CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of: **Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals - Medicare Fraction &** **Hall Render, Individual, Optional and CIRP DSH Dual/SSI Eligible Group Appeals-Medicare Fraction** **Provider** **vs.** **Medicare Administrative Contractors**	**Claim for:** **Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: Various** **Review of:** **PRRB Dec. No. 2017-D11** **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 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

[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.

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]

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 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

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

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 re-determined) 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 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

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

[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 SSI 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).

days where the individual actually received SSI payments, 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 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 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

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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.

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

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 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 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.

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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).

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

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 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 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

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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.

[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.

[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.

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' 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 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

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[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.
[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).

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 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]—
> (i) Determines the number of covered patient days that—
> (A) Are associated with discharges occurring during each month; and

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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.

[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."

> (B) Are furnished to patients who during that month were entitled to both Medicare 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 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 determining the number of inpatient days for individuals

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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.

[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 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

entitled to both Medicare Part A and SSI, as required for calculation of the numerator of the 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) 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 contain his or her SSN) is included on the Medicare inpatient hospital claim.

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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.")

[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

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 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]

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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 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)

[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.

and 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]

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.

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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).

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 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

[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).

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.
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> 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, Mo1, 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 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 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

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[38] Id., at 50280-50281 (Aug. 16, 2010).
[39] Id., at 50280-50281 (Aug. 16, 2010).
[40] 42 U.S.C §402.

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 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)(F)(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 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

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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.

[43] *Id*.

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 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 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

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

[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 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."

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 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

[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

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 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 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

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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.

[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.

> 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.
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> 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 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 conclusion that a DSH recalculation has been made pursuant to CMS Ruling 1498-R (including those cost years for which the Providers acknowledge no

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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.

[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).

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]

[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
Principal Deputy Administrator
Centers for Medicare & Medicaid Services