APPENDIX

App. 1

United States Court of Appeals
FOR THE DISTRICT OF COLUMBIA CIRCUIT

Argued April 14, 2023 Decided September 1, 2023

No. 22-5214

ADVOCATE CHRIST MEDICAL CENTER, ET AL.,
APPELLANTS

v.

XAVIER BECERRA, SECRETARY, UNITED STATES
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
APPELLEES

Appeal from the United States District Court
for the District of Columbia
(No. 1:17-cv-1519)

Daniel F. Miller argued the cause for appellants. With him on the briefs were *Sara Jean MacCarthy* and *Heather D. Mogden*.

Stephanie R. Marcus, Attorney, U.S. Department of Justice, argued the cause for appellees. With her on the brief were *Mark B. Stern*, Attorney, and *Brian M. Boynton*, Principal Deputy Assistant Attorney General.

Before: HENDERSON, KATSAS, and PAN, *Circuit Judges*.

Opinion for the Court filed by *Circuit Judge* KATSAS.

KATSAS, *Circuit Judge*: Hospitals treating Medicare beneficiaries receive greater reimbursements to the

extent that the beneficiaries are also entitled to supplemental security income benefits under Title XVI of the Social Security Act. The Secretary of Health and Human Services understands this population to include only patients receiving cash payments during the month in question. Various hospitals contend that this population also includes patients receiving a subsidy under Medicare Part D and vocational training. The district court disagreed with the hospitals, as do we.

I

A

This case involves benefits under three different titles of the Social Security Act. Title XVIII of that Act establishes the Medicare program, which provides health insurance to the elderly and disabled. Part A of Medicare covers inpatient hospital services, and Part D affords a prescription-drug benefit. Title XVI of the Social Security Act provides monthly cash payments, known as supplemental security income benefits, to financially needy individuals who are elderly, disabled, or blind. Title XI, among other things, provides vocational rehabilitation services for the disabled. In the United States Code, the Social Security Act is codified as chapter 7 of Title 42, and its individual titles are codified as subchapters of chapter 7. The Department of Health and Human Services administers Medicare, while the Social Security Administration administers the SSI program and the vocational rehabilitation services under Title XI.

Hospitals receive fixed payments for services provided to Medicare beneficiaries regardless of their actual costs. The payment formula, which approximates the costs that a well-run hospital would incur to provide the treatment at issue, seeks to "encourage efficiency by rewarding cost effective hospital practices." *Cape Cod Hosp. v. Sebelius*, 630 F.3d 203, 205 (D.C. Cir. 2011) (cleaned up). One variable in the formula is a "disproportionate share hospital" adjustment, which provides additional compensation to hospitals serving an "unusually high percentage of low-income patients." *Sebelius v. Auburn Reg'l Med. Ctr.*, 568 U.S. 145, 150 (2013). This adjustment accounts for the fact that low-income patients tend to be in worse health and therefore costlier to treat. *Id.*

The DSH adjustment derives from two statutory formulas known as the Medicare fraction and the Medicaid fraction. The Medicare fraction represents the percentage of a hospital's Medicare patients who are low-income, as measured by their entitlement to SSI benefits. The Medicaid fraction represents the percentage of a hospital's patients who are eligible for Medicaid, which provides health benefits to a different population of low-income individuals. The sum of these fractions, which is called the hospital's "disproportionate patient percentage," reflects all low-income patients served. *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

This case turns on the Medicare fraction, which consists of the following:

> 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. . . .

42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). In plain English, the numerator of the Medicare fraction is the number of patient days attributable to Medicare patients who are entitled to SSI benefits, while the denominator is the number of patient days attributable to all Medicare patients.

For our purposes, the key statutory terms are "entitled to benefits under part A" and "entitled to supplementary security income benefits . . . under subchapter XVI." The Department of Health and Human Services considers a patient "entitled to benefits under part A" if he satisfies the threshold requirements for Part A benefits—*i.e.*, if he is over 65 or suffers a long-term disability—regardless of whether Medicare pays for the specific service rendered. *See* Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates, 69 Fed. Reg. 48,916, 49,098–99, 49,246 (Aug. 11, 2004). The Supreme

Court recently endorsed this interpretation in *Becerra v. Empire Health Foundation*, 142 S. Ct. 2354 (2022).

The SSI program provides cash payments to financially needy individuals who are aged, blind, or disabled. 42 U.S.C. § 1382(a). Individuals must apply for this benefit. *Id.* § 1382(c)(7). Eligibility is determined monthly, depending on a beneficiary's "income" and "resources" during the month. *Id.* § 1382(c)(1). Once an individual qualifies for the cash payment during a particular month, he remains enrolled in the SSI program until failing to qualify for the payment for twelve consecutive months. *See* 20 C.F.R. § 416.1335. At that point, the individual must reapply to receive future payments.

Enrollees in the SSI program may receive two further benefits beyond the cash payments. First, they become eligible for a subsidy under Medicare Part D. *See* 42 U.S.C. § 1395w-114(a)(3)(B)(v)(I). Each enrollee receives this subsidy for at least six months regardless of whether he continues to qualify for the monthly payments. 42 C.F.R. § 423.773(c)(2). Second, blind or disabled enrollees may access the Ticket to Work and Self-Sufficiency Program, which provides vocational rehabilitation services through state agencies or private employment networks. 42 U.S.C. § 1320b-19. In some circumstances, SSI enrollees may use these services even after they fail to qualify for the monthly payments. *See* 20 C.F.R. §§ 411.100–660.

For purposes of the Medicare fraction, HHS interprets the phrase "entitled to supplementary

security income benefits . . . under subchapter XVI" to denote only those patients who are entitled to the cash payment during the month in question. In administering the SSI program, SSA assigns codes to track monthly (1) whether enrollees qualified for the payment and (2) the reason why or why not. For example, the code "N01" indicates that an enrollee failed to receive a payment for a particular month ("N") because of excess income during that month ("01"). After studying the various codes used by SSA, HHS concluded that codes C01, M01, and M02 capture the relevant universe of individuals entitled to the monthly payment. *See* Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Changes and FY 2011 Rates, 75 Fed. Reg. 50,042, 50,281 (Aug. 16, 2010).[1] To help HHS calculate the Medicare fraction of individual hospitals, SSA gives HHS data in the form of "monthly indicators," which denote whether SSI enrollees were coded as C01, M01, or M02 in any given month. *See id.* at 50,276. HHS calculates the Medicare fraction by comparing this data regarding who qualified for monthly cash payments against its own data regarding the inpatient admissions of individuals entitled to Part A benefits. *Id.* at 50,278.

To provide for a check on HHS's work, Congress enacted section 951 of the Medicare Prescription Drug,

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[1] Code C01 indicates that an SSI enrollee receives an automated cash payment. Codes M01 and M02 reflect enrollees whose cash payments SSA manages manually.

Improvement, and Modernization Act (MMA). It requires HHS to give each hospital "the data necessary" for the hospital "to compute the number of patient days used in computing the disproportionate patient percentage . . . for that hospital." Pub. L. No. 108-173 § 951, 117 Stat. 2066, 2427 (2003) (codified at 42 U.S.C. § 1395ww note). 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.

B

The plaintiffs in this case are more than 200 different hospitals seeking additional Medicare reimbursement for fiscal years 2006 to 2009. The hospitals dispute HHS's calculation of their respective Medicare fractions for those years. They contend that the phrase "entitled to supplementary security income benefits" includes all patients enrolled in the SSI program at the time of hospitalization, even if they did not then qualify for the monthly cash payment. The

Provider Reimbursement Review Board, a tribunal within HHS, denied relief to the hospitals. So did the Centers for Medicare and Medicaid Services, which administers Medicare for the Secretary. Consistent with the Secretary's longstanding view, CMS reasoned that "[b]ecause SSI is a cash benefit, only a person who is actually paid these benefits can be considered 'entitled' to these benefits." J.A. 568.

The hospitals sought review of the reimbursement decisions in the district court. They continued to argue that HHS has misconstrued the Medicare Act. Alternatively, they claimed that the HHS matching process is arbitrary even under HHS's construction. Finally, through a claim for mandamus, the hospitals sought an order directing HHS to provide them with the SSI payment codes for their respective patients. The district court rejected these claims and granted summary judgment to HHS. *Advoc. Christ Med. Ctr. v. Azar*, No. 17-cv-1519, 2022 WL 2064830 (D.D.C. June 8, 2022).

II

We review the grant of summary judgment *de novo*. *Gentiva Health Servs., Inc. v. Becerra*, 31 F.4th 766, 775 (D.C. Cir. 2022). Like the district court, we apply the arbitrary-and-capricious standard from the Administrative Procedure Act. *See* 5 U.S.C. § 706(2)(A); 42 U.S.C. § 1395*oo*(f)(1). Under that deferential standard, an agency decision need only be "reasonable

and reasonably explained." *FCC v. Prometheus Radio Project*, 141 S. Ct. 1150, 1155 (2021).

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.

III

We begin with the dispute over the phrase "entitled to supplementary security income benefits . . . under subchapter XVI." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). HHS reads it to cover only Medicare beneficiaries who are entitled to SSI cash payments at the time of their hospitalization. The hospitals read it to cover Medicare beneficiaries who are enrolled in the SSI program at the time of their hospitalization, regardless of whether they receive a cash payment at that time. To justify their position, the hospitals contend that SSI benefits under subchapter XVI include not only cash payments but also the Medicare Part D subsidy and vocational rehabilitation services.

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.[2]

Section 1320b-19 of Title 42 confirms this point. Housed in subchapter XI, it requires SSA to establish the Ticket to Work program, which provides vocational rehabilitation services to blind or disabled individuals who are "eligible for supplemental security income

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[2] *See*, *e.g.*, 42 U.S.C. § 1382(e)(1)(B) (setting forth "the benefit under this subchapter," in dollars, for certain individuals in treatment facilities); *id.* § 1382(h) (rules for "determining eligibility for, and the amount of, benefits payable under this section"); *id.* § 1382b(c)(1)(A)(iv) (rules for determining "the amount of the maximum monthly benefit payable under section 1382(b)"); *id.* § 1382c(f)(1) (rules for "determining eligibility for and the amount of benefits for" certain married individuals); *id.* § 1382d(a)(2) (treatment of minors "with respect to whom benefits are paid under this subchapter"); *id.* § 1382e(d)(5)(C) (permissible use of funds "appropriated for payment of benefits under this subchapter"); *id.* §1382f ("Cost-of-living adjustments in benefits"); *id.* § 1382h(b)(1)(D) (assessment whether certain "earnings" provide a "reasonable equivalent of the benefits under this subchapter"); *id.* § 1382i(b)(2) (certain "payments" qualify as "supplemental security income benefits" for certain purposes); *id.* § 1382j(a) (rules for determining "the amount of benefits under this subchapter" for aliens); *id.* § 1383 ("Procedure for payment of benefits . . . under this subchapter").

benefits under subchapter XVI." 42 U.S.C. § 1320b-19(k)(4). For purposes of this program, section 1320b-19 states expressly that "[t]he term 'supplemental security income benefit under subchapter XVI' means a cash benefit under section 1382 or 1382h(a) of this title." *Id.* § 1320b-19(k)(5). As noted above, section 1382 sets forth "[t]he" monthly cash benefit under subchapter XVI, *id.* § 1382(b), and section 1382h(a) sets forth a substitute monthly cash benefit for certain individuals who qualify under section 1382 in some months but not others, *id.* § 1382h(a)(1). Because "identical words used in different parts of the same act are intended to have the same meaning," *Gustafson v. Alloyd Co.*, 513 U.S. 561, 570 (1995) (cleaned up), the phrase "supplemental security income benefits under subchapter XVI" (or its equivalent "supplementary 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.

The hospitals respond that the word "benefits" can include cash or non-cash benefits, tangible or intangible. True enough, but the question here turns on what counts as "income" benefits "under subchapter XVI." Neither of the two benefits that the hospitals cite fits that description. Medicare Part D benefits are housed in subchapter XVIII. So too is the provision making individuals "who are recipients of supplemental security income benefits" also eligible

for a prescription-drug subsidy. 42 U.S.C. § 1395w-114(a)(3)(B)(v)(I). 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 cited by the hospitals are provided under subchapter XI, which requires SSA to establish that program for blind and disabled individuals "to obtain employment services, vocational rehabilitation services, or other support services from an employment network." *Id.* § 1320b-19(a). Subchapter XI sets forth the metes and bounds of that program, which SSA may run through state agencies that choose to administer approved plans, *see id.* § 1320b-19(c)(1), or through private employment networks selected by SSA, *see id.* § 1320b-19(d)(4). Subchapter XVI merely provides that, if a state chooses to participate in the Ticket to Work program, SSA may reimburse the state for the cost of providing covered vocational benefits to SSI enrollees. *Id.* § 1382d(d). That simply provides a funding mechanism for a subchapter XI benefit—and one that expressly defines the term "supplemental security income benefits under subchapter XVI" as "a cash benefit under section 1382 or 1382h(a)." *Id.* § 1320b-19(k)(5).

The hospitals further argue that *Empire* compels their construction of the phrase "entitled to supplementary security income benefits." *Empire* held that the phrase "entitled to benefits under part A," as used to determine the Medicare fraction, covers

patients who meet Part A's requirement of being elderly or disabled, even if Medicare does not pay for specific treatments because of coverage limitations, alternative insurance, or the like. 142 S. Ct. at 2364. The hospitals reason that if the phrase "entitled to benefits under part A" covers patients who meet basic eligibility requirements without regard to specific payment decisions, then so too must the adjacent phrase "entitled to [SSI] benefits."

This argument misses key distinctions between the Part A and SSI schemes. First, Part A benefits extend well beyond payment for specific services at specific times. As *Empire* explained, a beneficiary who reaches a Part A coverage limit for eye care still has coverage for a knee replacement, so he remains "entitled to benefits under part A" even if Medicare does not pay for his current medical needs. 142 S. Ct. at 2363. There is no comparable parallel in the SSI context because, as shown above, the phrase "[SSI] benefits . . . under subchapter XVI" means only cash payments. Moreover, age or chronic disability makes a person eligible for Part A benefits "without an application or anything more," and individuals rarely if ever lose this eligibility over time. *Id.* at 2363-64. The same does not hold true for SSI, where individuals routinely ping-pong in and out of "eligibility" depending on fluctuations in their income or wealth from one month to another. 42 U.S.C. § 1382(a), (c). Given this structure, it makes little sense to say that individuals are "entitled" to the benefit in months when they are not even eligible for it.

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

IV

The hospitals next argue that even under HHS's own construction of the Medicare Act, its matching process was arbitrary and capricious. We disagree.

First, the hospitals contend that HHS arbitrarily excluded patients whose SSI benefits were withheld under the so-called "cross-program recovery" scheme. When an SSI beneficiary receives an overpayment from another SSA program, SSA may correct the mistake by reducing SSI benefits correspondingly. 42 U.S.C. § 1320b-17. The hospitals assert that SSA assigns to individuals whose benefits are so withheld the E01 code, which indicates a loss of SSI eligibility, even though these individuals receive an SSI benefit that cancels another monetary liability. This assertion is mistaken. As the government explained at oral argument, individuals whose SSI benefits are clawed back under the cross-program recovery scheme still are assigned the C01, M01, or M02 codes, and therefore remain "entitled to [SSI] benefits" in the agency's calculation of the Medicare fraction.

Second, the hospitals contend that HHS unreasonably focused on whether patients receive SSI payments when hospitalized because the payments depend on income and resource levels from earlier

months. But "eligibility" for the SSI benefit "for a month" depends on the individual's income, resources, and other characteristics "in such month." 42 U.S.C. § 1382(c)(1). Thus, if an individual satisfies these criteria during one month yet does not receive the payment until a later month, HHS still counts the individual as "entitled to [SSI] benefits" during the first month.

Third, the hospitals contend that HHS unreasonably excluded from the Medicare fraction individuals assigned codes "S" and "E02." Because the hospitals first raised this argument in their reply brief, we do not consider it. *See Abdullah v. Obama*, 753 F.3d 193, 199 (D.C. Cir. 2014).

V

Invoking the Mandamus Act, 28 U.S.C. § 1361, the hospitals seek an order compelling HHS to provide them with the payment codes assigned by SSA to their respective patients. The hospitals want this data to verify or challenge CMS's calculation of their respective Medicare fractions.

Mandamus against an executive official is a drastic remedy to be "invoked only in extraordinary circumstances." *Fornaro v. James*, 416 F.3d 63, 69 (D.C. Cir. 2005) (cleaned up). The plaintiff must show (1) a clear and indisputable right to the relief sought; (2) the violation of a clear legal duty; and (3) the absence of an adequate alternate remedy. *See Am. Hosp. Ass'n v. Burwell*, 812 F.3d 183, 189 (D.C. Cir. 2016). Even if

these requirements are met, the plaintiff must also show "compelling equitable grounds" for relief. *Id.*

To establish the necessary rights and duties, the hospitals invoke section 951 of the MMA. It requires HHS to give each hospital the "data necessary" for the hospital "to compute the number of patient days used in computing [its] disproportionate patient percentage." 117 Stat. at 2427. The hospitals have received the matched data that HHS itself uses to calculate this percentage. But the hospitals want more than simply a binary code reflecting whether specific patient days were attributed to individuals coded by SSA as C01, M01, or M02. Instead, the hospitals want, for all patient days attributed to SSI enrollees, the specific codes used by SSA to track why those individuals did or did not qualify for the monthly cash payment.

Section 951 does not unambiguously compel release of this data. According to the hospitals, section 951 requires HHS to disclose what they describe as "input data" to help them re-do the entire determination of the Medicare and Medicaid fractions from start to finish. On the other hand, section 951 could simply mean that HHS must provide wholesale data that it uses for the actual computation. We are tempted to say that this ambiguity alone is enough to doom the claim, for mandamus is unavailable when the alleged duty depends on a statutory construction that is "not free from doubt." *Power v. Barnhart*, 292 F.3d 781, 786 (D.C. Cir. 2002) (cleaned up). But there is a simpler ground of decision: What 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. *See* 75 Fed. Reg. at 50,276.

VI

The district court correctly granted summary judgment to the Secretary of Health and Human Services.

Affirmed.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ADVOCATE CHRIST MEDICAL CENTER, *et al.*, Plaintiffs, v. **ALEX M. AZAR, II**, *Secretary, United States Department of Health and Human Services*, Defendant.	Civil Action No. 17-cv-1519 (TSC)

MEMORANDUM OPINION

(Filed Jun. 8, 2022)

Plaintiffs are more than 200 acute care hospitals located across the country. They provide inpatient care to Medicare beneficiaries, and in exchange are reimbursed for their services through the Medicare program. They challenge the Secretary of the Department of Health and Human Services' (HHS) interpretation of a statutory program that compensates hospitals for serving a disproportionately large number of low-income patients. Plaintiffs claim the Secretary's interpretation is unlawful under the Administrative Procedures Act ("APA") and ask the court to invalidate it and direct the Secretary to recalculate Plaintiffs' compensation for fiscal years 2006 to 2009. They also seek a writ of mandamus compelling the Secretary to

furnish them with information to verify the accuracy of their reimbursements under the statutory program.

Plaintiffs and the Secretary have cross-moved for summary judgment. For reasons set forth below, the court will DENY Plaintiffs' Motion for Summary Judgment and GRANT the Secretary's Cross-Motion for Summary Judgment.

I. BACKGROUND

A. Statutory and Regulatory Background

Medicare is a federal program that provides health insurance coverage to individuals who are at least 65 years old and entitled to monthly Social Security benefits, and to disabled individuals who meet eligibility requirements. *See* 42 U.S.C. § 1395. The Medicare statute is divided into five Parts. Part A provides hospital insurance benefits, *see id.* §§ 1395c–1395i-5, Part B provides coverage for outpatient and physician services, *see id.* §§ 1395j–1395w-5, Part C, known as the Medicare Advantage Program, allows participants to choose certain health plans as an alternative to the traditional fee-for-service model available under Parts A and B, *see id.* §§ 1395w-21–1395w-29, Part D provides coverage for prescription medication, *see id.* §§ 1395w-101–1395w-154, and Part E sets forth various "Miscellaneous Provisions," one of which is the Inpatient Prospective Payment System that reimburses Part A inpatient hospital services, *see Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 3 (D.C. Cir. 2011).

"Under the Medicare statute, the Secretary generally pays hospitals a sum for each covered inpatient service without regard to the hospital's actual cost." *Adena Reg'l Med. Ctr. v. Leavitt*, 527 F.3d 176, 177 (D.C. Cir. 2008) (citing 42 U.S.C. § 1395ww(d)). Instead of relying on a hospital's actual costs, "Medicare reimburses a hospital for services based on prospectively determined national and regional rates." *Northeast Hosp. Corp.*, 657 F.3d at 2 (citing 42 U.S.C. § 1395ww(d)(1)–(4)); *see also Nazareth Hosp. v. Sec'y U.S. Dep't of Health & Human Servs.*, 747 F.3d 172, 175 (3d Cir. 2014) (explaining that Medicare "payments are predicated upon prevailing rates for given services"). But the Medicare statute also "provides for certain adjustments" to those pre-determined payment rates. *Nazareth Hosp.*, 747 F.3d at 175.

One such adjustment is the "disproportionate share hospital" ("DSH") adjustment, which applies to hospitals that serve a "disproportionately large percentage of low-income patients." *Adena*, 527 F.3d at 177–78. The Centers for Medicare and Medicaid Services ("CMS") is responsible for administering the Medicare program and calculating each qualifying hospital's DSH adjustment using a formula established by statute. *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

The amount of any DSH adjustment depends on the hospital's "disproportionate patient percentage" ("DPP"). *See id.* § 1395ww(d)(5)(F)(v)–(vii). CMS calculates DPP by adding (1) the Medicaid fraction, and (2) the Medicare fraction, often referred to as the

Supplemental Security Income ("SSI") fraction.[1] *Id.* § 1395ww(d)(5)(F)(vi)(I)–(II). The Medicaid and SSI fractions represent two distinct and separate measures of low income that, added together, provide a proxy for the total low-income patient percentage. *See Cath. Health*, 718 F.3d at 916. The SSI fraction is at issue in this case.

CMS calculates the SSI fraction by dividing the time spent caring for patients entitled to benefits under both Medicare Part A and the SSI program by the time spent caring for patients entitled to benefits under only Medicare Part A. *See Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1809 (2019). A visual representation of the fraction is:

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[1] The SSI fraction is defined as:

> [T]he 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 [Medicare] and were entitled to supplementary security income [SSI] 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 [Medicare].

42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). "This language is downright byzantine and its meaning not easily discernible." *Cath. Health Initiatives Iowa Corp. v. Sibelius*, 718 F.3d 914, 916 (D.C. Cir. 2013).

$$\text{Medicare - SSI Fraction} = \frac{\text{Inpatient days for patients entitled to both Medicare Part A and SSI benefits}}{\text{Inpatient days for patients entitled to Medicare Part A benefits}}$$

The SSI fraction "effectively asks, out of all patient days *from Medicare beneficiaries*, what percentage of those days came from Medicare beneficiaries who *also* received SSI benefits?" *Cath. Health*, 718 F.3d at 917 (emphasis in original). The greater the number of patients that a hospital treats who are "entitled to [SSI] benefits," the larger the DPP, and thus the higher the hospital's reimbursement rate. *Id.* at 916.

The SSI program is administered by the Social Security Administration ("SSA"), which provides monthly cash payments to financially needy people who are aged 65 or older, blind, or disabled.[2] 42 U.S.C. § 1381a. The statute provides that individuals in these categories who are "determined . . . to be eligible on the basis of his income and resources shall, in accordance with and subject to the provisions of [Title XVI], be paid benefits by the Commissioner of Social Security." *Id.* The SSA maintains SSI records, including monthly "payment status codes" denoting whether an SSI applicant received payment during a given month and the reason for that payment status. *See* Soc. Sec. Admin.,

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[2] To be eligible for SSI benefits, 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* 42 U.S.C. § 1382; 20 C.F.R. § 416.202.

State Verification & Exch. Sys. (SVES) & State Online Query (SOLQ) Manual, Appx. F (April 2013), (hereinafter "SVES/SOLQ") [AR 7016; 41,725].

To enable CMS to calculate the SSI fraction, SSA sends CMS an annual "eligibility file" that includes information on all SSI applicants whom SSA has coded with one of three payment status codes: C01 (current pay), M01 (forced pay), and M02 (forced due). Medicare Program Rule, 75 Fed. Reg. at 50,042, 50,280 (Aug. 16, 2010). SSA does so at CMS' request, because CMS interprets those codes as reflecting an SSI applicant's "entitlement" to SSI benefits. *See id.* at 50,281 (stating that using SSI codes "C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits"); *id.* at 50,280 ("[W]e have requested, and are using in the data matching process, those SSA codes. . . ."). Specifically, those three codes reflect "whether or not SSA made a payment of SSI benefits to an individual who applied for SSI benefits." *Id.* at 50,277. SSA does not include payment status codes in the SSI eligibility file but does include monthly indicators denoting which month(s) each person received SSI payments. *See id.* at 50,276; *see also* 51 Fed. Reg. 31,454, 31,459 (Sept. 3, 1986) (stating that the SSI file "lists all SSI recipients for a 3-year period and denotes the months during that period in which the recipient was eligible for SSI benefits").

CMS then computes the SSI fraction by matching individuals appearing in the SSA's eligibility file with its own Medicare inpatient data to identify a patient's

entitlement to SSI benefits. *Pomona Valley Hosp. Med. Ctr. v. Azar*, No. CV 18-2763 (ABJ), 2020 WL 5816486, at *2 (D.D.C. Sept. 30, 2020) (citing Medicare Program Rule, 75 Fed. Reg. at 50,281). In other words, "CMS identifies the individuals appearing in both two data sets to determine the number of patients, and the inpatient days for those patients at each hospital, for the applicable fiscal year to calculate the hospital's SSI numerator." *Id.* (citing *Cath. Health*, 718 F.3d at 916). CMS also includes in the SSI numerator "patients who were retroactively found to be entitled to SSI benefits in a particular month in which they were hospitalized—regardless of whether they actually came into possession of benefits during the month of their hospitalization." Def. Mot. at 23; *see also* Medicare Program Rule at 75 Fed. Reg. 50,282 (noting CMS' "inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data"); *Baystate Medical Ctr. v. Leavitt*, 545 F. Supp. 2d 20, 26 n.12 (D.D.C. 2008) (explaining CMS' process for counting "hold and suspense" cases, which occur when the SSA is looking for a representative payee able and willing to accept checks on behalf of an SSI recipient, when "presumptively disabled" individuals receiving benefits during an initial period are awaiting additional state determinations, or when a state eligibility determination is pending).

Unlike the SSI program, which is a cash benefit program, the other entitlement relevant to the SSI fraction—Medicare Part A—is a federal health insurance

program. In determining which patients are "entitled to" Medicare Part A, the Secretary counts all patients who meet the statutory criteria for that entitlement. *See* Def. Mot. at 29 (citing Medicare Program Rule at 75 Fed. Reg. at 50,280) ("We believe that Congress used the phrase 'entitled to benefits under part A' in [the DPP provision] to refer to individuals who meet the criteria for entitlement under these sections")); *see also* 42 C.F.R. § 400.202 (2012) ("Entitled means that an individual meets all the requirements for Medicare benefits."). According to the Secretary, that interpretation holds true "regardless of whether the person's stay in a hospital is actually paid for under Medicare Part A" and "regardless of whether the person is hospitalized at all." Def. Mot. at 29.

B. Medicare Payment Determinations and Judicial Review

To obtain payment for services provided under Part A, hospitals submit cost reports at the end of each fiscal year to contractors known during the relevant time period as fiscal intermediaries or Medicare administrative contractors ("MACs"), which are generally private insurance companies acting on behalf of HHS. *See* 42 C.F.R. §§ 405.1801(b)(1), 413.24(f). The intermediary determines the total payment (including any DSH adjustment) and issues a Notice of Program Reimbursement ("NPR"), informing the provider how much it will be paid for the fiscal year. *See id.* § 405.1803.

A provider that meets statutory requirements may appeal the payment determination set forth in the NPR by requesting a hearing before the Provider Reimbursement Review Board (the "Board" or "PRRB"). *See* 42 U.S.C. § 1395oo(a)(1), (3). The PRRB's final decision is subject to review by the CMS Administrator pursuant to the Secretary's delegation of authority to the Administrator. *See id.* § 1395oo(f); 42 C.F.R. § 405.1875. Challenges to the Secretary's final decision may be brought in federal court. *See* 42 U.S.C. § 1395oo(f).

C. Procedural History

In the administrative proceedings below, Plaintiffs appealed their DPP calculations from 2006 to 2009 to the Board pursuant to 42 C.F.R. § 405.1837. The Board held combined hearings for these appeals on March 17, 2015 and September 15, 2015. *See* ECF No. 13, Pls. Mot. at 4. Plaintiffs argued that CMS violated the Medicare statute by treating only three payment codes—C01, M01, and M02—as indicators of SSI entitlement. *See* ECF No. 31, PRRB Dec. 2017-D11 [AR 66, 70–71]; PRRB Dec. 2017-D12 [AR 39,178, 39,182–83]. They contended that CMS should read the phrase "entitled to [SSI] benefits" in the same way that it reads the phrase "entitled to benefits under [Medicare] part A," to include both paid and unpaid SSI days. PRRB Dec. 2017-11 [AR 70]; PRRB Dec. 2017-D12 [AR 39,182].

Interpreting Plaintiffs' claim as a challenge to the data matching process, the Board found that it lacked

authority to grant the relief the hospitals sought. *See* PRRB Dec. 2017-D11 [AR 70–73]; PRRB Dec. 2017-D12 [AR 39,182–84].

On review, the CMS Administrator rejected Plaintiffs' statutory interpretation challenge. *See* Administrator Dec. 2017-D11 [AR 2-25]. The Administrator found that the Secretary's interpretation "is supported by the statutory design of the two programs," and that "there are meaningful statutory differences between Medicare Part A benefits and SSI benefits." *See id.* [AR 17]. He explained that the phrase "entitled to benefits under [Medicare] part A" has a specialized meaning under the Medicare statute, and that this entitlement is generally understood to be a "status determination" that, once established, does not change merely because healthcare services are not paid for under the program. *See id.* [AR 17-18]. By contrast, he explained, entitlement to SSI benefits under Title XVI tends to change from month-to-month because it is based on income and resources as well as other statutory criteria that can vary over time. *Id.* [AR 18]. He further explained that SSI is a "cash benefit program" and that it is thus reasonable to distinguish it from Medicare Part A, which is "a distinct set of health insurance benefits" under the Act. *Id.* Finally, he rejected Plaintiffs' challenge to the use of only the three payment codes as indicators of entitlement to SSI benefits, finding that none of the other codes indicates that a person was entitled to receive SSI benefits in a given month. *See id.* [AR 19].

Plaintiffs then brought this action for judicial review of the Administrator's decision, *see* 42 U.S.C. § 1395oo(f)(1), challenging the calculation of their DPP for the four fiscal years at issue. ECF No. 1, Compl. They ask the court to invalidate the Secretary's interpretation of the phrase, "entitled to [SSI] benefits" in the DPP provision and to require recalculation of Plaintiffs' DPP for fiscal years 2006 to 2009 "to include all SSI-enrolled patient days in the numerator of [that] fraction." *See id.* at 47–48 ("Request for Relief") ¶ a & c. They also seek mandamus relief "directing the Secretary to furnish [them] with CMS data from the [SSA] to identify the [SSA payment codes] of all SSI enrollees who were entitled to Part A and who received inpatient hospital services from the Plaintiffs during the cost report years at issue." *See id.* ("Request For Relief") ¶ b. The parties have cross-moved for summary judgment.

II. LEGAL STANDARD

A court typically must grant summary judgment when the pleadings and evidence show "there is no genuine dispute as to any material fact and [that] the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). However, in cases involving challenges to agency action under the Administrative Procedure Act ("APA"), Rule 56 "does not apply because of the limited role of a court in reviewing the administrative record." *Select Specialty Hosp.-Akron, LLC v. Sebelius*, 820 F. Supp. 2d 13, 21 (D.D.C. 2011) (citations omitted). In such cases, summary judgment "serves as a

mechanism for deciding, as a matter of law, whether the agency action is supported by the administrative record and is otherwise consistent with the APA standard of review." *Id.*

Under the APA, a court must "hold unlawful and set aside agency action, findings, and conclusions" that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," 5 U.S.C. § 706(2)(A), in excess of statutory authority, *id.* § 706(2)(C), or "without observance of procedure required by law," *id.* § 706(2)(D). Agency action is arbitrary and capricious if the agency (i) "has relied on factors which Congress has not intended it to consider"; (ii) "entirely failed to consider an important aspect of the problem"; (iii) "offered an explanation for its decision that runs counter to the evidence before the agency"; or (iv) "is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). In short, an agency must "articulate a satisfactory explanation for its action" with a "rational connection between the facts found and the choice made." *Id.*

That said, the scope of the court's review is narrow, and a court cannot "substitute its judgment for that of the agency." *Id.* at 43. Indeed, an agency's decision is presumed to be valid. *See Am. Radio Relay League, Inc. v. F.C.C.*, 617 F.2d 875, 879 (D.C. Cir. 1980). Furthermore, in Medicare cases, the "tremendous complexity of the Medicare statute . . . adds to the deference which

is due to the Secretary's decision." *Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46, 60 (D.C. Cir. 2015) (quoting *Methodist Hosp. of Sacramento v. Shalala*, 38 F.3d 1225, 1229 (D.C. Cir. 1994)). Accordingly, the burden rests with the plaintiff to show that an agency's decision is inconsistent with the APA. *Env't Def. Fund, Inc. v. Costle*, 657 F.2d 275, 283 n.28 (D.C. Cir. 1981).

When reviewing an agency's interpretation of a law it administers, a court must apply the two-step framework of *Chevron U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837 (1984). At *Chevron* step one, the court must first determine whether "the intent of Congress is clear," for if "Congress has directly spoken to the precise question at issue," then the court must give effect to Congress's clear intent. *Id.* at 842. At this first step, the court "employ[s] traditional tools of statutory construction," *id.* at 843 n.9, to determine whether Congress "has unambiguously foreclosed the agency's statutory interpretation," *Catawba Cty. v. EPA*, 571 F.3d 20, 35 (D.C. Cir. 2009). "Because at *Chevron* step one [the court] alone [is] tasked with determining Congress's unambiguous intent," it must conduct its analysis "without showing the agency any special deference." *Vill. of Barrington v. Surface Transp. Bd.*, 636 F.3d 650, 659–60 (D.C. Cir. 2011). If the court "determine[s] that statutory ambiguity has left the agency with a range of possibilities and that the agency's interpretation falls *within* that range, then the agency will have survived *Chevron* step one," and the court must proceed to step two. *Id.* at 660 (emphasis in original).

At *Chevron* step two, the court must "defer to the agency's permissible interpretation, but only if the agency has offered a reasoned explanation for why it chose that interpretation." *Id.* A court must "defer to an agency's statutory interpretations not only because Congress has delegated law-making authority to the agency, but also because that agency has the expertise to produce a reasoned decision." *Id.* (citing *Chevron*, 467 U.S. at 844–45). Where a "legislative delegation to an agency on a particular question is implicit rather than explicit," *Chevron*, 467 U.S. at 844, a court must uphold any "'reasonable interpretation made by the administrator' of that agency." *Am. Paper Inst., Inc. v. EPA*, 996 F.2d 346, 356 (D.C. Cir. 1993) (quoting *Chevron*, 467 U.S. at 844).

III. ANALYSIS

A. The Secretary's Interpretation of the Phrase "Entitled to [SSI] Benefits"

As noted above, the SSI fraction is defined as the number of patient days for individuals both "entitled to benefits under part A" and "entitled to [SSI benefits]," divided by the total number of patient days for patients "entitled to benefits under part A." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). Plaintiffs argue that the statutory text and legislative history compel the Secretary to interpret "entitled to [SSI benefits]" to include patient days for all patients enrolled in the SSI program, regardless of whether they receive an SSI payment during the month of their hospitalization

or are later found entitled to a retroactive SSI payment. Pls. Mot. at 18–19, 25–26. Plaintiffs also argue that the Secretary's current interpretation is arbitrary and capricious because it is narrower than the Secretary's interpretation of "entitled to benefits under part A." *Id.* at 26–36.

The Secretary argues that his interpretation of the phrase "entitled to [SSI benefits]" is consistent with statute and that the perceived inconsistency in how he interprets the words "entitled to [SSI benefits]" and "entitled to benefits under part A" is attributable to the two distinct types of entitlements at issue—SSI cash payments versus Medicare Part A insurance benefits—and the differing methods of qualifying for each benefit. Def. Mot. at 13, 27–32. The Secretary also contends that, even if the statute is ambiguous about the correct interpretation, his interpretation is nonetheless reasonable. *Id.* at 26–32.

1. *Chevron* Step One

The court first considers "whether Congress has directly spoken to the precise question at issue." *Chevron*, 567 U.S. at 842. In other words, has Congress "unambiguously foreclosed the Secretary's interpretation," *Northeast Hosp. Corp.*, 657 F.3d at 5, that persons "entitled to [SSI] benefits" are those who received SSI cash payments during the month of their hospitalization and those who are later determined to be entitled to retroactive SSI payments for the month(s) of their

hospitalization? The court concludes that Congress has not.

The DPP provision does not define the phrase "entitled to [SSI] benefits," *see* 42 U.S.C. § 1395ww, though its ordinary meaning is "to grant a legal right to or qualify for," *Entitle*, BLACK'S LAW DICTIONARY (11th ed. 2019). With regard to the DPP provision, courts have reasoned that "'entitlement' is not just an abstract ability to sign up for" Medicare benefits; "[r]ather, it is entitlement *to have payment made*." *Northeast Hosp. Corp.*, 657 F.3d at 20 (emphasis in original). Specifically, courts have distinguished between the phrase "eligible for," which appears in the Medicaid fraction, and the phrase "entitled to" which appears in the SSI fraction:

> In neighboring Medicare subsections, Congress uses the two different terms—"eligible" to refer to a patient's status with regard to the state Medicaid plan and "entitled" to refer to his status with regard to the federal Medicare plan. Even within the Medicaid proxy itself, this distinction is reinforced by the use of the two different words when referring to the two different programs: "patients who (for such days) were *eligible* for medical assistance under a State plan approved under [the Medicaid program], but who were not *entitled* to benefits under part A of [the Medicare program]." 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) (emphasis added). If Congress had wanted to use the word "entitled" throughout the

> Medicaid proxy as it had in the Medicare proxy, it could—and would—have done so.

Cabell Huntington Hosp., Inc. v. Shalala, 101 F.3d 984, 988 (4th Cir. 1996) (emphasis in original); *see also Cath. Health*, 718 F.3d at 917 (explaining that the SSI fraction focuses on Medicare beneficiaries who "received" SSI payments); *Jewish Hosp., Inc. v. Sec'y of Health and Hum. Serv.*, 19 F.3d 270, 275 (6th Cir. 1994) (noting that "[t]o be entitled to some benefit means that one possesses the *right* or *title* to that benefit) (emphasis in original).

Nothing in the statutory text shows that Congress "unambiguously foreclosed" the Secretary's interpretation that individuals who are neither receiving SSI benefit payments nor entitled to a retroactive payment should be excluded from the SSI fraction's numerator. *See Baystate*, 545 F. Supp. 2d at 37 (reaching "the inescapable conclusion that Congress did not intend that patients' ineligible for SSI payments would be counted in the numerator" of the SSI fraction). The Secretary's interpretation is also consistent with the nature of the benefits at issue, which are specifically defined under Title XVI as benefits that are "paid" to qualifying aged, blind, and disabled individuals. *See* 42 U.S.C.A. § 1381a.

Plaintiffs argue that apparent inconsistencies between the Secretary's interpretation of the phrase "entitled to [SSI] benefits" and a similar phrase in the same DPP provision, "entitled to benefits under [Medicare] part A," forecloses the Secretary's interpretation

of the former. Pls. Mot. at 20–24. Plaintiffs contend that this inconsistency arose in 2004, when CMS "broadened" its interpretation of the phrase "entitled to benefits under [Medicare] part A" to include Medicare patient days for which healthcare services were not paid for under Medicare part A, and that the Secretary must now similarly broaden his interpretation of entitlement to SSI benefits to include both "paid and unpaid" SSI days in the numerator of the SSI fraction. *Id.* at 13–17.

Plaintiffs' "inconsistency" argument is unavailing at step one of the *Chevron* analysis for at least two reasons. First, the D.C. Circuit and Sixth Circuit have upheld the Secretary's interpretation of the phrase, "entitled to benefits under [Medicare] part A," implying that there is no fatal inconsistency between that interpretation and the Secretary's interpretation of "entitled to [SSI benefits]." *See Cath. Health*, 718 F.3d at 914 (upholding the Secretary's interpretation of the phrase to include days for which Medicare coverage was exhausted); *Metro. Hosp. v. U.S. Dep't of Health and Hum. Servs.*, 712 F.3d 248 (6th Cir. 2013) (same); *Northeast Hosp. Corp.*, 657 F.3d at 13 (finding that the Secretary's determination that Medicare Part C patients were "entitled to benefits under part A" was not foreclosed under *Chevron* step one). Second, to say that two interpretations are "inconsistent," does not say anything about which of the two interpretations is correct, and it certainly does not show that Congress "unambiguously foreclosed" one interpretation in favor of another.

Plaintiffs also argue that the legislative history demonstrates that Congress intended "all SSI Enrollees" to be counted in the SSI fraction. Pls. Mot. at 25–26. The court disagrees. As an initial matter, legislative history does not factor heavily on this point because the statute plainly uses the term "entitled," not "enrolled," and because Title XVI itself creates no legally cognizable "enrollment" status in the SSI program. *See*, *e.g.*, *Ratzlaf v. United States*, 510 U.S. 135, 147–48 (1994) ("[W]e do not resort to legislative history to cloud a statutory text that is clear."); *Halverson v. Slater*, 129 F.3d 180, 187 n.10 (D.C. Cir. 1997) ("[O]rdinarily we have no need to refer to legislative history at *Chevron* step one.").

In any event, the legislative history does not support Plaintiffs' argument. The DPP provision was enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985. On December 19, 1985, the House issued a Conference Report attempting to harmonize the House and Senate versions of the proposed bill. *See* H.R. Rep. No. 99-453 (1985) [AR 6,621-27]. Plaintiffs quote from the Report's description of the Senate version, which used the term "enrolled in SSI" when describing the low-income proxy. *Id.* at 459–60 [AR 6623-24]. The Conference agreement, however, which combined the House and Senate versions into a new version, did not use the term "enrolled" and instead referred to SSI "beneficiaries." *Id.* at 461 [AR 6,625].

Consequently, neither the statutory text nor legislative history show that Congress intended the SSI

fraction to include all persons enrolled in the SSI program who did not receive SSI payments during the month of their hospitalization or who are later found to be entitled to receive SSI payments. And certainly, Congress has not "unambiguously foreclosed" the Secretary's interpretation. Rather, "it has left a statutory gap, and it is for the Secretary, not the court, to fill that gap." *Northeast Hosp. Corp.*, 657 F.3d at 13.

2. *Chevron* Step Two

Having found that the statute is ambiguous with respect to the Secretary's interpretation, the court proceeds to *Chevron*'s second step to determine whether the Secretary's interpretation "is based on a permissible construction of the statute," *Chevron*, 467 U.S. at 842, and concludes that it is.

As noted, in determining if an individual is "entitled" to Medicare Part A benefits, the Secretary's interpretation includes all patients who meet the statutory criteria for this entitlement, even if they have opted for a Medicare Part C plan and their hospital costs will be paid by their Part C plan. *See* Def. Mot. at 29–30; Medicare Program Rule, 75 Fed. Reg. at 50,280; *Northeast Hosp. Corp.*, 657 F.3d at 9. In contrast, patients are only considered to be "entitled" to SSI benefits when they are both eligible for this entitlement and receive an SSI payment or are later found entitled to retroactive SSI payments. *See* Def. Mot. at 23–24; Medicare Program Rule, 75 Fed. Reg. at 50,041, 50,281–82; *Baystate*, 545 F. Supp. 2d at 26 n.12. Plaintiffs seize

on this purported inconsistency to argue that the Secretary's interpretation of the DPP provision is arbitrary and capricious. *See* Pls. Mot. at 34–36. The court disagrees.

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. *See* Medicare Program Rule, 75 Fed. Reg. at 50,280–81. The Secretary also responded to arguments that its matching process improperly excludes certain SSA payment status codes that reflect persons who are "eligible for SSI, but not eligible for SSI payments, [and] that should be included as SSI-entitled for purposes of the matching process." *Id.* at 50,280. With regard to the codes provided by SSA, the Secretary has explained:

> [N]one of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used. SSI entitlement can change from time to time, and we believe that including SSI codes of C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits.

Id. at 50,281. This interpretation is reasonable.

Moreover, case law supports the Secretary's position. *See Fla. Health Scis. Ctr., Inc. v. Becerra*, 19-cv-3487-RC, 2021 WL 2823104, at *1 (D.D.C. July 7, 2021) (rejecting similar arguments about the same "purported inconsistency"); *Metro. Hosp.*, 712 F.3d at 268 (concluding that "the differences in the language used in the SSI and Medicare statutory schemes explain this apparent inconsistency"); *cf Env't Def. v. Duke Energy Corp.*, 549 U.S. 561, 574 (2007) ("A given term in the same statute may take on distinct characters from association with distinct statutory objects calling for different implementation strategies."); *Allina Health Sys. v. Sebelius*, 982 F. Supp. 2d 1, 11 (D.D.C. 2013) (noting that "as the Supreme Court has observed, varying interpretations, even within the same statute, do not irrefutably render an agency construction unreasonable") (citation omitted).

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. *See* SVES/SOLQ [AR 7016-18] (noting that the fifty "N" codes indicate "the applicant is not eligible for SSI/State Supplement payments or that a previously eligible recipient is no longer eligible"). Such ineligibility can be for many reasons, the most common reason being that a person's income exceeds the applicable statutory maximum. *See* Pls. Mot. at 2–3. For instance,

in 2010, 671,128 individuals enrolled in the SSI program were ineligible to receive SSI benefits due to excess income, as indicated by their payment status code "N01." *See* Soc. Sec. Admin., SSI Annual Statistical Report, 2013, Table 75 [AR 7007]; *see also* [AR 7013]. Counting those individuals as "entitled to [SSI] benefits" seems squarely at odds with the statute.

In Medicare cases such as this one, the "tremendous complexity of the Medicare statute . . . adds to the deference which is due to the Secretary's decision." *Dist. Hosp. Partners, L.P.*, 786 F.3d at 60 (quoting *Methodist Hosp. of Sacramento v. Shalala*, 38 F.3d 1225, 1229 (D.C. Cir. 1994)). The burden rests with the plaintiff to show that an agency's decision is arbitrary, *Costle*, 657 F.2d at 283 n.28, and Plaintiffs have failed to meet that burden.

B. Plaintiffs' Mandamus Act Claim

In addition to their APA claim, Plaintiffs seek a writ of mandamus compelling the Secretary to give them the SSA's payment status codes for all persons enrolled in the SSI program, whether CMS has deemed them "entitled to [SSI] benefits" or not, so that Plaintiffs can verify and challenge CMS' calculation of their DSH adjustments. Pls. Mot. at 36–45.

Jurisdiction over actions "in the nature of mandamus" under § 1361 is strictly limited. *In re Cheney*, 406 F.3d 723, 729 (D.C. Cir. 2005). As the D.C. Circuit has emphasized, mandamus is a "drastic" remedy available only in "extraordinary situations," and "is hardly ever

granted." *Id.* The minimum jurisdictional prerequisites to relief are: (1) that the plaintiff has a clear and indisputable right to relief, (2) that the defendant has a clear, nondiscretionary duty to act, and (3) that the plaintiff has exhausted all other avenues of relief and has no other adequate available remedy. *Power v. Barnhart*, 292 F.3d 781, 784 (D.C. Cir. 2002); *Bond v. U.S. Dep't of Just.*, 828 F. Supp. 2d 60, 75 (D.D.C. 2011). Even if a plaintiff meets these requirements, whether mandamus relief should issue is discretionary. *In re Cheney*, 406 F.3d at 729. The party seeking mandamus "has the burden of showing that 'its right to issuance of the writ is clear and indisputable.'" *Northern States Power Co. v. U.S. Dep't of Energy*, 128 F.3d 754, 758 (D.C. Cir. 1997) (quoting *Gulfstream Aerospace Corp. v. Mayacamas Corp.*, 485 U.S. 271, 289 (1998)).

As instructed by the D.C. Circuit, "[t]he court will discuss the first two jurisdictional elements for mandamus-type relief—clear right to relief and clear duty to act—concurrently," *Lovitky v. Trump*, 949 F.3d 753, 760 (D.C. Cir. 2020), and finds that Plaintiffs fail to satisfy either element.

Section 951 of the Medicare Prescription Drug, Improvement and Modernization Act requires the Secretary to "arrange to furnish . . . hospitals . . . with the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage . . . for that hospital for the current cost reporting year." Medicare Modernization Act, Pub. L. No. 108-173 § 951, 117 Stat. 2066, 2427 (2003) (codified at 42 U.S.C. § 1395ww Note). To

accomplish this, CMS gives hospitals data "contain[ing] the matched patient-specific Medicare Part A inpatient days/SSI eligibility data on a month-to-month basis." 70 Fed. Reg. 47,278, 47,440 (Aug. 12, 2005). But given the confidentiality of information retained by the SSA, CMS does not give hospitals the complete SSI eligibility file that it receives from the SSA. *See id.* (rejecting proposal that CMS release the data file of SSI eligibility information that the SSA gives CMS because CMS is prohibited from disclosing SSI eligibility information).

Plaintiffs argue that the Secretary must disclose "assigned [payment status] codes" for all "SSI Enrollees." Pls. Mot. at 37. As previously explained, the Secretary relies on the SSA's payment status codes in determining which SSI enrollees are "entitled to [SSI] benefits." The Secretary interprets three SSA payment status codes—C01 (current pay), M01 (forced pay), and M02 (forced due)—as reflecting "entitlement" to SSI benefits for purposes of calculating the SSI fraction. *See* Medicare Program Rule, 75 Fed. Reg. at 50,281. The Secretary furnishes data on these patients to hospitals, including indicators of the months patients received SSI payments, but does not provide hospitals with the SSA's payment status codes. *See* Pls. Mot. at 36–37, 42; Def. Mot. at 40. CMS itself does not receive the SSA's payment status codes. *See* Medicare Program Rule, 75 Fed. Reg. at 50,276 ("The SSI eligibility data that CMS receives from SSA contain monthly indicators to denote which month(s) each person was eligible for SSI benefits during a specific time period"); 51 Fed.

Reg. at 31,459 (stating that the SSI file "lists all SSI recipients for a 3-year period and denotes the months during that period in which the recipient was eligible for SSI benefits").

Section 951 of the Act is silent as to what constitutes "data necessary for such hospitals to compute the number of patient days" that are factored into the DPP. Moreover, CMS' interpreting regulations[3] "would hardly be sufficient to transform [the Act's] silence on the subject . . . into the 'clear duty' required to justify a grant of mandamus." *Power*, 292 F.3d at 786. In circumstances such as this, where an alleged "duty is not . . . plainly prescribed, but depends on a statute or statutes the construction or application of which is not free from doubt, it is regarded as involving the character of judgment or discretion which cannot be controlled by mandamus." *Consol. Edison Co. of N.Y. v. Ashcroft*, 286 F.3d 600, 605 (D.C. Cir. 2002) (quoting *Wilbur v. United States*, 281 U.S. 206, 218–219 (1930)).

Plaintiffs' request for payment status codes stems from their disagreement with the Secretary on where to draw the line between patients who are and are not "entitled to [SSI] benefits." Indeed, Plaintiffs

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[3] *See* 71 Fed. Reg. 17470, 17,473 (Apr. 6, 2006) ("Disclosure under this routine use shall be for the purpose of assisting the hospital to verify or challenge CMS' determination of the hospital's SSI ratio. . . . Disclosure shall be limited to data concerning the total number of patient days, the number of SSI/Medicare days, if any, and the number of Medicare covered days, if any, associated with each stay at the hospital's facility."); *see also* Medicare Program Rule, 75 Fed. Reg. at 50,280 (stating that "CMS is not authorized to share SSA data").

emphasize that payment status codes are necessary to compute a "specific damages figure" in the event the Secretary's interpretation of "entitled to [SSI] benefits" is unlawful. *See* Pls. Reply at 28. But as previously explained, the Secretary's interpretation of who is "entitled to [SSI] benefits" is valid, and "cannot be controlled by mandamus." *Consolidated Edison Co. of N.Y.*, 286 F.3d at 605. The same is true for the Secretary's interpretation that the "data necessary" for hospitals to compute the number of inpatient days for patients "entitled to SSI [benefits]" is data that the Secretary already provides: patient-specific data for all patients "entitled to [SSI] benefits." Def. Mot. at 40. For example, whether SSA denoted a patient with a payment status code C01, as opposed to M01, or M02, would not impact CMS' calculation of the SSI fraction because patient days for patients denoted with any of these three payment status codes are counted in the computation and provided to hospitals. And whether SSA denoted a patient with some other payment code, such as codes beginning with "T" (denoting that SSI payments were terminated), as opposed to "S" (suspended) or "N" (nonpayment), is likewise not relevant because those patients are not counted in the computation under the Secretary's interpretation. Medicare Program Rule, 75 Fed. Reg. 50,280-81.

Because 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. *See Lovitky*, 949 F.3d at 759 (explaining that unless all jurisdictional prerequisites are met, a court must dismiss a mandamus claim for lack of jurisdiction).

IV. CONCLUSION

For reasons explained above, the court will DENY Plaintiffs' Motion for Summary Judgment and GRANT Defendant's Cross-Motion for Summary Judgment.

Date: June 8, 2022

/s/ Tanya S. Chutkan
TANYA S. CHUTKAN
United States District Judge

CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals - Medicare Fraction & Hall Render, Individual, Optional and CIRP DSH Dual/SS' Eligible Group Appeals-Medicare Fraction **Provider** **vs.** **Medicare Administrative Contractors**	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: Various** **Review of: PRRB Dec. No. 2017-1111 Dated: February 27, 2017 & PRRB Dec. No. 2017-D12 Dated: February 28, 2017**[1]

These cases are before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. The CMS' Center for Medicare (CM) submitted comments, requesting review and modification

[1] The cases, PRRB Dec. No. 2017-D11 and PRRB Dec. No. 2017-D12, involve multiple groups and, in the case of PRRB Dec. No. 2017-D12, also includes individual appeals.

of the Board's decision. The Providers' submitted comments, requesting that the Administrator modify the Board's decision. All comments were timely received. Accordingly, these cases are now before the Administrator for final agency review.

Issue and Board Decision

In these appeal, the Providers are challenging the CMS policy of including only certain Supplemental Security Income (SSI) categories, as reflected in specified SSI codes, in the numerator of the Medicare fraction of the disproportionate share hospital (DSH) payment calculation. The Providers claimed that, as a result of this methodology, their DSH payments were understated. The Board found that the Providers' met the jurisdictional requirements for a hearing. In both cases, the Board stated that it was the Board's understanding that "the hospitals have received written notice of the recalculation through" a revised notice of program reimbursement (RNPR) or a notice of program reimbursement (NPR) or "are slated to receive such notice through an RNPR/NPR" and that the Providers contend: a) they are adversely impacted by the recalculation methodology (i.e., CMS' recognition of only three SSI codes to denote SSI eligibility; and b) this methodology adversely reduces their Medicare DSH reimbursement.[2]

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[2] The Transcript of Oral Hearing for PRRB Dec No. 2017-D12, indicates a disagreement or confusion concerning the issue raised in that consolidated case. *See* Transcript of Oral Hearing at 1-15

The Board held that it had jurisdiction to hold a hearing, but found that it lacked the authority to mandate specific revisions to the challenged CMS data matching process for the Medicare fraction of the Medicare DSH calculation for the fiscal years at issue. Based on 42 C.F.R. §405.1867, the Board determined that it was bound by CMS Rulings 1498-R and 1498-R2. Thus, as a result of these Rulings, the Board concluded that it had no authority to revise the data matching process described in great detail in the Federal Year (FY) 2011 Final Rule, including the SSI codes CMS used in the calculating the SSI fraction to be applied to these Providers in this case. The Board held that CMS Ruling 1498-R and the FY 2011 Final rule intended to bind the Agency and all IPPS hospitals to the specific data matching process prescribed for the cost reporting periods covered by those issuances.

Comments

The CM submitted comments requesting that the Administrator review and modify the Board's decision. CM contended the Board's decision is inconclusive as it is neither a Board's decision, nor an expedited judicial review (EJR) decision. If the decisions were to be reviewed by a court, the court would remand to CMS so that definitive, appropriate final decisions could be issued. Therefore, in the interest of administrative and

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(March 17, 2015). The Board decision subsequently noted a January 6, 2017 Post-Hearing Conference, n. 39, in referencing the issue as framed.

judicial economy, the Administrator should issue a definitive, appropriate final decision so that the matter will not be remanded to CMS, but rather subject to judicial review, without the need for a remand for further agency action.

More specifically, CM stated that the Administrator should issue a decision consisting of three main parts. First, the Administrator should rule that there is no Board jurisdiction over each cost reporting period where the Providers have merely been informed that a DSH recalculation will be done based on the challenged CMS methodology for calculation of the SSI fraction. Similarly, the Administrator should rule that there is no Board jurisdiction over each cost reporting period where the Providers were only slated to receive its notice of program reimbursement reflecting the DSH payment determination (or re-determination) based on the challenged CMS methodology for calculation of the SSI fraction. The Administrator should also rule that Board jurisdiction is limited to the specific cost reporting periods where the MAC has actually determined (or re-determined) the Providers' DSH payment on the basis of the challenged CMS methodology for calculation of the SSI fraction; determined a specific DSH payment amount based on application of the challenged SSI fraction calculation methodology; and issued a final MAC determination that specifically accounts for the resultant DSH payment amount in an appropriate notice of program reimbursement (NPR).

The CM contended that, Board jurisdiction cannot be based on the mere prospect that calculation of the SSI

fraction through the challenged CMS methodology for calculation "will be done" or that a provider is "slated to receive" an appropriate NPR showing that its DSH payment would be determined (or re-determined) based on the challenged CMS methodology for calculation of the SSI fraction. Instead, Board jurisdiction requires a final contractor determination, as set forth in an appropriate notice of program reimbursement (NPR).[3] In order for the Board to have jurisdiction over a hospital's challenge, for a specific cost reporting period, to CMS' methodology for calculation of the SSI fraction, the MAC must have actually determined (or redetermined) the Providers' DSH payment amount on the basis of the challenged calculation methodology, and the resultant DSH payment amount must be accounted for in an appropriate NPR. A mere promise "that a DSH recalculation will be done based on CMS' calculation methodology," or that a Provider is "slated to receive" an appropriate NPR is no substitute for the final MAC determination that is required for Board jurisdiction. Thus, CM stated that the Administrator should order the dismissal for lack of Board jurisdiction of every cost reporting period where the Medicare contactor had not yet: actually determined (or re-determined) the Providers' DSH payment on the basis of the challenged CMS methodology for calculation of the SSI fraction; determined a DSH payment amount based on application of the challenged SSI fraction calculation

[3] 42 C.F.R. §§ 405.1803, 405.1835(a).

methodology; and accounted for the resultant DSH payment amount in an appropriate NPR.[4]

Finally, CM stated that the Administrator should issue, for the cost reporting periods where the Board jurisdiction requirements were satisfied, a final decision rejecting the merits of the Providers' claims based on the Secretary's findings and conclusions in the 2010 notice and comment rulemaking. The Providers first maintain that the revised data matching process is based on an alleged statutory misinterpretation of the SSI fraction provisions of §1886(d)(5)(F)(vi)(I) of the Act. Under this section, the numerator of the SSI fraction consist of the number of inpatient hospital days where the individuals "were entitled to benefits under [Medicare] Part A of this title [XVIII of the Act] and were entitled to supplemental security income benefits ... under title XVI of this Act," whereas the denominator is the number of inpatient hospital days where the individuals "were entitled to benefits under [Medicare] Part A." Under the revised data matching process, an individual is entitled to SSI benefits on only those days where the individual actually received SSI payments,

[4] In addition to contravening the Board jurisdiction requirement of a final contractor determination as set forth in an appropriate NPR, CM maintained that the Providers cannot establish "standing" to challenge CMS' methodology for calculation of the SSI fraction, and any such challenge could not be "ripe" for review, until the challenged SS' fraction calculation methodology was actually applied, reflected in a specific DSH payment amount, and accounted for in an appropriate NPR. *See* generally *United States v. Windsor*, 133 S. Ct. 2675, 2685-86 (2013) (discussing requirements for standing); *AT&T Corp. v. FCC*, 349 F.3d 692, 699-704 (D.C. Cir. 2003) (dismissing case for lack of ripeness).

but a person is entitled to Medicare Part A benefits for every day on and after the individual first satisfies the statutory requirements for Medicare entitlement.[5]

The CM stated that the Providers erroneously maintain that the statutory term "entitled" in the numerator of the SSI fraction should be defined the same way for purposes of both SSI benefits and Medicare Part A benefits. However, as the Secretary explained in the 2010 published final rule, there are good reasons to define the term "entitled" differently with respect to the two programs. If a person is entitled to social security benefits under Title II of the Act, the individual is thereby "automatically" entitled to Medicare Part A benefits. Part A entitlement is a status determination that, once established for an individual, does not change regardless of whether the person qualifies for particular Part A benefits.[6] By contrast, under title XVI of the Act, an individual can meet the "eligibility" requirements for SSI program, but it is an open question whether such an eligible person is actually entitled to SSI payments on a given day. As the Secretary explained:

> [E]ligibility for SSI benefits does not automatically mean that an individual will receive SSI

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[5] *See* 75 Fed. Reg. at 50280-81 (Aug. 16, 2010) (final rule).

[6] *Id.*, For example, CM pointed out that if an individual is entitled to Part A benefits but exhaust available coverage of hospital services, the person does not lose the status of one entitled to Part A benefits simply because the individual has exhausted available coverage of hospital services.

> 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.[7]

In *Metropolitan Hospital v. U.S. Dep't of Health and Human Services*, 712 F.3d 248, 268-69 (6th Cir. 2013), the U.S. Court of Appeals for the Sixth Circuit upheld the Secretary's interpretation of the statutory reference in the numerator of the SSI fraction (also known as the "Medicare fraction") to "entitled to SSI benefits" and "entitled to Medicare Part A benefits." The court concluded that "[a]lthough seemingly in tension" with each other, the Secretary's different interpretation of the two references to "entitled" in the SSI fraction rest on the "difference in the language used in the SSI and Medicare statutory schemes [that] explain this apparent inconsistency." *Id.* at 268. As explained above, entitlement to Medicare Part A benefits is a permanent status that obtains "automatically" when one first becomes entitled to social security benefits under Title II of the Act, and one cannot "lose" entitlement to Medicare Part A benefits due to happenstance developments such as exhaustion of the individual's available coverage of hospital services. By contrast, one must apply for SSI benefits, and thus an individual who is "eligible" for SSI is not "entitled" to SSI benefits until the person actually submits an SSI application, the Social Security Administration (SSA) approves the

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[7] 75 Fed. Reg. at 50280-81.

application, and the statutory delayed effective date for SSI payments comes about. Thus, the Sixth Circuit held that "[t]he Secretary's nuanced interpretation of the Medicare fraction's numerator appropriately reflects this difference between the two benefit programs" of Medicare and SSI.[8] The Administrator should make clear that the Providers have waived any right to raise evidence, or arguments, in this appeal before the Board that could have been raised as public comments on the 2010 proposed rule for the SSI fraction calculation methodology at issue.

The Providers' submitted comments, requesting that the Administrator adopt the Providers' arguments and modify the Board's decision to reverse the MAC's adjustments and order the recalculation of the Providers' Medicare DSH payment adjustments in accordance with the plain dictates of the DSH statute. The Providers' contended that the Board should have decided this appeal on the merits and ruled that, by including only those SSI-enrollees who received a cash payment during the month in which they are hospitalized in the

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[8] *Id.*, at 268-269. Put simply, SSI is a cash benefit program, so a person is entitled to SSI benefits only if the individual is actually receiving SSI payments. By contrast, Medicare part A is an insurance program, so a person does not lose entitlement to Part A benefits because the individual happens to not use this insurance or because specific services are not covered or certain coverage has been exhausted. Given the fundamental differences between the SSI cash benefit program and the Medicare Part A insurance program, the Secretary has reasonably interpreted the SSI fraction's reference to "entitled" differently for purposes of SSI entitlement versus Medicare Part A entitlement. *See*, *Metropolitan Hospital*, 712 F.3d 248, 268-69 (6th Cir. 2013).

numerator of the Medicare fraction, CMS violated the plain meaning and intent of the DSH statute. The Providers' argued that the revised data matching process used by CMS is based on a statutory misinterpretation of the SSI fraction provisions of §1886(d)(5)(F)(vi)(I) of the Act. The Providers maintained that the statutory term "entitled" in the numerator of the SSI fraction should be defined the same way for purposes of both SSI benefits and Medicare Part A benefits. That is, as CMS interprets entitlement to Part A to include both paid and unpaid Part A benefits as well as Part C enrolled individuals, CMS should count individuals entitled to SSI regardless of whether these individuals receive an SSI payment. CMS' decision to count only those SSI beneficiaries coded with PSC Codes C01, M01 and M02, while all other SSI enrollees assigned one of the other 74 PSC codes leads to absurd results.

In addition, the Providers argued that they have not waived their right to challenge CMS' application of the DSH regulations in these appeals. The Providers content that the doctrines of waiver, estoppel and exhaustion (review preclusion) have no application to the instant appeal. The Providers argued that the waiver rule only applies to direct challenges to a rule or regulation immediately following its promulgation; it does not apply when, as here, the rule in question is challenged after it has been applied by the agency.[9] Moreover, this appeal is fundamentally different from those to which the CM cites in which the parties have been

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[9] *See*, *Koretoff v. Vilsack*, 707 F.3d 394, 399 (D.C. Cir. 2013).

deemed to have waived issues not presented first to the agency. Here, the Providers did not bypass the agency. but rather filed an administrative appeal following receipt of its NPR. Moreover, the instant appeals do not involve a direct challenge to the policy announced by the Secretary in the *Federal Register*, but rather they involve a challenge to the Secretary's application of that policy to the Providers through the Medicare cost report audit process, which as a proscribed appeal process. Furthermore, parties who did not comment at the rulemaking may challenge an agency rule once it has been applied to them.[10]

Finally, the Board did not err in finding that the Providers met the jurisdictional requirements for this appeal. The Providers' contended that the Administrator should reject CM's claim that this appeal was not ripe for review, or that those Providers without a revised NPR, who appealed from a valid NPR, lacked standing to challenge CMS' methodology for calculating the Medicare fraction. Having never raised an objection prior to hearing and having stipulated to the Board's jurisdiction over these matters subsequent to the hearing, no basis now exists for the Administrator to "order the dismissal for lack of Board jurisdiction." Alternatively, if the Administrator concludes an as-applied challenge to the DSH calculation methodology is lacking without an revised NPR, then it should simply

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[10] *See*, *e.g.*, *Koretoff*, 707 F.3d at 299 (failure to submit rulemaking comments is no bar to arguments raised to an application challenge to agency rule); *Baystate Medical Center*, CMS Admin. Dec. May 11 2006.

modify the Board's Decisions, accordingly, and remand those two Providers' fiscal years to the Board and order them stayed until the MAC issues their respective revised NPRs.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

While Title XIX implemented medical assistance pursuant to a cooperative program with the States for certain low-income individuals, the Social Security Amendments of 1965[11] established Title XVIII of the Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program provides medical services to aged and disabled persons and originally consisted of two Parts: Part A, which provides payment reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,[12] and Part B, which is the supplemental voluntary insurance program for

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[11] Pub. Law No. 89-97.

[12] Section 1811-1821 of the Act, codified at 42 U.S.C. §1395f(a)-42 U.S.C. §1395i-5.

hospital outpatient services, physician services and other services not covered under Part A.[13]

Section 1811 of the Social Security Act[14] explains that the insurance program, provides basic protection against the costs of hospital, related post-hospital, home health services, and hospice care in accordance with this part for individuals for whom entitlement is established by §226 and §226A of the Social Security Act. These are: (1) individuals who are age 65 or over and are eligible for retirement benefits under title II of this Act (or would be eligible for such benefits if certain government employment were covered employment under such title) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under title II of this Act (or would have been so entitled to such benefits if certain government employment were covered employment under such title) or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

Section 226 of the Social Security Act[15] defines an individual's "entitlement" to Medicare Part A services and provides that an individual is automatically 'entitled'

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[13] Section 1831-1848(j) of the Act, codified at 42 U.S.C. §1395j-42 U.S.C. §1395w-4(s)

[14] Section 811 of the Act is codified at 42 U.S.C. §1395c.

[15] Section 226 of the Act is codified at 42 U.S.C. §426. The ESRD provisions are set forth at section 226A of the Act.

to benefits under Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits under § 202 of the Act, or becomes disabled and has been entitled to disability benefits under § 223 of the Act for 24 calendar months. Once a person becomes entitled to benefits under Medicare Part A, the individual does not lose such entitlement simply because there was no direct payment by the program to the hospital of a specific inpatient stay. Entitlement to Medicare Part A reflects an individual's entitlement to Medicare Part A benefits, not the provider's entitlement or right to receive payment for services provided to such individual.

Concerned with increasing Medicare costs, Congress enacted Title VI of the Social Security Amendments of 1983.[16] This provision added § 1886(d) of the Act[17] and established the inpatient prospective payment system (IPPS) for reimbursement of Part A inpatient hospital operating costs for all items and services provided to Medicare beneficiaries, other than physician's services, associated with each discharge. The purpose of IPPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices.[18] These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under IPPS, hospitals and other health care providers are reimbursed their

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[16] Pub. Law No. 98-21.

[17] Section 1886(d) of the Act is codified at 42 U.S.C. § 1395ww(d).

[18] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. Thus, hospitals are paid based on a predetermined amount depending on the patient's diagnosis at the time of discharge. Hospitals are paid a fixed amount for each patient based on diagnosis related groups (DRG) subject to certain payment adjustments.

The IPPS provides for several add-on payments or adjustments to the DRG payment which includes for additional payments relating to direct graduate medical education (DGME) and indirect medical education (IME) adjustment and an adjustment payment made for hospitals that serve a disproportionate share of low income patients referred to as the DSH payment. Originally, IME and GME payments to teaching hospitals were made only related to traditional Medicare fee-for-service (FFS). Sections 4622 and 4624 of the Balanced Budget Act (BBA) of 1997, began providing hospitals with additional payments for IME and DGME costs for patients enrolled in a Medicare managed care program.

Because of the possible payment inequities for IPPS hospitals that treat a disproportionate share of low-income patients, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, "for hospitals serving a significantly disproportionate

number of low-income patients"[19] referred to as the disproportionate share hospital adjustment or DSH adjustment. There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[20] To be eligible for the DSH payment, an IPPS hospital must meet certain criteria concerning, *inter alia*, its disproportionate patient percentage or DPP. Relevant to this case, §1886(d)(5)(F)(vi) of the Act states that the terms "disproportionate patient percentage" means the sum of two fractions which is expressed as a percentage for a hospital's cost reporting period. The fractions are often referred to as the "Medicare low-income proxy" (or Medicare/SSI fraction) and the "Medicaid low-income proxy" (or Medicaid fraction). The Medicare/SSI fraction is defined at §1886(d)(5)(F)(vi)(I) of the Act (Clause I) as:

> (I) the fraction (expressed as a percentage) the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under Part A of this title and were entitled to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act and the denominator of which is the number of such hospital's patients day for such fiscal year which were made up of patients who (for

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[19] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272). See also 51 Fed. Reg. 16,772, 16,773-16,776 (1986).

[20] The Pickle method is set forth at §1886(d)(F)(i)(II) of the Act.

> such days) were entitled to benefits under Part A of this title.

The regulations located at 42 C.F.R. §412.106[21] govern the Medicare DSH payment adjustment and specifically describes the method by which the disproportionate patient percentage is calculated as well as the method of counting beds and patient days in determining the Medicare DSH payment adjustment. Because the DSH payment adjustment is part of the hospital inpatient payment, the statutory references under §1886(d)(5)(F) of the Act to "days" apply only to hospital acute care inpatient days. The first computation, the Medicare/SSI fraction, is set forth at 42 C.F.R. §412.106(b)(2) and states:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, [CMS]—
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> (i) Determines the number of covered patient days that—
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare

[21] Paragraph (a)(1) sets forth the "General considerations." that "The factors considered in determining whether a hospital qualifies for a payment adjustment include the number of beds, the number of patient days, and the hospital's location."

> Part A and SSI, excluding those patients who received only State supplementations[22]
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of patient days that—
>
> (A) Are associated with discharges that occur during that period: and
>
> (B) Are furnished to patients entitled to Medicare Part A.

For the purposes of the Medicare fraction, the agency originally found it appropriate to use the Medicare Provider Analysis and Review (MedPAR) data as the source for the Medicare DSH calculation. Principally, as documented in the Federal Register, the MedPAR system has been the Medicare Part A data source for the Medicare DSH calculation since the implementation of the DSH adjustment. The MedPAR files contains information for all Medicare beneficiaries using hospital inpatient services. Data is provided by State and then by DRG for all short stay and inpatient hospitals based upon filed claims. The accumulation of claims from a beneficiary's date of admission to an inpatient hospital, where the beneficiary has been

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[22] The cost years in this case include time periods during which the regulation was amended, pursuant to the FFY 2007 technical correction, to state: "(B) Are furnished to patients who during that month were entitled to both Medicare Part A (or Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;"). The latter Part C days are not at issue in these cases.

discharged, or to a skilled nursing facility, where the beneficiary may still be a patient, represents one stay. A stay record may represent one claim or multiple claims. MedPAR records represent final action claims data in which all adjustments have been resolved. Since the SSI/Medicare percentages are determined by CMS on a fiscal year basis, hospitals have the option (for settlement purposes) of determining their SSI/Medicare percentage based upon data matching their own cost reporting period. If a hospital avails itself of this option, it must furnish its MAC, in a manner and format prescribed by CMS, data on its Medicare patients for the cost reporting period. CMS will match these data to the data supplied by SSA to determine the patients dually entitled to Medicare Part A and SSI for the hospital's cost reporting period.

As the Secretary discussed in the FY 2011 IPPS/LTCH PPS proposed rule[23] and final rule, from the inception of the Medicare DSH adjustment in 1986, CMS has calculated the SSI fraction for each acute care hospital paid under the IPPS. This fraction, in combination with the Medicaid fraction, is used to determine whether the provider qualifies for a DSH payment adjustment and the amount of any such payment.[24] In

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[23] *See*, *e.g.*, 75 Fed. Reg. 23852, 24002 (May 4, 2010) ("Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2011 Rates") (proposed rule). *See also* 75 Fed. Reg. 50,041, 50275-85 (Aug 16, 2010) (final rule).

[24] *See*, *e.g.*, 51 Fed. Reg. 16772, 16777 (May 6, 1986) ("Medicare Program; Fiscal Year 1986 Changes to the Inpatient Hospital

determining the number of inpatient days for individuals entitled to both Medicare Part A and SSI, as required for calculation of the numerator oldie SSI fraction, CMS matches the Medicare records and SSI eligibility records for each hospital's patients during the Federal fiscal year, unless the provider requests calculation of the SSI fraction on a cost reporting period basis (in which case the provider would receive its SSI fraction based on its own cost reporting period). The data underlying the match process are drawn from: (a) MedPAR data file; and (b) SSI eligibility data provided by the Social Security Administration (SSA). CMS has matched Medicare and SSI eligibility records using Title II numbers (included in the SSI records)

Prospective Payment System.") ("The number of patient days of those patients entitled to both Medicare Part A and SSI will be determined by matching data from the Medicare Part A Tape Bill (PATBILL) file with the Social Security Administration's (SSA's) SSI file. This match will be done at least annually and will involve a match of the individuals who are SSI recipients for each month during the Federal fiscal year in which the hospital's cost reporting period begins with the Medicare Part A beneficiaries who received inpatient hospital services during the same month. Thus, if a Medicare beneficiary is eligible for SSI benefits (excluding State supplementation only) during a month in which the beneficiary is a patient in the hospital, the covered Medicare Part A inpatient days of hospitalization in that month will be counted for the purpose. of determining the hospital's disproportionate patient percentage. The match of SSI eligibility records to Medicare inpatient hospital days for a hospital will consist of counting the days in which Medicare inpatient hospital services are furnished during each month to patients entitled to both Medicare Part A and SSI, summing those days, and dividing by the total number of days for which Medicare inpatient hospital services are furnished to all Medicare Part A beneficiaries in the hospital.")

and Health Insurance Claims Account Numbers (HICANs) (contained in the MedPAR file). CMS explained the Title II number [25] and a HICAN. When a person becomes entitled to Medicare benefits, he or she is assigned a HICAN for purposes of processing claims submitted on his or her behalf for Medicare services. A beneficiary's HICAN [26] (which may not necessarily

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[25] The Secretary explained that: "Title II Number: If a person qualifies for retirement or disability benefits under Title II of the Act (42 U.S.C. 401 et seq.), SSA assigns a "Title II number" to the individual. If the Title II beneficiary's own earnings history (or the individual's disability) were the basis for such benefits, the person's Social Security number (SSN) would constitute the 'root' of the individual's Title II number. However, if the person's Title II benefits were based on the earnings history of another individual (for example, a spouse), that other person's SSN would provide the root for the beneficiary's Title II number. In addition to a root SSN, each Title II number ends with a Beneficiary Identification Code (BIC) that identifies the basis for an individual's entitlement to benefits. For example, a person who becomes eligible for benefits under his or her own account would be described by his or her SSN followed by the BIC 'A' whereas a wife who becomes eligible for benefits under her husband's account would be described by his SSN followed by the BIC 'B.' Children who become eligible under a parent's account would be described by the parent's SSN followed by the BIC 'C1, 'C2, etc.'" 75 Fed. Reg. 23852, 24002 (May 4, 2010)

[26] The Secretary explained that: "Each HICAN for a beneficiary should be identical, at the same point in time, to that individual's Title II number. This is because HICANs and Title II numbers are both assigned on the basis of the same data source, the SSA-maintained Master Beneficiary Record, and by using the same rules (that is, the rules for determining which person's SSN will serve as the root for an individual's HICAN and Title II number and for determining the BIC for both types of numbers). We note that a person's Title II number and HICAN can change over time. For example, if the individual's entitlement to Title II and Medicare benefits was originally based on the earnings history of a first

contain his or her SSN) is included on the Medicare inpatient hospital claim.

The SSI eligibility data that CMS receives from SSA contain monthly indicators to denote which month(s) each person was eligible for SSI benefits during a specific time period. The current matching process uses only one Title II number (which is included in the SSI file) and one HICAN (found in the MedPAR file) for each beneficiary. In the current matching process, CMS has used the HICAN because it is the patient identifier that is provided by hospitals on the Medicare claim. Because SSNs are not included on Medicare inpatient claims, CMS has not historically used SSNs in the match process.

For a given fiscal year, CMS determines the numerator of the hospital's SSI fraction (that is, the number of the hospital's inpatient days for all of its patients who were simultaneously entitled to Medicare Part A benefits and SSI benefits) by calculating the sum of the number of the hospital's inpatient days that are associated with all of the identical Title II numbers and HICANs for the hospital's claims that are found through the data matching process. In turn, CMS determines the denominator of the hospital's SSI fraction by

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spouse, but the beneficiary later qualified for such benefits on the basis of a second spouse's earnings history, the beneficiary's HICAN and Title II number would change accordingly. Specifically, the first spouse's SSN would be the root of the beneficiary's original HICAN and Title II number; later, the second spouse's SSN would become the root of the beneficiary's second HICAN and Title II number." 75 Fed. Reg. 23852, 24002 (May 4, 2010)

calculating the sum of the number of the hospital's inpatient days for patients entitled to benefits under Medicare Part A (regardless of SSI eligibility) that are included in the hospital's inpatient claims for the period.

The Supplemental Security Income or SSI is Federal program that provides cash assistance to certain low-income people who are either aged 65 or older, blind, or disabled. The Social Security Administration administers the SSI, which is funded from the U.S. Treasury general funds.[27] The controlling law refers to whether an individual is "eligible for benefits." In order to be eligible for SSI benefits, 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.[28] An individual who is currently eligible for SSI benefits may later become ineligible for SSI benefits. The SSA conducts periodic redeterminations to ensure continued eligibility[29] and

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[27] See e.g. Section 1611 of the Social Security Act. ("Part A-Determination of Benefits ELIGIBILITY FOR AND AMOUNT OF BENEFITS"); Supplemental Security Income Home Page, https://www.ssa.gov/ssi/ ("What Is Supplemental Security Income? Supplemental Security Income (SSI) is a Federal income supplement program funded by general tax revenues (not Social Security taxes): It is designed to help aged, blind, and disabled people, who have little or no income: and it provides cash to meet basic needs for food, clothing, and shelter.")

[28] 20 C.F.R. §416.202.

[29] 20 C.F.R. § 416.204.

may terminate,[30] suspend,[31] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[32] For example, SSI eligibility may be lost if a person no longer meets the basic requirements or because one of the reasons set forth in §§ 416.207-416.216 applies at the time of a redetermination.[33]

The SSI matching data underlying the Medicare DSH payment adjustment was the matter in controversy in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d 37 (D.D.C. 2008), wherein the district court concluded that, in certain respects, CMS' method for matching SSI data and Medicare records for purposes of the DH payment match process did not use the best available data in matching Medicare and SSI eligibility data (a problem in part due to "stale" data no longer an issue). In response to *Baystate*, CMS revised its data matching process for calculating hospitals' SSI fractions and on April 28, 2010, issued CMS Ruling 1498-R (Ruling), which addressed the SSI data matching issue and two other issues.[34]

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[30] 20 C.F.R. § 416.1331-1335.

[31] 20 C.F.R. § 416.1320-1330.

[32] 20 C.F.R. § 416.1320.

[33] 20 C.F.R. 416.200.

[34] *See* CMS-1498-R (dated April 28, 2010).

With respect to the SSI data matching process issue, the Ruling requires the Medicare administrative appeals tribunal (that is, the Administrator of CMS, the PRRB, the fiscal intermediary hearing officer, or the CMS reviewing official) to remand each qualifying appeal to the appropriate Medicare contractor. The Ruling also explains how, on remand, CMS and the contractor will recalculate the provider's DSH payment adjustment and make any payment determined owed. The Ruling further provides that CMS and the Medicare contractors would apply the provisions of the Ruling, on the data matching process issue (and two other DSH issues, as applicable), in calculating the DSH payment adjustment for each hospital cost reporting period where the contractor has not yet final settled the provider's Medicare cost report through the issuance of an initial notice of program reimbursement (NPR) (42 CFR 405.1801(a) and 405.1803). More specifically, the Ruling provided that, for qualifying appeals for the data matching issue and for cost reports not yet final settled by an initial NPR, CMS would apply any new data matching process that is adopted in the: "FY 2011 IPPS final rule for each appeal that is subject to the Ruling. The data matching process provisions of the Ruling would apply to properly pending appeals and open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."

The Ruling further stated that, if a new data matching process is not adopted in the forthcoming FY 2011

IPPS final rule, CMS would apply to claims subject to the Ruling the same data matching process as the agency used to implement the *Baystate* decision by recalculating that hospital's SSI fractions. A final rule was issued on August 16, 2010 adopting in essence the same revised data matching process as was applied in the *Baystate* case. (*See* 75 Fed. Reg. 50,041, 50275-85 (Aug 16, 2010) (final rule); 75 Fed. Reg. 23,852 (May 4, 2010) (proposed rule)[35]

CMS published the new data matching process in the FY IPPS 2011 proposed rule published on May 4, 2010[36] and finalized that data matching process in the final rule published on August 16, 2010.[37] The final rule addressed several comments submitted following the

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[35] Subsequently, CMS Ruling 1498-R2 was issued. The modification and amendment of CMS Ruling 1498-R affected a change only with respect to Medicare-SSI fractions, and the interaction between Medicare-SSI fractions that have been suitably revised to address the data matching process issue and the issue of non-covered or exhausted benefit days for cost reporting periods involving patient discharges before October 1, 2004. ("In sum, the purpose of this amendment is to make clear that in light of the D.C. Circuit Court's decision in *Catholic Health*, we are allowing providers to elect whether to receive suitably revised Medicare-SSI fractions on the basis of "covered days" or "total days" for Federal fiscal year 2004 and earlier, or for hospital-specific cost reporting periods, for those patient discharges occurring before October 1, 2004. This election is available for hospital cost reporting periods where the Medicare contractor has not yet settled finally the provider's Medicare cost report, as well as appeals remanded to the contractor pursuant to CMS Ruling 1498-R (assuming any such hospital cost reporting period involves patient discharges prior to October 1, 2004).")

[36] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

[37] 75 Fed. Reg. 50041, 50276-50281 (August 16, 2010).

notice and comment procedures. In particular, the Secretary recognized that:

> 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

The Secretary responded to the concerns raised in the comment, stating:

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, §1611(c)(7) of the Act provides that an application for SSI befits 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.

On the other hand, §226 of the Act provides that an individual automatically "entitle" to Medicare Part A when the person reaches age 65 and is entitle to Social Security benefits under §202 of the Act (42 U.S.C. 402) or becomes disabled and has been entitled to

disability benefits under §223 of the Act (42 U.S.C. 423) for 24 calendar months. Section 226A of the Act provides that qualifying individuals with end-stage renal disease shall be entitled to Medicare Part A. In addition, § 1818(a) (4) of the Act provides that, "unless otherwise provided, any reference to an individual entitled to benefits under [Part A] includes an individual entitled to benefits under [Part A] pursuant to enrollment under [§1818 or § 1818A." We believe that Congress used the phrase "entitled to benefits under part A" in § 1886(d)(5)(F)(vi) of the Act to refer individuals who meet the criteria for entitlement under these sections.

Moreover, unlike the SSI program (in which entitlement to receive SSI benefits is based on income and resources and, therefore, can vary from time to time), once a person becomes entitled to Medicare Part A, the individual does not lose such entitlement simply because there was no Medicare Part A coverage of a specific inpatient stay. Entitlement to Medicare Part A reflects an individual's entitlement to Medicare Part A benefits, not the hospital's entitlement or right to receive payment for services provided to such individual. Such Medicare entitlement does not cease to exist simply because Medicare payment for an individual inpatient hospital claim is not made. Again, we are bound by § 1886(d)(5)(F)(vi)(I) of the Act, which defines the SSI fraction numerator as the number of SSI-entitled inpatient days for persons who were "entitled to benefits under [P]art A," and

the denominator as the total number of inpatient days for individuals who were "entitled" to Medicare Part A benefits.

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

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

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

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

Code "E01" represents an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but has countable income of $30 or more. Such an individual is not entitled to receive SSI payment. Alternatively, an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but does not have countable income of at least $30, would be reflected on the SSI files as a "C01" (which denotes SSI entitlement) for any month in which the requirements described in this sentence are met. Code "E02" is used to identify a person who is not entitled to SSI payments in the month in which that code is used pursuant to §1611(c) (7) of the Act, which provides that an application for SSI benefits shall be effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date the individual becomes eligible for SSI based on that application. Such an individual is not entitled to SSI benefits during the month that his or her application is filed or is determined to be eligible for SSI, but, for the following month, would be coded as a "C01"

because he or she would be entitled to SSI benefits.

Therefore, both codes E01 and E22 represent individuals who are not entitled to SSI benefits and are reflected accordingly on the SSI file. If the individual's entitlement to SSI benefits is initiated the ensuing month, that individual would then be coded as a "C01" on the SSI file and would be included as SSI-entitled for purposes of the data matching process.

As we have describe above, none of the SSI status codes that the commenter mentioned would be used to describe an individual who was entitled to receive SSI benefits during the month that one of those status codes was used. SSI entitlement can change from time to time, and we believe that including SSI codes of C01, M01, and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitled to receive SSI benefits.[38]

After consideration of the public comments we received, we are adopting the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed data matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB, which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional

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[38] Id., at 50280-50281 (Aug. 16, 2010).

> step in our validation process in response to public comments to provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay.[39]

In this case, the fiscal periods at issue are governed by CMS Ruling 1498-R, as incorporating the FFY 2011 IPPS final rule, published in 2010. The Administrator finds the Secretary's interpretation of the term "entitled" with respect to "patients who (for such days) were *entitled* to benefits under Part A of this title" and "were *entitled* to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act" is supported by the statutory design of the two programs. In particular, there are meaningful statutory differences between Medicare Part A benefits and SSI benefits with respect to both initial eligibility and continued eligibility when describing that a person is "entitled" to the benefits of each respective program. With respect to Medicare Part A, a person become eligible for benefits merely by reaching age 65 and filing an application or becoming disabled and entitled to disability benefits before reaching retirement age.[40] Part A entitlement is a status determination that, one established for and individual, does not change regardless of whether the person qualifies for particular Part A benefits. For, example, if an

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[39] Id., at 50280-50281 (Aug. 16, 2010).

[40] 42 U.S.C §402.

individual is entitled to Part A benefits but exhausts available coverage of hospital services, the person does not lose the status of one entitle to Part A benefits simply because the individual has exhausted available coverage of hospital services. By contrast, an individual must satisfy more requirements to become eligible (and stay eligible) for SSI benefits, and the requirements are variable from month-to-month and less easily ascertainable when compared to determining whether an individual is entitled to Medicare Part A benefits.[41] As the Secretary explained: [E]ligibility for SSI benefits does not automatically mean that an individual will receive SSI benefits for a particular month. For example, § 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."[42]

Congress uses the phrase "entitled to benefits under part A" to consistently refer to an individual's status

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[41] *See*, *Metropolitan Hospital v. U.S. Dep't of Health and Human Services*, 712 F.3d 248, 268-69 (6th Cir. 2013). In Metropolitan Hospital, the U.S. Court of Appeals for the Sixth Circuit upheld the Secretary's interpretation in the 2010 final rule of the references in the numerator of the SSI fraction (also known as the "Medicare fraction") to "entitled to SSI benefits" and "entitled to Medicare Part A benefits." The court concluded that [a]lthough seemingly in tension" with each other, the Secretary's differential interpretation of the two references to "entitled" in the SSI fraction rest on "differences in the language used in the SSI and Medicare statutory schemes [that] explain this apparent inconsistency."

[42] 75 Fed. Reg. at 50280.

as a Medicare beneficiary. Further evidence of this use of the term as referring to the status as a Medicare Part A beneficiary is that the phrase "entitled to benefits under [Medicare] part A" is set forth in multiple other sections of the Medicare statute, indicating that the phrase has a specific, consistent technical term of art meaning throughout the statutory scheme and not a varying, context-specific meaning in each section and subsection. In addition, under Medicare, "payment" for the service is not the focus of the phrase at issue, but rather the focus is on entitlement to the benefit in determining the proper inclusion in the DSH formula. Section 1886(d)(5)(1)(vi)(I) of the Act specifically notes that the numerator of the Medicare fraction must reflect patient days for patients "entitled to benefits under part A" who are also "entitled to supplementary security income benefits (excluding any State supplementation) under title XVI of this Act."

Entitlement to Medicare Part A is different from entitlement to SSI benefits as SSI is a cash benefit. Unlike the permanent, unchanging status of Medicare Part A entitlement, "entitlement to receive SSI benefits is based on income and resources and, therefore can vary from time to time."[43] Further, one must apply for SSI benefits and thus an individual who is eligible for SSI is not entitled to SSI until the person actually submits an SSI application and the SSA approves the application and the statutorily delayed effective date for SSI payments occurs. Further, the "entitlement" to SSI

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[43] *Id.*

benefits, pursuant to § 1602 of the Act states that "Every 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 Social Security." Because SSI is a cash benefit, only a person who is actually paid these benefits can be considered "entitled" to these benefits. This differs from entitlement to Medicare benefits under Part A, a distinct set of health insurance benefits described under §1812 of the Act, including coverage of inpatient hospital, inpatient critical access hospital, and post-acute care services as well as post-institutional home health and hospice services under certain conditions. As the court in *Metropolitan Hospital*[44] concluded, given the fundamental difference between the SSI cash benefit program and the Medicare Part A insurance program the Secretary has reasonably interpreted the SSI fraction reference to "entitled" differently for purposes of SSI entitlement verse Part A entitlement.

Accordingly, the Administrator finds that it is necessary to show that patients are actually eligible for SSI benefits (i.e., receiving a cash benefit) before including their days of care in the Medicare fraction. The Secretary reasonably decided against including the days of care for patients for which it cannot be demonstrated with accuracy are receiving SSI benefits. The Secretary reasonably rejected the inclusion of other SSA codes

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[44] *Metropolitan Hospital*, 712 F. 3d. at 268-69.

because "SSI entitlement can change from time to time" and none of these 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."[45] Thus, the Social Security Act, with respect to Medicare beneficiaries and SSI recipients, supports the Secretary's interpretation of the term "entitled" as used in the §1886(d)(5)(F)(vi)(I) of the Act. Further, the Secretary has reasonably excluded from the revised data match any computer codes that SSA may use to indicate that a person is eligible for SSI but is not actually receiving SSI payments and so is not "entitled" to SSI benefits.

While a decision on the merits is within the scope of the Administrator's authority, it does not negate the fact that the appeal is a challenge to the SSI matching methodology of the CMS Ruling 1498R as described and adopted in the FY 2011 Final rule for the IPPS. As such, a review on the merits here does not negate or waive the legal principle that where "an agency issued a rule under the APA notice and comment provision . . . , courts ordinarily refuse to consider objections not submitted in accordance with the agency procedures during the rulemaking process. *See Appalachian Power v EPA*, 251 F.3d 1036 (D.C. Cir. 2001).

Under § 1878(f) of the Social Security Act,[46] the Board may determine (on own motion, or the request of a

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[45] *Id.*

[46] Section 1878(f) states in pertinent part: "Providers shall also have the right to obtain judicial review of any action of the fiscal

provider), with respect to a final determination of the Medicare administrative contractor (formerly the intermediary) which involves a question of matter of law or regulation, that it is without the authority to determine a question. The Board decision on whether to grant or deny expedited judicial review (for which jurisdiction must first be determined) is specifically outside the scope of the Administrator's review. The Providers in these cases did not request expedited judicial review, nor did the Board on own motion invoke it. Therefore, this case is in an unusually procedural posture of having the Board determine that it is without authority to decide the legal question outside the parameters of the expedited judicial review process. Because of that, a matter that would usually be an expedited judicial review challenge to a rulemaking record has been positioned within the context of a decision on the merits.

Therefore, the Secretary has 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 that term in the use of specific codes in the SSI matching process in the FY 2011 final rule. as incorporated in the CMS Ruling 1498-R. The Administrator finds that CMS and the MAC properly incorporated the

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intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received."

methodology contained therein in issuing the recalculated SSI matching data for purposes of the Medicare Fraction for the DSH payment.

However, these case raised jurisdictional issues as to whether all the cost report NPPRs/ revised NPRs appealed in fact reflected the recalculated SSI matching data for purposes of the Medicare Fraction for the DSH payment. The Board held that it had jurisdiction to hold a hearing, but found that it lacked the authority to mandate specific revisions to the challenged CMS data matching process for the Medicare fraction of the Medicare DSH calculation for the fiscal years at issue. The CM submitted comments that, the Administrator should rule that there is no Board jurisdiction over each cost reporting period where the Providers' have merely been informed that a DSH recalculation will be done based on the challenged CMS methodology for calculation of the SSI fraction. The Provider submitted comments, that the Board did not err in finding that the Providers met the jurisdictional requirements for this appeal, or in the alternative, the Providers still awaiting a final recalculation under the CMS Ruling, should be remanded.

To address any potential jurisdictional issues that might arise if the MAC issued a recalculation prior to or just after the Board's decision in this case, the Parties in PRRB Decision No. 2017-D11on February 22, 2017 stipulated to three Hospitals as not having yet

received NPRs reflecting the recalculation.[47] In PRRB Decision No 2017-D12, there does not appear to be a similar stipulation and all but one provider appear to have NPRs that were issued prior to the CMS Ruling in April 2010.

Pursuant to §1878 of the Act, a provider has a right to a hearing before the Board, if such provider is dissatisfied with a final determination of the organization serving as its fiscal intermediary as to the amount of total program reimbursement due the provider for the

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[47] *See also* Providers' Comments, Exhibit A, dated May 4, 2017, in response to the Administrator's Notice of Review, dated March 27, 2017. The stipulation provided: 1) Three Providers (52-0051, 01-0090 and 05-0093) in the Combined Appeals have yet to receive their Revised Notice of Program Reimbursement pursuant to CMS Ruling 1498-R. 2) Providers 52-0051 and 01-0090 are expected to receive RNPRs from their Medicare Administrative Contractor prior to July 2017. 3) The RNPRs the MAC may issue to Providers 52-0051 and 01-0090, will not incorporate the SSI Eligible patients days that are at issue in the Combined Appeals into the numerator of the Medicare fraction of the DSH calculation.4) The Board's Decision in the Combined Appeals will be binding on Providers 52-0051 and 01-0090. 5) The third Provider, 05-0093, currently has an appeal in the District of Columbia District Court from PRRB Case No. 12-0522GC for its FYE 06/30/2006, and, therefore, the MAC cannot stipulate as to when the RNPR for this Provider will be issued. 6) The Parties agree that the Provider 05-0093 can request a transfer of its claim in the Combined Appeals for its 2006 fiscal year to PRRB Case No. 17-0489G that is pending before the Board. For three providers and respective cost years, in PRRB Dec. 2017-D11, the parties stipulated that the Board's decision would be binding on Columbia St. Mary's Hospital, 52-0051 and Providence Hospital, 01-0090 and that the claim of St. Agnes Medical Center, 05-0093 would be transferred to a group appeal which is pending as PRRB Case No. 17-0489G that is not subject to this decision.

items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report. These provisions likewise apply to group appeals. According to 42 C.F.R. § 1801(a), an "intermediary determination" is defined as: a determination of the amount of total reimbursement due the provider, pursuant to § 405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report." This determination is reflected in notice of amount of program reimbursement or "NPR." Finally, 42 C.F.R. §405.1889, is applicable to revised NPRs, which are considered separate and distinct determinations to which the appeal provisions apply.[48]

In addition, relevant to this case, on April 28, 2010, CMS issued CMS Ruling CMS-1498-R. The Ruling provided notice that the Board and the other Medicare administrative appeals tribunals lacked jurisdiction over three specific types of provider appeals regarding the calculation of the Medicare disproportionate share hospital (DSH) adjustment. The CMS-1498-R titled "Medicare Program Hospital Insurance (Part A)-Jurisdiction over appeals of disproportionate share hospital (DSH) payments and recalculations of DSH payments

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[48] On its face, 42 C.F.R. §405.1889 would appear to preclude the application of a *Bethesda* analysis, that latter of which arose from an appeal under the authority of §1878 of the Act.

following remands from Administrative Tribunals" provides the following:

> CMS is issuing, contemporaneously with this Ruling, a proposed rule that begins, for Federal fiscal year (FY) 2011, the annual IPPS rulemaking through which payment rates for inpatient hospitals are updated and new payment policies are implemented. In the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process, effective October 1, 2010, as the agency used to implement the *Baystate* decision by recalculating that provider's SSI fractions. In the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments 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. As explained below in Section 5 of this Ruling, the outcome of the FY 2011 IPPS rulemaking will determine the suitably revised data matching process that CMS will use in implementing this Ruling. If the FY 2011 IPPS final rule results in a new data matching process, then CMS will 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. However, if a new data matching process is not adopted in the FY 2011 IPPS final rule, then CMS will implement this Ruling by using the same revised data matching process as the agency used to implement the *Baystate* decision.

In accordance with the foregoing history and determination, CMS and the Medicare contractors will resolve each properly pending DSH appeal of the SSI fraction data matching process issue, by applying a suitably revised data matching process (as set forth below in Section 5.a. of this Ruling) for purposes of recalculating the hospital's SSI fraction by matching Medicare and SSI eligibility data, and then recalculating the hospital's DSH payment adjustment for the period at issue. *CMS' action eliminates any actual case or controversy regarding the hospital's previously calculated SSI fraction and DSH payment adjustment and thereby renders moot each properly pending claim in a DSH appeal involving the hospital's previously calculated SSI fraction and the process by which CMS matches Medicare and SSI eligibility data, provided that such claim otherwise satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines. Accordingly, it is hereby held that the PRRB and the other administrative tribunals lack jurisdiction over each properly pending claim on the SSI fraction data matching process issue, provided that such claim otherwise satisfies the applicable jurisdictional and procedural requirements for appeal.*

As explained below in Sections 4 and 5 of this Ruling, CMS and the Medicare contractors will take the steps necessary to apply a suitably revised data matching process in

> determining the SSI fraction, and recalculating the DSH payment adjustment, *for each properly pending claim on the SSI fraction data matching process issue that is remanded by an administrative appeals tribunal and is found to qualify for relief under this Ruling*.(Emphasis added.)

Specifically, CMS Ruling CMS-1498-R prohibits the Board and the Administrator from review and removes jurisdiction to review provider appeals regarding three issues most notably the data matching for the calculation of the SSI fraction. The issue raised in this case at this time involves the data matching for the calculation of the SSI fraction for cost reporting periods prior to 2010. The Board decisions recognize that some of the providers have not yet received NPRs showing the recalculation of Medicare fraction pursuant to the SSI matching process pursuant to CMS Ruling 1498-R as incorporating the 2010 published methodology..

The Administrator finds that, in light of the directives of CMS Ruling 1498-R and the necessity of finality specifically embodied in the Social Security Act, the CMS regulations, cost reporting rules, and, more generally, recognized in administrative law, the Board review cannot be based on the mere prospect that calculation of the SSI fraction through the challenged CMS methodology "will be done" or that a Provider is "slated to receive" an appropriate NPR showing that its DSH payment would be determined (or redetermined) based on the challenged CMS methodology for calculation of the SSI fraction. The Board jurisdiction requires a final

contractor determination, as set forth in an appropriate NPR or revised NPR and instructed by CMS 1498-R. In order for the Board to have jurisdiction for review over a hospital's challenge, for a specific cost reporting period involving the CMS methodology for calculation of the SSI fraction, the MAC must have actually determined (or redetermined) the Provider's DSH payment amount on the basis of the challenged calculation methodology, and the resultant DSH payment amount must be accounted for in an appropriate NPR or revised NPR in accordance with CMS 1498-R.

Applying the applicable controlling policy and law to the facts of these case, the Administrator finds that in PRRB Dec. No. 2017-D11, the record shows that the parties stipulated that three of the Providers,[49] have yet to receive their Revised NPRs pursuant to CMS Ruling 1498-R. In addition, the record shows that certain other members of that same PRRB Group No. 13-1627G[50] show NPRs issued prior to the CMS Ruling hence leading one to conclude an NPR/revised NPR showing the recalculation pursuant to the CMS ruling has not yet occurred.[51] In PRRB Dec. No. 2017-D12, a review of the schedule of providers (both groups and

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[49] Columbia St. Mary's Hospital, (52-0051), Providence Hospital, (01-0090), and St. Agnes Medical Center,(05-0093).February 2017 stipulations in PRRB Dec. No 2017-D11.

[50] Except for Seton Saint Mary's Hospital (33-0232) for FYE 12/31/2006).

[51] Whether a provider could argue that it had a cost year recalculated pursuant to CMS Ruling 1498, which resulted in no change of its DSH payment and the possibility of no revised NPR, was not a procedural posture suggested in the Board decision.

individually) shows all but one Provider in all the consolidated cases (group and individual) were appealing from NPRs issued prior to the April 2010 CMS Ruling and hence leading one to conclude an NPR/revised NPR showing the recalculation pursuant to the CMS ruling has not yet occurred.[52] The record on its face is also not clearly defined as to the date the Providers raised or added the SSI matching issue to their appeals with the required specificity.[53]

For Board jurisdiction to be properly asserted over a cost report for purposes of a hearing on the merits (as opposed to remand under CMS Ruling 1498-R), the MAC must have actually determined (or re-determined) the Providers' DSH payment on the basis of the challenged CMS methodology for calculation of the SSI fraction; determined a specific DSH payment amount based on application of the challenged SSI fraction calculation methodology; and issued a final MAC determination that specifically accounts for the resultant DSH payment amount in an appropriate NPR or revised NPR.

Therefore, the Administrator determines that the Board decision is vacated, finding jurisdiction for a hearing for those cost years in PRRB Dec. Nos. 2017-D11 and 2017-D12, for which the date on the NPR under appeal is prior to the April 28, 2010 CMS Ruling 1498-R and, therefore, would not be consistent with a

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[52] The exception appears to be University of Virginia Medical Center for FYEs 6/30/07 through 2009.

[53] *See* Transcript of Oral Hearing at 1-15 (March 17, 2015). *See also*, Jurisdictional documents,. *e. e.g.*, Volume 1 of 2, Schedule of Providers, PRRB Case No. 07-2872G).

conclusion that a DSH recalculation has been made pursuant to CMS Ruling 1498-R (including those cost years for which the Providers acknowledge no recalculation has occurred).[54] The foregoing cost years are properly remanded to the Board and, if appropriate, 1) the cost year should be remanded to the MAC for resolution consistent with CMS-1498-R; or 2) to allow the Board to consider further documentation to demonstrate whether a final determination has been issued pursuant to CMS Ruling 1498-R or CMS Ruling 1498-R2;[55] or 3) for the Board to consider further documentation on whether the issue was timely added with sufficient specificity and whether the respective provider has a properly pending appeal on that issue in accordance with CMS Ruling 1498R and the regulations.[56]

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[54] This initial review is based upon an assumption that NPRs dated after the date of the CMS Ruling, reflected in the schedule of providers, were issued pursuant to the application of the Ruling, Because of the number of providers and cost years in this consolidation of many groups (exceeding 500 cost years in PRRB Dec. No. 2017-D11) and individually (PRRB Dec. No. 2017-D12), the Administrator also preserves the right to raise the lack of finality with respect to the recalculation under CMS Ruling 1498-R should, in further proceedings, other appealed Hospital cost reports are determined to have failed to demonstrate that this criteria was met.

[55] A possible issue raised in the consolidation of various groups under one decision and as one administrative record, is that the each Group, while entitled to file in the District of Columbia, have a right to file in the judicial district where the greatest number of the Providers in the individual group reside under §1878(f)(1) of the Act, which may vary..

[56] *See*, *e.g.*, 42 CFR 405.1835(e) and the final rule at 73 Fed. Reg. 30190 (May 23, 2008) with respect to timely adding issues.

DECISION

The decision of the Board is modified in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 5/30/17 /s/ Demetrios L. Kouzoukas
Demetrios L. Kouzoukas
Principal Deputy Administrator
Centers for Medicare & Medicaid Services

PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2017-D11

PROVIDER – Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction Provider No.: Various **vs.** **INTERMEDIARY –** Wisconsin Physicians Services; Palmetto GBA c/o National Government Services; CGS Administrators; National Government Services Inc.; Novitas Solutions Inc.; Cahaba GBA c/o National Government Services Inc.; Noridian Healthcare Solutions, LLC	**DATE OF HEARING –** September 15, 2015 Cost Reporting Periods Ended: Fiscal Years 2006, 2007, 2008, and 2009 **CASE NOs.:** 13-1862GC, et al.

INDEX

[2] **ISSUE**

Whether the Medicare Disproportionate Share Hospital ("DSH") reimbursement calculations for the Providers ("Hospitals") were understated due to the failure of the Centers for Medicare & Medicaid Services ("CMS") and the relevant Medicare Administrative Contractors ("Medicare Contractors")[1] to include all supplementary security income ("SSI") eligible patient days in the numerator of the Medicare fraction of the Medicare DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[2]

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds that it lacks the authority to mandate specific revisions to CMS' data matching process for the Medicare fraction of the Medicare DSH calculation for the fiscal years at issue. Accordingly, the Board holds that

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[1] The lead Medicare contactor in this case is Wisconsin Physicians Services.

[2] Transcript ("Tr.") at 6-7.

it does not have the authority to reverse the Medicare Contractors' adjustments.

INTRODUCTION

This case consolidates multiple group appeals involving numerous acute care hospitals for fiscal years 2006 to 2009.[3] The Hospitals challenge CMS' policy of including only some of the SSI eligibility categories in the numerator of the Medicare fraction of the DSH calculation.[4] The Hospitals claim that, as a result of this policy, they received less DSH reimbursement than they are entitled.

Each of the Hospitals timely appealed this issue and met the jurisdictional requirements for a hearing. Accordingly, the Board held a consolidated hearing on these appeals on September 15, 2015. The Hospitals were represented by Daniel F. Miller, Esq. of Hall, Render, Killian, Heath & Lyman, P.C. The Medicare Contractors were represented by Brendan G. Stuhan, Esq. of the Blue Cross and Blue Shield Association.

STATEMENT OF THE FACTS

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's

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[3] The Schedule of Providers is attached as Appendix A and it is organized by fiscal year and group case number.

[4] Providers' Combined Final Position Paper, Vol. II, at 00072.

inpatient prospective payment system ("IPPS").[5] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[6] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. The Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days ... which were made up of patients who (for such days) were entitled to [3] benefits under part A of the subchapter and were entitled to supplementary security income benefits ... under subchapter XVI of this chapter ... "; and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A.[7] The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[8] administered by the Social Security Administration ("SSA"). The SSI statute, generally, does

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[5] 42 C.F.R. Part 412.

[6] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I) (copy included at Provider Exhibit P-3).

[7] 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I). *See also* 42 C.F.R. § 412.106(b)(2)(i)(B) (copy included at Provider Exhibit P-9).

[8] 42 U.S.C. § 1382 (copy included at Provider Exhibit P-8).

not use the term "entitled" to SSI benefits. Rather, the SSI statute typically refers to whether an individual is "eligible for benefits."[9] In order to be "eligible" for SSI benefits, 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.[10]

The Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[11] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[12]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[13] and may terminate,[14]

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[9] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added) (copies included at Provider Exhibits P-7, P-8 respectively).

[10] 20 C.F.R. § 416.202.

[11] 42 U.S.C. § 426.

[12] 42 U.S.C. § 426-1.

[13] 20 C.F.R. § 416.204.

[14] 20 C.F.R. §§ 416.1331-1335.

suspend[15] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[16] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in Sections §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[17]

2. The individual fails to apply for other benefits to which the individual may be entitled;[18]

3. The individual fails to participate in drug or alcohol addiction treatment;[19]

[4] 4. The individuals is absent from the United States for more than 30 days;[20] or

5. The individual becomes a resident of a public institutions or prison.[21]

Under certain circumstances, the Social Security Administration may not pay benefits for administrative reasons, including removal of a representative

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[15] 20 C.F.R. §§ 416.1320-1330.

[16] 20 C.F.R. § 1320.

[17] 20 C.F.R. § 416.207.

[18] 20 C.F.R. § 416.210.

[19] 20 C.F.R. § 416.214.

[20] 20 C.F.R. § 416.215.

[21] 20 C.F.R. § 416.211.

payee, an unknown address for the beneficiary, or because of income from a previous month.[22]

After the Medicare DSH statutory provisions were enacted in 1984, the Health Care Financing Administration ("HCFA"), the predecessor to CMS, announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, the Social Security Administration ("SSA").[23] HCFA noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[24] To compute the Medicare fraction, HCFA had to match individual Medicare billing records to individual SSI records.[25] Considering the administrative burdens and complexity of the data matching process, HCFA concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based

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[22] *See* Provider Exhibit P-38 (copy of SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events)).

[23] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).

[24] *Id.*

[25] *Id.*

on discharges occurring in the federal fiscal year.[26] HCFA/CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[27]

The Medicare DSH payment adjustment has been the subject of much litigation and the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient. On April 28, 2010 CMS published Ruling 1498-R to respond to a court order in *Baystate.* Specifically, 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."[28] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching

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[26] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).

[27] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.

[28] CMS-1498-R at 5 (copy included at Providers Exhibit P-18).

process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to [5] 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."[29] 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."[30]

Consistent with Ruling 1498-R, CMS published the new data matching process in the FY 2011 proposed rule published on May 4, 2010[31] and finalized that data matching process in the final rule published on August 16, 2010 ("FY 2011 Final Rule").[32] Significantly, in the preamble to the FY 2011 Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "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 match process."[33] CMS responded in detail to this

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[29] *Id.*

[30] *Id.* at 5-6.

[31] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

[32] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010) (copy included at Provider Exhibit P-17).

[33] *Id.* at 50280.

comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[34] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these 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."[35] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[36]

While the new data matching process established in the FY 2011 Final Rule was effective October 1, 2010, Ruling 1498-R directed that the Medicare Contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the

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[34] *Id.* at 50280-50281.

[35] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.

[36] *Id.* at 50285.

SSI fraction data matching process issue.[37] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[38]

[6] Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending 1498-R by allowing providers to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[39]

As a result of the Rulings and new regulation, CMS recalculated new SSI percentages for the Hospitals for all of fiscal years at issue in this appeal. The Hospitals either have received a written notice through a RNPR or have been informed that a DSH recalculation will be done based on the methodology articulated in the preamble, *i.e.*, use only the three SSI codes to denote SSI eligibility.[40] The Hospitals believe that this

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[37] CMS-1498-R at 6-7, 31.

[38] *Id.* at 28, 31.

[39] CMS-1498-R2 at 2, 6 (copy included Provider Exhibit P-37).

[40] *See* Stipulation (Feb. 2017) (note that the Board transferred the provider discussed in ¶¶ 5-6 to Case No. 17-0489G as agreed to by the parties).

methodology has, or will, adversely reduce their Medicare DSH reimbursement.[41]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

At the outset, the Board notes that the Hospitals are challenging the methodology CMS uses to calculate the SSI fraction (*i.e.*, challenging the data matching process) rather than CMS' execution of that process (*i.e.*, whether that process was executed correctly or accurately). Specifically, the Hospitals dispute CMS' recognition of only three SSI codes (*i.e.*, C01, M01, and M02) in that process to define entitlement to SSI benefits for purposes of the Medicare fraction for the Medicare DSH calculation. The Hospitals argue that federal statute at 42 U.S.C. § 1382h(b) continues non-cash benefits (*i.e.*, Medicaid benefits), and that SSA policy allowing the resumption of SSI cash payments without reapplying illustrates a beneficiary's continued entitlement to SSI benefits.[42] In addition, the Hospitals assert that certain additional SSI codes illustrate continued SSI eligibility even when the individual's SSI payments are suspended or placed in

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[41] *See* Providers' Optional Responsive Brief, Vol. III, at 00719-00721; Provider Exhibits P-41–P-56.

[42] Providers' Optional Responsive Brief, Vol. III at 00716–00719. *See also* Provider Exhibits P-63 (copy of POMS guidance from www.Medicare.gov on Part D low income subsidies), P-64 (copy of POMS §§ NL 0082.010, HI 03001.005 (addressing SSI notice of award and Medicare Part D low income subsidy respectively)).

a stop payment status and that these individuals continue to be "entitled to" SSI benefits.[43] Accordingly, the Hospitals conclude these additional SSI codes should be included in the data matching process used to determine the SSI ratio for the Medicare DSH calculation.

The Hospitals argue that, because the regulation governing the numerator of the Medicare fraction, 42 C.F.R. § 412.106(b)(2)(i)(B), refers to entitlement in two ways (*i.e.*, individuals "entitled to both Medicare Part A ... and SSI"), then each use of that term must be interpreted the same way. That is, as CMS interprets entitlement to Part A to include both paid and unpaid Part A benefits as well as Part C-enrolled individuals, then CMS should count individuals entitled to SSI regardless of whether these individuals receive a SSI payment.[44] The Hospitals conclude that CMS violates the language of the Medicare DSH statute and the intent of Congress by only using SSI codes C01, M01 and M02 to determine entitlement to SSI benefits.[45]

[7] The Hospitals explain that they did not identify specific inpatients who, as they maintain, are entitled to SSI benefits but had SSI codes other than C01, M01 or M02 because the data use agreement between CMS and SSA prohibits CMS from releasing

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[43] *See* Provider Exhibit P-38 (copy of POMS § SI 02301.201 describing certain SSI post-eligibility events).

[44] Providers' Post Hearing Brief, Vol. IV, at 01310-01311.

[45] *Id.* at 01311-01312. *See also* Tr. at 21:17-22:18.

this information.[46] To address this problem, the Hospitals introduced evidence of additional patients who were Medicaid-eligible in Virginia and Indiana—two states, known as "209(b)" states, whose Medicaid income eligibility level is higher than that to qualify for SSI.[47] They reasoned that, if inpatients in these states are eligible for Medicaid, they are likely to be entitled to SSI benefits but were not identified as such because the SSA-CMS data matching process only identifies those individuals who have SSI-eligibility codes of M01, M02 or C01.[48]

The Hospitals argued that some of these patients had to be "entitled to SSI benefits" but not necessarily receiving SSI benefits and should, therefore, be included in the numerator of the Medicare DSH calculation—in the same way as the inpatients who, for whatever reason, are entitled to Medicare Part A but for whom Part A has made no payment to the hospital are included in the definition of those inpatients "entitled to Medicare Part A benefits." The Hospitals

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[46] 70 Fed. Reg. 47278, 47440 (Aug. 12, 2005) (copy included at Provider Exhibit P-75).

[47] 42 U.S.C. § 1396a(f) allows states that, as of January 1, 1972, had more stringent Medicaid eligibility criteria than that which was established under the SSI program to maintain this criteria. These states are referred to as "209(b) states." *See Gray Panthers v. Administrator, Health Care Financing Admin., Dep't of Health and Human Servs*., 629 F.2d 180, 182 (D.C. Cir. 1980), *cert. granted*, 449 U.S. 1123 (1981), *rev'd sub nom, Schweiker v. Gray Panthers*, 453 U.S. 34 (1981).

[48] Providers' Combined Final Position Paper, Vol. II, at 00086-00087.

request that the Board remand this case to the Medicare Contractors to recalculate the Medicare DSH adjustments to include all SSI patient days in the Hospitals' Medicare fraction.[49]

In reviewing this case, the Board points to the following excerpt from the Federal regulations at 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 must 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 the CMS Rulings 1498-R and 1498-R2. As previously discussed, the Rulings direct that "the same, unitary relief" consisting of the data matching process approved through notice and comment in the FY 2011 Final Rule be applied to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[50] Indeed, the Ruling states that it "*resolve*[*s*] each properly pending appeal of the SSI fraction data matching process issue, by applying a suitably revised data matching process" and further that "CMS' action *eliminates any actual case or controversy* regarding the hospital's previously calculated

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[49] Providers' Post Hearing Brief, Vol. IV, at 01335.

[50] Ruling 1498-R at 5-6, 31.

SSI fraction and DSH payment adjustment and thereby *renders moot* each properly pending claim in a DSH appeal."[51] Thus, as a result of the Ruling, the Board does not have the authority [8] to revise the data matching process described in great detail 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. In this regard, the preamble explicitly states that "including SSI codes of C01, M01 and M02 accurately captures *all SSI-entitled individuals* during the month(s) that they are entitle to receive SSE benefits."[52]

In summary, CMS explained in Ruling 1498-R that it was going through the notice and comment rule-making process to propose and finalize the "suitably revised" data matching process that it would use to provide "the same, unitary relief" to calculate the SSI ratio for open cost reports and any pending DSH SSI appeals. Through this notice and comment process, CMS confirmed that it would utilize three specific SSI codes (*i.e.*, C01, M01, and M02) as part of its data matching process in order to establish SSI entitlement for the purposes of the Medicare DSH calculation. As such, the Board finds that it is bound by Ruling 1498-R and must give great weight to the preamble to the FY 2011 Final Rule (as incorporated into that Ruling) and does not have the authority to grant the relief sought by the Hospitals in these appeals. Based on the

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[51] *Id.* at 6 (emphasis added).

[52] 75 Fed. Reg. at 50281.

above, the Board concludes that CMS wrote Ruling 1498-R and the FY 2011 Final Rule with the intent to bind the Agency and all IPPS hospitals to the specific data matching process prescribed for the cost reporting periods covered by those issuances.

DECISION AND ORDER

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Board finds that it lacks the authority to mandate specific revisions to CMS' data matching process for the Medicare fraction of the Medicare DSH calculation for the fiscal years at issue. Accordingly, the Board holds that it does not have the authority to reverse the Medicare Contractors' adjustments.

BOARD MEMBERS PARTICIPATING:

L. Sue Andersen, Esq.,
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA, CHFP

FOR THE BOARD:

/s/
L. Sue Andersen, Esq.
Chairperson

DATE: March 27, 2017

PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2017-D12

PROVIDER – Hall Render Individual, Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction Provider No.: Various **vs.** **MEDICARE CONTRACTOR –** Wisconsin Physicians Services, Palmetto GBA c/o National Government Services, CGS Administrators	**DATE OF HEARING –** March 17, 2015 Cost Reporting Periods Ended: December 31, 2004 – June 30, 2009 **CASE NOs.:** 07-0413, 07-2872G, 09-1039GC, 09-1830G, 09-1863GC, 12-0365GC, 12-0373GC, 12-0412, 13-0140GC, 13-0591, 15-0266 and 15-0270

INDEX

[2] **ISSUE**

Whether Medicare Disproportionate Share Hospital ("DSH") reimbursement calculations for the Providers ("Hospitals") were understated due to the failure of the Centers for Medicare & Medicaid Services ("CMS") and the relevant Medicare administrative contractors ("Medicare Contractors")[1] to include all supplementary security income ("SSI") eligible patient days in the numerator of the Medicare fraction of the Medicare DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[2]

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds that it lacks the authority to review or mandate specific revisions to CMS' data matching process for the Medicare fraction of the Medicare DSH calculation for the fiscal years at issue. Accordingly, the Board holds that it does not have the authority to reverse the Medicare Contractors' adjustments.

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[1] The lead Medicare contractor in this case is Wisconsin Physicians Services.

[2] Transcript ("Tr.") at 6-7 and Providers' Post-Hearing Brief at 01828.

INTRODUCTION

This case consolidates multiple appeals involving numerous acute care hospitals for fiscal years 2004 to 2009.[3] The Hospitals challenge CMS's policy of including only some of the SSI eligibility categories in the numerator of the Medicare fraction of the DSH calculation. The Hospitals claim that, as a result of this policy, they receive less DSH reimbursement than they are entitled.

Each of the Hospitals timely appealed this issue and met the jurisdictional requirements for a hearing. Accordingly, the Board held a consolidated hearing on these appeals on March 17, 2015. The Hospitals were represented by Daniel F. Miller, Esq. of Hall, Render, Killian, Heath & Lyman, P.C. The Medicare Contractors were represented by Brendan G. Stuhan, Esq. of the Blue Cross and Blue Shield Association.

STATEMENT OF THE FACTS

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[4] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low

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[3] The Schedule of Providers is attached as Appendix A and it is organized by fiscal year and case number.

[4] 42 C.F.R. Part 412.

income patients.[5] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. The Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days ... which were made up of patients who (for such days) were entitled to benefits under part A of the subchapter and were entitled to supplementary security income [3] benefits ... under subchapter XVI of this chapter ... "[6]; and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The dispute in these appeals involves CMS' determination of which patients are "entitled to both Medicare Part A and SSI benefits" for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[7] administered by the Social Security Administration ("SSA"). The SSI statute, generally, does not use the term "entitled" to SSI benefits. Rather, the SSI statute typically refers to whether an individual is "eligible for benefits."[8] In order to be eligible for SSI benefits, a person must be: (1) 65 years of age or older,

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[5] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I) (copy included at Provider Exhibit P-68).

[6] 42 U.S.C. 1395d(5)(F)(vi)(I). *See also* 42 C.F.R. § 412.106(b)(2)(i)(B) (copy included at Provider Exhibit P-74).

[7] 42 U.S.C. § 1382 (copy included at Provider Exhibit P-73).

[8] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added) (copies included at Provider Exhibits P-72, P-73 respectively).

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.[9]

The Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits, or becomes disabled and had been entitled to disability benefits for 24 calendar months.[10] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[11]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[12] and may terminate,[13] suspend[14] or stop payments to individuals who are temporarily or permanently ineligible for payment of SSI benefits.[15] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the

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[9] *See* 20 C.F.R. § 416.202.

[10] *See* 42 U.S.C. § 426.

[11] 42 U.S.C. § 426-1.

[12] 20 C.F.R. § 416.204.

[13] 20 C.F.R. §§ 416.1331-1335.

[14] 20 C.F.R. §§ 416.1320-1330.

[15] 20 C.F.R. § 1320.

individual is no longer is disabled or the individual meets one of the following reasons set forth in Sections §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[16]
2. The individual fails to apply for other benefits to which the individual may be entitled,[17]
3. The individual fails to participate in drug or alcohol addiction treatment;[18]
4. The individual is absent from the United States for more than 30 days;[19] or
5. The individual becomes a resident of a public institutions or prison.[20]

[4] Under certain circumstances, the Social Security Administration may not pay benefits for administrative reasons, including removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[21]

After the Medicare DSH legislation was enacted in 1984, the Health Care Financing Administration ("HCFA"), the predecessor to CMS, announced that

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[16] 20 C.F.R. § 416.207.

[17] 20 C.F.R. § 416.210.

[18] 20 C.F.R. § 416.214.

[19] 20 C.F.R. § 416.215.

[20] 20 C.F.R. § 416.211.

[21] *See* Provider Exhibit P-117 at Tab A (copy of SSA Program Operations Manual ("POMS") § S1 02301.201 (describing certain SSI post-eligibility events)).

the Secretary of Health and Human Services, rather than the hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to compute the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, the Social Security Administration ("SSA").[22] HCFA noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[23] To compute the Medicare fraction, HCFA had to match individual Medicare billing records to individual SSI records.[24] Considering the administrative burdens and complexity of the data matching process, HCFA concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[25] HCFA/CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting ratios on its website. The Medicare contractors then use the posted SSI ratio to calculate the Medicare DSH percentage

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[22] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).

[23] *Id.*

[24] *Id.*

[25] *Id.* at 31459-31460; 42 C.F.R. § 412.106(b).

used to determine the hospital's Medicare DSH payment adjustment.[26]

The Medicare DSH payment adjustment has been the subject of much litigation and the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient. On April 28, 2010, CMS published Ruling 1498-R to respond to a court order in *Baystate*. This Ruling stated that CMS 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."[27] 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 final rule, CMS expects to respond to public comments 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."[28] Finally, CMS stated that it [5] would use that new data

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[26] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.

[27] CMS-1498-R at 5 (copy included at Provider Exhibit P-83).

[28] *Id.*

matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling.[29]

Consistent with Ruling 1498-R, CMS published the new data matching process in the FY 2011 proposed rule published on May 4, 2011[30] and finalized that data matching process in the final rule published on August 16, 2010 ("FY 2011 Final Rule").[31] Significantly, in the preamble to the FY 2011 Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction;" and (2) provided examples of "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 match process."[32] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, or M02 "accurately captures all SSI-entitled individuals, during the month(s) they are entitled to receive SSI benefits."[33] CMS explicitly

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[29] *Id.* at 5-6.

[30] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

[31] 75 Fed. Reg. 50041, 50280-50281 (Aug. 16, 2010) (copy included at Provider Exhibit P-82).

[32] *Id.* at 50280.

[33] *Id.* at 50280-50281.

rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these 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."[34] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[35]

While the new data matching process established in the FY 2011 Final Rule was effective October 1, 2010, Ruling 1498-R directed that the Medicare Contractors apply "the same, unitary relief' consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[36] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42

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[34] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.

[35] *Id.* at 50285.

[36] CMS-1498-R at 6-7.

U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[37]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending 1498-R by allowing providers to elect whether to use new Medicare SSI fractions calculated on the basis of [6] "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[38]

As a result of these Rulings and new regulation, CMS recalculated new SSI percentages for the Hospitals for all of the fiscal years at issue in this appeal. It is the Board's understanding that the Hospitals have received written notice of the recalculation through either an RNPR or NPR (or are slated to receive such notice through an RNPR/NPR), and they contend that: (a) they are adversely impacted by the same methodology (*i.e.*, CMS' recognition of only three SSI codes to denote SSI eligibility); and (b) this methodology adversely reduces their Medicare DSH reimbursement.[39]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

At the outset, the Board notes that the Hospitals are challenging the methodology CMS uses to calculate

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[37] *Id.* at 28, 31.

[38] CMS-1498-R2 at 2, 6 (copy included at Provider Exhibit P-114).

[39] Post-Hearing Conference Call (Jan. 6, 2017).

the SSI fraction (*i.e.*, challenging the data matching process) rather than CMS' execution of that process (*i.e.*, whether that process was executed correctly or accurately). Specifically, the Hospitals dispute CMS' recognition of only three SSI codes (*i.e*., C01, M01, and M02) in that process to define entitlement to SSI benefits for purposes of the Medicare fraction for the Medicare DSH calculation, The Hospitals argue that federal statute, 42 U.S.C. § 1382h(b), continues non-cash benefits (*i.e.*, Medicaid benefits), and that SSA policy allowing the resumption of SSI cash payments without reapplying illustrates a beneficiary's continued entitlement to SSI benefits.[40] In addition, the Hospitals assert that certain additional SSI codes illustrate continued SSI eligibility even when the individual's SSI payments are suspended or placed in a stop payment status and that these individuals continue to be "entitled to" SSI benefits.[41] Accordingly, the Hospitals conclude that these additional SSI codes should be included in the data matching process used to determine the SSI ratio for the Medicare DSH calculation.

The Hospitals argue that, because the regulation governing the numerator of the Medicare fraction, 42

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[40] Providers' Optional Responsive Brief, Vol. III, at 01400. *See also* Provider's Supplement to Post Hearing Brief at 01979; Provider Exhibits P-129 – P-132 (copies of a CMS web posting, excerpts from the Medicare Prescription Drug Benefit Manual, excerpts from POMs, and an SSA publication).

[41] *See* Provider Exhibit P-91 (excerpt from the State Verification and Exchange System (SVES and State Online Query (SOLQ) Manual (Apr. 2013) published by SSA).

C.F.R. § 412.106(b)(2)(i)(B), refers to entitlement in two places (*i.e.*, individuals "entitled to both Medicare Part A ... and SSI"), then each use of that term must be interpreted the same way. That is, as CMS interprets entitlement to Part A to include both paid and unpaid Part A benefits as well Part C-enrolled individuals, then CMS should count individuals entitled to SSI regardless of whether these individuals receive an SSI payment.[42] The Hospitals conclude that CMS violates the language of the Medicare DSH statute and the intent of Congress by only using SSI codes C01, M01 and M02 to determine entitlement to SSI benefits.[43]

[7] The Hospitals explain that they did not identify specific inpatients who, as they maintain, are entitled to SSI benefits but had SSI codes other than C01. M01 or M02 because the data use agreement between CMS and SSA prohibits CMS from releasing this information.[44] To address this problem, the Hospitals introduced evidence of additional patients who were Medicaid-eligible in Virginia and Indiana—two states, known as "209(b)" states, whose Medicaid income eligibility level is higher than that to qualify for SSI.[45]

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[42] Providers' Post Hearing Brief, Vol. IV, at 01832-01833.

[43] *See* Tr. 27:15-28:25; Providers' Post Hearing Brief, Vol. IV, at 01856.

[44] 70 Fed. Reg. 47278, 47440 (Aug. 12, 2005) (copy included at Provider Exhibit P-133). *See also* Provider Exhibit P-135 (communications between the Hospitals' counsel and SSA regarding this issue).

[45] Federal statute, 42 U.S.C. § 1396a(f), allowed states that, as of January 1, 1972, had more stringent Medicaid eligibility criteria than that which was established under the SSI program to

They reasoned that if inpatients in these states are eligible for Medicaid, they are likely to be entitled to SSI benefits but were not identified as such because the SSA-CMS data matching process only identifies those individuals who have SSI-eligibility codes of M01, M02 or C01.[46]

The Hospitals argued that some of these patients had to be "entitled to SSI benefits" but not necessarily receiving SSI benefits and should, therefore, be included in the numerator of the Medicare DSH calculation—in the same way as the inpatients who, for whatever reason, are entitled to Medicare Part A but for whom Part A has made no payment to the hospital are included in the definition of those inpatients "entitled to Medicare Part A benefits." The Hospitals request that the Board remand this case to the Medicare Contractor to recalculate the Medicare DSH adjustments to include all SSI patient days in the Hospitals' Medicare fraction.[47]

In reviewing this case, the Board points to the following excerpt from the Federal regulations at 42 C.F.R. §405.1867:

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maintain this criteria. These states are referred to as "209(b) states." *See Gray Panthers v. Administrator, Health Care Financing Admin., Dep't of Health and Human Servs.*, 629 F.2d 180, 182 (D.C. Cir. 1980), rev'd *sub nom. Schweiker v. Gray Panthers*, 453 U.S. 34, (1981).

[46] Providers' Combined Final Position Paper, Vol. II, at 01100-01101.

[47] Providers, Post Hearing Brief, Vol. IV, at 01827.

> [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 must 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 the CMS Rulings 1498-R and 1498-R2. As previously discussed, the Rulings direct that "the same, unitary relief" consisting of the data matching process approved through notice and comment in the FY 2011 Final Rule be applied to: (1) any Medicare cost report that has not been settled; and (2) all properly pending Medicare DSH appeals of the SSE fraction data matching process issue.[48] Indeed, the Ruling states that it "*resolve*[*s*] each properly pending appeal of the SSI fraction data matching process issue, by applying a suitably revised data matching process" and further that "CMS' action *eliminates any actual case or controversy* regarding the hospital's previously calculated SSI fraction and DSH payment adjustment and thereby *renders moot* each properly pending claim in a DSH appeal."[49] Thus, as a result of the Ruling, the Board must apply the data matching [8] process described in great detail 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. In this regard, the preamble explicitly states that

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[48] Ruling 1498-R at 5-6, 31.

[49] *Id.* at 6 (emphasis added).

"including SSI codes of C01, M01 and M02 accurately captures all SSI-entitled individuals during the month(s) that they are entitle to receive SSI benefits."[50]

In summary, CMS explained in Ruling 1498-R that it was going through the notice and comment rulemaking process to propose and finalize the "suitably revised" data matching process that it would use to provide "the same, unitary relief" to calculate the SSI ratio for open cost reports and any pending DSH SSI appeals. Through this notice and comment process, CMS confirmed that it would utilize three specific SSI codes (*i.e.*, C01, M01, and M02) as part of its data matching process in order to establish SSI entitlement for the purposes of the Medicare DSH calculation. As such, the Board finds that it is bound by Ruling 1498-R and must give great weight to the preamble to the FY 2011 Final Rule (as incorporated into that Ruling) and does not have the authority to grant the relief sought by the Hospitals in these appeals. Based on the above, the Board concludes that CMS wrote Ruling 1498-R and the FY 2011 Final Rule with the intent to bind the Agency and all IPPS hospitals to the specific data matching process prescribed for the cost reporting periods covered by those issuances.

DECISION AND ORDER

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Board finds that it lacks the authority to review or

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[50] 75 Fed. Reg. 50281.

mandate specific revisions to CMS' data matching process for the Medicare fraction of the Medicare DSH calculation for the fiscal years at issue. Accordingly, the Board holds that it does not have the authority to reverse the Medicare Contractors' adjustments.

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

/s/
L. Sue Andersen, Esq.
Chairperson

DATE: March 28, 2017

42 U.S.C. § 1395ww(d)(5)(F)(vi) provides:

Payments to hospitals for inpatient hospital services

(d) Inpatient hospital service payments on basis of prospective rates; Medicare Geographic Classification Review Board

. . .

(5)(F)(vi) In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of –

(I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this 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, and

(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, but who were not entitled to benefits under part A of this subchapter, and the

denominator of which is the total number of the hospital's patient days for such period.

In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under subchapter XI.

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42 U.S.C. § 1381a provides:

Basic entitlement to benefits

Every 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 subchapter, be paid benefits by the Commissioner of Social Security.

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42 U.S.C. § 1382(a), (b), (c), (e)(1)(A)-(B) provides:

Eligibility for benefits

(a) "Eligible individual" defined

(1) Each aged, blind, or disabled individual who does not have an eligible spouse and –

(A) whose income, other than income excluded pursuant to section 1382a(b) of this title, is at a rate of not more than $1,752 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974 or any calendar year thereafter, and

(B) whose resources, other than resources excluded pursuant to section 1382b(a) of this title, are not more than (i) in case such individual has a spouse with whom he is living, the applicable amount determined under paragraph (3)(A), or (ii) in case such individual has no spouse with whom he is living, the applicable amount determined under paragraph (3)(B),

shall be an eligible individual for purposes of this subchapter.

(2) Each aged, blind, or disabled individual who has an eligible spouse and –

(A) whose income (together with the income of such spouse), other than income excluded pursuant to section 1382a(b) of this title, is at a rate of not more than $2,628 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974, or any calendar year thereafter, and

(B) whose resources (together with the resources of such spouse), other than resources excluded pursuant to section 1382b(a) of this title, are not more than the applicable amount determined under paragraph (3)(A),

shall be an eligible individual for purposes of this subchapter.

(3)(A) The dollar amount referred to in clause (i) of paragraph (1)(B), and in paragraph (2)(B), shall be $2,250 prior to January 1, 1985, and shall be increased to $2,400 on January 1, 1985, to $2,550 on January 1, 1986, to $2,700 on January 1, 1987, to $2,850 on January 1, 1988, and to $3,000 on January 1, 1989.

(B) The dollar amount referred to in clause (ii) of paragraph (1)(B), shall be $1,500 prior to January 1, 1985, and shall be increased to $1,600 on January 1, 1985, to $1,700 on January 1, 1986, to $1,800 on January 1, 1987, to $1,900 on January 1, 1988, and to $2,000 on January 1, 1989.

(b) Amount of benefits

(1) The benefit under this subchapter for an individual who does not have an eligible spouse shall be payable at the rate of $1,752 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to section 1382a(b) of this title, of such individual.

(2) The benefit under this subchapter for an individual who has an eligible spouse shall be payable at the rate of $2,628 (or, if greater, the amount determined under section 1382f of this title) for the calendar year 1974 and any calendar year thereafter, reduced by the amount of income, not excluded pursuant to

section 1382a(b) of this title, of such individual and spouse.

(c) Period for determination of benefits

(1) An individual's eligibility for a benefit under this subchapter for a month shall be determined on the basis of the individual's (and eligible spouse's, if any) income, resources, and other relevant characteristics in such month, and, except as provided in paragraphs (2), (3), (4), (5), and (6), the amount of such benefit shall be determined for such month on the basis of income and other characteristics in the first or, if the Commissioner of Social Security so determines, second month preceding such month. Eligibility for and the amount of such benefits shall be redetermined at such time or times as may be provided by the Commissioner of Social Security.

(2) The amount of such benefit for the month in which an application for benefits becomes effective (or, if the Commissioner of Social Security so determines, for such month and the following month) and for any month immediately following a month of ineligibility for such benefits (or, if the Commissioner of Social Security so determines, for such month and the following month) shall—

(A) be determined on the basis of the income of the individual and the eligible spouse, if any, of such individual and other relevant circumstances in such month; and

(B) in the case of the first month following a period of ineligibility in which eligibility is

restored after the first day of such month, bear the same ratio to the amount of the benefit which would have been payable to such individual if eligibility had been restored on the first day of such month as the number of days in such month including and following the date of restoration of eligibility bears to the total number of days in such month.

(3) For purposes of this subsection, an increase in the benefit amount payable under subchapter II (over the amount payable in the preceding month, or, at the election of the Commissioner of Social Security, the second preceding month) to an individual receiving benefits under this subchapter shall be included in the income used to determine the benefit under this subchapter of such individual for any month which is—

(A) the first month in which the benefit amount payable to such individual under this title is increased pursuant to section 1382f of this title, or

(B) at the election of the Commissioner of Social Security, the month immediately following such month.

(4)(A) Notwithstanding paragraph (3), if the Commissioner of Social Security determines that reliable information is currently available with respect to the income and other circumstances of an individual for a month (including information with respect to a class of which such individual is a member and information with respect to scheduled cost-of-living

adjustments under other benefit programs), the benefit amount of such individual under this subchapter for such month may be determined on the basis of such information.

(B) The Commissioner of Social Security shall prescribe by regulation the circumstances in which information with respect to an event may be taken into account pursuant to subparagraph (A) in determining benefit amounts under this subchapter.

(5) Notwithstanding paragraphs (1) and (2), any income which is paid to or on behalf of an individual in any month pursuant to (A) a State program funded under part A of subchapter IV, (B) section 672 of this title (relating to foster care assistance), (C) section 1522(e) of title 8 (relating to assistance for refugees), (D) section 501(a) of Public Law 96-422 (relating to assistance for Cuban and Haitian entrants), or (E) section 13 of title 25 (relating to assistance furnished by the Bureau of Indian Affairs), shall be taken into account in determining the amount of the benefit under this subchapter of such individual (and his eligible spouse, if any) only for that month, and shall not be taken into account in determining the amount of the benefit for any other month.

(6) The dollar amount in effect under subsection (b) as a result of any increase in benefits under this subchapter by reason of section 1382f of this title shall be used to determine the value of any in-kind support and maintenance required to be taken into account in determining the benefit payable under this subchapter

to an individual (and the eligible spouse, if any, of the individual) for the 1st 2 months for which the increase in benefits applies.

(7) For purposes of this subsection, an application of an individual for benefits under this subchapter shall be effective on the later of—

(A) the first day of the month following the date such application is filed, or

(B) the first day of the month following the date such individual becomes eligible for such benefits with respect to such application.

(8) The Commissioner of Social Security may waive the limitations specified in subparagraphs (A) and (B) of subsection (e)(1) on an individual's eligibility and benefit amount for a month (to the extent either such limitation is applicable by reason of such individual's presence throughout such month in a hospital, extended care facility, nursing home, or intermediate care facility) if such waiver would promote the individual's removal from such institution or facility. Upon waiver of such limitations, the Commissioner of Social Security shall apply, to the month preceding the month of removal, or, if the Commissioner of Social Security so determines, the two months preceding the month of removal, the benefit rate that is appropriate to such individual's living arrangement subsequent to his removal from such institution or facility.

(9)(A) Notwithstanding paragraphs (1) and (2), any nonrecurring income which is paid to an individual in the first month of any period of eligibility shall

be taken into account in determining the amount of the benefit under this subchapter of such individual (and his eligible spouse, if any) only for that month, and shall not be taken into account in determining the amount of the benefit for any other month.

(B) For purposes of subparagraph (A), payments to an individual in varying amounts from the same or similar source for the same or similar purpose shall not be considered to be nonrecurring income.

(10) For purposes of this subsection, remuneration for service performed as a member of a uniformed service may be treated as received in the month in which it was earned, if the Commissioner of Social Security determines that such treatment would promote the economical and efficient administration of the program authorized by this subchapter.

* * *

(e) Limitation on eligibility of certain individuals

(1)(A) Except as provided in subparagraphs (B), (C), (D), (E), and (G), no person shall be an eligible individual or eligible spouse for purposes of this subchapter with respect to any month if throughout such month he is an inmate of a public institution.

(B) In any case where an eligible individual or his eligible spouse (if any) is, throughout any month (subject to subparagraph (G)), in a medical treatment facility receiving payments (with respect to such individual or spouse) under a State plan approved under subchapter XIX, or an eligible individual is a child

described in section 1382c(f)(2)(B) of this title, or, in the case of an eligible individual who is a child under the age of 18, receiving payments (with respect to such individual) under any health insurance policy issued by a private provider of such insurance the benefit under this subchapter for such individual for such month shall be payable (subject to subparagraph (E))—

(i) at a rate not in excess of $360 per year (reduced by the amount of any income not excluded pursuant to section 1382a(b) of this title) in the case of an individual who does not have an eligible spouse;

(ii) in the case of an individual who has an eligible spouse, if only one of them is in such a facility throughout such month, at a rate not in excess of the sum of—

(I) the rate of $360 per year (reduced by the amount of any income, not excluded pursuant to section 1382a(b) of this title, of the one who is in such facility), and

(II) the applicable rate specified in subsection (b)(1) (reduced by the amount of any income, not excluded pursuant to section 1382a(b) of this title, of the other); and

(iii) at a rate not in excess of $720 per year (reduced by the amount of any income not excluded pursuant to section 1382a(b) of this title) in the case of an individual who has an eligible spouse, if both of them are in such a facility throughout such month.

For purposes of this subsection, a medical treatment facility that provides services described in section 1396p(c)(1)(C) of this title shall be considered to be receiving payments with respect to an individual under a State plan approved under subchapter XIX during any period of ineligibility of such individual provided for under the State plan pursuant to section 1396p(c) of this title.

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42 U.S.C. § 1382d provides:

Rehabilitation services for blind and disabled individuals

(a) Referral by Commissioner of eligible individuals to appropriate State agency

In the case of any blind or disabled individual who—

(1) has not attained age 16; and

(2) with respect to whom benefits are paid under this subchapter,

the Commissioner of Social Security shall make provision for referral of such individual to the appropriate State agency administering the State program under subchapter V.

(b) Repealed. Pub. L. 97–35, title XXI, §2193(c)(8)(B), Aug. 13, 1981, 95 Stat. 828

(c) Repealed. Pub. L. 106–170, title I, §101(b)(2)(B), Dec. 17, 1999, 113 Stat. 1874

(d) Reimbursement by Commissioner to State agency of costs of providing services to referred individuals

The Commissioner of Social Security is authorized to reimburse the State agency administering or supervising the administration of a State plan for vocational rehabilitation services approved under title I of the Rehabilitation Act of 1973 [29 U.S.C. 720 et seq.] for the costs incurred under such plan in the provision of rehabilitation services to individuals who are referred for such services pursuant to subsection (a), (1) in cases where the furnishing of such services results in the performance by such individuals of substantial gainful activity for a continuous period of nine months, (2) in cases where such individuals receive benefits as a result of section 1383(a)(6) of this title (except that no reimbursement under this subsection shall be made for services furnished to any individual receiving such benefits for any period after the close of such individual's ninth consecutive month of substantial gainful activity or the close of the month with which his or her entitlement to such benefits ceases, whichever first occurs), and (3) in cases where such individuals, without good cause, refuse to continue to accept vocational rehabilitation services or fail to cooperate in such a manner as to preclude their successful rehabilitation. The determination that the vocational rehabilitation services contributed to the successful return of an individual to substantial gainful activity, the

determination that an individual, without good cause, refused to continue to accept vocational rehabilitation services or failed to cooperate in such a manner as to preclude successful rehabilitation, and the determination of the amount of costs to be reimbursed under this subsection shall be made by the Commissioner of Social Security in accordance with criteria determined by the Commissioner in the same manner as under section 422(d)(1) of this title.

(e) Reimbursement for vocational rehabilitation services furnished during certain months of nonpayment of insurance benefits

The Commissioner of Social Security may reimburse the State agency described in subsection (d) for the costs described therein incurred in the provision of rehabilitation services—

(1) for any month for which an individual received—

(A) benefits under section 1382 or 1382h(a) of this title;

(B) assistance under section 1382h(b) of this title; or

(C) a federally administered State supplementary payment under section 1382e of this title or section 212(b) of Public Law 93–66; and

(2) for any month before the 13th consecutive month for which an individual, for a reason

other than cessation of disability or blindness, was ineligible for—

(A) benefits under section 1382 or 1382h(a) of this title;

(B) assistance under section 1382h(b) of this title; or

(C) a federally administered State supplementary payment under section 1382e of this title or section 212(b) of Public Law 93–66.