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**CMS Rulings****Department of Health  
and Human Services****Centers for Medicare &  
Medicaid Services**

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Ruling No.: CMS-1498-R

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This Ruling provides notice of the determination of the Centers for Medicare & Medicaid Services (CMS) that the Provider Reimbursement Review Board (PRRB) and the other Medicare administrative appeals tribunals lack jurisdiction over provider appeals of any of three issues (described below) regarding the calculation of the Medicare disproportionate share hospital (DSH) payment adjustment. The Ruling also requires the pertinent administrative appeals tribunal (that is, the PRRB, the Administrator of CMS, the Medicare fiscal intermediary hearing officer, or the CMS reviewing official) to remand each qualifying appeal to the appropriate Medicare contractor. Moreover, the Ruling explains how CMS and the contractor will recalculate the provider's DSH adjustment and make any payment deemed owing. CMS and the Medicare contractors will also apply the provisions of this Ruling, on all

three DSH issues, to each qualifying hospital cost reporting period where the contractor has not yet settled finally the provider's Medicare cost report.

## **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

**CITATIONS:** Sections 1878 and 1886(d)(5)(F) of the Social Security Act (42 U.S.C. §§ 1395oo and 1395ww(d)(5)(F)); 42 C.F.R. Part 405, Subpart R and 42 C.F.R. § 412.106.

## **BACKGROUND**

Under the inpatient prospective payment system (IPPS), which is set forth in section 1886(d) of the Act, inpatient hospital services for Medicare patients are paid on the basis of nationally applicable payment rates. In addition, section 1886(d)(5) of the Act provides for various adjustments to the IPPS rates.

Under section 1886(d)(5)(F) of the Act, a hospital subject to IPPS may qualify for a DSH payment adjustment if the hospital provides inpatient services for a significantly disproportionate number of low-income patients. One means of determining a hospital's DSH payment adjustment for a cost reporting period requires the calculation of the provider's "disproportionate patient percentage

(DPP),” which is the sum of two fractions. First, under section 1886(d)(5)(F)(vi)(I) of the Act and 42 C.F.R. § 412.106(b)(2), the "Supplemental Security Income (SSI) fraction" (also known as the “SSI ratio” or "Medicare fraction") is the number of the hospital’s inpatient days for patients who were entitled (for such days) both to SSI benefits under Title XVI of the Act (42 U.S.C. § 1381 *et seq.*) and to benefits under Medicare Part A (including patients who are enrolled in a Medicare Advantage (Part C) plan), divided by the total number of the provider’s inpatient days for patients who were entitled to Medicare Part A benefits (including patients who are enrolled in a Medicare Advantage (Part C) plan). Second, under section 1886(d)(5)(F)(vi)(II) of the Act and § 412.106(b)(4), the “Medicaid fraction” is the number of the hospital’s inpatient days for patients who (for such days) were eligible for medical assistance under a State Medicaid plan approved under Title XIX of the Act (42 U.S.C. § 1396 *et seq.*) but who were not entitled to benefits under Medicare Part A, divided by the total number of the provider’s inpatient days. (We note that, because the DSH payment is part of the IPPS, the references in section 1886(d)(5)(F) of the Act to "days" apply only to hospital acute care inpatient days. *See* 42 C.F.R. § 412.106(a)(1)(ii).

The DSH payment adjustment has been the subject of substantial litigation. This Ruling addresses three recurring issues pertaining to the calculation of the DPP under section 1886(d)(5)(F)(vi) of the Act and § 412.106(b) of the regulations and the jurisdiction of the PRRB and the other administrative tribunals over appeals of these issues. (However, this Ruling does not address the increased Medicaid payments that are required by sections 1902(a)(13)(A)(iv) and 1923 of the Act (42 U.S.C. §§1396a(a)(13)(A)(iv), 1396r-4) for hospitals that serve a disproportionate number of low income patients with special needs.)

## **DSH APPEAL ISSUES AND REVISED DATA MATCHING PROCESS**

### **1. Appeals of the Data Matching Process Used in Calculating the SSI Fraction**

From the inception of the DSH adjustment in 1986, CMS (formerly HCFA) has calculated the SSI fraction for each acute care hospital paid under the IPPS. The Medicare contractor then uses the SSI fraction, along with the Medicaid fraction, in determining whether the hospital qualifies for a DSH payment adjustment and the amount of any such payment. 51 Fed. Reg. 16772, 16777 (May 6, 1986) (interim final rule).

In determining the number of inpatient days for individuals 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, although a provider may elect to have its SSI fraction determined on the basis of the provider's cost reporting period. *See* 42 C.F.R. § 412.106(b)(2), (3). The data underlying the match process are drawn from: (1) the Medicare Provider Analysis and Review (MedPAR) data file; and (2) SSI eligibility data provided by the Social Security Administration (SSA). CMS has historically matched Medicare and SSI eligibility records using Title II numbers (included in the SSI records) and Health Insurance Claim Account Numbers (HICANs) (contained in the MedPAR file).

Hospitals have filed numerous PRRB appeals challenging CMS's data matching process, which the agency uses in determining the SSI fraction by matching Medicare and SSI eligibility data. In *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008), the district court concluded that, in certain respects, CMS did not use the best available data in matching Medicare and SSI eligibility data. The court ordered the agency to recalculate the hospital's

SSI fractions and DSH adjustments, and pay the provider the additional monies due plus interest.

*Baystate*, 587 F. Supp. 2d at 43.

CMS continues to believe that its data matching process and the resultant SSI fractions and DSH payments were lawful. Nonetheless, the agency did not appeal the *Baystate* decision. Accordingly, CMS implemented the *Baystate* decision by recalculating the plaintiff's SSI fractions and DSH payment adjustments for its fiscal years 1993 through 1996 on the basis of a revised data matching process that comports with the district court's decision. In implementing the *Baystate* decision, CMS revised its data matching process by, for example, making appropriate use of 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. *Cf.*, *Baystate*, 545 F. Supp. 2d at 42-49.

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. Such suitably revised data matching process will consist of any new data matching process that is adopted in the FY 2011 IPPS final rule; or, if a new data matching process is not adopted in the FY 2011 IPPS final rule, CMS will use the same revised data matching process as it used to implement the *Baystate* decision. Furthermore, in order to avoid, or at least minimize, the filing of new administrative appeals on the SSI fraction data matching process issue, CMS and the Medicare contractors will apply the same suitably revised data matching process in determining the SSI fraction, and calculating the DSH payment adjustment, for each "open" hospital cost reporting period where the contractor has not yet settled finally the provider's Medicare cost report through the issuance of an initial notice of program reimbursement (NPR), *see* 42 C.F.R. §§ 405.1801(a), 405.1803.

2. Appeals of the Exclusion from the DPP of Non-Covered Inpatient Hospital Days for Patients Entitled to Medicare Part A, and Days for Which the Patient's Part A Inpatient Hospital Benefits were Exhausted

Hospitals have also filed DSH appeals to the PRRB challenging the exclusion from the DPP of non-covered inpatient hospital days for patients entitled to Medicare Part A, including appeals of days for which the patient's Part A hospital benefits were exhausted. Under CMS' original policy, inpatient days were included in the numerator of the DSH SSI fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the SSI fraction. *See, e.g.*, 42 C.F.R. § 412.106(b)(2)(i) (2003). CMS' original policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A

inpatient hospital benefits were exhausted, were excluded from the numerator of the DSH Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days in its Medicare cost report). *See* 69 Fed. Reg. 48916, 49098 (Aug. 11, 2004) (“FY 2005 IPPS final rule”).

However, the FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. 69 Fed. Reg. at 49246 (amending 42 C.F.R. § 412.106(b)(2)(i)). *See also id.* at 49098-99 (discussing the removal of the term “covered” from § 412.106(b)(2)(i), with respect to the days of a patient who was both entitled to Medicare and eligible for Medicaid (“dual eligible patient”) but whose Part A inpatient hospital benefits were exhausted). Under our revised policy, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital’s DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual’s inpatient hospital stay was covered under Part A or whether the patient’s Part A hospital benefits were exhausted. (We note that, as a practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004. *Id.* at 48916, 49099.

For cost reports with discharges before October 1, 2004, hospitals have filed PRRB appeals seeking inclusion in the DPP of inpatient days where the patient was entitled to Medicare Part A but the



inpatient hospital stay was not covered under Part A. For example, some hospitals have appealed the exclusion from the DPP of inpatient hospital days of patients (whether dual eligible or entitled only to Medicare) whose Part A hospital benefits were exhausted. Providers have also appealed the exclusion from the DPP of inpatient hospital days that, based on the Medicare secondary payer (MSP) provisions in section 1862(b) of the Act (42 U.S.C. § 1395y(b)), were covered and paid by a group health plan even though the patient was also entitled to Medicare Part A. Various DSH appeals regarding non-covered inpatient hospital days of patients entitled to Part A, including appeals of days where the patient's Part A hospital benefits were exhausted, have already been resolved through settlements.

On CMS' view, the inpatient days of a person who was entitled to Medicare Part A should be included in the DPP, regardless of whether a specific inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. More specifically, we believe that the inpatient days of an individual who was entitled to Part A belong in the DSH SSI fraction even if the inpatient stay was not covered under Part A or the patient's Part A hospital benefits were exhausted. Under section 1886(d)(5)(F)(vi)(I) of the Act, the SSI fraction numerator consists of the number of SSI-eligible inpatient days for persons who were "entitled to benefits under Part A," and the denominator is the total number of inpatient days for individuals who were "entitled" to Part A benefits. Thus, for example, section 226(a) of the Act (42 U.S.C. § 426(a)) provides that an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 or becomes disabled, provided that the individual is entitled to Social Security benefits under section 202 of the Act (42 U.S.C. § 402). Once a person becomes entitled to Medicare Part A, the individual does not lose such entitlement simply because there was no Part A coverage of a specific inpatient stay. In the case of MSP days, for example,

if an inpatient hospital stay were covered and paid by a group health plan (the primary insurer), the patient would still be entitled to benefits under Medicare Part A (the secondary insurer); as such, if the group health plan were not available when the patient was hospitalized a second time, then the second inpatient stay would be paid by Medicare unless the second hospital stay was not covered under Part A or the patient's Part A hospital benefits were exhausted. Similarly, a patient (whether dual eligible or entitled only to Medicare) does not lose entitlement to Medicare Part A simply because the individual's Part A hospital benefits have been exhausted; other items and services (for example, certain physician services and skilled nursing services) still might be covered under Part A and the patient would even qualify for an additional 90 days of Part A hospital benefits if at least 60 days elapsed between the individual's first and second hospital stay. 42 C.F.R. §§ 409.60(a), (b)(1), 409.61(a)(1), (c). On the other hand, we believe that the non-covered inpatient days (for example, MSP days) and the exhausted benefit days of patients who were still entitled to Part A do not belong in the numerator of the Medicaid fraction because, under section 1886(d)(5)(F)(vi)(II) of the Act, the Medicaid fraction numerator consists of the number of Medicaid-eligible inpatient days of persons "who were not entitled to benefits under Part A;" again, a beneficiary remains entitled to Medicare Part A even if an inpatient stay is not covered under Part A (for example, because the inpatient days were covered and paid by a primary group health plan) and even when a patient's Part A hospital benefits were exhausted.

In accordance with the foregoing history and determination, CMS and the Medicare contractors will resolve each properly pending DSH appeal, for cost reports with patient discharges before October 1, 2004, in which the hospital seeks inclusion in the DPP of inpatient days where the patient was entitled to Part A benefits but the inpatient hospital stay was not covered under Part A or the

patient's Part A hospital benefits were exhausted. For such properly pending appeals, CMS and the contractors will recalculate the hospital's SSI fraction and DSH payment adjustment for the period at issue by including the inpatient days of a person entitled to Medicare Part A in the numerator of the hospital's SSI fraction (provided that the patient was also entitled to SSI) and in that fraction's denominator, even if the inpatient stay was not covered under Part A or the patient's Part A hospital benefits were exhausted. This resolution of such properly pending appeals, for cost reports with pre-October 1, 2004 discharges, comports with CMS' view that, as explained above, the non-covered or exhausted inpatient hospital days of an individual entitled to Part A belong in the SSI fraction (assuming, for purposes of the numerator of that fraction, the person is also entitled to SSI), regardless of whether the inpatient stay was not covered under Part A or the patient's Part A hospital benefits were exhausted. CMS' action eliminates any actual case or controversy regarding the hospital's previously calculated DSH payment adjustment and thereby renders moot each properly pending claim in a DSH appeal, for cost reports with pre-October 1, 2004 discharges, in which the hospital seeks inclusion in the DPP of the non-covered inpatient hospital days (for example, MSP days) or exhausted benefit inpatient hospital days of a person entitled to Part A, 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 Medicare administrative tribunals lack jurisdiction over each properly pending claim on the non-covered or exhausted benefit inpatient hospital day issue for a cost report with discharges before October 1, 2004, 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 include the non-covered inpatient hospital days (for example, MSP days) and exhausted benefit inpatient hospital days of patients entitled to Part A in the SSI fraction numerator (to the extent the patient is also entitled to SSI benefits) and in the denominator of that fraction, and to recalculate the DSH payment adjustment, for each properly pending claim (on the non-covered or exhausted benefit inpatient hospital day issue) for a cost report with pre-October 1, 2004 discharges that is remanded by an administrative appeals tribunal and is found to qualify for relief under this Ruling. Moreover, in order to avoid, or at least minimize, the filing of new DSH administrative appeals on the non-covered or exhausted benefit inpatient hospital day issue, CMS and the Medicare contractors will ensure that the non-covered inpatient hospital days (for example, MSP days) and the exhausted benefit inpatient hospital days of persons entitled to Part A are included in both the SSI fraction numerator (to the extent the patient is also entitled to SSI benefits) and in the denominator of that fraction, in calculating the DSH payment adjustment for each open cost report with pre-October 1, 2004 discharges where the contractor has not yet settled finally the provider's Medicare cost report through the issuance of an initial NPR, *see* 42 C.F.R. §§ 405.1801(a), 405.1803. For properly pending DSH appeals on the non-covered or exhausted benefit inpatient hospital day issue and for qualifying open cost reports, CMS will account for such non-covered and exhausted benefit days in the determination of the SSI fraction, by including those days in the same suitably revised data matching process (as set forth in Section 5.a. of this Ruling) that the agency will use to match Medicare and SSI eligibility data in determining the hospital's SSI fraction for the period at issue.

CMS recognizes that a hospital might seek, as the remedy in a pending administrative appeal or

through a claim in or for its open cost report, to include non-covered or exhausted benefit inpatient hospital days in the numerator of the Medicaid fraction instead of in the SSI fraction. As explained above, however, CMS' view is that a beneficiary remains entitled to Medicare Part A even if an inpatient stay is not covered under Part A and even when a patient's Part A hospital benefits were exhausted; thus, non-covered or exhausted benefit days do not belong in the Medicaid fraction numerator, which consists of the number of Medicaid-eligible inpatient days of persons "who were not entitled to benefits under Part A." In any event, the administrative appeals tribunals should remand, in each qualifying appeal, each pending claim on the non-covered or exhausted benefit inpatient hospital day issue to the Medicare contractor for implementation of this Ruling (in accordance with the instructions set forth in Section 4 of this Ruling), regardless of whether the hospital seeks, as the remedy in a pending appeal, to include non-covered or exhausted benefit days in the numerator of the Medicaid fraction or in the SSI fraction or whether the provider has specifically requested that such days be included in either of the two DSH fractions. Similarly, for qualifying open cost reports, CMS will include non-covered or exhausted benefit inpatient hospital days in the SSI fraction (in accordance with the instructions set forth in Section 5 of this Ruling), regardless of whether the hospital sought, through a claim in or for its open cost report, to include such days in the numerator of the Medicaid fraction or in the SSI fraction or whether the provider has specifically claimed such days in or for either of the two DSH fractions. We note that, after the Ruling is applied to properly pending claims on appeal and to qualifying open cost reports, and non-covered and exhausted benefit days are included in the SSI fraction and the SSI fraction and the DSH adjustment are then recalculated (or calculated initially), the hospital might be satisfied with such recalculated (or calculated) DSH payment even though the provider originally sought to include such

days in the Medicaid fraction. Moreover, even if the hospital were dissatisfied with such recalculated (or calculated) DSH payment, Section 5 of this Ruling provides that the resultant NPR (whether revised or initial) would be subject to administrative and judicial review in accordance with the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines.

### 3. Appeals of the Exclusion from the DPP of Labor/Delivery Room Inpatient Days

Hospitals have also filed DSH appeals to the PRRB challenging the exclusion from the DPP of labor/delivery room (LDR) inpatient days. Before December 1991, an inpatient day for a LDR patient admitted at the census-taking hour was counted for purposes of both the DSH payment adjustment and for allocating costs on a provider's cost report. *See* 74 Fed. Reg. 43754, 43899 (Aug. 27, 2009) ("FY 2010 IPPS final rule"). In response to judicial precedent, CMS later revised both its DSH policy and its cost allocation policy by counting LDR inpatient days only if the patient occupied a routine care bed prior to occupying an ancillary LDR bed before the census-taking hour. *Id.* at 43899-900. *See also* 68 Fed. Reg. 45346, 45419-20, 45490 (Aug. 1, 2003) (final rule) (amending 42 C.F.R. § 412.106(a)(1)(ii)(B)).

In the FY 2010 IPPS final rule, CMS again revised its DSH policy by including LDR inpatient days in the DPP if the LDR patient was admitted as a hospital inpatient, regardless of whether the LDR patient had occupied a routine care bed prior to occupying an ancillary LDR bed before the census-taking hour. 74 Fed. Reg. at 43900-01, 43997 (amending 42 C.F.R. § 412.106(a)(1)(ii)(B)). The FY 2010 amendment to the DSH regulation was effective for cost reporting periods beginning on or after October 1, 2009. *Id.* at 43754, 43901.

For cost reporting periods beginning before October 1, 2009, some hospitals have filed PRRB appeals seeking inclusion of LDR inpatient days in the DPP regardless of whether the LDR patient had occupied a routine care bed prior to occupying an ancillary LDR bed before the census-taking hour. Various DSH appeals regarding LDR inpatient days have already been resolved by including the disputed LDR inpatient days in the calculation of the DPP, provided that the LDR days otherwise met the requirements for inclusion in the Medicaid fraction or the SSI fraction and all jurisdictional and procedural requirements were satisfied. As explained in the FY 2010 amendment to the DSH regulation, we believe that LDR inpatient days belong in the DPP if such days meet the requirements for inclusion in the Medicaid fraction or the SSI fraction, regardless of whether the LDR patient had occupied a routine care bed prior to occupying an ancillary LDR bed before the census-taking hour.

In accordance with the foregoing history and determination, CMS and the Medicare contractors will resolve each properly pending claim, in a DSH appeal for a cost reporting period beginning before October 1, 2009, in which the hospital seeks inclusion in the DPP of LDR inpatient days. For such properly pending appeals, CMS and the contractors will recalculate the hospital's DSH payment adjustment for the period at issue by including the LDR days in the Medicaid fraction or the SSI fraction (whichever proves to be applicable), regardless of whether the LDR patient had occupied a routine care bed prior to occupying an ancillary LDR bed before the census-taking hour. This resolution of properly pending appeals, for pre-October 1, 2009 cost reporting periods, comports with CMS' view that LDR inpatient days belong in the DPP if such days satisfy the requirements for inclusion in the Medicaid fraction or the SSI fraction, regardless of whether the LDR patient had occupied a routine care bed prior to occupying an ancillary LDR bed before the census-taking hour. CMS' action eliminates any actual

case or controversy regarding the hospital's previously calculated DSH payment adjustment and thereby renders moot each properly pending claim in a DSH appeal, for a pre-October 1, 2009 cost reporting period, in which the hospital seeks inclusion in the DPP of LDR inpatient days, provided that the disputed LDR inpatient days otherwise meet the requirements for inclusion in the Medicaid fraction or the SSI fraction and the claim 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 LDR inpatient day issue for a cost reporting period beginning before October 1, 2009, 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 include LDR inpatient days in the DPP (to the extent that a given LDR inpatient day otherwise meets the requirements for inclusion in the Medicaid fraction or the SSI fraction), and to recalculate the DSH payment adjustment, for each properly pending claim on the LDR inpatient day issue for a pre-October 1, 2009 cost reporting period that is remanded by an administrative appeals tribunal and is found to qualify for relief under this Ruling. Also, in order to avoid, or at least minimize, the filing of new DSH administrative appeals on the LDR inpatient day issue, CMS and the Medicare contractors will ensure that a hospital's LDR inpatient days are included in the Medicaid fraction or the SSI fraction (whichever proves to be applicable), in calculating the DSH payment adjustment for each open cost report for a pre-October 1, 2009 cost reporting period where the contractor has not yet settled finally the provider's Medicare cost report through the issuance of an initial NPR, *see*



42 C.F.R. §§ 405.1801(a),405.1803. For properly pending DSH appeals on the LDR inpatient day issue and for qualifying open cost reports, and to the extent that the disputed LDR days were for patients who were entitled to Part A benefits (as described in Section 2 of this Ruling), CMS will account for such LDR days in the determination of the SSI fraction, by including those days in the same suitably revised data matching process (as set forth in Section 5.a. of this Ruling) that the agency will use to match Medicare and SSI eligibility data in determining the hospital's SSI fraction for the period at issue.

## **IMPLEMENTATION OF THIS RULING**

### **4. Implementation by the Administrative Appeals Tribunals**

#### **a. The Standard Implementation Procedure**

\_\_\_\_\_ In order to resolve in an orderly manner pending administrative appeals of any of the three DSH issues for qualifying patient discharge dates and cost reporting periods (as described above in Sections 1, 2, and 3 of this Ruling) that have been rendered moot by the Ruling, the administrative appeals tribunals will use one of two procedures to begin the overall process of implementing the Ruling. Under the standard or default implementation procedure, the administrative tribunal (i.e., the PRRB, the Administrator of CMS, the fiscal intermediary hearing officer, or the CMS reviewing official) before which the appeal is pending will determine whether each claim at issue is for one of the three DSH issues and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines. If the administrative tribunal finds that the applicable jurisdictional and procedural requirements are satisfied for a given claim on one of the three DSH issues, then the appeals tribunal will issue a brief written

order, remanding each claim that qualifies for relief under the Ruling to the appropriate Medicare contractor for recalculation of the DSH payment adjustment (in accordance with the instructions set forth below in Section 5 of this Ruling) for the period at issue.

However, if the administrative tribunal finds that a given claim is outside the scope of the Ruling (because such claim is not for one of the three DSH issues) or the claim fails to meet the applicable jurisdictional and procedural requirements for relief under the Ruling, then the appeals tribunal will issue a written order, briefly explaining why the tribunal found that such claim is not subject to the Ruling. The appeals tribunal will then process the provider's original appeal of the same claim in accordance with the tribunal's usual, generally applicable appeal procedures.

b. The Alternative Implementation Procedure

CMS recognizes that, given the substantial number of appeals pending before the PRRB and the other administrative tribunals, it could take considerable time for the appeals tribunals to identify and decide which claims in the many pending appeals would qualify under this Ruling for a remand to the Medicare contractor for recalculation of the DSH payment adjustment. Accordingly, CMS is authorizing an alternative procedure for implementation of the Ruling, in order to expedite the orderly disposition of appeals of any of the three DSH issues and to avoid any inordinate delay.

Under this alternative implementation procedure, the hospital in a single provider appeal may submit a single written request to the pertinent administrative tribunal, requesting a remand of each and every specific claim on any of the three DSH issues for qualifying patient discharge dates and cost reporting periods (as described above in Sections 1, 2, and 3 of this Ruling) that was raised in such appeal to the appropriate Medicare contractor for implementation of the Ruling, without the

administrative tribunal first determining whether each of the provider's claims is for one of the three DSH issues and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines. On remand, under this alternative procedure, the Medicare contractor would then assume the responsibility for determining whether each of the provider's claims is subject to the Ruling.

The same alternative implementation procedure is available for pending group appeals on one of the three DSH issues, provided that the group's designated representative submits a single written request, on behalf of every provider and for every period at issue in the group appeal, to the administrative tribunal, requesting that the entire group appeal be remanded to the appropriate Medicare contractor for implementation of the Ruling; here too, the Medicare contractor, instead of the administrative appeals tribunal, would then determine whether each claim in the group appeal is for one of the three DSH issues and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines. (However, if a provider in the group appeal were to submit a written objection to the group representative's prior request for a remand under this alternative implementation procedure, and the administrative tribunal received such written objection before it had issued a remand order under the alternative implementation procedure, then the tribunal will instead follow the standard implementation procedure (as described in Section 4.a. of this Ruling); as a result, the appeals tribunal would then determine whether each claim in the group appeal is for one of the three DSH issues and whether such claim satisfies all applicable jurisdictional and procedural requirements for relief under the Ruling.)

If the Medicare contractor determines on remand, under this alternative implementation

procedure, that a specific claim is for one of the three DSH issues and such claim satisfies all applicable jurisdictional and procedural requirements for relief under this Ruling, then CMS and the contractor will recalculate the hospital's DSH payment adjustment (in accordance with the instructions set forth below in Section 5 of this Ruling) for the period at issue. However, if the contractor determines that the provider's claim is not for one of the three DSH issues or that such claim does not meet all applicable jurisdictional and procedural requirements, then the contractor will issue a written notice to the provider (or, for a group appeal, to the group representative), explaining briefly why the contractor found that such claim did not qualify for relief under the Ruling. The provider then may resume without prejudice its original appeal of the same claim before the same administrative appeals tribunal that previously remanded such claim to the contractor, provided that the hospital submits to the appeals tribunal a brief written notice, informing the tribunal that the provider has elected to resume its original appeal of the same claim. Upon receipt of such a written notice from the provider, the appeals tribunal will then process the provider's original appeal of the same claim in accordance with the tribunal's usual, generally applicable appeal procedures.

c. Provider Responsibilities Under the Alternative Implementation Procedure

In order for a hospital to invoke the alternative implementation procedure, the provider must submit an appropriate written request to the pertinent administrative appeals tribunal. The provider also must serve promptly a full copy of its written remand request on the opposing party in the pending appeal, which is the Medicare contractor (in single provider appeals) or the designated "lead" Medicare contractor (in group appeals). Before addressing the requisite contents of such written requests, we should emphasize that a hospital's remand request to the appeals tribunal may not include supporting

documentation (such as copies of the NPR, the provider's original request for a hearing, and any relevant request to add issues to a single provider appeal). However, the provider must submit such supporting documentation to the Medicare contractor, along with the service copy (for the contractor) of the provider's written remand request to the appeals tribunal.

For a single provider appeal, the hospital's single written request for a remand must include the provider's full name and address and its Medicare Provider Number, along with any case number for the such appeal. Also, the hospital must request a remand of each and every specific claim on any of the three DSH issues that was raised in its single provider appeal. The hospital's written request also must include, separately for each particular pending claim on any of the three DSH issues, the following information: the specific DSH matter and cost reporting period at issue; the date of the initial NPR and any relevant revised NPR; the date of the provider's original request for a hearing; and the date of any relevant request by the hospital to add issues to its single provider appeal. Furthermore, the provider's written request must identify the Medicare contractor that is currently assigned to the hospital.

As for group appeals, the group representative's single written request for a remand under this alternative implementation procedure must satisfy similar requirements. (We note that, since any group appeal can include a very large number of providers and an even greater number of specific cost reporting period claims for the single DSH matter at issue in the group appeal, it is especially important that the group representative's remand request complies fully with the requirements of this Ruling.) The written remand request to the administrative appeals tribunal must describe the specific DSH matter at issue in the group appeal, and the group representative must expressly request a remand of each and every DSH claim at issue in the group appeal. Also, the group representative's single written request

must include all of the information that is required, under the PRRB's standing instructions for group appeals, for a standard "Schedule of Providers." Furthermore, the written remand request must identify the Medicare contractor that is currently assigned to each hospital that is participating in the group appeal.

As provided in the first paragraph of this Section 4.c. of the Ruling, a hospital remand request to the appeals tribunal may not include supporting documentation (such as copies of the NPR, the provider's original request for a hearing, and any relevant request to add issues to a single provider appeal). However, such supporting documentation must be provided to the Medicare contractor, along with the service copy (for the contractor) of the written remand request to the appeals tribunal. The foregoing requirements regarding supporting documentation apply to remand requests for both single provider appeals and group appeals. Thus, the usual supporting documentation (required under the PRRB's standing instructions for group appeals) for a Schedule of Providers may not be included in the hospital's remand request to the appeals tribunal; however, the requisite supporting documentation for a Schedule of Providers must be given to the designated lead Medicare contractor for the group appeal, along with the service copy (for the lead contractor) of the provider's written remand request to the appeals tribunal.

In response to an appropriate remand request under this alternative implementation procedure, the administrative tribunal will issue to the parties to the appeal a brief written order, remanding the matter to the appropriate Medicare contractor for a determination of whether each remanded claim in such appeal is for one of the three DSH issues and whether such claim satisfies all applicable jurisdictional and procedural requirements for relief under this Ruling. It would be sufficient for the

appeals tribunal's remand order to simply grant the request for a remand under this alternative implementation procedure, and attach to the remand order a full copy of the written provider request for remand under the alternative procedure. After an appeal is remanded to the appropriate Medicare contractor under this alternative implementation procedure, the provider must respond appropriately and promptly to all requests by the contractor for documentation and other information that is necessary for the contractor to implement the Ruling. The contractor should already have much of the supporting documentation and information necessary to determine whether a specific remanded claim is for one of the three DSH issues and whether such claim meets all applicable jurisdictional and procedural requirements for relief under the Ruling; again, as provided in the first paragraph of this Section 4.c. of the Ruling, the service copy (for the Medicare contractor) of the provider remand request to the appeals tribunal must include the supporting documentation (such as copies of the NPR, the provider's original request for a hearing, and any relevant request to add issues to a single provider appeal) that is necessary for the contractor to determine whether each remanded claim is for one of the three DSH issues and whether such claim meets all applicable jurisdictional and procedural requirements for relief under the Ruling.

However, if the contractor determines that a specific DSH claim qualifies for relief under the Ruling, the contractor then might need additional information from the provider in order to recalculate the DSH payment adjustment for the period at issue. For example, if a provider's appeal of the LDR inpatient day issue qualified for relief under the Ruling, the contractor might ask the hospital to provide documentation that is necessary for the contractor to determine whether some or all of the disputed LDR days should be included in the DSH Medicaid fraction or the SSI fraction. Given that this alternative

implementation procedure will likely be employed in numerous appeals for a very large number of specific claims, it is imperative that hospitals provide promptly all of the documentation and other information that is necessary for the contractors to implement the Ruling under this alternative procedure.

d. “Mixed” Appeals Where Some Claims Are, But Other Claims Are Not, Subject to the Ruling

We note that a given administrative appeal might include some claims that qualify for relief under this Ruling, along with other claims that are not subject to the Ruling. For example, a single provider appeal could include a specific claim on one of the three DSH issues (described above in Sections 1, 2, and 3 of this Ruling) that is found to qualify for relief under the Ruling, in addition to a second particular claim (whether on a different DSH issue or an issue completely unrelated to the DSH payment adjustment) for which the Ruling is deemed inapplicable. Similarly, if one of the three DSH issues were raised in a group appeal, the Ruling might be found to apply to some, but not all, of the specific claims at issue because the applicable jurisdictional and procedural requirements were satisfied for only some, but not all, of the particular disputed claims.

If, under the standard implementation procedure (as set forth in Section 4.a. of this Ruling), the administrative tribunal finds that only some, but not all, of the specific claims raised in a given appeal qualify for relief under this Ruling, then the appeals tribunal should remand to the contractor, for recalculation of the DSH payment adjustment, only those particular DSH claims for which the Ruling was deemed applicable by the appeals tribunal. The other claims in such appeal (whether different DSH claims or claims unrelated to DSH), which the appeals tribunal found did not qualify for relief under the



Ruling, should be processed in accordance with the tribunal's usual, generally applicable appeal procedures.

Similarly, if the Medicare contractor finds, under the alternative implementation procedure (as set forth in Section 4.b. of the Ruling), that some, but not all, of the particular claims at issue in an appeal are subject to the Ruling, then the contractor should recalculate the hospital's DSH payment adjustment, in accordance with the applicable provisions of the Ruling, for only those specific DSH claims that were found by the contractor to qualify for relief under the Ruling. As for the remaining claims in such appeal (whether other DSH claims or claims with no bearing on DSH), which the contractor found were not subject to the Ruling, the provider may resume without prejudice its original appeal of such claims before the administrative tribunal that previously remanded the claims to the contractor under the alternative implementation procedure. If the provider elects to resume its original appeal of such claims, then those claims should be processed in accordance with the tribunal's usual, generally applicable appeal procedures.

e. Requests for Review of a Finding That a Claim Is Not Subject to the Ruling

We recognize that, if a specific claim were found outside the scope of, or not in compliance with all applicable jurisdictional and procedural requirements for relief under, this Ruling, then the provider might seek administrative and judicial review of such a finding. For example, if a Medicare contractor were to find, under the alternative implementation procedure (as set forth in Section 4.b. of this Ruling), that a specific claim was not for one of the three DSH issues and thus such claim was outside the scope of the Ruling, then the provider might elect to resume its original PRRB appeal of the same claim, and ask the PRRB to review the contractor's finding that the Ruling was not applicable to the claim. Or, if a

Medicare fiscal intermediary hearing officer were to find, under the standard implementation procedure (as set forth in Section 4.a. of this Ruling), that a particular claim on one of the three DSH issues was not subject to the Ruling because the provider's appeal of such DSH claim did not meet a jurisdictional requirement (such as the requirement of timely filing of the provider's appeal), then the provider might request the CMS reviewing official to review the hearing officer's finding that the Ruling was inapplicable. Similarly, if the PRRB were to find, also under the standard implementation procedure, that the Ruling did not apply to a specific claim on one of the three DSH issues because the provider's appeal of such DSH claim did not meet one of the PRRB's procedural requirements (such as the requirement of the timely filing of appropriate position papers), then the provider might seek review by the Administrator of CMS of the PRRB's finding that the specific DSH claim did not qualify for relief under the Ruling.

We believe that it is within the discretion of the administrative appeals tribunals, and certainly of the federal courts, to decide whether the Medicare statute and regulations would support subject matter jurisdiction over a provider's challenge to a finding that a particular claim is outside the scope of the Ruling or that such claim does not satisfy all applicable jurisdictional and procedural requirements for relief under the Ruling. Accordingly, this Ruling does not decide whether the Medicare statute and regulations would support, under any circumstances, administrative and judicial review of a provider's challenge to a finding that a particular claim is not subject to the Ruling.

Nonetheless, we believe that it is entirely appropriate to address the timing of any administrative and judicial review of a provider's challenge to a finding that a specific claim is outside the scope of the Ruling or does not satisfy all applicable jurisdictional and procedural requirements for relief under the

Ruling. Accordingly, it is hereby held that the administrative appeals tribunals may not review or decide a provider's interlocutory appeal of a finding, whether made by an appeals tribunal or by a Medicare contractor on remand from an appeals tribunal, that a specific claim is outside the scope of the Ruling or that such claim does not satisfy all applicable jurisdictional and procedural requirements for relief under the Ruling. Instead of reviewing or deciding any such interlocutory appeal, the pertinent administrative appeals tribunal should address, through its usual, generally applicable appeal procedures, the provider's challenge to a finding that a specific claim is not subject to the Ruling. Moreover, the administrative appeals tribunal should not review or decide the "merits" of a provider's challenge, to a finding that a particular claim is outside the scope of the Ruling or that such claim does not satisfy all applicable jurisdictional and procedural requirements for relief under the Ruling, unless and until the appeals tribunal were to conclude specifically that the Medicare statute and regulations support subject matter jurisdiction over the provider's challenge to a finding that the Ruling does not apply to a particular claim. Also, if the administrative appeals tribunal were to decide whether the same appeals tribunal or a different administrative tribunal had jurisdiction over a provider's challenge to a finding that a specific claim is not subject to the Ruling, the tribunal should issue a written decision that includes an explanation of the specific legal and factual bases for the tribunal's jurisdictional ruling.

## 5. Implementation by CMS and the Medicare Contractors

### a. Appeals on the SSI Data Matching Process Issue

If this Ruling is found applicable to a hospital's DSH appeal of the process by which CMS matches Medicare and SSI eligibility data in determining the SSI fraction, then CMS will apply, on remand, a suitably revised data matching process in recalculating the SSI fraction for each properly

pending claim (on the SSI fraction data matching process issue) in such appeal. Specifically, if a new data matching process is adopted in the forthcoming FY 2011 IPPS final rule (as described in Section 1 of this Ruling), then CMS will apply that new data matching process to each properly pending claim (on the SSI fraction data matching process issue) in such appeal. However, if a new data matching process is not adopted in the forthcoming FY 2011 IPPS final rule, CMS will instead apply to each properly pending claim (on the SSI fraction data matching process claim issue) in such appeals the same revised data matching process as the agency used to implement the *Baystate* decision by recalculating that provider's SSI fractions. In any event, the suitably revised data matching process that is used eventually by CMS, in matching Medicare and SSI eligibility data for each properly pending claim that is subject to this Ruling, will include in the hospital's SSI fraction the non-covered inpatient hospital days (for example, MSP days) and the exhausted benefit inpatient hospital days of persons entitled to Medicare Part A, along with any LDR inpatient days for patients who were entitled to Part A benefits (as described in Section 2 of this Ruling). Based on the suitably revised data matching process that is used eventually by CMS in implementing this Ruling, the agency will recalculate the hospital's SSI fraction for the period at issue. Then CMS will provide the revised SSI fraction to the appropriate Medicare contractor, and the contractor will recalculate the provider's DSH adjustment; issue a revised notice of program reimbursement (revised NPR) for the period at issue, *see* 42 C.F.R. §§ 405.1801(a), 405.1803, 405.1889; and pay the provider any monies deemed owing as a result of such DSH recalculation. The revised NPR will be subject to administrative and judicial review in accordance with the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines.

b. Appeals on Non-Covered Inpatient Day or Exhausted  
Benefit Day Issues

If this Ruling is found applicable to a provider's DSH appeal of the exclusion from the DPP of non-covered inpatient hospital days (for example, MSP days) or exhausted benefit inpatient hospital days of persons entitled to Medicare Part A, then CMS will include, on remand, such non-covered and exhausted benefit inpatient hospital days in the SSI fraction numerator (to the extent the patient is also entitled to SSI benefits) and in the denominator of that fraction, for each properly pending claim (on the non-covered or exhausted benefit inpatient hospital day issue) in such appeal. Specifically, CMS will account for such non-covered and exhausted benefit inpatient hospital days in the recalculation of the SSI fraction, by including those days in the same suitably revised data matching process (as set forth in Section 5.a. of this Ruling) that the agency will use to match Medicare and SSI eligibility data in determining the hospital's SSI fraction for each properly pending claim at issue in such appeal. Based on the suitably revised data matching process (including the disputed non-covered and exhausted benefit inpatient hospital days) that is used by CMS to implement this Ruling, the agency will recalculate the hospital's SSI fraction for each properly pending claim at issue and provide the revised SSI fraction to the appropriate Medicare contractor. The contractor will then recalculate the provider's DSH adjustment; issue a revised NPR for the period at issue, *see* 42 C.F.R. §§ 405.1801(a), 405.1803, 405.1889; and pay the provider any monies deemed owing as a result of such DSH recalculation. The revised NPR will be subject to administrative and judicial review in accordance with the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines.

c. Appeals on the Labor/Delivery Room Inpatient Day

Issue

If this Ruling is found applicable to a provider's DSH appeal of the exclusion from the DPP of LDR inpatient days, then CMS and the Medicare contractors will include, on remand, such LDR inpatient days in the hospital's Medicaid fraction or its SSI fraction (whichever proves to be applicable), for each properly pending claim (on the LDR inpatient day issue) in such appeal. First, the appropriate Medicare contractor will obtain from the hospital the information necessary for the contractor to determine whether some or all of the LDR inpatient days at issue should be included in the hospital's Medicaid fraction or its SSI fraction. Second, if the contractor finds that some or all of the disputed LDR inpatient days should be included in the Medicaid fraction, then the contractor will include such LDR inpatient days in recalculating the Medicaid fraction for the period at issue. Third, if the contractor determines that some or all of the contested LDR inpatient days were for patients who were entitled to Part A benefits (as described in Section 2 of this Ruling), then CMS will include such LDR days in the same suitably revised data matching process (as set forth in Section 5.a. of the Ruling) that the agency will use to match Medicare and SSI eligibility data in determining the hospital's SSI fraction for each properly pending claim at issue. Based on the suitably revised data matching process (including any disputed LDR days for patients who were entitled to Part A benefits), that is used by CMS to implement this Ruling, the agency will recalculate the hospital's SSI fraction for each properly pending claim at issue and provide the revised SSI fraction to the Medicare contractor. Fourth, if the hospital's Medicaid fraction or its SSI fraction is recalculated (based on the inclusion of some or all of the disputed LDR inpatient days in either fraction), then the contractor will recalculate the provider's DSH adjustment;

issue a revised NPR for the period at issue, *see* 42 C.F.R. §§ 405.1801(a), 405.1803, 405.1889; and pay the provider any monies deemed owing as a result of such DSH recalculation. The revised NPR will be subject to administrative and judicial review in accordance with the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines.

d. Cost Reports Not Settled Finally by an Initial NPR

CMS and the Medicare contractors will apply the foregoing provisions of this Section 5 of the Ruling, regarding each of the three DSH issues for the above-described patient discharge dates and cost reporting periods (as set forth in Sections 1, 2, and 3 of this Ruling), in calculating the DSH payment adjustment for each qualifying open cost reporting period where the contractor has not yet settled finally the provider's Medicare cost report through the issuance of an initial NPR, *see* 42 C.F.R. §§ 405.1801(a), 405.1803. The initial NPR will be subject to administrative and judicial review in accordance with the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines.

e. Provisions for Unitary Relief on All Three DSH  
Issues

As set forth in the foregoing paragraphs of this Section 5 of the Ruling, the same, unitary relief will be provided under the Ruling for properly pending claims in appeals of the SSI fraction data matching process issue and the non-covered or exhausted benefit day issue; for properly pending claims in appeals of the LDR day issue, to the extent that the disputed LDR days were for patients who were entitled to Part A benefits (as described in Section 2 of this Ruling); and for qualifying open cost reports

(with respect to all three of the DSH issues). For a qualifying open cost report and a properly pending claim in an appeal of any one (or more than one) of the three DSH issues, CMS will apply the same suitably revised data matching process for matching Medicare and SSI eligibility data in determining the hospital's SSI fraction and its DSH payment adjustment. More specifically, CMS' suitably revised data matching process will include the non-covered inpatient hospital days (for example, MSP days) and the exhausted benefit inpatient hospital days of persons entitled to Medicare Part A, along with any LDR inpatient days for patients who were entitled to Part A benefits. Accordingly, if a hospital were to appeal only the exclusion from the DPP of non-covered or exhausted benefit inpatient days, those non-covered and exhausted benefit days would be accounted for in the revised DPP by virtue of CMS' uniform inclusion of non-covered and exhausted benefit days in the agency's suitably revised data matching process for matching Medicare and SSI eligibility data in determining hospitals' SSI fractions and their DSH payment adjustments. Similarly, if a provider were to appeal only the SSI fraction data matching process issue, the uniform inclusion of non-covered and exhausted benefit inpatient days and qualifying LDR days in CMS' suitably revised data matching process will produce a more accurate revised SSI fraction than would result from the alternative approach, of not uniformly including non-covered and exhausted benefit inpatient days and qualifying LDR days in the agency's revised data matching process. Furthermore, the suitably revised data matching process, which CMS will use in implementing the Ruling for qualifying open cost reports and for properly pending claims in appeals of any of the three DSH issues, will include, in important part, an "automated," computer-supported comparison of records from multiple electronic sources. CMS' decision to provide the same, unitary relief for qualifying open cost reports and for properly pending claims in appeals of any of the three DSH issues, through one



suitably revised data matching process, will produce one determination of the relevant SSI fraction to be used in calculating (or recalculating) the hospital's DSH payment adjustment and settling finally its cost report for each claim that is subject to this Ruling. This single determination comports with CMS' longstanding interpretation of the Medicare statute as providing for one unitary data matching process, and with the agency's established practice of performing a single, automated data match each fiscal year. *See* 51 Fed. Reg. at 16777 ("This data match will be done at least annually and will involve a match of the individuals who are SSI recipients for each month . . . [with Medicare] beneficiaries who received inpatient hospital services during the same month.") Moreover, we believe that it is most efficient to provide relief under the Ruling, with respect to qualifying open cost reports and for properly pending claims in appeals of any of the three DSH issues, through the same automated data matching process, and the Ruling's provisions for the same, unitary relief on all three issues should also facilitate the elimination of, or at least a substantial reduction in, litigation regarding the three issues. The alternative course, of trying to fashion ad hoc relief for qualifying claims regarding only the non-covered or exhausted benefit day issue or the LDR day issue, would likely prove to be administratively infeasible; would be at best very time-consuming and difficult to effectuate; and would likely yield increased litigation on the three DSH issues.

## **RULING**

First, it is CMS' Ruling that the agency and the Medicare contractors will resolve each properly pending claim in a DSH appeal in which a provider challenges CMS' process for matching Medicare and SSI eligibility data in determining the SSI fraction; CMS will apply a suitably revised data matching process (as set forth in Section 5 of this Ruling) in recalculating the hospital's SSI fraction, and the

contractor will then recalculate 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 in determining the SSI fraction, provided that such claim (on the SSI fraction data matching process issue) otherwise satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines for appeal.

Second, it is also CMS' Ruling that the agency and the Medicare contractors will resolve, in accordance with the instructions set forth in Section 5 of this Ruling, each properly pending claim in a DSH appeal, for cost reports with patient discharges before October 1, 2004, in which a provider challenges the exclusion from the DPP of non-covered inpatient hospital days (for example, MSP days) or exhausted benefit days for persons entitled to Medicare Part A; CMS will include such non-covered and exhausted benefit days in the SSI fraction, by applying the same suitably revised data matching process (which will include non-covered and exhausted benefit days) in recalculating the hospital's SSI fraction, and the contractor will then recalculate 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 DSH payment adjustment and thereby renders moot each properly pending claim in a DSH appeal, for cost reports with patient discharges before October 1, 2004, in which the hospital seeks inclusion in the DPP of non-covered inpatient hospital days (for example, MSP days) or exhausted benefit inpatient hospital days of a person entitled to Part A, provided that such claim (on the

non-covered or exhausted benefit day issue) otherwise satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines for appeal.

Third, it is CMS' further Ruling that the agency and the Medicare contractors will resolve, in accordance with the instructions set forth in Section 5 of this Ruling, each properly pending claim in a DSH appeal, for cost reporting periods beginning before October 1, 2009, in which a provider challenges the exclusion from the DPP of LDR inpatient days. To the extent that such disputed LDR inpatient days should be included in the hospital's Medicaid fraction, the contractor will include such LDR days in recalculating the Medicaid fraction, and the contractor will then recalculate the hospital's DSH payment adjustment for the period at issue. If any of the contested LDR days were for patients who were entitled to Part A benefits (as described in Section 2 of this Ruling), CMS will include such LDR days in the SSI fraction, by applying the same suitably revised data matching process (which will include any LDR days for patients who were entitled to Part A benefits) in recalculating the hospital's SSI fraction, and the contractor will then recalculate 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 DSH payment adjustment and thereby renders moot each properly pending claim in a DSH appeal, for a pre-October 1, 2009 cost reporting period, in which the hospital seeks inclusion in the DPP of LDR inpatient days, provided that such claim (on the LDR day issue) otherwise satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines for appeal.

Fourth, it is also CMS' Ruling that the pertinent administrative appeals tribunal (that is, the

PRRB, the Administrator of CMS, the fiscal intermediary hearing officer, or the CMS reviewing official) and the appropriate Medicare contractor will process, in accordance with the instructions set forth in the last paragraph of Section 2 and in Section 4 of this Ruling, each appeal (including any interlocutory appeals) and each putative claim (in such appeal) involving any of the three DSH issues for the above-described patient discharge dates and cost reporting periods (as described in Sections 1, 2, and 3 of the Ruling).

Fifth, it is CMS' further Ruling that the agency and the appropriate Medicare contractor will process, in accordance with the instructions set forth in the last paragraph of Section 2 and in Section 5 of this Ruling, each properly pending claim on any of the three DSH issues for the above-described patient discharge dates and cost reporting periods (as set forth in Sections 1, 2, and 3 of this Ruling) that is remanded by the administrative appeals tribunal and is found to qualify for relief under this Ruling.

Sixth, it is also CMS' Ruling that the agency and the appropriate Medicare contractor will apply the provisions of the last paragraph of Section 2 and of Section 5 of this Ruling, regarding each of the three DSH issues for the above-described patient discharge dates and cost reporting periods (as set forth in Sections 1, 2, and 3 of this Ruling), in calculating the DSH payment adjustment for each open hospital cost reporting period where the contractor has not yet settled finally the provider's Medicare cost report through the issuance of an initial NPR, *see* 42 C.F.R. §§ 405.1801(a),405.1803.

Seventh, it is CMS' further Ruling that, pursuant to 42 C.F.R. §§ 405.1801(a), 405.1885(c)(1), (2), this Ruling is not an appropriate basis for the reopening of any final determination of the Secretary or a fiscal intermediary or of any decision by a reviewing entity; accordingly, it is hereby held that the administrative appeals tribunals, the fiscal intermediaries, and other Medicare contractors may not

reopen any determination or decision with respect to any of the three DSH issues for the above-described patient discharge dates and cost reporting periods (as set forth in Sections 1, 2, and 3 of this Ruling).

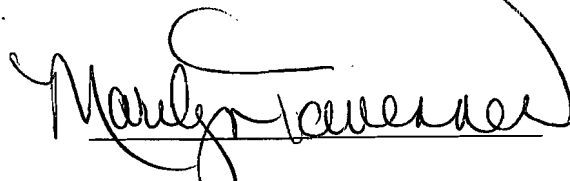
Eighth, it is also CMS' Ruling that, pursuant to 42 C.F.R. § 401.108, this Ruling is a final precedent opinion and order and a binding statement of policy and interpretation that does not give rise to any putative retroactive rulemaking issues; in any event, it is hereby held that, if this Ruling were deemed to implicate potential retroactive rulemaking issues, then, in accordance with section 1871(e)(1)(A) of the Act, retroactive application of this Ruling is necessary to ensure compliance with the DSH payment adjustment requirements of section 1886(d)(5)(F) of the Act and to serve the public interest.

CMS-1498-R

**EFFECTIVE DATE**

This Ruling is effective April 28, 2010.

Dated: APR 29 2010

A handwritten signature in black ink, appearing to read "Marilyn Tavenner", written over a horizontal line.

Marilyn Tavenner

Acting Administrator,

Centers for Medicare & Medicaid Services