No. 23-715

In The
Supreme Court of the United States

ADVOCATE CHRIST MEDICAL CENTER, ET AL.,
Petitioners,

v.

XAVIER BECERRA,
SECRETARY OF HEALTH AND HUMAN SERVICES,
Respondent.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF OF TWENTY-SIX STATE AND REGIONAL HOSPITAL ASSOCIATIONS AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

HOOPER, LUNDY & BOOKMAN, P.C.
Sven C. Collins
999 18TH STREET
SUITE 3000
DENVER, CO 80202

Lloyd A. Bookman
1875 Century Park East
Suite 1600
Los Angeles, CA 90067

Robert L. Roth
Counsel of Record
Rachel L. Zacharias
David J. Vernon
Kelly A. Carroll
HOOPER, LUNDY & BOOKMAN, P.C.
401 9th Street, N.W., Suite 550
Washington, DC 20004
(202) 580-7700
rroth@hooperlundy.com

Counsel for Amici Curiae

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Other Authorities

STATEMENT OF INTEREST OF AMICI CURIAE[1]

The *amici*, 26 non-profit state and regional hospital associations listed in the appendix filed herewith, respectfully submit this brief as *amici curiae*. Combined, these state and regional hospital associations represent thousands of hospitals and health systems across the United States, as well as other providers, including nursing homes, home health, hospice, and assisted living.

Amici, and their member hospitals and health systems, are directly and indirectly affected by changes to Medicare's Disproportionate Share Hospital ("DSH") payment program. Many of these member hospitals and health systems rely on DSH payments to offset their costs of treating the most vulnerable, low-income patients in our country. For this reason, *amici* have an interest in ensuring that the Secretary complies with the statutory mandate to make the full DSH payments required by statute. When the Secretary systematically undercounts SSI days, resulting in reduced DSH payments, it puts hospitals and their low-income patients at risk.

Given the unique position of the *amici* and their members on the front lines of providing medical care to low-income patients, *amici* respectfully submit this brief to provide the Court with relevant information on two issues at the heart of this case: (1) how the Secretary's current complex and

---

[1] No party or counsel for a party authored or paid for this brief in whole or in part, or made a monetary contribution to fund the brief's preparation or submission. No one other than *amici* or their counsel made a monetary contribution to the brief.

unworkable approach to calculating DSH Medicare fractions harms hospitals and their most vulnerable, low-income patients, and (2) why a consistent reading of "entitled to benefits" in the DSH statute is more transparent, easier to administer, and more fair to hospitals that treat a large number of low-income patients.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

As explained in the Brief for Petitioners, the Secretary's "actual receipt" and/or "payment due" approaches to calculating the Medicare fraction used for Medicare DSH payment purposes result in the exclusion from the numerator of that fraction inpatient days for patients who are "entitled to [SSI] benefits" under a plain meaning, contextual, Congressional purpose, and common sense interpretation of that statutory phrase.

At the more technical programmatic level, and regardless of whether the Secretary's approach is characterized as "actual receipt" or "payment due," the Secretary calculates the Medicare fraction by (1) determining the SSI code that SSA assigned to a patient for the month of an inpatient stay, and (2) including the inpatient days from an inpatient stay in the numerator of the Medicare fraction only if SSA assigned to the patient one of three of SSA's myriad SSI codes for that month, C01, M01, or M02 (the denominator includes all inpatient days for patients "entitled to Medicare part A"). By using only these three SSI codes, the Secretary excludes from the numerator of the Medicare fraction inpatient hospital days for numerous patients that are indisputably low-income under the

Congressional definition in, and in furtherance of the purpose of, the DSH payment statute.

This brief explains how the understatement of the Medicare fraction caused by the Secretary's use of only the three Secretary-approved SSI codes results not only in reduced (or completely eliminated) Medicare DSH payments for hospitals, but also financial harm in other ways. Most notably, it can render hospitals unable to qualify for participation in the 340B Program because hospitals paid under the Medicare Hospital Inpatient Prospective Payment System ("IPPS") must qualify for DSH in order to participate in the 340B Program. The harm from the Secretary's approach is exacerbated because, under the Secretary's rounding rules used for purposes of DSH qualification, the exclusion of even a single inpatient day from the numerator of the Medicare fraction can be the difference between qualifying and not qualifying for DSH and, thus, participating or not participating in the 340B Program.

To help further the understanding of the Court on these technical matters, *Amici* herein identify some of the SSI codes that are presently excluded from the CMS-SSA data-match but should be included in order to comply with the DSH statute, with examples of the patients that come within those codes. *Amici* also explain how the Secretary's approach especially harms hospitals in rural areas.

This brief also explains the extensive errors that result from the Secretary's complicated three-code data-matching with SSA and the harm to hospitals resulting from the lack of transparency with regard

to the data that the Secretary uses to calculate Medicare fractions.

Amici also explain the benefit to hospitals and their patients from using the "program eligibility" approach to calculate DSH Medicare fractions, as described in the Brief for Petitioners, particularly if the approach is implemented with the same transparency and auditing that the Secretary has used for many years when calculating inpatient hospital days based on Medicaid eligibility for purposes of determining hospitals' DSH Medicaid fractions.

ARGUMENT

I. THE SECRETARY'S APPROACH TO CALCULATING DSH MEDICARE FRACTIONS HARMS HOSPITALS AND THEIR PATIENTS DIRECTLY AND INDIRECTLY.

A. The Secretary's Failure to Include in the Numerator of the Medicare Fraction All Inpatient Days for Patients Entitled to Medicare Part A and SSI Causes Hospitals Not to Qualify for DSH or to be Underpaid If They Qualify.

1. The failure of the Secretary to include in the numerator of the Medicare fraction the inpatient days for all Medicare patients who were also "entitled to [SSI] benefits" during their inpatient stay unlawfully reduces that fraction, which can cause a hospital's combined Medicare and Medicaid fractions percentage (the "disproportionate patient

percentage"[2]) not to meet the 15% threshold to qualify for a DSH payment.[3] Hospitals that miss the 15% threshold by even a single day in the numerator of their Medicare fraction can be left in the cold because CMS rounds disproportionate patient percentages "to 4 decimal places" (for example 14.9999% is not rounded to 15%) for purposes of determining qualification for Medicare DSH (an example is presented at page 12, *infra*). *See* Provider Reimbursement Manual, Pub. 15-2 §4000.1, https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021935; *see also*, *e.g.*, *Sacred Heart Hosp. v. Novitas Solutions, Inc.*, ¶83,674, Ctrs. for Medicare & Medicaid Servs. (Oct. 23, 2023) (directing the Medicare Contractor to add additional Medicaid-eligible days, increasing the provider's disproportionate patient percentage from 14.99 (DSH nonqualifying) to 15.69 (DSH qualifying)).

In addition to losing out on their share of the annual projected DSH payments (estimated at $3.34

---

[2] *See* 42 U.S.C. §1395ww(d)(5)(F)(vi) (definition of "disproportionate patient percentage") (JA 128).

[3] Hospitals can also qualify for DSH under the "Pickle" method, which is not relevant here and is used only by a small number of DSH qualifying hospitals. *See, e.g.*, CMS, Pub. 100-04 Medicare Claims Processing, Transmittal 4138, Confirmation of "Pickle Hospital" Status (Sept. 28, 2018), https://www.cms.gov/regulations-and-guidance/guidance/transmittals/2018downloads/r4138cp.pdf (at that time, CMS identified only ten current "Pickle Hospitals").

billion in FY 2024),[4] a hospital that fails to qualify for DSH is also ineligible to receive Uncompensated Care payments (approximately $5.94 billion in FY 2024)[5] or to participate in the 340B drug discount program (*see* Section I.B, *infra*). Notably, although the amount of Uncompensated Care payments is based on the relative amount of uncompensated care provided by the hospital (rather than the DSH fractions), a hospital that fails to meet the 15% DSH-qualifying "disproportionate patient percentage" threshold is ineligible for any Uncompensated Care payments, regardless of how much uncompensated care it provided. Thus, if the Medicare fraction undercounts days, some hospitals risk losing access to three safety-net programs designed by Congress to recognize their additional costs (DSH payment), defray some of their spending on uncompensated care (Uncompensated Care payment), and reduce their drug costs (340B Program participation).

Moreover, even where undercounting in the numerator of the Medicare fraction does not cause a hospital to miss qualifying for a DSH payment, an understated disproportionate patient percentage will reduce the hospital's DSH payments and the aggregate amount of Uncompensated Care

---

[4] CMS has estimated that DSH payments will total $3,338,397,007.29 in FFY 2024. FFY 2024 IPPS Final Rule, 88 Fed. Reg. 58,640, 58,997 (Aug. 28, 2023).

[5] To qualify to receive Uncompensated Care payments, a hospital must qualify for DSH (*i.e.*, meet the 15 percent threshold). *See* 42 U.S.C. §1395ww(r); *see also* 42 C.F.R. §412.106(g)(1). For FFY 2024, CMS set aggregate Uncompensated Care payments at $5,938,006,756.87. 88 Fed. Reg. at 59,001.

payments. (With respect to Uncompensated Care payments, aggregate amounts are determined annually through a process that starts with a prospective DSH estimate under 42 U.S.C. § 1395ww(r)(2)(A). *See* note 4, *supra*. The systemic undercounting of SSI days thus necessarily reduces the pool available to defray eligible hospitals' uncompensated care costs under this program.)

2. The Secretary's approach excludes from the Medicare fraction many low-income patients, depriving hospitals of statutorily-mandated DSH payments designed to offset some of the increased hospital costs incurred serving low-income communities. *See* 42 U.S.C. §1395ww(d)(5)(F)(i)(I) ("the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which . . . serves a significantly disproportionate number of low-income patients").[6]

---

[6] Congress created the Medicare DSH program in recognition that "low-income individuals are often more expensive to treat than higher income ones, even for the same medical conditions." *Becerra v. Empire Health Foundation*, 597 U.S. 424, 429 (2022). "In compensating for that disparity, the DSH adjustment encourages hospitals to treat low-income patients." *Id.* Recognizing that low-income patients are typically sicker and more costly to treat in a hospital setting than other patients with similar diagnoses, and that these additional costs are not captured by the IPPS' payment of fixed rates based on average costs, Congress requires the Secretary to make Medicare DSH payments to those hospitals that serve a disproportionate share of low-income patients. Medicare Payment Advisory Commission, "Report to the Congress: Medicare and the Health Care Delivery System," p. 67 (June 2022),

As Petitioners note, "for SSI-eligible patients in Medicaid-paid medical facilities, including nursing homes, SSI payments are reduced to $0 if countable income exceeds $30—which it almost always does by virtue of Social Security retirement or disability benefits." *See* Pet'r Br. 45 (citing 42 U.S.C. §1382(e)(1)(B); *id*. §426(a)-(b)). "When these patients are transferred to a hospital for inpatient care (a common occurrence), they will not count in the Medicare fraction numerator because their SSI payments are $0." *Id*. And "because they are eligible for Medicare part A, they also will be excluded from the Medicaid fraction—meaning they are not counted as low-income at all." *Id*. "Thus, "[m]ost egregiously, many SSI-eligible, low-income patients will be excluded because they need extensive medical care." *Id.*

As discussed by *amici curiae* the American Hospital Association, *et al.*, "petitioners estimate that HHS's interpretation lowered DSH payments to the sample hospitals by 15%," which "[e]xtrapolated to hospitals nationwide," "yields approximately $1.5 billion in losses annually." *See Amici Curiae* Br. for Am. Hospital Ass'n, Ass'n of Am. Med. Colleges, America's Essential Hospitals, Catholic Health Association, Federation of Am. Hospitals, and Nat'l Rural Health Ass'n ("AHA Br.") 25 (citing Pet. for Writ of Cert. 18).

DSH underpayments have a more acute impact on urban hospitals with 100 or more beds, and also rural hospitals with more than 500 beds, because

---

https://www.medpac.gov/wpcontent/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_v2_SEC.pdf.

those hospitals are not subject to a DSH payment cap.[7] As other *amici* also recognize, *see* AHA Br. 23–30, losing DSH and other payments has a profound impact on hospitals' ability to provide care.

B. IPPS Hospitals that Do Not Qualify for DSH Do Not Qualify for 340B Program Participation.

1. Potentially even more harmful financially, hospitals that do not qualify for DSH may not be able to participate in the 340B Drug Pricing Program, which both helps control hospitals' drug costs and enables hospitals to "provide a wide range of medical services in low-income and rural communities." *Am. Hosp. Ass'n v. Becerra*, 596 U.S. 724, 730–31 (2022).

Qualification for participation in the 340B Program is available to nonprofit or government-owned or operated hospitals with a DSH payment adjustment (not a DSH qualifying percentage) of at least 11.75% for their most recently filed cost reporting period. 42 U.S.C. §256b(a)(4)(L); *see also* Health Res. & Servs. Admin., 340B Drug Pricing Program: Disproportionate Share Hospitals (June 2024), https://www.hrsa.gov/opa/eligibility-and-registration/hospitals/disproportionate-share-hospitals. If an IPPS hospital does not qualify for a DSH payment, its DSH payment adjustment will be

---

[7] CMS, MLN Fact Sheet: Medicare Disproportionate Share Hospital, at 6 (Jan. 2023), https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/disproportionate_share_hospital.pdf.

zero and it thus will not qualify for 340B Program participation.

But even if an IPPS hospital qualifies for a DSH payment, 340B Program participation requires the hospital to have had a DSH payment percentage of at least 11.75 for the applicable fiscal period (*i.e.*, the hospital's DSH payment must have been at least 11.75% of the hospital's total IPPS payments for that fiscal period). Thus, the undercounting in the numerator of the Medicare fraction can cause non-DSH hospitals and DSH hospitals not to qualify for 340B Program participation. DSH qualification is the only mechanism for IPPS hospitals, and for most specialty hospitals,[8] to qualify for participation in the 340B Program.

When a hospital loses its DSH qualification entry into 340B Program participation, the financial effect can be devastating. As *amici* American Hospital Association, *et al.*, describe, a hospital can stand to lose more than $100 million in 340B Program benefits if it falls short of the DSH threshold. *See* AHA Br. 26.

2. *Amici* and their counsel have identified 177 instances, from hospital fiscal years 2013 through

---

[8] Some non-IPPS hospitals can qualify for the 340B Program participation through their status as children's hospitals, critical access hospitals, freestanding cancer hospitals, rural referral centers, or sole community hospitals. *See* 42 U.S.C. §256b(a)(4)(M)–(O). But, even under most of these categories, hospitals must meet a certain DSH payment percentage threshold. *Id.* at §256b(a)(4)(M); (O). Further, manufacturers are not required to provide these special qualifying hospitals (other than children's hospitals) with orphan drugs under the 340B Program. *Id.* at §256b(e).

2022, where DSH hospitals missed qualifying for 340B Program participation because their DSH payment percentages were between 10.5% and 11.74%, just below the 11.75% 340B Program qualifying DSH payment percentage (this can happen to the same hospital for more than one fiscal year). *Amici* and their counsel also have identified the number of additional inpatient hospital days that would have been needed to be added to the numerator of each hospitals' Medicare fraction in order for that hospital to have qualified for the amount of DSH payment necessary to meet the 11.75% 340B DSH payment threshold.

The smallest number of additional inpatient days needed to be added to the numerator of the Medicare fraction to so qualify was 115 days for a hospital in Mississippi for fiscal year 2019. The addition of the 115 days would increase the numerator of the Medicare fraction from 4,477 days to 4,592 days. That shortfall of 115 days was approximately 2.57% of the total number of days in the numerator of the Medicare fraction.[9]

Importantly, hospitals can expect far more than an additional 2.57% of inpatient days to be added to the numerator of their Medicare fractions by including other SSA codes that squarely fit within the statutory phrase "entitled to [SSI] benefits." As explained in more detail in Section II, *infra*, the Secretary's three-code policy excludes all other codes

---

[9] In this example, each day is .0223%. Thus, under CMS rounding rules, if this hospital were at 14.98% it would not be rounded to 15%, but the addition of this one day would allow the hospital to cross the 15% threshold.

in their entirety, including those that address a circumstance that SSA defines as a "stop payment":

> *A **stop payment** is an interruption in payment. It is not a loss of eligibility.*

Social Security Administration, Program Operations Manual System SI 02301.201: Description of SSI Posteligibility (PE) Events (Aug. 30, 2023), https://secure.ssa.gov/poms.nsf/lnx/0502301201#b (bold in original, underlining and italicizing added). An individual, *ipso facto*, would have to be entitled to an SSI payment in order for such payment to be stopped.

Among the reasons that a stop payment occurs:

> • The FO is searching for a representative payee, PSC [i.e., Payment Service Code] **S08**, GN 00502.100, [and]
>
> • A recipient is eligible, but due no payment, PSC **E01**, SI02005.020, ...

Id. (bold in original). There is no basis under the DSH statute or otherwise for excluding such patients, among others, from the numerator of the Medicare fraction.

The Secretary's three-code policy also excludes several "payment suspension" codes, which are used (emphasis added): "When SSI payments have been temporarily stopped because the recipient is not currently eligible, ***or they were interrupted for other reasons***." SSA - POMS: SI 02301.201 - Description of SSI Posteligibility (PE) Events - 08/30/2023. For example, where a recipient is due an SSI payment for a particular month, but SSA does not have a valid address for the recipient or a

check is returned for a reason other than address, SSA assigns "payment suspension" codes S06 and S07, respectively. Section SI 02301.201B.2.

The complaint filed in *University of Washington Medical Center and Harborview Medical Center v. Burwell*, No. 16-1587 (RSL) (W.D. WA Oct. 13, 2016), at 13, identifies the percent of inpatient days that would be added to the numerator of the Medicare fractions for the hospital-plaintiffs in that action based on inclusion of SSI codes other than the three approved by CMS. Of particular note are two such codes: (1) E01, which by itself would add approximately 3.92% of days to the numerator of the Medicare fraction, and (2) S06, which by itself would add approximately 1.81% of days to the numerator of the Medicare fraction. The combined 5.73% is far more than the 2.57% shortfall that resulted in the Mississippi hospital being excluded from the 340B Program.

In programs such as DSH, Uncompensated Care payments, and 340B, where small errors in the numerator of the Medicare fraction can disqualify a hospital from being able to benefit from key safety-net programs mandated by Congress, the erroneous exclusion of Medicare beneficiaries who are also manifestly "entitled to [SSI] benefits" during their inpatient stay will have significant business-critical consequences for some hospitals, to the detriment of their financial health and the well-being of the communities they serve.

C. DSH Underpayments Especially Harm Rural Hospitals.

The detrimental effect of losing DSH and other affiliated payments is magnified for hospitals in

rural areas, which are already experiencing increasing provider closures with corresponding decreasing care access. *See* AHA Br. 23–30. Due to various inherent inequities involving these hospitals, including Medicare providing a higher percentage of their overall reimbursement and their lack of access to payments under the Secretary's program known as "Capital DSH," these already strapped hospitals suffer more harm when the Secretary undercounts the SSI inpatient days in the numerators of their Medicare fractions. (Rural hospitals are entirely excluded from this program, even if they receive a DSH payment.[10] Hospitals that qualify for Capital DSH are expected to receive total Capital DSH payments of approximately $226.8 million in FFY 2024.[11])

Fluctuations in Medicare payments tend to have greater harm on revenue of rural hospitals, compared to non-rural hospitals, and on the patients

---

[10] *See* 42 C.F.R. §412.320; *see also* CMS, Medicare Claims Processing Manual, Transmittal 1811, Change Request 6564 (Sept. 4, 2009) ("A hospital qualifies for a capital DSH adjustment if it is located in a large urban or other urban area, has at least 100 beds, and has a DSH percentage greater than 0."). Rural hospitals and urban hospitals with less than 100 beds are ineligible for Capital DSH.

[11] Each year, when CMS publishes the IPPS final rule, the agency also releases data files related to the rule. For the 2024 IPPS Final Rule, the data files can be found here: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page. One of these files is the FY 2024 Final Rule: HCRIS Data File, which contains capital DSH payments by hospital. The total capital DSH payments to hospitals added $226.8 million to the estimated $6.1 billion in capital payments.

they serve. This is because Medicare beneficiaries rely heavily on rural hospitals to provide care—approximately one out of every four Medicare beneficiaries lives in a rural area and depends on rural hospitals for care—and rural hospitals generally provide higher rates of uncompensated care than urban hospitals. *See, e.g.*, Krystal G. Garcia, MSPH, Kristie Thompson, MA, Hilda A. Howard, BS, and George H. Pink, PhD, *Geographic Variation in Uncompensated Care Between Rural and Urban Hospitals*, NC Rural Health Research Program Findings Brief (June 2018), https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2018/06/Geographic-Variation-in-Uncompensated-Care-between-Rural-Hospitals-and-Urban-Hospitals.pdf (finding that rural hospitals have higher median uncompensated care as a percent of operating expense than urban hospitals); *see also* CMS, *Improving Health in Rural Communities: FY 2021 Year in Review*, 1-2, 9 (Nov. 2021), (hereinafter, "CMS, *Improving Rural Health*"), https://www.cms.gov/files/document/fy-21-improving-health-rural-communities508compliant.pdf.

Rural hospitals' uncompensated care costs stem from multiple causes, including because rural residents are more likely to be low-income, unemployed, and under- or uninsured than urban residents. CMS, *Improving Rural Health*, at 1. Patients in rural areas also tend to be on average older, sicker, and have more disabilities. CMS, *Improving Rural Health*, at 1–2; Katrina Crankshaw, *Disability Rates Higher in Rural Areas Than Urban Areas*, U.S. Census Bureau (June 26, 2023),

https://www.census.gov/library/stories/2023/06/disability-rates-higher-in-rural-areas-than-urban-areas.html. And, because non-hospital care tends to be less available and accessible in rural communities, *see* CMS, *Improving Rural Health*, at 1–2, residents in rural areas tend to get less preventative and primary care, which means that rural hospitals often serve patients who have deferred care, making their conditions more complicated and costly to treat.

For the reasons stated above and in the AHA Br. (at 23–30), many rural hospitals are already on a razor's edge of solvency. Indeed, ten of the states that *amici* Hospital Associations represent (Arkansas, Georgia, Indiana, Kansas, Louisiana, Maine, Mississippi, Missouri, Tennessee, and West Virginia) are those in which 25% or more of rural hospitals are at high risk of closure. *See* David Mosley, Daniel DeBehnke, Sarah Gaskell & Alven Weil, *2020 Rural Hospital Sustainability Index*, Guidehouse (April 2022), https://guidehouse.com/-/media/www/site/insights/healthcare/2020/guidehouse-navigant-2020-rural-analysis.ashx. And in four of these states (Arkansas, Mississippi, Tennessee, and West Virginia), 50% or more of the rural hospitals are at high risk. *Id.*

In nine of the states that *amici* Hospital Associations represent (Arizona, Arkansas, California, Florida, Mississippi, Louisiana, North Carolina, Tennessee, and Washington), 100% of the high-financial-risk rural hospitals are considered "highly essential" to their communities in terms of service to vulnerable populations, geographic isolation, economic impact, and social vulnerability. *Id.* And in thirteen more (Georgia, Illinois, Indiana,

Iowa, Kansas, Maine, Missouri, New York, Ohio, Pennsylvania, Texas, Vermont, and West Virginia), at least half of the at-risk hospitals are considered "highly essential." *Id.*

Furthermore, the detrimental effect of losing DSH and related payments is especially magnified in rural areas with higher racial and ethnic minority populations, as these areas are increasingly likely to experience hospital closures. *See* Arrianna M. Planey et al., *Since 1990, Rural Hospital Closures Have Increasingly Occurred in Counties that Are More Urbanized, Diverse, and Economically Unequal,* UNC Cecil G. Sheps Center for Health Servs. Research (March 2022), https://www.shepscenter.unc.edu/product/rural-hospital-closures-have-increasingly-occurred-in-counties-that-are-more-urbanized-diverse-and-economically-unequal/. Making the position of rural hospitals even more precarious, the Secretary's undercounting of SSI days improperly reduces, or totally eliminates, crucial funding for these already vulnerable hospitals and their residents.

II. THE SECRETARY'S METHODOLOGY FOR CALCULATING DSH MEDICARE FRACTIONS IS UNLAWFULLY NARROW.

The concession in the Secretary's Brief in Opposition to the Petition for Writ of *Certiorari* ("BIO")—that the Secretary's approach to calculating DSH Medicare fractions actually deviates from the approach as historically implemented by CMS—acknowledges the inherent unworkable complexity of that approach. *See* BIO 16 ("What matters is whether the individual was entitled to an SSI payment for the month, not the timing of the actual

receipt of such payment.").[12] But, even with this concession, the government's litigating position is still, on its face, an unlawfully narrow interpretation of the DSH statute.

Accepting for purposes of argument that "[w]hat matters is whether the individual was entitled to an SSI payment for the month," BIO 16, the Secretary's approach unlawfully excludes codes reflecting circumstances where the individual was obviously "entitled to an SSI payment." This occurs, for example, where payment is due but is not made in a given month because the beneficiary (1) does not have a bank account (*see, e.g.*, Pet'r Br. 10), (2) is considered by SSA to need a representative payee but no payee has yet been designated and direct payment is prohibited under SSA policy (Pet'r Br. 10), (3) is someone for whom SSA does not have a current mailing address (Pet'r Br. 10), or (4) in some circumstances, must repay an SSI overpayment that is larger than, and is entirely offset by, the SSI payment amount (Pet'r Br. 9).

As previewed above, among the myriad SSI codes excluded from the Secretary's three-code policy are those assigned by SSA where the SSI benefit is subject to a "stop payment," which is defined by SSA as follows:

> A **stop payment** is an interruption in payment. It is not a loss of eligibility. Payments may be reinstated for past or current month(s) on a **stop pay**

---

[12] Pet'r Br. 16 ("CMS's 'actual receipt' rule is indefensible and the government does not defend it.").

> record regardless of the period in nonpay. If you find ineligibility in a stop pay period, benefits must be suspended subject to the rules of administrative finality in SI 04070.001.

Social Security Administration, Program Operations Manual System SI 02301.201: Description of SSI Posteligibility (PE) Events (Aug. 30, 2023), https://secure.ssa.gov/poms.nsf/lnx/0502301201#b (bold in original, underlining added). Again, an individual, *ipso facto*, would have to be entitled to an SSI payment in order for such payment to be stopped.

SSA continues (in relevant part, bold in original):

> A stop payment **only** happens when:
>
> • The FO is searching for a representative payee, PSC [i.e., Payment Service Code] **S08**, GN 00502.100, [and]
>
> • A recipient is eligible, but due no payment, PSC **E01**, SI02005.020, ...

Id. Based on this authority, inpatient days for individuals assigned SSA codes S08 and E01 should be included in the numerator of the Medicare fraction under the plain meaning of "entitled to [SSI] benefits."

SSA also has numerous "payment suspension" codes, which are used (emphasis added): "When SSI payments have been temporarily stopped because the recipient is not currently eligible, ***or they were interrupted for other reasons***." SSA - POMS: SI

02301.201 - Description of SSI Posteligibility (PE) Events - 08/30/2023. As noted above, where a recipient is due an SSI payment for a particular month, but SSA does not have a valid address for the recipient or a check is returned for a reason other than address, SSA assigns "payment suspension" codes S06 and S07, respectively. Section SI 02301.201B.2. *See also* Pet'r Br. 10 (SSA may suspend payments if issuing the payment directly to the recipient "would cause substantial harm") 20 C.F.R. §416.611(a),(b) (withholding payment to entitled beneficiaries who have a drug addiction or alcoholism condition or are legally incompetent). Here again, an individual would *ipso facto* have to be "entitled to an SSI payment" in order for such payment to be suspended or "withheld" for these reasons.

As another example, nursing home patients who are simultaneously eligible for both Medicare and Medicaid ("dually eligible") typically lose their SSI payment benefit after 60 days in a nursing home if they have countable income above $30, which is common because Medicaid is paying for 50% or more of their care. *See* Pet'r Br. 45.

Data from two hospitals, one in Indiana and the other in Virginia, show that only 5–15% of their dually eligible nursing home patients on average were being counted in their Medicare fraction numerators when the hospitals' dually eligible nursing home days data was compared to the data from CMS. For example, for one hospital's 2008 DSH calculation, for dually eligible nursing home patients with a length of stay over 30 days, only 1 of 5 such patients, and only 41 of 560 corresponding days were counted in the Medicare fraction

numerator. Among other stays wholly excluded was a patient stay that lasted 367 days.

These dually eligible nursing home patients are obviously of the type that the DSH statute was designed to include because they are low income and sicker than average. Pet'r Br. 45 ("as patients eligible for both Medicaid and Medicare part A, [SSI-eligible patients in Medicaid-paid medical facilities] are generally poorer, have worse health status, and have higher hospitalization rates than other Medicare beneficiaries.") (internal quotations omitted). Yet, as Petitioners explain: when these dually eligible patients "are transferred to a hospital for inpatient care (a common occurrence), they will not count in the Medicare fraction numerator because their SSI payments are $0." *Id.* (internal citations omitted). "But because they are eligible for Medicare part A, they also will be excluded from the Medicaid fraction—meaning they are not counted as low-income at all." *Id.* In short, "[m]ost egregiously, many SSI-eligible, low-income patients will be excluded *because* they need extensive medical care." *Id.* (emphasis in original).

III. THE SECRETARY APPLIES THE NARROW INTERPRETATION OF THE STATUTORY PHRASE "ENTITLED TO [SSI] BENEFITS" USING A DATA-MATCH PROCESS THAT IS PRONE TO ERROR AND LACKS TRANSPARENCY.

The Secretary's unlawfully narrow interpretation of the DSH statute has proven unworkable in practice. Experience has shown that the Secretary has been unable to accurately apply that interpretation when matching Medicare data

with SSI-entitlement data so that the match is done in a way that results in a correct numerator for the Medicare fraction under the Secretary's interpretation. Specifically, hospitals have decades of experience showing that the Secretary has been unable to correctly implement even this unlawfully cramped approach. *See Pomona Valley Hosp. Med. Ctr. v. Becerra ("Pomona")*, 82 F.4th 1252 (D.C. Cir. 2023); *see also Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008), *amended in part*, 587 F. Supp. 2d 37 (D.D.C. Nov. 7, 2008), *judgment entered*, 587 F. Supp. 2d 44 (D.D.C. Dec. 8, 2008). Further, because the Secretary discloses only the *final* results of the data-match process, it is difficult, if not impossible, for hospitals to figure out where the data-match process goes off the rails.

As an important starting point, CMS unilaterally determines Medicare fractions with no input from, or review by, hospitals. CMS does so by matching CMS's Medicare inpatient records with SSA records from an SSI-eligibility data file, which SSA prepares solely for, and then transmits to, CMS. These SSA records identify on a month-by-month basis only those SSI enrollees to whom SSA assigned one of the three CMS-approved SSI payment status codes. *See* 75 Fed. Reg. 50,042, 50,277, 50,663 (Aug. 16, 2010); *see also Baystate Medical Center*, 545 F. Supp. 2d at 25 (stating that the "SSI eligibility data … is prepared solely for CMS's use").

In an effort to provide accountability to hospitals about this data-matching process, Congress required CMS to "arrange to furnish" hospitals participating in Medicare part A with "the data necessary for such hospitals to compute the number of patient days used in computing" their

Medicare fractions. *See* Section 951 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA"), Pub. L. No. 108-173 § 951, 117 Stat. 2066, 2427 (2003) (codified at 42 U.S.C. §1395ww note). However, CMS does not furnish hospitals any of the underlying SSI-eligibility data related to their Medicare inpatients, which is obviously data that is "necessary to" compute their Medicare fractions. Rather, CMS only provides the final results of its match process. 75 Fed. Reg, at 50,280.

In *Pomona*, a DSH hospital suspected "that CMS's [Medicare fraction] determinations were too low [and] sought to redo them." 82 F.4th at 1256. When both CMS and SSA "refused to give [the hospital] any underlying data from the SSI eligibility file…, [the hospital] sought to determine its Medicare fractions with data obtained from state agencies administering two benefit programs that piggyback on SSI." 82 F.4th at 1256. That state Medicaid data revealed thousands more SSI-cash payment days that CMS had failed to include in the hospital's Medicare fraction numerators for fiscal years 2006 through 2008, showing that "[o]ver the three fiscal years at issue, the Medicare fractions determined by CMS were about 20 percent lower than those determined by Pomona…[,which] equates to disputed Medicare reimbursements of over $3 million." *Id.*

Using the state agency data, which incorporated data from SSA itself, the hospital was able to make a *prima facie* showing that CMS had significantly understated the hospital's Medicare fractions due to "inaccurate transmission of data from SSA to CMS, coding errors, or other systemic problems with the

matching process." *Id.* at 1257, 1260. Nevertheless, and without any countervailing evidence, the Secretary's final decision rejected the hospital's administrative challenge to its Medicare fractions. On appeal, the D.C. Circuit (affirming the district court) reversed the Secretary, recognizing that while the hospital "went about as far as it could, in attempting to reverse-engineer the SSI-eligibility data" from state Medicaid agency data, "[o]nly CMS or SSA possess the SSI-eligibility data that would definitively establish the correct numerators" for the hospital's Medicare fractions. *Id.* at 1261.

Crucially, despite acknowledging that hospitals have "the right to appeal" if they believe there are "error[s] from the SSI/MedPAR system data match," *see* 70 Fed. Reg. 47,278, 47,441 (Aug. 12, 2005), the Secretary's policy is not to give hospitals "access to patient-level detail data, including SSI eligibility information." *See* 75 Fed. Reg. at 50,279–280. The Secretary's lack of transparency with the data-match process forces DSH hospitals to divert their time and resources from patient care to constructing data from alternative sources to challenge the Secretary's unlawful implementation of the DSH statute. Although laborious, the process often indicates how far the Secretary's calculations are off-the-mark, even under the Secretary's already cramped statutory reading.

IV. THE MORE STRAIGHT-FORWARD PROGRAM ELIGIBILITY APPROACH WOULD BE EASIER FOR THE SECRETARY TO ADMINISTER AND MORE FAIR FOR HOSPITALS, ESPECIALLY WITH ADDITIONAL TRANSPARENCY.

Pomona shows that the Secretary's method for calculating Medicare fractions is both fraught with error and inappropriately shrouded in secrecy, resulting in wasteful, potentially intractable disputes. In contrast, the simpler approach of basing Medicare fraction determinations on SSI eligibility would not only be consistent with the plain reading of the statutory language "entitled to [SSI] benefits," but would also be (1) far easier for the Secretary to administer, (2) less prone to error, and (3) far more transparent. In fact, this is precisely the approach that the Secretary has used for decades when calculating DSH Medicaid fractions.

The Secretary's Medicare Contractors (not the Secretary) determine the DSH Medicaid fractions using data supplied by hospitals and state Medicaid agencies showing hospital inpatients who were eligible for Medicaid during their inpatient stay. *See* 42 C.F.R. §412.106(b)(4). This Medicaid-eligibility data includes much of the same data that the hospital relied on in *Pomona*, because entitlement to SSI cash payments in California (as is true in the vast majority of states) triggers automatic enrollment in Medicaid. *See State Medicaid Eligibility and Enrollment Policies and Rates of Medicaid Participation among Disabled Supplemental Security Income Recipients*, https://www.ssa.gov/policy/docs/ssb/v76n3/v76n3p17.

html (stating that SSA provides for "automatic Medicaid enrollment of SSI awardees" in more than 30 states). Enrollment in Medicaid, like enrollment in SSI (*see* Pet'r Br. 21–22), tends to be steady and easy to determine.

At the end of their cost reporting periods, hospitals include data in their cost reports identifying all of the then-available Medicaid-eligible days for their DSH Medicaid fraction numerators. The transparency of this process allows hospitals to verify that their DSH Medicaid fractions are calculated accurately and to challenge them meaningfully on appeal, if necessary. *See Sacred Heart Hosp., supra*, ¶83,674, Ctrs. for Medicare & Medicaid Servs.

Similarly, basing Medicare fraction determinations on SSI eligibility, rather than cash payment, would bring much needed simplicity, accuracy, and transparency to CMS's process. The CMS/SSA data-match process would be much simpler – it would be based on the effective date of SSI beneficiary enrollment, rather than having beneficiaries ping-ponging in and out of the Medicare fraction numerators based on the happenstance of their actual receipt of a cash payment in a given month. CMS could also provide hospitals the SSI-enrollment data for the inpatients included in the numerators and denominators of their Medicare fractions so that hospitals could verify the accuracy of CMS's calculations and would not need to file time consuming and expensive appeals simply to try to get access to the data necessary to determine whether their Medicare fractions are correct.

Thus, besides being required by the plain reading of the statute, basing Medicare fraction determinations on SSI eligibility would eliminate the unnecessary complexity and inaccuracy in the Secretary's current determination of Medicare fractions. This approach would, if implemented similarly to the way the agency calculates the Medicaid fraction, bring much needed transparency to the process.

Beyond improving the process, using SSI-enrollment as the metric would provide DSH hospitals with the funding that Congress intended them to have. Doing so also would free up resources hospitals otherwise would have to spend challenging the current approach. This would allow hospitals to focus more closely on providing the care for impoverished patient populations that Congress provided.

CONCLUSION

For the foregoing reasons and those contained in the Brief for Petitioners, the judgment of the court of appeals should be reversed.

Respectfully submitted.

Robert L. Roth
Counsel of Record
Rachel L. Zacharias
David J. Vernon
Kelly A. Carroll
HOOPER, LUNDY & BOOKMAN, P.C.
401 9th Street, N.W.,
Suite 550
Washington, DC 20004
(202) 580-7700
rroth@hooperlundy.com

HOOPER, LUNDY & BOOKMAN, P.C.
Sven C. Collins
999 18TH STREET
SUITE 3000
DENVER, CO 80202

Lloyd A. Bookman
1875 Century Park East
Suite 1600
Los Angeles, CA 90067

Counsel for Amici Curiae

August 14, 2024

APPENDIX

APPENDIX TABLE OF CONTENTS

APPENDIX

Arizona Hospital and Healthcare Association

Arkansas Hospital Association

California Hospital Association

Florida Hospital Association

Georgia Hospital Association

Healthcare Association of Hawaii

Illinois Health and Hospital Association

Indiana Hospital Association

Iowa Hospital Association

Kansas Hospital Association

Louisiana Hospital Association

Maine Hospital Association

Massachusetts Health & Hospital Association

Mississippi Hospital Association

Missouri Hospital Association

New Jersey Hospital Association

Healthcare Association of New York State

Greater New York Hospital Association

North Carolina Healthcare Association

Ohio Hospital Association

The Hospital & Healthsystem Association of Pennsylvania

Tennessee Hospital Association

Texas Hospital Association

Vermont Association of Hospitals & Health Systems

Washington State Hospital Association

West Virginia Hospital Association