NURSING AND ALLIED HEALTH EDUCATION: CMS SHOULD NOT CLAW BACK PRIOR PAYMENTS

On August 21, 2020, CMS issued Transmittal No. 10315, Change Request 11642, directing Medicare Administrative Contractors ("MACs") to use revised figures to recalculate past Medicare Advantage (MA)-related payments for nursing and allied health education ("NAHE"). If implemented according to the August 21 instructions, the revisions will lead MACs to recoup $50 million - $100 million a year, for each year stretching back as much as one or two decades, from hospitals that train nurses. CMS's revisions will also reduce NAHE payments by that scale for this year and every year going forward. As this memorandum explains, CMS need not retroactively alter the NAHE payments related to MA care, nor should it as the hospitals relied on such funding in good faith in helping to train and develop nurses critical to our national healthcare system.

BACKGROUND

Before Medicare Advantage was established in the late 1990s, a hospital that trained medical residents would receive additional payments, alongside its fee-for-service ("FFS") payments for inpatient care, to cover the cost of medical education (direct graduate medical education or "DGME," and indirect GME). Hospitals that trained nurses received NAHE payments that were similar in concept to DGME, though different in formula.

Once Medicare Part C, now known as MA, was established, hospitals received payments for some patient care from MA insurers, rather than through the FFS system. Congress recognized that this shift in payment mechanisms would reduce DGME and NAHE payments, and that those payments would need to be supplemented to continue providing proper reimbursement for the important training services that these hospitals provide. In 2000, Congress mandated supplemental payments. For NAHE, the supplemental payment would be based on a hospital's overall NAHE payment, and on an overall payment "pool" that CMS would set, not to exceed $60 million.[1] A 2001 amendment changed the statutory formula to its current text, at 42 U.S.C. § 1395ww(l), in which a hospital's annual total MA patient days is also an important factor.

CMS adopted regulations implementing the NAHE MA supplement in 2000 and 2001. In those rulemakings, CMS explained that it would determine the amount of the pool in advance for each year, through a notice-and-comment rulemaking. 65 Fed. Reg. 47,026, 47,037 (Aug. 1, 2000). CMS said the pool is "an estimated dollar figure, a number that is plugged into a formula to calculate the amount of additional payments," and not "a discrete fund of money that is set aside in order to make the additional payments." *Id.*

The regulation sets out CMS's formula for calculating NAHE MA supplemental payments. In a given calendar year, the MAC calculates a hospital's total NAHE payment from two years

[1] "Such ratio [comparing MA supplemental DGME payments to ordinary DGME payments in the FFS system] shall be applied to the Secretary's estimate of total payments for nursing and allied health education determined under section 1395x(v) of this title for portions of cost reporting periods occurring in the year to determine a total amount of additional payments for nursing and allied health education to be distributed to hospitals under this subsection for portions of cost reporting periods occurring in the year; except that in no case shall such total amount exceed $60,000,000 in any year." 42 U.S.C. § 1395ww(*l*)(2)(B).

previously; the hospital's total MA patient days from that two-year-old period; and the hospital's total patient days from that period. The ratio of the hospital's MA days to its overall patient days is multiplied by its total NAHE payment to form its "MA proportion." CMS said in the regulation it would calculate the nationwide total Part C days, the nationwide total patient days, and the nationwide total NAHE payments, to form a nationwide aggregate "MA proportion." A hospital's MA proportion is divided by the nationwide MA proportion, and that ratio is multiplied by the pool; the result—again, using the two-year-old figures—is the hospital's additional MA-related NAHE supplemental payment in a calendar year. 42 C.F.R. § 413.87.

In a 2003 instruction, Transmittal A-03-043, Change Request 2692, CMS set out the figures for the first year of the supplemental payments program. The pool to be used for payments in calendar year 2001 was $43.6 million. The nationwide total of NAHE payments, calculated from 1999 data, was $204.8 million. The total patient days was 56.8 million, and the total MA days was 1.7 million. Thus the "nationwide MA proportion" was $6.1 million.

Under the statute, CMS is also required to reduce overall MA DGME payments by the amount of the "pool." In that 2003 instruction, CMS calculated the MA DGME reduction to be 14.1% of overall MA DGME payments for each hospital that received such payments.

For 17 years after that, CMS did not provide fresh values for any of these figures. Our understanding is that MACs continued to use the figures from the 2003 instruction to calculate NAHE supplemental payments and MA DGME reductions.

This year, recognizing the situation, CMS issued its new instruction providing figures for years back to 2002. The reduction to DGME payments is much lower in every year, ranging from 4% to 7%. The pool increases from $43 million over the first few years and is $60 million for every year since 2009. But the "nationwide MA proportion" increases even more dramatically. For 2018, it is $34.6 million, nearly six times larger than the amount in the 2003 transmittal.

CMS further instructed MACs to recalculate the payments for hospitals for all cost reports that can be reached—either because they are still open, or because they are within three years of closing—and reduce the NAHE MA supplemental payments in accordance with the new figures. For example, consider a hospital that had a "MA proportion" for its 2018 calculation of $10,000 (the amount used in the example in the original 2003 instruction). Under the figures that MACs have been using, that hospital would get a NAHE supplemental payment of $71,179. Under the revised figures, that hospital would get a payment of $5,766 instead. Because hospitals have already received the amounts for those past years, CMS's latest directive states that it is now requiring the hospitals to *pay back* these significant amounts.

Overall, the increase in the nationwide MA proportion is the inevitable result of growth in the Medicare Advantage program. In 2000, 6-7 million people, representing 15%-18% of Medicare beneficiaries, were enrolled in the program. As of 2019, Advantage has 22 million enrollees, representing 34% of Medicare beneficiaries. MA services do indeed represent a larger proportion of hospital care. Conversely, the growth in Medicare Advantage has made the NAHE MA supplement

more important for hospitals that receive it, because the shift of patients from fee-for-service ("FFS") care to MA care leads to a long-term reduction in FFS-linked NAHE payments.[2]

ANALYSIS

I. CMS SHOULD NOT RECOVER PAYMENTS ALREADY MADE USING THE PREVIOUS FIGURES.

The most immediate impact of the August 21 instruction is that MACs will claw back payments previously made, stretching back years, that they had calculated using the previous figures from the 2003 instruction. CMS does not have to do this, and in fact it is not allowed to do it.

A. CMS is not obligated to recover past payments that were based on CMS's notices and calculations.

MACs calculated payments in past years in accordance with the instructions and figures that were available from CMS at the time. These payments involved no misconduct or misrepresentation by hospitals or by MACs, and no misuse of appropriations by CMS. If CMS applied the statute incorrectly by not providing updated figures, that error does not necessarily have to be corrected by recovering past payments.

1. The past payments did not exceed appropriations.

From the outset, CMS has said that the "pool" is only a calculation figure, not a fixed pot of money. Thus, as CMS has interpreted the statute, the $60 million limit is an instruction about how to calculate payments, rather than an actual limit on spending. We take for granted that is CMS's view, because if CMS thought the $60 million was an appropriations constraint then the past payments would have violated the Anti-Deficiency Act and CMS would have reported the excess to GAO. The statute is consistent with CMS's past interpretation.

In other situations involving erroneous payments, CMS has consistently taken the position that it does not have an absolute obligation to go back to adjust payments to be within statutory limits; and courts have agreed. For example, for outlier payments, the statute says "[t]he total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent" of total DRG payments. 42 U.S.C. § 1395ww(d)(5)(A)(iv). CMS has long interpreted that to mean it has to choose figures that it believes will likely result in total payments in the 5 to 6 percent range. Its longstanding position is that it is not required to recover payments if they end up above 6 percent or make additional payments if they end up below 5 percent, and the D.C. Circuit has repeatedly approved that view. *County of Los Angeles v. Shalala*, 192 F.3d 1005 (D.C. Cir. 1999); *Banner Health v. Price*, 867 F.3d 1323 (D.C. Cir. 2017). As another example, in the recent "two-midnights" litigation, the court held that CMS had improperly adopted a policy that reduced PPS rates. CMS came up with a practical solution that did not pay hospitals in actual conformance with the statute, and the D.C. Circuit found that acceptable. The lesson from these cases is clear for the NAHE MA supplement:

(a) CMS was correct in its original interpretation that the reference to $60 million is not an

[2] A hospital receives payment for the costs of NAH education through its FFS payments, and those costs are apportioned for FFS utilization. 42 C.F.R. § 413.85(d)(2)(iv). MA payments do not necessarily cover the costs of education.

appropriations limit. It is simply an instruction about how CMS should calculate the amount of the supplemental payments.

(b) If CMS has made or specified that calculation incorrectly, it has no duty to claw back amounts that were paid under the erroneous calculation.

2. Hospitals did nothing wrong.

This is not a situation where hospitals were submitting inaccurate information, gaming the system, or otherwise taking improper advantage of the rules. Hospitals submit their overall cost report data, including FFS claims and the rest. They don't calculate and claim the NAHE supplemental payments. MACs calculate those amounts and make the payments. And they did that accurately under the information available from CMS at the time. Also, hospitals had no real way to know the total amount of payments. A hospital would have had no way, short of analyzing all the HCRIS data, to see that the aggregate overall supplemental payments were more than what CMS expected. There was no misconduct here for which CMS should impose consequences, and there were no amounts improperly claimed for which CMS should demand repayment. This is purely a matter of amounts that were paid that, in retrospect, would have been paid in lesser amounts if CMS had calculated the figures differently at the time.

B. The regulation does not permit CMS to reclaim NAHE supplemental payments made in past years.

The NAHE MA regulation operates in real time. It says that "each calendar year" a MAC is supposed to calculate the NAHE supplemental payments using the hospital's data from the two-year-old settled cost reports. The point of using the two-year-old cost reports is that a MAC can calculate and remit the payments in the course of current operations. The regulation about interim payments and retroactive adjustments, 42 C.F.R. § 413.87, refers to payments that are based on data about the cost reporting period at issue, and those adjustments are necessary because the relevant final information is not known until the cost reporting period is over and the cost reporting and review process is over. In contrast, the NAHE MA supplemental payments in a given year do not require or depend on data from that year, precisely so that the payments can simply be made, based on settled data, and be final.

For CMS's calculation of the aggregate figures, CMS emphasized that this model is meant to be current. The regulation says that "CMS will determine, using the best available data," the various figures across all hospitals "for all cost reporting periods ending in the fiscal year that is 2 years prior to the ***current*** calendar year." 42 C.F.R. § 413.87(e)(3) (emphasis added). And CMS "will determine" the nationwide aggregates "for all cost reporting periods ending in the fiscal year that is 2 years prior to the ***current*** calendar year." *Id.* § 413.87(e)(4) (emphasis added).

The regulation, and the whole model for NAHE MA supplemental payments, requires CMS to determine the nationwide figures each year, for the *current* year—so that MACs can make their payments. The calculation is not required to be precise or accurate; CMS has committed only to using "the best available data," a phrase that signals the calculation does not need to be precise. What CMS cannot do, under the regulation, is calculate, in a given year, what the figures were for 3, 5, 10, or 18 years ago. The recent August 21 directive was not a calculation of the nationwide figures for the "current calendar year." It was a recalculation of figures for nearly two decades past. That long lookback is not consistent with the plain language of the regulations.

C. The Medicare Act does not permit CMS to recalculate the nationwide figures retroactively.

Hospitals need to know how to plan their operations, including their nursing training programs. Those programs do not earn revenue directly through fee-for-service, but Congress has provided support through NAHE payments and NAHE MA supplements. Congress understood that hospitals would need to know in a given year what amount of those supplemental payments they could expect; that is why the statute directs CMS to base a hospital's current-year payment on the two-year-old data, which would be settled by the time of the payments. CMS understood this point when it adopted the regulation, given that the regulation speaks of determining the amounts for a "current" calendar year using the two-year-old data.

The recent directive would radically change the rules under which hospitals were paid for two decades, after they already undertook the activities and trained the nurses. Had CMS told hospitals in a given year that the nationwide MA proportion—the denominator in the calculation of their payments—would increase from $6 million to $36 million, hospitals would surely have changed their operations. Indeed many are going to be forced to cut back their programs now, for exactly that reason. But they ran the programs, and trained the nurses, based on the payment rules that they had.

The Medicare Act, as interpreted in *Bowen v. Georgetown Hospital*, 488 U.S. 204, 214 (1988), does not allow CMS to change the rules retroactively like that. The statute says CMS can make adjustments for overpayments, but there were no overpayments here. The payments made were in accordance with the instructions available at the time, using nationwide figures that CMS simply had not updated as it originally meant to do.

D. CMS cannot establish the nationwide figures without notice and comment.

When CMS issued its original instructions in 2003, it was common for CMS to issue rules like that simply through directives. We now know that all substantive legal standards, even those framed as interpretive, must go through notice and comment. The determination of the nationwide MA proportion and the other nationwide figures used for calculating NAHE supplemental payments is a substantive legal standard. It changes the amount of payments that hospitals are legally entitled to. And it is not simply a ministerial calculation. Under the regulation, CMS uses the "best available data"; and under the statute CMS is supposed to "estimate" these figures. These are words that indicate CMS must make some judgments in the course of the calculation. Under *Allina*, CMS's decisions and calculations must go through notice and comment. For that reason too, the August 21 instruction, which did not go through notice and comment, cannot be applied or enforced.

II. IF CMS NONETHELESS CONCLUDES IT MUST RECOVER THESE PAYMENTS BACK TO THE FUND, IT SHOULD USE MONIES FROM THE PROVIDER RELIEF FUND UNDER THE CARES ACT TO MAKE HOSPITALS WHOLE.

We trust that CMS understands how seriously the August 21 instruction will impact hospitals. The instruction, if carried out, will suck $50 million to $100 million per affected year out of the 180 or so hospitals that train nurses. At a minimum that will be five years' worth of cost reports (three years from closing, plus two years to close a cost report), but in reality it is likely to be closer to 7-10 years' worth on average. That totals to $350 million to $1 billion coming unexpectedly out of the pockets

of these hospitals – a rate of $2 million to $6 million each. Hospitals that are already facing the twin burdens of an economic crisis and an unfolding public health disaster simply cannot bear this hit.

If, despite the arguments above, CMS ends up deciding to proceed with recouping the past NAHE MA payments, it should use whatever resources are available to minimize the harm to the hospitals. One tool that is available is the Public Health and Social Services Emergency Fund. Our understanding is that a substantial amount of that money remains unused. Spending it to reimburse hospitals for the lost NAHE MA funding would be consistent with the purpose and the text of the appropriation. As for purpose, CMS would be using the money for the laudable goal of making sure that the consequences of its 20-year recalculation of NAHE payments does not endanger care providers at a time when they are needed most. The text also supports this use: Funds are specifically available for "increased workforce and trainings," whether delivered as prospective or retrospective payments.