...bears the same meaning in calculating the Medicare fraction in subchapter XVIII that it bears (1) throughout subchapter XVI and (2) in determining eligibility for the Ticket to Work program in subchapter XI.” That is, a cash benefit. Neither the Medicare Part D subsidy nor vocational rehabilitation services can be considered “benefits under subchapter XVI.” The Medicare Part D benefits are housed in subchapter XVIII. 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 are provided under

subchapter XI. **(Exhibit C-7, p. 10)**

**iii. 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 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.

In 20 C.F.R. § 416.200, it states that “**We determine your eligibility for each month** on the basis of your countable income in that month. You continue to be eligible unless **you lose your eligibility because you no longer meet the basic requirements** or because of one of the reasons given in §§ 416.207 through 416.216.” (emphasis added) (**Exhibit C-11, p. 1**). 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 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. (**Exhibit C-11, p. 4**)

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. 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. 20 C.F.R. § 416.200. Thus, a person who was eligible, but obtains more income or resources than are permitted, flees from prosecution or violates parole would no longer meet the basic requirements. *See* 20 C.F.R.

§ 416.202. 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. (**Exhibit C-11**) 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 (75 FR 50280-50281 at **Exhibit C-4, pp. 7-8**).

[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.

Because SSI entitlement is impermanent, difficult to establish and easy to lose, the Providers’ complaint that CMS excluded patient days for individuals who were otherwise entitled to SSI benefits 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,[[12]](#footnote-12) 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. In *Pomona Valley Hospital Medical Center v. Azar*, 1:18-cv-02763-ABJ, 2020 WL 5816486 (D.D.C. 2020), the Provider went to great lengths to attempt to validate its published SSI fraction and submitted Medicaid data indicating that its SSI fraction could be understated.[[13]](#footnote-13)  The Providers here simply contend there are SSI unpaid days that were not included in the Medicare fraction. The Providers have failed to supply 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. In fact, any discussion of data specific errors posited by the Providers notably did not pertain to the Providers subject to this appeal. 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.

**iv. The Medicare Part D Extra Help Program Should Not Be Construed to Indicate SSI Entitlement For the Length of the Medicare Subsidy**

The Medicare Part D Extra Help subsidy is a program for Medicare beneficiaries to get help paying for the costs – monthly premiums, annual deductibles and prescription co-payments – related to a Medicare prescription drug plan. To qualify for Extra Help, a beneficiary must reside in the 50 U.S. states or the District of Columbia, have limited resources (bank accounts, stocks, bonds, mutual funds, Individual Retirement Accounts (“IRA’s”), real estate (except primary residence), etc.) and have limited income. The benefits of this program are valued at about $4,000 per year. Applications can be made through the SSA or a local Medicaid agency and the agency that makes the subsidy decision is responsible for on-going case activity, including redeterminations of LIS [low income subsidy] eligibility. Reference **Exhibit C-12** and CMS Pub. 100-18, Chapter 13, § 40.1.6 **(Exhibit C-13)**.

The Providers equate this program to “a “supplemental security income benefit” equivalent to a cash benefit”, like normal SSI benefit payments. However, the Part D Extra Help plan is a Medicare savings plan for low-income individuals and is not a direct “SSI benefit” provided for under Title XVI. The U.S. Court of Appeals in *Advocate Christ* **(Exhibit C-7)** stated that the hospitals were mistaken in trying to equate SSI cash payments under Title XVI with non-cash benefits such as the Medicare Part D subsidy provided under Title XVIII.

In addition, the SSI Award Letter can be used to initially qualify for the Part D program and in accordance with CMS Pub. 100-18, Chapter 13, § 40.1.2 **(Exhibit C-13)**, “Initial LIS determinations are made for a period not to exceed 12 months.” However, that does not necessarily mean that the beneficiary would remain SSI entitled that entire 12 months. SSI entitlement is dependent on income, residency status, etc. on a monthly basis, but the Extra Help program only considers a subsidy-changing event to be marriage, divorce, death of spouse, separation, reunion after separation and annulment. CMS Pub. 100-18, Chapter 13, § 40.1.3 **(Exhibit C-13)**. Based on this publication, income changes do not affect the Part D subsidy. The SSA may periodically contact Extra Help beneficiaries and review to ensure that the beneficiaries are still receiving the benefits they deserve. Reviews are usually done at the end of August. Should the SSA determine that a beneficiary should receive more or less Extra Help payment or be terminated from the program, the change would not become effective until January of the following year. Reference **Exhibit C-14**. This is another difference in the Extra Help program versus SSI entitlement. SSI payments can change monthly, whereas Extra Help payments will continue to be paid in a current year, even if the SSA is aware that a beneficiary no longer qualifies for the benefit. Therefore, it is logical to assume that not all Part D Extra Help patients are SSI entitled for the entire length of the Part D Extra Help program.

**v. The Board is Bound by 42 C.F.R. § 405.1867**

On April 28, 2010, CMS published Ruling 1498-R to respond to a court order in *Baystate v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) *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 fraction 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.”

Consistent with the Ruling, CMS finalized the new data matching process in the FY 2011 Final Rule published on August 16, 2010. 75 FR 50041, 50280-50281 **(Exhibit C-4)**. 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 fraction. CMS stated that SSI codes C01, M01 and M02 “accurately capture 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 C.F.R. § 405.1867,

[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 C.F.R. § 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*, PRRB Dec. 2017-D11 (March 27, 2017) and *Hall Render Individual, Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction*, PRRB Dec. 2017-D12 (March 28, 2017).

The Administrator reviewed the Board’s decisions on May 30, 2017. The Administrator found that the Secretary effectively addressed the statutory interpretation of the term “entitled” as used in § 1886(d)(5)(F)(vi)(I) of the Act and the application of the term in the use of specific codes in the SSI matching process in the FY 2011 Final Rule, as incorporated in CMS Ruling 1498-R. The Administrator found that CMS and the MAC properly incorporated the methodology contained therein in issuing the recalculated SSI matching data for purposes of the Medicare fraction for the DSH payment. However, the Administrator vacated the Board’s decision based on jurisdictional issues of the appealing providers.[[14]](#footnote-14)

The current Providers’ fiscal years end on 12/31/2007 and 12/31/2008 and the Notices of Program Reimbursement (“NPRs”) in dispute were issued by the MAC several years after CMS Ruling 1498-R was issued. The Providers’ cost reports were settled with an SSI fraction that incorporated the revised data matching process described in the FY 2011 Final Rule and CMS Ruling 1498-R. Therefore, as the Administrator upheld the decision of the Board based on the merits of the issue in dispute, the Board’s decision in 2017-D11 and 2017-D12 should apply and the Board should dismiss this issue.

**C. Conclusion**

In view of the foregoing factors, the Providers have failed to establish that CMS improperly excluded SSI eligible and unpaid days from the SSI fraction or that the published SSI fractions are inaccurate. Accordingly, the burden of proof, which is upon the Providers, has not been met. Therefore, the Board must find that CMS’ calculation of the SSI fractions was not arbitrary or capricious and that the MAC’s use of the CMS published SSI fractions did in fact adhere to Medicare law, regulation and Program instructions. Thus, the Board should conclude that the Providers are not entitled to an increase in their DSH payments and dismiss this appeal.

IV. CITATION OF PROGRAM LAW, REGULATIONS, INSTRUCTIONS, CASE LAW AND OTHER SOURCES

Law:

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| SSA § 1886(d)(5)(F) | Payments to hospitals for inpatient hospital services |
| 5 U.S.C. § 552a | The Privacy Act of 1974 |
| 42 U.S.C. § 402 | Old-age and survivors insurance benefit payments |
| 42 U.S.C. § 1395ww(d)(5) | Payments to hospitals for inpatient hospital services |
| 42 U.S.C. § 1395ww(d)(5)(F) | Payments to hospitals for inpatient hospital services: disproportionate share hospital payments |
| Pub. L. 108-173, § 951 | Medicare Prescription Drug, Improvement and Modernization Act of 2003 |

Regulations:

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| 20 C.F.R. §§ 416.200 – 416.216 | Supplemental Security Income for the Aged, Blind, and Disabled: Eligibility |
| 42 C.F.R. § 405.1837 | Group Appeals |
| 42 C.F.R. § 405.1867 | Scope of Board’s legal authority |
| 42 C.F.R. § 412.106 | Special treatment: Hospitals that serve a disproportionate share of low-income patients |
| 42 C.F.R. § 413.20 | Financial Data and reports |
| 42 C.F.R. § 413.24 | Adequate cost data and cost finding |

Federal Registers:

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| 65 FR 50548 | August 18, 2000 |
| 70 FR 47438-47441 | August 12, 2005 |
| 75 FR 50275-50281 | August 16, 2010 |

Program Instructions – CMS Manuals:

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| CMS Pub. 100-18, Chapter 13, § 40 | Medicare Prescription Drug Benefit Manual |

Case Law:

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| *Advocate Christ Medical Center v. Azar,* Civil Action 17-cv-1519 (D.D.C. 2022) |
| *Advocate Christ Medical Center v. Becerra,* No. 22-5214 (D.C. Cir. 2023) |
| *Allina Health System v. Sebelius*, 982 F. Supp. 2d 1, 5 (D.D.C. 2013) |
| *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) |
| *Becerra v. Empire Health Foundation,* 597 U.S. \_\_\_\_ (2022) |
| *Chevron U.S.A.*, *Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984) |
| *Empire Health Foundation v. Price*, Doc. No. 2:16-CV-209-RMP (E.D. Wash. 2018) |
| *Empire Health Foundation v. Azar*, 958 F.3d 873 (9th Cir. 2020) |
| *McCreary v. Offner*, 172 F.3d 76, 78 (D.C. Cir. 1999) |
| *Pomona Valley Hospital Medical Center v. Azar,* 1:18-cv-02763-ABJ, 2020 WL 5816486 (D.D.C. 2020) |
| *Pomona Valley Hospital Medical Center v. Becerra*, No. 20-5350 (D.C. Cir. 2023) |

Board Decisions:

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| *Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction*, PRRB Dec. 2017-D11, March 27, 2017 |
| *Hall Render Individual, Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction*, PRRB Dec. 2017-D12, March 28, 2017 |

Administrator Decision:

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| *Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction & Hall Render Individual, Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction*, Adm. Review of PRRB Dec. Nos. 2017-D11 and 2017-D12, May 30, 2017 |

Other Sources:

|  |  |
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| CMS Ruling 1498-R | April 28, 2010 |
| Board Rule 8 | Framing Issues for Adjustments Involving Multiple Components |

V. EXHIBITS

C-1. Schedule of Providers

C-2. Group Issue Statement from Appeal Request, dated September 20, 2017

C-3. 70 FR 47438 - 47441 (August 12, 2005)

C-4. 75 FR 50275 - 50281 (August 16, 2010)

C-5. CMS MedPAR Data Response

C-6. *Advocate Christ Medical Center v. Azar*, Civil Action 17-cv-1519 (D.D.C. 2022)

C-7. *Advocate Christ Medical Center v. Becerra*, No. 22-5214 (D.C. Cir. 2023)

C-8. SSA Data Exchange Overview

C-9.SSA Program Status Codes

C-10. *Becerra v. Empire Health Foundation*, 597 U.S. (2022)

C-11. 20 C.F.R. §§ 416.200-416.216 SSI Program Eligibility

C-12.SSA: What is Extra Help?

C-13. CMS Pub. 100-18, Chapter 13, § 40

C-14. SSA Medicare Part D Extra Help Recertification

1. *See* Issue statement from the Providers’ appeal request, dated September 20, 2017, at **Exhibit C-2.** [↑](#footnote-ref-1)
2. Providers’ Preliminary Position Paper at page 1. [↑](#footnote-ref-2)
3. Providers’ Preliminary Position Paper at page 32. [↑](#footnote-ref-3)
4. The Providers here are referring to the CMS’s production of the Medicare Provider Analysis and Review (“MedPAR”) data. [↑](#footnote-ref-4)
5. Providers’ Preliminary Position Paper at page 35, footnote 19. [↑](#footnote-ref-5)
6. Providers’ Preliminary Position Paper at pages 1 and 2. [↑](#footnote-ref-6)
7. Providers’ Preliminary Position Paper at page 31, footnote 16. [↑](#footnote-ref-7)
8. It should be noted that none of the Providers in this appeal are located in Indiana. [↑](#footnote-ref-8)
9. Providers’ Preliminary Position Paper at page 1. [↑](#footnote-ref-9)
10. The U.S. Court of Appeals for the Ninth Circuit affirmed the District Court’s ruling, but on different grounds on May 5, 2020. [↑](#footnote-ref-10)
11. Providers’ Preliminary Position Paper at page 22. [↑](#footnote-ref-11)
12. 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-12)
13. The U.S. District Court for the District of Columbia found that the Board’s decision was not supported by “substantial evidence” and remanded the case to the agency for further proceedings. Each party filed an appeal to the U.S. Court of Appeals and, on September 1, 2023, the U.S. Court of Appeals affirmed the district court’s order remanding the case to the Board.  *Pomona Valley Hospital Medical Center v. Becerra*, No. 20-5350 (D.C. Cir. 2023)**.** [↑](#footnote-ref-13)
14. The majority of the providers in PRRB Decisions 2017-D11 and 2017-D12 appealed from an NPR/RNPR that was issued prior to the issuance of CMS Ruling 1498-R. Therefore, the Administrator remanded the cases back to the Board to determine whether or not a final determination incorporating the revised data matching process pursuant to CMS Ruling 1498-R was made and to determine if the SSI matching issue was timely added with sufficient specificity and whether the respective provider had a properly pending appeal on the issue in accordance with CMS Ruling 1498-R and the regulations. [↑](#footnote-ref-14)