Whether the providers are entitled to additional Supplemental Security Income (SSI) days in the calculation of their SSI ratios (or Medicare fraction)?

1. **Facts**

By way of background, hospitals are paid for services to Medicare patients under the inpatient prospective payment system (“IPPS”). Under IPPS, inpatient operating costs are reimbursed based on a prospectively determined formula taking into account national and regional operating costs. The IPPS legislation contains a number of provisions that adjust reimbursement based on hospital-specific factors. *See* 42 U.S.C. § 1395ww(d)(5). This case involves one of the hospital-specific adjustments, the DSH adjustment. The DSH adjustment, effective in 1986, requires the Secretary to provide increased PPS reimbursement to hospitals that serve a “significantly disproportionate number of low-income patients.” 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). Whether a hospital qualifies for the DSH adjustment, and the amount of the adjustment it receives, depends on the hospital's “disproportionate patient percentage” (“DPP”). *See* 42 U.S.C. § 1395ww(d)(5)(F)(v).

A hospital’s DPP is determined by adding the results of two computations and expressing the results as a percentage. As indicated in 42 U.S.C. § 1395ww(d)(5)(F)(v) and 42 C.F.R. § 412.106, the two computations are the Medicare fraction (first computation) and the Medicaid fraction (second computation). The Medicare fraction is determined by dividing the number of days of care that are furnished to patients who were entitled to Medicare Part A (or Medicare Part C) benefits and who were “entitled to Supplemental Security Income benefits” by the number of days of care that are furnished to patients who were entitled to Medicare Part A (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).

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. 50,041, 50,276 (Aug. 16, 2010). 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.*

The providers contend that the SSI ratios supplied by CMS to the MACs for the cost reporting years at issue did not include all SSI days and therefore, were not correct. As a result, the providers assert that the DSH payments were understated.

In Becerra v. Empire Health Foundation, for Valley Hospital Medical Center, 20-1312, (U.S. Supreme Court, June 24, 2022), the Court ruled that:

In calculating the Medicare fraction, individuals “entitled to [Medicare Part A] benefits” are all those qualifying for the program, regardless of whether they receive Medicare payments for part or all of a hospital stay. Pp. 7–19.

HHS’s regulation is consistent with the text, context, and structure of the DSH provisions. The agency has interpreted the phrase “entitled to benefits” in those provisions to mean just what it means throughout the Medicare statute: qualifying for benefits. And counting everyone who qualifies for Medicare benefits in the Medicare fraction and no one who qualifies for those benefits in the Medicaid fraction accords with the statute’s attempt to capture, through two separate measurements, two different segments of a hospital’s low-income patient population.

In Advocate Christ Medical Center, ET AL v. Becerra, the United States Court of Appeals for the District of Columbia Circuit, No. 22-5214, decided September 1, 2023, the court granted summary judgement to the Secretary of Health and Human Services (HHS). Briefly, the court concluded that HHS properly determined that only paid SSI days belong in the numerator of the SSI proxy (Medicare fraction). The court also found that Section 951 of the Medicare Prescription Drug Improvement and Modernization ACT (MMA) does not require HHS make available all patient days attributed to SSI enrollees and the specific codes used by SSA to track why those individuals did or did not qualify for the monthly cash payment.[[1]](#footnote-2)

## **Arguments**

As previously noted, the MAC will file a jurisdictional challenge because the providers included two issues in this CIRP group appeal. With the first issue (a technical issue), the providers questioned CMS’s SSI data match process. With the second issue (a policy issue), the providers questioned CMS’s treatment of patient days related to Dual Eligible (Medicare/Medicaid) patients that did not receive SSI benefits while receiving services from the Provider. CIRP and Optional group appeals are limited one common issue, in accordance with 42 C.F.R. § 405.1837(b). Board Rule 8.1 notes that some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible. The MAC will address both issues, notwithstanding the Board accepts jurisdiction over both issues.

The MAC contends that CMS properly included all SSI days that have been sufficiently documented for purposes of calculating the providers’ Medicare fractions.

SSI Data Match Issue

The CMS regulations do not allow for re-computations based on later or “corrected data.” Regulation 42 C.F.R. § 412.106 provides that CMS will calculate a hospital’s Medicare fraction based on its discharge data for a FFY or based on its discharge data for its cost-reporting period. There is no provision for doing re-computations based on later or corrected data, and thus one should not be implied. CMS’s establishment of the recalculation process specified in section 412.106 gives further support to the MAC’s position. The recalculation process exists not for the purpose of simply using updated or corrected data, but, rather, to calculate a hospital’s Medicare fraction for a different time period, i.e., its cost reporting period rather than the fiscal year in which its cost reporting period began.[[2]](#footnote-3) Where a provider seeks to have its Medicare fraction recalculated on the basis of its cost reporting period, instead of on the basis of the Federal Fiscal Year (FFY), CMS will do so, but the resulting percentage, higher or lower, is the provider’s Medicare fraction. See 42 C.F.R. § 412.106. Responding to a comment, in which the submitter suggested that hospitals that request a recalculation be “held harmless” if the resulting percentage were lower, CMS stated:

Concerning the request for a "hold harmless" provision, it has been our consistent policy that a hospital that requests a recalculation of its Medicare Part A/SSI percentage based on its cost reporting period must accept the result of that calculation in place of the Federal fiscal year calculation. We believe that this policy prevents hospitals from taking advantage of the opportunity to request this procedure merely so that they can choose the higher percentage.

60 Fed. Reg. at 45812.

The policy on recalculations evinces a clear intent that the determination is final when made and not subject to change based on later data, including later data available at the time of an appeal. Thus, a provider that has a cost reporting period different from the FFY could not receive a recalculation based on its cost reporting period and then file an appeal so as to obtain a different Medicare fraction through the use of later data. Similarly, a provider that has a cost reporting period that is the same as the FFY cannot obtain a different Medicare fraction through the use of later data. This reading of the regulations is consistent with CMS’s stated goal to derive approximate, not perfect, disproportionate patient percentages.[[3]](#footnote-4) In sum, regulation 412.106 should be read as not allowing re-computations based on later data.

Even if the Board could rule on the question of whether subsequent or different data could be used, however, CMS’s policy should be upheld. Courts have recognized that in implementing the inpatient hospital IPPS, CMS is entitled to rely on the best data available at the time it makes a determination and is not obligated to correct its determinations based on later or corrected data. If, based on later data, the Secretary was to revise a provider’s SSI fraction under their reopening authority at 42 C.F.R. § 405.1885-1889 (or under other authority developed especially for this purpose), it could result in increasing or decreasing a provider’s DSH payments, or awarding or denying altogether a DSH adjustment, thus leading to unexpected shifts in basic reimbursement rates, which would erode the predictability and finality that underlie the PPS scheme. Performing re-computations also would be administratively burdensome. Therefore, should the Board decide it has the authority to address CMS’s policy of not performing re-computations, it should uphold CMS’s policy as reasonable and not arbitrary and capricious, and no adjustment to the provider’s SSI fractions should be made in this case. This is not the first, nor will it be the last time the Secretary’s “finality rationale” is challenged by a provider. The United States Court of Appeals for the District of Columbia has spoken on the issue of finality:

“The Secretary refers to this as the "finality" rationale, and we cannot conclude under our deferential standard of review that it is arbitrary and capricious. In addition to promoting efficiency, the Secretary’s emphasis on finality protects Medicare providers as well as the Secretary from unexpected shifts in basic reimbursement rates.” *Methodist Hospital of Sacramento v. Shalala* ***38 F.3d 1225 (D.C. Cir. 1994)***

The providers are simply arguing that there may be additional SSI days. They have not identified errors with the Secretary’s SSI ratio, even though MEDPAR data has been available to the providers to reconcile its listing of SSI days they believe were omitted from its SSI percentage. MEDPAR data was available to the providers prior to the date of its appeal request. The providers’ claim that it has not been able to reconcile its listing with MEDPAR data is inaccurate and misleading. How can the providers claim dissatisfaction with their own failure to reconcile its records with the MEDPAR data?

The regulation at 42 C.F.R. § 413.20 states that a provider must permit the MAC to examine their records and documents as necessary to ascertain information pertinent to the determination of the proper amount of program payments due. The providers argue that the DSH Medicare fraction should be modified but has provided no documentation or support as to how it arrived at the modification. A provider claiming that additional SSI days should be included in its SSI percentage, at a minimum, should provide a listing of SSI days it believes should be used to calculate its SSI percentage. The providers claim in their appeal request and position paper that it has not received the MEDPAR data. Through their own fault, the providers have not reconciled the MEDPAR data with their records. The providers should not be able to express dissatisfaction with their inability to gather MEDPAR data.

The matching process was revised with the Ruling No. CMS-1498-R as stated “…in order to avoid, or at least minimize, the filing of new administrative appeals on the SSI fraction data matching process issue, CMS and the Medicare contractors will apply the same suitably revised data matching process in determining the SSI fraction, and calculating the DSH payment adjustment, for each "open" hospital cost reporting period where the contractor has not yet settled finally the provider’s Medicare cost report through the issuance of an initial notice of program reimbursement (NPR)…” see 42 C.F.R. § 405.1801(a), 405.1803. CMS and the Medicare contractors will also apply the provisions of this Ruling, on all three DSH issues, to each qualifying hospital cost reporting period where the contractor has not yet settled finally the provider’s Medicare cost report.

If additional SSI days exist, the providers have failed to explain why such days were not included in its SSI percentage. At this time, the Providers have failed to identify any listing of additional SSI days. There is no support of any effort put forth by the providers to identify what additional days, if any, should be included in the computation of its SSI percentage. The MAC believes the Providers’ failure to support its contention related to additional SSI days demonstrates that this issue should be dismissed.

SSI Entitlement/Eligibility Days – Dual Eligible (Medicare/Medicaid) Patients

The MAC contends that CMS properly included all SSI days that have been sufficiently documented for purposes of calculating the providers’ Medicare fractions. The providers’ argument is primarily related to dual eligible patients. 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 68 Fed. Reg. 27,154, 27,207 (May 19, 2003), stating:

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.

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 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, CMS explained why it had excluded these days in responses to comments raising complaints similar to those made by the providers:

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

E01 and E02

N06, N10, N11, N18, N35, N39, N42, N43, N46, N50, and N54

P01

S04, S05, S06, S07, S08, S09, S10, S20, S21, S90, and S91

T01, T20, T22, and T31

CMS responded definitively to the concerns included in the comment:

In response to the comment that we are incorrectly applying a different standard in interpreting the word “entitled” with respect to SSI entitlement versus Medicare entitlement, we disagree. The authorizing DSH statute at section 1886(d)(5)(F)(vi)(I) of the Act limits the numerator to individuals entitled to Medicare benefits who are also “entitled to supplemental security income benefits (excluding any State supplementation)” (emphasis added). Consistent with this requirement, we have requested, and are using in the data matching process, those SSA codes that reflect “entitlement to” receive SSI benefits. Section 1602 of the Act provides that “[e]very aged, blind, or disabled individual who is determined under Part A to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of this title, be paid benefits by the Commissioner of the Social Security” (emphasis added). However, eligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month. For example, section 1611(c)(7) of the Act provides that an application for SSI benefits becomes effective on the later of either the month following the filing of an application for SSI benefits or the month following eligibility for SSI benefits.

75 Fed. Reg. 50,041, 50,280 (Aug. 16, 2010).

Later in CMS’s response, it addressed each code submitted in the comment and explained why days with these codes did not establish that the patients were entitled to SSI benefits. *Id.*, at 50,281.

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, merely 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. 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. The providers are simply arguing that there may be additional SSI days. They have not substantiated errors exist within the Secretary’s SSI ratios, even though MEDPAR data has been available to the providers to reconcile their listings of SSI days they believe were omitted from their SSI percentages. The providers make a number of unsubstantiated allegations in their position paper. If additional SSI days exist, the group has failed to explain why, and more importantly, document that any specific days were not included in their SSI percentages. There is no support that any effort was put forth on the part of the providers to identify what additional days if any should be included in their SSI percentages. The providers failed to even supply a total listing of days they believe should be included in their respective SSI percentages.

The providers suggested that Medicaid eligibility should be used to substantiate SSI entitlement for dual-eligible beneficiaries. The providers are in possession, or have had access to their own records, Medicaid eligibility data, and MEDPAR data. Nothing prevented the providers from submitting evidence to substantiate their position related to Medicaid data. Similarly, the provider made other allegations related to Medicare Part D benefits. Again, the providers are in possession, or have had access to their own records, Medicare Part D data, and MEDPAR data. Nothing prevented the providers from submitting evidence to substantiate their position related to Medicare Part D benefits.

The providers have attempted to shift the burden of proof away from themselves, even though they are the proponents of this action and owners of this appeal, and therefore, bear the burden of proving their case through adequate documentation. The providers cannot shift their burden of proof to the MAC or CMS by claiming they do not have access to the data, when they do have access to MEDPAR data, and their own internal records. Each provider should submit the listing of days they believed belong in their SSI percentages and identifying within such listing those days they believe have been omitted. The providers contend that there are additional codes they believe are wrongfully excluded from the match process. The contentions are speculative in nature because none of the providers have submitted a listing of days or documented where MEDPAR data confirms any of the contentions. 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. It is also reasonable for CMS to conclude that patients who were suspended from the SSI program and ineligible for SSI benefits, were also not entitled to receive benefits.

The MAC contends that CMS properly included all SSI days that have been sufficiently documented for purposes of calculating the providers’ Medicare fractions. The providers contend that entitlement to SSI benefits is analogous to entitlement to Medicare Part A. The MAC has previously pointed out that this is an “apples to oranges” comparison, as an individual becomes automatically entitled to Medicare Part A by reaching age 65 and filing an application or becoming disabled and entitled to disability benefits before reaching retirement age.[[4]](#footnote-5) The United States Court of Appeals for the District of Columbia Circuit spoke to the question of entitlement to Part A benefits in *Hall vs. Sebelius* (Decided February 7, 2012, No. 1:08-cv-01715). [[5]](#footnote-6) In its opinion, the Court stated:

“Plaintiffs’ lawsuit faces an insurmountable problem: Citizens who receive Social Security benefits and are 65 or older are automatically entitled under federal law to Medicare Part A benefits. To be sure, no one has to take the Medicare Part A benefits. But the benefits are available if you want them. There is no statutory avenue for those who are 65 or older and receiving Social Security benefits to disclaim their legal entitlement to Medicare Part A benefits. For that reason, the District Court granted summary judgment for the Government.”

The Court’s opinion in *Hall* went on to point out that individuals may refuse to request Medicare payment for services they receive and instead pay for the services themselves or with other insurance.[[6]](#footnote-7) As the Court points out, “If you are 65 or older and sign up for Social Security, you are automatically entitled to Medicare Part A benefits. You can decline those benefits. But you still remain entitled to them under the statute.” Clearly, entitlement to Part A benefits is not reliant upon payment for those services. Subsequent changes in circumstances typically cannot nullify one’s entitlement to Medicare Part A.

To the contrary, the eligibility for payment, and the payment of benefits, are intrinsic to basic SSI entitlement.[[7]](#footnote-8) Statute requires the Commissioner of Social Security to pay SSI benefits to every individual who is determined to be eligible. There is no automatic entitlement to SSI. In fact, there are several requirements an individual must meet before achieving eligibility for SSI and receiving SSI benefits.[[8]](#footnote-9) Further, regulation requires redeterminations of SSI eligibility on a scheduled basis at periodic intervals.[[9]](#footnote-10)

Where one is entitled to SSI benefits, payment is made; therefore, it is more than reasonable for CMS to conclude that an individual was not entitled to SSI where the individual was not paid SSI benefits. Eligibility and entitlement to SSI benefits are much less straightforward and much less static than entitlement to Medicare Part A. 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. *See* 20 C.F.R. § 416.202.

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 residents of public institutions (such as prisons) (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 to Medicare Part A to no longer be eligible for Medicare Part A.[[10]](#footnote-11) Accordingly, it is necessary to show that patients were entitled to SSI benefits before including their days of care in the Medicare fraction. 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.

*Id.*, 75 Fed. Reg. at 50,280.

The House and Senate agreed to define the low-income patients in both the Medicare Fraction, and the Medicaid Fraction. The agreement between the House and the Senate suggests that the SSI percentage should include the total number of inpatient days attributable to Federal Supplemental Security Income beneficiaries (FSSIBs), divided by the total number of Medicare patient days. The eventual statute defined the SSI percentage as:

the fraction (expressed as a percentage), the numerator of which is the number of such hospital’s patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplementary security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital’s patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter.[[11]](#footnote-12)

As previously noted, statute requires that all individuals eligible for SSI benefits must be paid those benefits by the Commissioner of Social Security. The Commissioner of Social Security provided many clues as to who is or is not eligible for SSI benefits, that is, individuals must meet all basic requirements listed in 20 CFR § 416.202.

The providers argue that suspension from the SSI program, and the corresponding suspension of benefits, is in no way indicative of entitlement to SSI. As previously noted, statute dictates that basic entitlement requires eligibility for and payment of SSI benefits.[[12]](#footnote-13) Further, statute goes on to require that individuals meet a number of criteria to be eligible for payment of SSI benefits.[[13]](#footnote-14) The providers argue that until an individual is terminated from the SSI program, all of his or her patient days must be counted in the Medicare Fraction. The providers’ contention related to termination must be rejected.

The Social Security Administration Program Operations Manual System (POMS) identifies suspension and termination both as post-eligibility (PE) events and found it important to note that the term eligible as it pertains to SSI, means that a recipient meets all basic SSI eligibility requirements.[[14]](#footnote-15) Like an individual who has terminated from the SSI program, an individual who has been suspended from the program is no longer eligible for SSI benefits. Even though termination and suspension both result in a lack of eligibility and payment of SSI benefits (both basic elements of SSI entitlement), termination is much less probable, which is the likely reason the providers contend termination should be the measure. Whether a patient terminates from the SSI program, or is suspended from the SSI program, he or she is no longer eligible for or entitled to SSI benefits. Further, as noted in the August 16, 2010, Federal Register, the Social Security Administration (SSA) confirmed that individuals in a suspended status are not entitled to SSI benefits.[[15]](#footnote-16) Clearly, patients who are enrolled in the SSI Program, whose SSI eligibility and payments have been suspended, are not entitled to SSI benefits.

Because SSI entitlement is impermanent, difficult to establish and easy to lose, the providers’ complaint that CMS and the MACs excluded patient days based on codes that do not “prove” ineligibility 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 no longer has an address on file and is suspended from the SSI program, this person is no longer entitled to SSI benefits and may properly be excluded from the Medicare fraction, barring evidence to the contrary. The providers have failed to produce such evidence to the contrary. The providers simply contend there are dual eligible days that were not included in the Medicare fraction. The documentation in the record does not satisfy the auditable documentation requirements of 42 C.F.R. §§ 413.20 and 413.24 necessary to award the providers any relief.

The providers suggest that CMS should allow Medicaid eligibility to substantiate SSI entitlement. In short, the providers believe patient days related to those Medicare beneficiaries who are eligible for Medicaid[[16]](#footnote-17), should automatically be counted within their SSI percentages. First, the providers’ suggestion that “dual eligible status” should verify SSI entitlement is flawed. SSI entitlement is impermanent, difficult to establish, and easy to lose. The providers have failed in any way to verify that the gain or loss of SSI entitlement would require the gain or loss of Medicaid eligibility, or that the gain or loss of Medicaid eligibility would require the gain or loss of SSI entitlement. Second, the providers possess the Medicaid eligibility data, and have not produced listings of days they believe should be included in their SSI percentages based upon Medicaid data.

The providers argue that CMS’s treatment of fully subsidized Medicare Part D prescription drug coverage somehow demonstrates a discordant construction of the DSH statute. This is not the case. Individuals can be deemed automatically eligible for the full Medicare Part D subsidy because they were enrolled and eligible for SSI benefits, or eligible for full Medicaid benefits, or eligible for a Medicare Savings Program. If not automatically deemed eligible, individuals could obtain a full subsidy through an application process. Clearly, eligibility to have one’s Part D coverage subsidized, is not indicative of being entitled to SSI benefits. Part D Extra Help ensures patients do not pay premiums or deductibles for drugs and limits the price of drugs covered by individuals’ plans. Extra Help is not a benefit paid to individuals. On the other hand, SSI benefits are a monthly cash benefit paid to SSI eligible individuals by the Commissioner of Social Security. Medicare Part D and SSI are separate programs. Entitlement to Medicare Part D does not make an individual entitled to monthly SSI payments.

The providers argue that there is one PSC code (E01) used to identify recipients of SSI benefits for the purpose of the full Part D subsidy, but that same code is not identified as an SSI eligible code when identifying individuals entitled to SSI benefits. PSC Code E01 represents an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit but has countable income of $30 or more. Such individual is not entitled to receive SSI payments. Alternatively, an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but does not have countable income of at least $30, would be reflected on the SSI file as a C01 (which denotes SSI entitlement) for any month in which the requirements of this sentence are met. Therefore, code E01 represents an individual who is not entitled to SSI benefits and is reflected accordingly in the SSI file.

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 their purported inability to obtain documentation from a party that is not before the Board.

The providers allege that Medicaid data and Medicare Part D data support their contentions. As previously noted, not a single provider in the group has submitted a listing of days that they believe are supported by Medicaid or Medicare Part D data. Nor has any provider in the group submitted a shred of Medicaid or Medicare Part D data. The providers are free to include whatever argument they wish in their position paper; however, where the providers fail to substantiate their arguments with documenting evidence, their arguments must be dismissed.

The providers contend that CMS’s policy is arbitrary and capricious because it leads to such absurd results that any explanation CMS has offered or could offer cannot be accepted. There is really no support for the provider’s contention, as they fail to provide any examples of patient days that substantiate any of their speculation. More importantly, the providers’ contention requires one to disregard the applicable statute and direct instruction from the Commissioner of Social Security. The providers’ contention requires patient days to be included in the count of SSI days within their Medicare fractions that are related to individuals who are suspended from the SSI program, ineligible for SSI benefits, and fail to meet the basic requirements for entitlement to SSI benefits. 42 U.S.C. §1381a requires every individual who is entitled to SSI benefits be paid benefits by the Commissioner of Social Security, and the Commissioner of Social Security has clearly stated that individuals who are suspended from the SSI program are not entitled to SSI benefits and fail to meet the basic requirements for eligibility. When all facts are considered, CMS’s policy is logical and reasonable, rather than absurd as the Providers would have the Board believe.

Providers’ claim that failure to use best available data rises to ultra vires action and violates both steps of Chevron.

The providers state that because CMS does not use the best data available, they are giving rise to ultra vires and are steps of the *Chevron.* The providers in Advocate Christ Medical Center, et al., vs Becerraheld this same position. The United States Court of Appeals for the District of Columbia Circuit dismissed this argument. The Court stated:

We have also deferentially reviewed HHS interpretations of the Medicare Act under *Chevron U.S.A. Inc. v. NRDC*, 467 U.S. 837 (1984). *See Gentiva*, 31 F.4th at 775. However, we need not apply the *Chevron* framework if we conclude that the agency has correctly construed the governing statute. *See Empire*, 142 S. Ct. at 2362.[[17]](#footnote-18)

Because we agree that the Secretary offered the correct interpretation of the Medicare fraction, we adopt it without considering any question of *Chevron* deference.

Medicare Prescription Drug, Improvement, and Modernization (MMA) § 951

The providers argue that under MMA § 95, CMS is required to give each hospital the data necessary for the hospital to compute number of patients days used in computing their DSH percentages. The MAC asserts that CMS has made available the necessary data that they can are required submit to the providers.

The providers in Advocate Christ Medical Center, et al., vs Becerraheld this same position, as the provider of this instant case. The United States Court of Appeals for the District of Columbia Circuit dismissed this argument. The Court stated:

To comply with the MMA, the agency gives hospitals data of the “matched patient-specific Medicare Part A inpatient days/SSI eligibility data on a month-to-month basis.” Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates, 70 Fed. Reg. 47,278, 47,440 (Aug. 12, 2005). This amounts to a list of inpatient days along with a binary yes-or-no marker indicating whether the patient for those days was counted as being entitled to SSI benefits. HHS neither receives from SSA, nor gives to the hospitals, the individual codes reflecting SSA’s determination of why specific enrollees were or were not entitled to SSI benefits month-to-month.

1. **Conclusion**

The Board should dismiss this CIRP group appeal because the providers have included two separate issues in the appeal. The data match issue (a technical issue) and the Dual Eligible Days issue (a policy issue) should have been included in two different appeals.

In view of the foregoing, the providers have failed to establish that CMS or the MACs improperly excluded SSI days from the Medicare fraction. Accordingly, the burden of proof, which was upon the providers, has not been met. Therefore, the Board must find that the MACs’ 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 Providers’ appeals.

IV. LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

United States Statutes:

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)(v)

Federal 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. § 416.211;20 C.F.R. § 416.214;20 C.F.R. § 416.215;42 C.F.R. § 412.106(a);42 C.F.R. § 412.106(b);42 C.F.R. § 413.20;42 C.F.R. § 413.24;42 C.F.R. § 405.1837(b)

Federal Cases:

*Allina Health System v. Sebelius*, 982 F. Supp. 2d 1, 5 (D.D.C. 2013);*McCreary v. Offner*, 172 F.3d 76, 78 (D.C. Cir. 1999)

Federal Register Notices:

68 Fed. Reg. 27,154, 27,207 (May 19, 2003);75 Fed. Reg. 50,041, 50,276-50,281 (Aug. 16, 2010).

V. EXHIBITS

C-1. Schedule of Providers

C-2. Advocate Christ Medical Center, et al., v. Becerra, United States Court of Appeals for the District of Columbia Circuit, decided September 1, 2023.

1. See Exhibit C-2 [↑](#footnote-ref-2)
2. CMS’s policy on the data that it uses for calculations based on the federal fiscal year is consistent with the data that it uses for recalculations, because, for purposes of recalculations based on the provider’s cost reporting period, CMS uses the latest update of MEDPAR existing at the time it performs the recalculation. CMS’s policy is consistent because in both situations (calculations based on the federal fiscal year and recalculations based on the provider’s cost reporting period), the latest data available at the time are used. Further, as noted below, in neither situation will CMS perform an additional calculation or recalculation based on data that is updated subsequent to the calculation or recalculation. [↑](#footnote-ref-3)
3. In the final rule implementing the DSH adjustment, CMS explained that its preferred method was to calculate Medicare fractions based on the FFY, rather than on the hospital’s cost reporting period. It stated:

   We do not believe that there are likely to be significant fluctuations from one year to the next in the percentage of patients served by the hospital who are dually entitled to Medicare Part A and SSI. [↑](#footnote-ref-4)
4. 42 U.S.C. § 402 [↑](#footnote-ref-5)
5. The plaintiffs (including Hall) wished to disclaim their legal entitlement to Medicare Part A benefits, because the plaintiffs preferred to receive coverage from their private insurers rather than from the government. [↑](#footnote-ref-6)
6. See Medicare Claims Processing Manual Chapter 1, § 50.1.5. [↑](#footnote-ref-7)
7. See 42 U.S. Code § 1381a. [↑](#footnote-ref-8)
8. See 20 CFR § 416.202. [↑](#footnote-ref-9)
9. See 20 CFR § 416.204. [↑](#footnote-ref-10)
10. While a beneficiary might become ineligible by for instance, becoming eligible via a permanent disability that miraculously was cured, such events are “rare to remote” and, moreover, the Medicare fraction is merely a proxy measure, not an exact measurement, and the providers have not demonstrated that such events occur anywhere nearly as often as commonplace events such as a slight income increase that would make someone ineligible for and no longer entitled to SSI benefits. [↑](#footnote-ref-11)
11. See 42 U.S.C. § 1395ww(d)(5)(F)(vi) [↑](#footnote-ref-12)
12. *Id.*at 42 U.S.C. § 1381a [↑](#footnote-ref-13)
13. 42 U.S.C. § 1382 [↑](#footnote-ref-14)
14. See SSA POMS SI 02301.201 [↑](#footnote-ref-15)
15. FR Vol. 75, No. 157, Monday August 16, 2010, at page 50281. [↑](#footnote-ref-16)
16. Dual eligible beneficiaries. [↑](#footnote-ref-17)
17. Exhibit C-2, page 8. [↑](#footnote-ref-18)