

PRRB-DEC, MED-GUIDE, ¶81,450, **Oakwood Hospital & Medical Center (Dearborn, Mich.) v. Blue Cross Blue Shield Ass'n/United Government Services, LLC (Wis.)**, *PRRB Hearing Dec. No. 2006-D2, Case No. 02-1686*, (Nov. 16, 2005)

**Oakwood Hospital & Medical Center (Dearborn, Mich.) v. Blue Cross Blue Shield Ass'n/United Government Services, LLC (Wis.)**

*PRRB Hearing Dec. No. 2006-D2, Case No. 02-1686*, (cost reporting period ending 12/31/1998), Nov. 16, 2005.

### **Medicare: Judicial Review of DSH Determination**

#### **Cost reports, appeals & audits —Payment determinations and appeals procedures —Expedited judicial review. —**

A provider who had established that CMS failed to include 72 SSI days from the calculation of the provider's disproportionate share hospital (DSH) adjustment was not entitled to expedited judicial review (EJR). EJR is not available when: the Provider Reimbursement Review Board (PRRB) has authority to decide the legal issues or there are disputed facts for the PRRB to decide. Despite the provider's argument, under the applicable law and published policy, the PRRB had authority to review the calculations, including the number of SSI days and to grant the relief requested, recalculation of the fraction. There was no evidence supporting the provider's claim that CMS had refused to disclose data needed for the PRRB to resolve the issue. No statute, regulation or ruling prohibited CMS from reconsidering its calculations or disclosing the number of dual eligibles who also were eligible for SSI. Although there was no dispute as to the number of SSI-eligible patients, the number who also were dual eligibles was a fact in dispute, so that the requirements for EJR were not met.

See [¶7659](#).

#### **[Text of Decision]**

##### **Issue**

Is expedited judicial review (EJR) appropriate for the question of whether the Centers for Medicare & Medicaid Services (CMS) undercounted the patient days for patients entitled to Supplemental Security Income (SSI) which is used to compute the disproportionate share (DSH) adjustment?

##### **Statutory and Regulatory Background**

This dispute arises under the Federal Medicare program administered by CMS, formerly the Health Care Financing Administration (HCFA). The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. CMS is the agency of the Department of Health and Human Services responsible for administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law, regulations and interpretative guidelines published by CMS. *See*, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20-413.24.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS).<sup>1</sup> The regulations governing PPS require a provider of inpatient hospital services to file an annual cost report with the fiscal intermediary.<sup>2</sup> The fiscal intermediary — typically an insurance company — then audits the cost report and makes a final determination of the total amount of reimbursement owed by Medicare to the provider for that fiscal year. The total amount of reimbursement due the provider is set forth by the intermediary in a Notice of Program Reimbursement (NPR).<sup>3</sup> A provider that is dissatisfied with that determination may timely file a request for hearing before

the Provider Reimbursement Review Board (Board).<sup>4</sup>

### ***Disproportionate Share Hospital and Supplemental Security Income Background***

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.<sup>5</sup> This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased reimbursement to hospitals that serve a “significantly disproportionate number of low-income patients.”<sup>6</sup> Whether a hospital qualifies for the DSH adjustment, and how large an adjustment it receives, depends upon the hospital's “disproportionate patient percentage.”<sup>7</sup>

The disproportionate share percentage is the sum of two fractions expressed as a percentage.<sup>8</sup> The first fraction, referred to as the “Medicare fraction,” is determined using a formula based on patient days. The numerator consists of patient days for which patients were entitled to both SSI and Medicare Part A. The denominator is the number of patient days for all patients entitled to Medicare Part A.<sup>9</sup> The second fraction is the Medicaid fraction and is not in dispute in this appeal.

To determine the numerator of the Medicare fraction for a particular hospital, CMS obtains a data file containing SSI eligibility information from the Social Security Administration. CMS matches the SSI eligible individuals against its own data file (MedPAR file) that contains details of Medicare inpatient hospital stays. The match of the hospital days furnished by a hospital to Medicare beneficiaries that are also eligible for SSI constitutes the numerator of the DSH fraction. This number is then divided by the total number of days for which Medicare inpatient hospital services are furnished to all Medicare Part A beneficiaries (the denominator of the DSH fraction). The Provider contends that CMS undercounted its patient days for patients entitled to SSI, resulting in its DSH adjustment for fiscal year 1998 being less than it should have been.

The Provider in this case is represented by Steven Roosa, Esq., of Reed Smith, LLP, Princeton, New Jersey. The Intermediary is represented by Bernard M. Talbert, Esq., of Blue Cross Blue Shield Association, Chicago, Illinois.

### ***Statement of the Case and Procedural History***

The Provider filed this appeal on March 28, 2002, from a Notice of Program Reimbursement dated September 30, 2001. The appeal initially involved issues related to graduate medical education reimbursement. On February 5, 2003, the Provider added the issue of whether the SSI patient days used to calculate the DSH adjustment were correct. *See*, 42 U.S.C. §1395ww(d)(5)(F)(vi)(I) (the numerator of the DSH fraction consists of hospital patients days for such patients who were entitled to Medicare Part A and SSI). The graduate medical education issues have been settled, so the only issue in dispute in this case is the SSI patient days.

On July 13, 2005, the Provider requested that the Board grant EJR over the SSI issue asserting that the Board lacks the authority to decide the issue of whether the Medicare statute and regulations allow a hospital to challenge the SSI fraction. In response to the request for EJR, the Board sought additional information from the Provider regarding its request for EJR on July 20, 2005. This request for additional information affected the 30-day time limit required for a Board response to the request for EJR. *See*, 42 C.F.R. §405.1842(d)(3).

In its request for additional information, the Board pointed out that there appeared to be factual issues for it to resolve and that the Provider did not provide a legal basis for its assertion that the Board does not have the authority to decide the issue, i.e., there was no legal authority regarding the Board's being bound by CMS' policy statements. The only authority cited for the Provider's position that the Board cannot decide the question of whether the DSH adjustment should be recalculated using later data obtained from CMS, is based upon arguments set forth in another Federal court case and stipulations in another case pending before the Board. It was also unclear how the referenced letter from a CMS employee stating that providers

cannot calculate their own SSI percentage is applicable. It did not appear that the Provider wished to calculate its own SSI percentage; rather it appeared that the Provider wished to have CMS recalculate the percentage using the Provider's conclusions after evaluating new SSA and MedPAR data. The Provider was asked to further explain the applicability of these arguments to support its position that the Board does not have the authority to decide the legal question presented.

### ***Provider's Response to Request for Comments***

The Provider responded on October 14, 2005 (received October 17, 2005). The parties stipulated to the facts regarding two categories of patient days at issue. The parties stipulated that there are 72 patient days for which patients were entitled to SSI but were not included in CMS' calculation of the DSH fraction. The parties also agreed that, without more information from CMS, 170 dual eligible patient days identified by the Provider cannot be included in the SSI calculation.

The Provider indicated that the only dispute with the 72 SSI days is whether CMS must revisit its calculation once it is made. The initial EJR request included a stipulation submitted in *Baystate Medical Center*, PRRB case numbers 96-1822, 97-1579 *et al.*, and signed by counsel from the Office of General Counsel, which states that, among other things, the accuracy of the SSI fraction could not be the subject of a Board hearing.<sup>10</sup> The Provider admits that this stipulation is not the legal basis for denying that the Board has the authority to hear a case involving the calculation of the SSI fraction, rather 42 C.F.R. §412.106 is the authority. Section 412.106(b)(2)(i)(B) states that CMS "(i) determines the number of patient days ... [that](B) are furnished to patients who during that month were entitled to both Medicare Part A and SSI." The Provider asserts that the Board can only review intermediary determinations;<sup>11</sup> therefore, only intermediary reimbursement and total determinations are subject to review. The Provider believes that the Board cannot review CMS' determinations such as the SSI day count, nor can the Board order CMS to recalculate the SSI fraction. Further, the Provider asserts the Board cannot review CMS' decision<sup>12</sup> not to release the SSA files from which the data is taken to determine SSI eligibility.

### ***Findings of Fact, Conclusions of Law and Discussion***

The Board, after consideration of the Medicare law, the Provider's comments and the stipulations of the parties, hereby denies the Provider's request for EJR. When determining whether EJR is appropriate, the Board must consider:

- (1) The controlling facts in the case;
- (2) The applicability of law, regulations or HFCA rulings;
- (3) Whether there are factual issues for the Board to resolve; and
- (4) Whether there are legal issues within the authority of the Board to decide.

*See*, 42 C.F.R. §405.1841(f). The Board has determined that, under the facts of this case, there is no statute, regulation or CMS ruling that specifically precludes granting the remedy sought by the Provider.

In this case, the Provider takes the position that the Board's authority is limited to the decision made by the Intermediary and there is no authority over CMS decisions. The Board disagrees. The Board has the authority and routinely hears cases on various exemption and exception determinations in which CMS determines whether a provider is entitled to additional reimbursement. In this particular case, the language of the August 18, 2000 Federal Register, which deals with release of information under the "routine use" exception of the Privacy Act, contradicts the Provider's position. The Federal Register permits disclosure of MEDPAR data used in the calculation of the DSH adjustment where:

... a hospital that has an appeal properly pending before the [Board] or before an intermediary, on the issue of whether it is entitled to disproportionate share hospital payments, or the amount of such payments.

65 Fed. Reg. 50548, 50549 (August 18, 2000). Clearly, if the Board had no authority to review and make a decision regarding whether a provider is “entitled to disproportionate share payments, or the amount of such payments,” then the right of appeal to the Board would be meaningless.

### ***72 Additional Days***

There are no facts in dispute regarding the additional 72 days that the Provider has identified as additional SSI days. The issue is purely a legal question of whether CMS must recalculate the DSH adjustment using additional days. There is no statute, regulation or ruling that precludes CMS from recalculating the DSH adjustment. Nor is there a statute, regulation or ruling that requires CMS' use of a number in the DSH calculation which is proven incorrect by virtue of a successful appeal.

### ***Dual Eligible Days***

The Board finds the statement the Provider submitted regarding dual eligible days confusing. In Stipulation number 5, the parties state that “CMS ... provided Oakwood with an additional *data file that CMS obtained directly from SSA.*” (emphasis added) However, on pages 2-3 of the Provider's “Supplemental Submission Regarding [EJR],” the Provider states that “CMS has decided not to provide the SSA data files” and attaches Exhibit B, an e-mail from Robyn Thomas of CMS, as evidence of CMS' position. Regardless of the confusion created by these conflicting statements, based upon the Provider's characterization of the facts, a factual dispute clearly exists: were any of the 170 dual eligibles also SSI eligible. To grant a request for EJR there must be no facts in dispute.

The Provider alleges that it is impossible for the Board to resolve the factual disputes because CMS will not disclose the data necessary to permit the Board to resolve the issue. While this may eventually prove to be true, there is no evidence in the record to support this position and it does not relieve the parties of their obligation to follow the Board's procedures, such as requesting discovery or subpoenas, to attempt to obtain the critical information. The Secretary, in the Federal Register discussing the routine use of MedPAR data used to calculate the DSH adjustment, stated that:

Disclosure under this routine use shall be for the purpose of assisting the hospital to verify or challenge [CMS'] determination of a hospital's SSI ratio (i.e., the total number of Medicare days compared to the number of Medicare/SSI days), and shall be limited to *data concerning the SSI eligibility status* of individuals who had stays at the inpatient hospital facility during the period that is relevant to the appeal. (emphasis added)

65 Fed. Reg. *supra*. The Secretary's policies as set out in the Federal Register regarding the nature and scope of an appeal challenging the SSI fraction appear to contradict the Provider's position that the Board has no authority to review DSH SSI percentage determinations or that CMS will refuse to furnish information necessary to make a correct determination. Under these circumstances, EJR is inappropriate.

### **Decision of the Board**

The Provider's request for EJR is hereby denied. The Board finds that it can grant the remedy sought by the Provider.

This decision is not subject to review under the provisions of 42 C.F.R. §405.1875. *See*, 42 C.F.R. §405.1842(g)(4).

\*\*\*\*\* prospective payment system from the total reimbursable costs claimed in the aggregate by the providers; and

(iii) The adjusted total reimbursable costs due the providers (in the aggregate) on a reasonable cost basis under other than the prospective payment system from the total reimbursable costs claimed in the aggregate by the providers.

(2) *Providers not under prospective payment.* For providers that are not paid under the prospective payment system, by deducting the adjusted total reimbursable program costs due the providers (in the aggregate) on a reasonable cost basis from the total reimbursable costs claimed in the aggregate by the providers.

[49 FR 323, Jan. 3, 1984]

§405.1841 Time, place, form, and content of request for Board hearing.

(a) *General requirements.* (1) The request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider or, where notice of the determination was not timely rendered, within 180 days after the expiration of the period specified in §405.1835(c). Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position. Prior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary's determination with which it is dissatisfied and furnish any documentary evidence in support thereof.

(2) Effective April 20, 1983, any request for a Board hearing by providers that are under common ownership or control (see §413.17 of this chapter) must be brought by the providers as a group appeal (see §405.1837(b)) with respect to any matters at issue involving a question of fact or of interpretation of law, regulations, or HCFA Rulings common to the providers and for which the amount in controversy is \$50,000 or more in the aggregate. If a group appeal is filed, the provider seeking the appeal must be separately identified in the request for hearing, which must be prepared and filed consistently with the requirements of paragraph (a)(1) of this section.

(b) *Extension of time limit for good cause.* A request for a Board hearing filed after the time limit prescribed in paragraph (a) of this section shall be dismissed by the Board, except that for good cause shown, the time limit may be extended. However, no such extension shall be granted by the Board if such request is filed more than 3 years after the date the notice of the intermediary's determination is mailed to the provider.

[48 FR 39836, Sept. 1, 1983, as amended at 51 FR 34793, Sept. 30, 1986]

§405.1842 Expediting Board proceedings.

(a) *Basis and purpose.* This section implements section 1878(f)(1) of the Social Security Act, as amended by section 955 of Pub. L. 96-499 (42 U.S.C. 1395oo(f)(1)). The amendment provides an opportunity for providers to obtain expedited administrative review when the Board determines that it does not have the authority to decide a question of law, regulation, or HCFA Ruling relevant to the case (see §405.1867).

(b) *Basic rule.* (1) Except as provided in paragraph (b)(4) of this section, a provider may submit a written request to the Board, with supporting documentation, to determine whether the Board has the authority to decide a question of law, regulations, or HCFA Rulings relevant to and controlling upon an issue to be reviewed by the Board. The Board is required to make an expedited review determination in writing, either denying or granting the request, within 30 days after the date of receipt of the request, as defined in paragraph (1) of this section. The Board may also issue a determination on its own motion that it lacks

authority to decide a question of law, regulations or HCFA Rulings.

(2) The Board must determine that the provider (including each provider in a group appeal) is entitled to a hearing under section 1878(a) of the Act before making the determination described in paragraph (b)(1) of this section. Thus, the provider must file (or have already filed) a written request for a Board hearing that meets the requirements in §405.1841. The information and documentation required with respect to the filing of a request for a hearing is used by the Board to determine jurisdiction under section 1878(a) of the Act.

(3) A provider's request for an expedited review determination cannot be considered to be filed with the Board, nor can the 30-day time period during which the Board is required to make an expedited review determination begin, until such time as the Board accepts jurisdiction of the case.

(4) Proceedings conducted by the Board under an authority other than section 1878(a) of the Act and §§405.1835 through 405.1873 of this subpart are not hearings for purposes of this section and are not subject to the expedited Board proceedings set forth in this section. For example, proceedings concerning reimbursement for capital expenditures conducted under section 1122(f) of the Act and §405.1890 of this subpart are not hearings for purposes of this section. (Section 1122(f) specifically bars any administrative or judicial review.)

(c) *“Own motion” review.* If the Board is considering issuing a determination on its own motion that it lacks the authority to decide a question of law, regulations, or HCFA Rulings, it will notify the provider and intermediary of its proposed determination and allow them a reasonable period of time to file evidence or arguments either to support or oppose the proposed determination.

(d) *Provider requests.* (1) If a provider seeks an expedited Board proceeding, it must —(i) File its appropriately documented request in writing with the Board; and

(ii) Send a copy of the request and documentation simultaneously to the intermediary.

(2) The request to the Board for an expedited review determination must —(i) Identify the issues and the controlling law, regulation or HCFA Ruling for which the Board is to make a determination;

(ii) Allege and demonstrate that there are no factual issues in dispute;

(iii) Contain an explanation of why the provider believes the Board cannot decide the legal issue or issues that are in dispute; and

(iv) Include all other information or details that support the request.

(3) If the information in the provider request is insufficient for the Board to determine whether it has the authority to decide an issue, the Board will request more information from the provider. Such a request will affect the 30-day time limit as provided in paragraph (i) of this section. If the provider does not send more information or sends inadequate information, the Board will determine that it has the authority to decide the issue and will begin the regular procedure for a hearing.

(e) *Intermediary participation* (1). After receiving a copy of the provider's request for an expedited review determination, the intermediary may send comments to the Board on the provider's request and supporting documentation. The intermediary will send a copy of its comments to the provider simultaneously.

(2) If the intermediary's comments raise questions about the provider's request for expedited review, the Board may request additional information from the provider as provided in paragraph (d)(3) of this section.

(f) *Criteria for a Board determination.* The Board will review all documentation forwarded by the provider and the intermediary relevant to the request for a Board determination concerning the Board's authority to decide an issue. In its review, the Board will consider —

- (1) The controlling facts in the case;
- (2) The applicability of law, regulations, or HCFA rulings;
- (3) Whether there are factual issues for the Board to resolve; and
- (4) Whether there are legal issues within the authority of the Board to decide.

(g) *Board determination.* (1) Within 30 days after the date of receipt (as defined in paragraph (i) of this section) of a provider's request and all necessary documentation the Board will issue a determination concerning its authority to decide the question of law, regulations, or HCFA Rulings relevant to the issues identified by the provider in its request.

(2) If there are factual or legal issues in dispute on an issue within the authority of the Board to decide, the Board will not make an expedited review determination on the particular issue but will proceed with a hearing. The Board has the authority to decide when two or more issues are sufficiently related to preclude separation for purposes of an expedited review determination on one or more of them and a hearing on the other or others.

(3) The Board will promptly notify the provider in writing of its determination and will send a copy of the determination to the intermediary.

(4) The Board's determination concerning its authority or its lack of a determination is not subject to the Secretary's review under §405.1875.

(h) *Effect of a Board decision.* (1) The Board's determination, issued on its own motion or at the request of a provider, that it lacks authority to decide a question of law, regulations or HCFA Rulings is a final decision permitting a provider to seek judicial review with respect to the matter or matters in controversy contained in the determination, within 60 days of the date of the Board's determination.

(2) After the Board has determined that it does not have the authority to decide an issue, the provider will not be granted a hearing on the same issue.

(3) If the Board fails to issue an expedited review determination within 30 days of the date of receipt of a complete request (as determined under paragraph (i) of this section), the provider may, within 60 days from the end of that period, seek judicial review of the matters for which it requested the Board's determination.

(4) If the Board fails to make an expedited review determination within the required 30 days, it will begin regular hearing procedures as though it has the authority to decide the issue.

(5) If the provider seeks judicial review because the Board fails to make a determination as provided in paragraph (g)(1) of this section, it should notify the Board at the time it files for judicial review. The Board will not hold a hearing, even if one has been scheduled, on the matter or matters for which the provider is seeking judicial review.

(6) The Board's determination does not affect the right of the provider to a Board hearing for issues for which the provider did not request expedited review, or for which the Board determines it does have the authority to decide, or for which the Board did not make a determination and the provider did not request judicial review.

(i) *Date of receipt.* For purposes of this section, the date of receipt of the provider's request is the later of —

(1) The actual date of receipt by the Board of the information required under paragraph (d)(2) of this section, or of additional information requested by the Board under paragraph (d)(3) of this section, whichever the Board receives later; or

(2) The date indicated on the Board's written notification to the provider that the Board has accepted jurisdiction of the case.

(j) *Examples.* Below are examples showing when a provider may expect to receive an expedited review determination, in relation to various circumstances affecting its request for the determination.

(1) The provider requests a hearing and expedited review at or about the same time. If all information is complete, the Board could send notification that it has accepted jurisdiction of the case and the expedited review determination simultaneously.

(2) The provider requests both a hearing and an expedited review determination, and supplies complete information. The Board accepts jurisdiction but, for example, because of the complexity of the case, the Board makes its expedited review determination within 30 days after it has accepted jurisdiction.

(3) The provider requests both a hearing and an expedited review determination, but the request for a hearing does not contain enough information for the Board to determine jurisdiction. The Board would request more information to determine jurisdiction and would make its expedited review determination within 30 days after it has accepted jurisdiction.

(4) The provider requests both a hearing and an expedited review determination, but does not send enough information for the Board to make an expedited review determination. Assuming the Board accepts jurisdiction, the Board would request more information about the request for expedited review and make its determination within 30 days after it receives the additional information.

(5) The provider requests an expedited review determination after the Board has accepted jurisdiction. The Board would make its determination within 30 days after receipt of an appropriately documented request for an expedited review determination.

[47 FR 31690, July 22, 1982, as amended at 48 FR 22925, May 23, 1983]

§405.1843 Parties to Board hearing.

(a) The parties to the Board hearing shall be the provider, the intermediary (including the Health Care Financing Administration when acting directly as intermediary) that rendered the determination being appealed (see §405.1833), and any other entity found by the intermediary to be a related organization of such provider.

(b) Except as provided in paragraph (a), neither the Secretary nor the Health Care Financing Administration may be made a party to the hearing. However, the Board may call as a witness any employee or officer of the Department of Health and Human Services having personal knowledge of the facts and the issues in controversy in a hearing pending before the Board and may call as a consultant to the Board in connection with any such hearing any individual designated by the Secretary for such purpose. (See §405.1863.)

§405.1845 Composition of Board.

(a) The Board will consist of five members appointed by the Secretary. All shall be knowledgeable in the

field of cost reimbursement. At least one shall be a certified public accountant. Two Board members shall be representative of providers of services.

(b) The term of office for Board members shall be 3 years, except that initial appointments may be for such shorter terms as the Secretary may designate to permit staggered terms of office. No member shall serve more than two consecutive 3-year terms of office. The Secretary shall have the authority to terminate a Board member's term of office for good cause.

(c) One member of the Board shall be designated by the Secretary as Chairman thereof and shall coordinate and direct the administrative activities of the Board, and shall have such other authority which may be granted to him by the Board.

(d) A quorum shall be required for the rendering of Board decisions. Three members, at least one of whom is representative of providers of services, shall be required to constitute a quorum. The Chairman of the Board, with approval of the provider, may designate one or more Board members to conduct any hearing and to prepare a recommended decision (where less than a quorum conducts the hearing). (See §405.1869.)

[39 FR 34515, Sept. 26, 1974, as amended at 41 FR 52051, Nov. 26, 1976. Redesignated at 42 FR 52826, Sept. 30, 1977]

#### §405.1847 Disqualification of Board members.

No Board member shall join in the conduct of a hearing in a case in which he is prejudiced or partial with respect to any party or in which he has any interest in the matter pending for decision before him. Notice of any objection which a party may have with respect to a Board member shall be presented in writing to such Board member by the objecting party at its earliest opportunity. The Board member shall consider the objection and shall, in his discretion, either proceed to join in the conduct of the hearing or withdraw. If he does not withdraw, the objecting party may petition the Board, presenting its objection and reasons therefor, and be entitled to a ruling thereon before the hearing can proceed.

#### §405.1849 Establishment of time and place of hearing by the Board.

The Board shall fix the time and place for the hearing and shall mail \*\*\*\*\*

<sup>1</sup> 42 U.S.C. §1395ww(d).

<sup>2</sup> 42 C.F.R. §413.20(b).

<sup>3</sup> 42 C.F.R. §405.1803(a)(2).

<sup>4</sup> 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835- 405.1841.

<sup>5</sup> 42 U.S.C. §1395ww(d)(5).

<sup>6</sup> 42 U.S.C. §1395ww(d)(5)(F)(i)(I).

<sup>7</sup> 42 U.S.C. §1395ww(d)(5)(F)(v).

<sup>8</sup> 42 U.S.C. §1395ww(d)(5)(F)(vi).

<sup>9</sup> 42 U.S.C. §1395ww(d)(5)(F)(vi)(I)

<sup>10</sup> Provider's July 13, 2005 Request for Expedited Judicial Review, Ex. 5 at 2.8 (since the inception of the DSH program, CMS has computed the SSI fraction) and 3.3 (in 1995 CMS (Nancy Edwards, a CMS employee) wrote a letter stating that no provider can calculate its own SSI percentage).

<sup>11</sup> 42 C.F.R. §405.1801(a)(1)

<sup>12</sup> Provider's October 14, 2005 Supplement Submission Regarding [EJR] Ex. B (e-mail from Robyn Thomas, Ph.D., Director, Division of Quality Coordination and Data Distribution, CMS, (the SSI eligibility file is not covered by the routine use)).