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|  | Whether the Secretary properly calculated the Provider’s Disproportionate Share Hospital (“DSH”) / Supplemental Security Income (“SSI”) percentage. |

**A. Facts**

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 results 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 which results in increased PPS payment for inpatient hospital services. 42 U.S.C. § 1395ww(d)(5)(F)(ii).

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 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 forthcoming FY 2011 IPPS final rule for each appeal that is subject to the Ruling. CMS specified that “[t]he data matching process provisions of the Ruling would apply to properly pending appeals and open cost 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 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 Fed. Reg. 50276-50278 (Aug. 16, 2010) at **Exhibit C-3**. CMS tabulated the number of Medicare entitled/SSI days in PPS units of the hospitals and also the total number of Medicare entitled days in inpatient prospective payment system ("IPPS") units of the hospitals. *Id*. It then sent the resulting percentage (SSI ratio or Medicare fraction) to each hospital's MAC, *Id*. The MACs used the SSI ratio to determine whether the hospitals should receive DSH payments and, if so, the amount of such payments. *Id*.

This appeal also concerns a dispute involving “dual eligible” days and whether or not these days are properly included in the published SSI percent. 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*, F. Supp. 2d, CA No. 09-cv-1889, 2013 WL 5530609, \*1, \* 2 (D.D.C. Oct. 8, 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 SSI benefits ("SSI dual eligible days") in the Medicare fraction.

The Providers in this appeal contend that the “MAC’s determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers of Medicare and Medicaid Services (“CMS”) and used by the MAC to settle their Cost Report incorporates a new methodology inconsistent with the Medicare statute.”[[1]](#footnote-1)

The Providers contend that the SSI percentages calculated by the Centers for Medicare and Medicaid Services and used by the MAC to settle its cost report was improperly computed due to the following reasons:

* Availability of MEDPAR and SSA Records
* Paid Days vs. Eligible Days
* Not In Agreement With Provider’s Records
* Fundamental Problems In The SSI Percentage Calculation
* Covered Days Vs. Total Days
* Failure To Adhere To Required Notice and Comment Rulemaking Procedures

See **Exhibit C-2** for the Group’s issue statement.

The Providers’ argument is that CMS’s calculation of SSI percent is not calculated properly because there is not a proper and consistent definition of the term “entitled” and that CMS’s treatment of the term “entitled” is against the intentional language of Congress and violates the Medicare Statute. The Providers further argue that they are unable to determine whether their Medicare DSH payments are correct because they do not have access to the necessary underlying information needed to calculate their SSI fractions.

**B. Arguments**

* + 1. **CMS Properly Included All SSI Dual Eligible Days in the SSI Percentages**

The MAC contends that CMS properly included all SSI dual eligible days that have been sufficiently documented for purposes of calculating the Providers' Medicare fractions.

It has long been CMS's position that, in general, dual eligible days should be included in the Medicare fraction. CMS specifically addressed dual eligible patient days in the May 19, 2003 Federal Register:

If a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual-eligible and the patient days are included in the Medicare fraction of the DSH patient percentage but not the Medicaid fraction.

68 Fed. Reg. 27154, 27207 (May 19, 2003). The Providers' primary argument is that the term "entitled to SSI benefits" must be construed to include all patients who enrolled in the SSI program and were not terminated from the SSI program, even if the patients were not eligible for benefits while they were enrolled in the SSI program. The MAC disagrees. What creates the controversy is that in calculating the Medicare fraction, CMS does look at “entitled to Medicare Part A” and “entitled to SSI” differently.[[2]](#footnote-2) The Providers focus on patient days that were excluded because these days have been matched with SSA codes indicating that the patients had not demonstrated that they were eligible for SSI benefits on the days for which care was provided. In the August 16, 2010 Federal Register at **Exhibit C-3**, CMS explained how it interprets “entitled to SSI benefits” and why it had excluded these days in responses to comments raising complaints similar to those made by the Providers here:

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

* E01 and E02
* N06, N10, N11, N18, N35, N39, N42, N43, N46, N50, and N54
* P01
* S04, S05, S06, S07, S08, S09, S10, S20, S21, S90 and S91
* T01, T20, T22 and T31

CMS responded definitively to the concerns included in the comment:

*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 Fed. Reg. 50280 (August 16, 2010).

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-4**.) 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 percentage 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 percentage, 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.” … [T]he Court 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. *Chevron*, 467 U.S. at 843.” [[3]](#footnote-3)

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.” Reference **Exhibit C-5**. 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.

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

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

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

By comparison, eligibility and entitlement to SSI benefits are much less straightforward and much less static. Initially, there are multiple SSI eligibility requirements: a person must be (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits. Reference 20 C.F.R. § 416.202 at **Exhibit C-6**.

In contrast to the generally, immutable and generally age-based eligibility requirements that make most beneficiaries permanently entitled to Medicare Part A benefits once they become entitled to receive them initially, many of the conditions that make a person eligible for and entitled to SSI benefits are subject to change in a way that makes an eligible person become ineligible and not entitled to SSI benefits at a later date. The Regulations explicitly provide for redeterminations of SSI eligibility 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. There are virtually no similar events that would cause people who were initially eligible for Medicare Part A to no longer be eligible for Medicare Part A. Accordingly, it is necessary to show that patients were actually entitled to SSI benefits before including their days of care in the Medicare fraction, rather than simply including these days because patients were potentially entitled to SSI benefits, as the Providers seek to do. CMS also recognized this distinction when it discussed SSI eligibility in the August 16, 2010 Federal Register:

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

75 Fed. Reg. at 50280-50281 at **Exhibit C-3**.

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

There are a variety of reasons why a person might lose entitlement to SSI benefits, and it is reasonable for CMS to conclude, for instance, that once a person's SSI benefits are suspended or the person no longer has an address on file[[4]](#footnote-4), 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 (Sept. 30, 2020), the Provider went to great lengths to attempt to validate its published SSI percentage and submitted Medicaid data indicating that its SSI percent could be understated.[[5]](#footnote-5)  The Providers here simply contend there are dual eligible and 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 whom were not included in the Medicare fraction. The documentation in the record does not satisfy the auditable documentation requirements of 42 C.F.R. §§ 413.20 and 413.24 necessary to award the Providers any relief.

* + 1. **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. 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 ratio 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 ratio issued by CMS and the resulting audit adjustments made by the MAC remain flawed. 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 data 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 Fed. Reg. 47438-47439 (August 12, 2005) at **Exhibit C-7**. 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:

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 in the group.[[6]](#footnote-6) Reference **Exhibit C-8**. 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 ratio was properly computed.

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 percent. The Providers only received the detailed patient data that CMS used to calculate the published SSI percent, 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 percent.

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 percent 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). The Providers 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 (including, but not limited to, patients who were entitled to benefits under Section 1619(B) of the SSA).

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 Ratio and should be able to identify if any additional days exist that should have been included in the SSI ratio. The Providers have failed to identify any discrepancies in the MedPAR data and has failed to carry its burden of proof and persuasion.

Per the SSA website’s data exchange instruction at **Exhibit C-9**, 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 percentages.

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 which they believe patients are entitled to SSI, but not included in the published SSI percentages. 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 percentages. 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.

* + 1. **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-10** and CMS Pub. 100-18, § 40.1.6.

The Providers equate this program to a supplemental security income benefit equivalent to a 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”.

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, § 40.1.2, “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, § 40.1.3. 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-11**. This is another difference in the Extra Help program vs. 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.

* + 1. **“Entitled” vs. “Eligible” for Medicare Part A Benefits**

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-12**) and by the District Court of the District of Columbia in *Allina Health System v. Sebelius*, --- F. Supp. 2d ---, 2013 WL 5530609, \*1, \* 2 (D.D.C. Oct. 8, 2013) (**Exhibit C-13**). 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). *Catholic Health Initiatives,* 718 F.3d at 920. 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 Providers 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 under 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*, --- F. Supp. 2d ---, 2013 WL 5530609, \*1, \* 2 (D.D.C. Oct. 8, 2013). 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. *Id.*, at \*3. 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). 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). 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. *Id.*, at \*4.

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* 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. *Id.*, at \*6.

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). *Id.*, at \*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. *Id.*

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. *See* *Allina*, 2013 WL 5530609 at \*1. 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.

* + 1. **The Secretary Did Not Violate the Administrative Procedures Act**

Pursuant to the version of 42 C.F.R. § 412.106(b)(2)(i) (2003) in place before the 2005 Final Rule was promulgated, CMS included only “covered” patient days in the Medicare fraction of a hospitals DSH adjustment. This had the effect of excluding dual eligible exhausted coverage patient days from the numerator and denominator of the Medicare fraction. In addition, CMS also excluded the days from the Medicaid fraction. As a result, the days were not counted at all when calculating a hospitals DSH adjustment.

However, on May 19, 2003, the Department of Health and Human Services (HHS) issued a Notice of Proposed Rulemaking (NPRM), wherein it stated that the current Medicare policy was to include dual eligible exhausted coverage patient days in the Medicare fraction of the DSH adjustment. 68 Fed. Reg. 27207-27208 at **Exhibit C-14**. Several commenters responded to the proposed ruling and pointed out the misstatement. On August 1, 2003, HHS issued the FY 2004 Final Rule stating that it was “still reviewing the large number of comments received on the proposed provision relating to dual-eligible patient days in the May 19, 2003” proposed rule. 68 Fed. Reg. 45421. As a result, it did not finalize any change in policy. On May 18, 2004, HHS issued the FY 2005 NPRM and stated that it would address comments from the FY 2003 NPRM in the FY 2005 Final Rule. 69 Fed. Reg. 28286. A few days before the end of the FY 2005 comment period, HHS posted a webpage notice acknowledging the 2003 NPRM’s misstatement of the then-applicable rule. It stated, “[o]ur policy has been that only covered patient days are included in the Medicare fraction.” A few commenters acknowledged HHS’s correction, while others voiced support for the erroneously stated status quo. In the FY 2005 Final Rule dated August 11, 2004, HHS noted,

Comment: We received numerous comments that commenters were disturbed and confused by our recent Web site posting regarding our policy on dual-eligible patient days. The commenters believed that this posting was a modification or change in our current policy to include patient days of dual-eligible Medicare beneficiaries whose Medicare Part A coverage has expired in the Medicaid fraction of the DSH calculation. In addition, the commenters believed that the information in this notice appeared with no formal notification by CMS and without the opportunity for providers to comment.

69 Fed. Reg. 49098 at **Exhibit C-15**. In response, HHS explained that the webpage posting “was not a change in our current policy,” but a “correction of an inadvertent misstatement” made in the FY 2003 NPRM. *Id*. The FY 2005 Final Rule finalized a policy of including dual eligible exhausted coverage patient days in the Medicare fraction of the DSH adjustment. 69 Fed. Reg. 49099.

Providers have argued that HHS did not follow the proper notice-and-comment procedures in implementing the FY 2005 Final Rule. Specifically, Providers contended that the Secretary misstated the then-existing policy in 2003 when he stated the policy included all dual-eligible days in the Medicare fraction and excluded them from the Medicaid fraction, even when the patient’s Medicare Part A benefits were exhausted. Therefore, HHS did not adequately give commenters an opportunity to respond before issuing the FY 2005 Final Rule, which violated the Administrative Procedure Act (APA).

On May 5, 2020, the U.S. Court of Appeals for the Ninth Circuit ruled in *Empire Health Foundation v. Azar*, 958 F.3d 873 that “HHS undoubtedly misstated the then-applicable rule in the 2003 Notice. Nevertheless, the 2003 Notice did describe the content of the 2005 Rule, even if it incorrectly characterized it as the then-applicable rule.” It ruled that the rulemaking process was certainly not perfect, but the FY 2005 Final Rule was a logical outgrowth of the proposed rule change, as commenters could reasonably foresee that after consideration of the proposed rule, HHS might choose to adopt the proposal or to withdraw it. “Commenters on the 2005 Rule were similarly apprised of a binary choice – under the new rule, dual eligible exhausted coverage patient days would be included in either the Medicare or the Medicaid fraction. In the end, they were included in the Medicare fraction.” Reference **Exhibit C-16**. The Court went on to affirm the district court’s summary judgment in favor of *Empire* and order vacating the 2005 Final Rule because it held that the 2005 Rule was substantively invalid, based on its previous binding decision in *Legacy Emanuel*. The MAC notes that the Ninth Circuit does not encompass the states where the disputed Providers are located, and this decision is therefore, not legally binding on them. However, this same issue was addressed by the U.S. District Court for the District of Columbia in *Stringfellow Memorial Hospital v. Azar*, 317 F.Supp.3d 168 (2018), which does govern the Providers in dispute. Reference **Exhibit C-17**. In *Stringfellow*, the Court agreed that the 2004 and 2005 Proposed Rules included “sloppy and confusing misstatements”, but that the FY 2005 Final Rule was a “logical outgrowth” of the 2004 Proposed Rule and was therefore, not a violation of the APA. It further ruled that the FY 2005 Final Rule is procedurally sound and the product of reasoned decision-making.

**C. Conclusion**

In view of the foregoing factors, the Providers have failed to establish that CMS or the MAC improperly excluded SSI eligible days from the Medicare fraction or that the published SSI percentage is still inaccurate. Accordingly, the burden of proof, which was upon the Providers, has not been met. Therefore, the Board must find that the MAC’s determinations were not arbitrary or capricious and 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 the case.

IV. LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

**Law:**

SSA § 1886(d)(5)(F);5 U.S.C § 552a;42 U.S.C. § 402;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);42 U.S.C. § 1395ww(d)(5)(F)(vi);Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-173, § 951)

**Regulations:**

20 C.F.R. § 416.200;20 C.F.R. § 416.202;20 C.F.R. § 416.204;20 C.F.R. § 416.207;20 C.F.R. § 416.210;20 C.F.R. § 416.211;20 C.F.R. § 416.212;20 C.F.R. § 416.214;20 C.F.R. § 416.215;20 C.F.R. § 416.216;42 C.F.R. § 412.106;42 C.F.R. § 413.20;42 C.F.R. § 413.24

**Federal Registers:**

65 Fed. Reg. 50548 (August 18, 2000);68 Fed. Reg. 27154, 27207 - 27208 (May 19, 2003);68 Fed. Reg. 45421 (August 1, 2003);69 Fed. Reg. 28286 (May 18, 2004);69 Fed. Reg. 49098 – 49099 (August 11, 2004);70 Fed. Reg. 47438 – 47441 (August 12, 2005);75 Fed. Reg. 50276 – 50281 (August 16, 2010)

**Program Instructions – CMS Manuals:**

CMS Pub. 100-18, § 40.1.2, 40.1.3, 40.1.6

**Case Law:**

*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);*Allina Health System v. Sebelius*, F. Supp. 2d 1, 5 (D.D.C. 2013) (citing *McCreary v. Offner*, 172 F.3d 76, 78 (D.C. Cir. 1999));*Baystate v. Leavitt,* 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008);*Becerra v. Empire Health Foundation*, 597 U.S. (2022);*Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013);*Empire Health Foundation v. Price*, the U.S. District Court, Eastern District of Washington, Doc. No. 2:16-CV-209-RMP (August 13, 2018);*Empire Health Foundation v. Azar*, 958 F.3d 873 (2020);*Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 398, U.S. App. D.C. 43 (2011);*Pomona Valley Hospital Medical Center v. Azar*, 1:18-cv-02763-ABJ, 2020 WL 5816486 (Sept. 30, 2020);*Stringfellow Memorial Hospital v. Azar*, 317 F.Supp.3d 168 (2018)

**Other**

CMS Ruling 1498-R April 28, 2010

V. EXHIBITS

C-1: Final Schedule of Providers

C-2: Group Appeal Issue Statement

C-3: 75 Fed. Reg. 50276 - 50281 (August 16, 2010)

C-4: SSA Program Status Codes

C-5: *Becerra v. Empire Health Foundation*, 597 U.S. \_\_\_\_ (2022)

C-6: 20 C.F.R. §§ 416.200-416.216 SSI Program Eligibility

C-7: 70 Fed. Reg. 47438-47441 (August 12, 2005)

C-8: CMS MedPAR Data Response

C-9: SSA Data Exchange Overview

C-10: SSA Brochure: What is Extra Help?

C-11: SSA Medicare Part D Extra Help Recertification

C-12*: Catholic Health Initiatives Iowa Corp. v. Sebelius* (D.C. Cir. 2013)

C-13: *Allina Health System v. Sebelius* (D.D.C. Oct. 8, 2013)

C-14: 68 FR 27207-27208 (May 19, 2003)

C-15: 69 FR 49098-49099 (August 11, 2004)

C-16: 9th Circuit Ct of Appeals Decision in *Empire Health Foundation v. Azar* (2020)

C-17: *Stringfellow Memorial Hospital v. Azar* (D.C. Cir. 2018)

1. Group issue statement, **Exhibit C-2.** [↑](#footnote-ref-1)
2. “Entitled” is defined in Black’s Law Dictionary (10th ed. 2014) as “to grant a legal right to” and “to qualify for”. (*Empire Health Foundation v. Price*, the U.S. District Court, Eastern District of Washington, Doc. No. 2:16-CV-209-RMP (Aug. 13, 2018)) [↑](#footnote-ref-2)
3. The US Court of Appeals for the Ninth Circuit affirmed the District Court’s ruling, but on different grounds on May 5, 2020. [↑](#footnote-ref-3)
4. 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-4)
5. 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 for further proceedings. Each party has filed an appeal to the U.S. Court of Appeals and final briefs are pending. [↑](#footnote-ref-5)
6. Requests were received by the Providers on multiple occasions between 2019 and 2020. [↑](#footnote-ref-6)