Whether the MACs properly recovered Medicare NAH MA payments through RNPRs.

**A. Facts**

When enacting Part C of the Medicare Act, Congress phased-in additional direct graduate medical education (DGME) payments to address hospital inpatients, who were enrolled in Part C plans. Medicare also pays hospitals for costs of approved NAH programs. 42 C.F.R. § 413.85. Starting in 2000, Congress required CMS to provide additional payments to hospitals that operate N&AH programs to reimburse the hospitals for costs associated with services to MA enrollees (“MA N&AH payments”). The statute addressing MA NAH payments is found at 42 U.S.C. §1395ww(l) and CMS’s implementing regulation is found at 42 C.F.R. § 413.87, which currently states:

**(a) *Statutory basis*.—** This section implements section 1886(l) of the Act, which provides for additional payments to hospitals that operate and receive Medicare reasonable cost reimbursement for approved nursing and allied health education programs and the methodology for determining the additional payments.

**(b) *Scope*.—** This section sets forth the rules for determining an additional payment amount to hospitals that receive payments for the costs of operating approved nursing or allied health education programs under §413.85.

**(c) *Qualifying conditions for payment.***

**(1)** For portions of cost reporting periods occurring on or after January 1, 2000 and before January 1, 2001, a hospital that operates and receives payment for a nursing or allied health education programunder §413.85 may receive an additional payment amount associated with Medicare+Choice utilization.

The hospital may receive the additional payment amount, which is calculated in accordance with the provisions of paragraph (d) of this section, if both of the conditions specified in paragraphs (c)(1)(i) and (c) (1)(ii) of this section are met.

**(i)** The hospital must have received Medicare reasonable cost payment for an approved nursing or allied health education program under §413.85 in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year. (For example, if the current year is calendar year

2000, the fiscal year that is 2 years prior to calendar year 2000 is FY 1998.) For a hospital that first establishes a nursing or allied health education program after FY 1998 and receives reasonable cost payment for the program as specified under §413.85 after FY 1998, the hospital is eligible to receive an additional payment amount in a calendar year that is 2 years after the respective fiscal year so long as the hospital also meets the condition under paragraph (c)(1)(ii) of this section.

**(ii)** The hospital must be receiving reasonable cost payment for an approved nursing or allied health education program under §413.85 in the current calendar year.

**(2)** For portions of cost reporting periods occurring on or after January 1, 2001, in addition to meeting the conditions specified in paragraphs (c)(1)(i) and (c)(1)(ii) of this section, the hospital must have had a

Medicare+Choice utilization greater than zero in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year.

**(d) *Calculating the additional payment amount for portions of cost reporting periods occurring on or after January 1, 2000 and before January 1, 2001*.—** For portions of cost reporting periods occurring on or after January 1, 2000 and before January 1, 2001, subject to the provisions of §413.76(d)(4) relating

to calculating a proportional reduction in Medicare+Choice direct GME payments, the additional payment amount specified in paragraph (c) of this section is calculated according to the following steps:

**(1) *Step one*.—** Each calendar year, determine the hospital's total nursing and allied health education program payments from its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year.

**(2) *Step two*.—** Determine the ratio of the hospital's payments from step one to the total of all nursing and allied health education program payments across all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year.

**(3) *Step three*.—** Multiply the ratio calculated in step two by the Medicare+Choice nursing and allied health payment "pool" determined in accordance with paragraph (f) of this section for the current calendar year. The resulting product is each respective hospital's additional payment amount.

**(e) *Calculating the additional payment amount for portions of cost reporting periods occurring on or after January 1, 2001*.—** For portions of cost reporting periods occurring on or after January 1, 2001, subject to the provisions of §413.76(d) relating to calculating a proportional reduction in Medicare+Choice direct GME payments, the additional payment amount specified in paragraph (c) of this section is calculated according to the following steps:

**(1) *Step one*.—** Each calendar year, determine for each eligible hospital the total—

**(i)** Medicare payments received for approved nursing or allied health education programs based on data from the settled cost reports for the period(s) ending in the fiscal year that is 2 years prior to the

current calendar year; and

**(ii)** Inpatient days for that same cost reporting period.

**(iii)** Medicare+Choice inpatient days for that same cost reporting period.

**(2) *Step two*.—** Using the data from step one, determine the ratio of the individual hospital's total nursing or allied health payments, to its total inpatient days. Multiply this ratio by the hospital's total Medicare +Choice inpatient days.

**(3) *Step three*.—** CMS will determine, using the best available data, for all eligible hospitals the total of all

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**(i)** Nursing and allied health education program payments made to all hospitals for all cost reporting

periods ending in the fiscal year that is 2 years prior to the current calendar year;

**(ii)** Inpatient days from those same cost reporting periods; and

**(iii)** Medicare+Choice inpatient days for those same cost reporting periods.

**(4) *Step four*.—** Using the data from step three, CMS will determine the ratio of the total of all nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year, to the total of all inpatient days from those

same cost reporting periods. CMS will multiply this ratio by the total of all Medicare+Choice inpatient days for those same cost reporting periods.

**(5) *Step 5*.—** Calculate the ratio of the product determined in step two to the product determined in step four.

**(6) *Step 6*.—** Multiply the ratio calculated in step five by the amount determined in accordance with paragraph (f) of this section for the current calendar year. The resulting product is each respective hospital's additional payment amount.

**(f) *Calculation of the payment “pool.”.***

**(1)** Subject to paragraph (f)(3) of this section, each calendar year, CMS will calculate a Medicare+Choice nursing and allied health payment "pool" according to the following steps:

**(i)** Determine the ratio of projected total Medicare + Choice direct GME payments made in accordance with the provisions of §413.76(c) across all hospitals in the current calendar year to projected total direct GME payments made across all hospitals in the current calendar year.

**(ii)** Multiply the ratio calculated in paragraph (f)(1)(i) of this section by projected total Medicare nursing and allied health education reasonable cost payments made to all hospitals in the current calendar year.

**(2)** The resulting product of the steps under paragraphs (f)(1)(i) and (f)(1)(ii) of this section is the Medicare+Choice nursing and allied health payment "pool" for the current calendar year.

CMS issued a Program Memorandum (PM) A-03-043[[1]](#footnote-1) on May 23, 2003, instructing MACs to reimburse hospitals for the Medicare + Choice Nursing and Allied Health Education Payments. The PM A-03-043 addresses implementing §512 of the Benefits Improvement and Protection Act (BIPA). It also implements §541 of the Balanced Budget Refinement Act (BBRA) of 1999 regarding Medicare + Choice Nursing and Allied Health Payments for portions of cost reporting periods occurring on or after January 1, 2000.

The Centers for Medicare & Medicaid Services (CMS) issued Transmittal 10315 (Change Request 11642)[[2]](#footnote-2) in December of 2020, which identified the qualifying conditions NAH MA, instructed the MACs how to calculate the NAH MA payments and to reopen cost reports that are within the three-year reopening period. In Change Request 11642, CMS addressed reduction of MA DGME payments.

C. Proportional Reduction to MA Direct GME Payments

In conjunction with the additional payments for nursing and allied health programs, the BBRA provided that payments that are made to teaching hospitals for costs of direct GME associated with services to MA enrollees will be reduced by an estimated percentage in each CY. Specifically, the law provides that the estimated reductions in MA direct GME payments must equal the estimated total additional MA nursing and allied health education payments.

(See Attachment A for these amounts). Accordingly, for portions of cost reporting periods occurring in a calendar year, all hospitals that receive MA direct GME payments (including those that do not receive additional nursing and allied health payments under the BIPA provision) will have these payments reduced by the percent reduction stated in Attachment A. (This percent reduction occurs on CMS-2552-96 lines 6.05 and 6.08 of Worksheet E-3 Part IV, and CMS-2552-10, line 30, of Worksheet E-4).

Each hospital with a calendar year cost reporting period that is receiving MA direct GME payments will have those payments reduced by the applicable percentage stated in Attachment A for the period of January through December. If a hospital does not have a calendar year cost reporting period, then the reductions to its MA direct GME payments will depend upon the portion of its cost reporting period that falls within the current calendar year. For example, if a hospital has an October through September FY, its MA direct GME payments from October through December will be reduced by that calendar year’s percent. However, the hospital’s MA direct GME payments from January through September (from the same cost reporting period), and its MA direct GME payments from October through December (from its following cost reporting period), will be reduced by that calendar year’s percent. Similarly, if a hospital has a July through June cost reporting period, its MA direct GME payments from July through December will be reduced by that calendar year’s percent. However, its MA direct GME payments from January through June of the same cost reporting period, and its MA direct GME payments from July through December of the next cost reporting period, will be reduced by that calendar year’s percent.

D. Nursing and Allied Education MA “Pool” and Proportional Reduction to MA Direct GME Payments

As stated previously, CMS provided instructions to the Medicare Administrative Contractors (MACs) in May 23, 2003, in the form of Transmittal A-03-043, CR 2692, for the purpose of making the Calendar Year (CY) 2001 nursing and allied health Medicare+Choice payments. CMS has not updated the “pool” and percent reduction to MA direct GME payments. Attachment A of this CR contains the updated annual “pool” amounts, not to exceed $60,000,000, and the corresponding MA direct GME percent reduction. MACs shall calculate the correct MA nursing and allied health education add-on and the correct MA direct GME payment for the applicable years, and reconcile overpayments or underpayments for these years, according to the instructions below.

*Priority Order: MACs shall first correct the payments of Priority Hospitals listed in column A of Attachment B. Then MACs shall correct the payments of each hospital part of group appeals together with a Priority Hospital (see column E of Attachment B which lists case numbers; many of these case numbers are group appeals of which the Priority Hospital is one of the group), and next MACs shall correct the payments of all other hospitals that receive MA nursing and allied health education payments AND/OR MA direct GME payments.”*

F. Reconciliation of Payment for Already Settled Cost Reports, But That Are Still Within the Three-Year Reopening Period

• **For each applicable hospital, MACs shall identify each and every cost report that IS settled, but is still within the 3-year reopening period (as of the time of the implementation date of this CR, and potentially as far back as a cost report that contains portions of CY 2002).**

**• MACs shall reopen these cost reports.**

• MACs shall refer to Attachment A to find the amounts needed to calculate each respective calendar year’s payments for each applicable hospital.

• MACs shall use the steps above to calculate each hospital’s MA NAHE add-on, and each applicable hospital’s percent reduction to MA direct GME payments, and report the payment amounts on the cost report lines specified previously. MACs shall recalculate BOTH the NAHE MA amount AND the DGME MA amount, REGARDLESS of what a hospital appealed or did not appeal. Since MA NAHE add-on payments and MA DGME reductions are made on a calendar year basis, for hospitals with cost reporting periods that are not January 1 to December 31, MACs shall refer to the hospital’s Provider Statistical & Reimbursement (PS&R) report, report type 118, to access the portion of MA inpatient days. Beginning in 2007, the PS&R report type 118 contains the hospital’s MA days on a monthly basis. Therefore, MACs shall use the monthly information to access the MA days that fall either prior to or after January 1 of the hospital’s cost report. For cost reports prior to 2007, the monthly break out of MA days is not available, and therefore, MACs shall prorate the total amount of MA days on report type 118 to account for portions of the hospital’s cost reporting period that falls before and after January 1 of each applicable year.

The statutes at 42 U.S.C. § 1395hh(e)(1)(A) allows CMS to make retroactive changes to the regulations.

(e) 1 Retroactivity of substantive changes; reliance upon written guidance

(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this subchapter shall not be applied (by extrapolation or otherwise) retroactively to

items and services furnished before the effective date of the change, unless the Secretary determines that—

(i) such retroactive application is necessary to comply with statutory requirements; or

(ii) failure to apply the change retroactively would be contrary to the public interest.

In conjunction with the issuance of Change Request 11642 hospitals that received DGME payments and MA DGME were subject to a lower reduction of their MA DGME payment. The MA DGME payment reduction lowered from 14.13 percent to 5.86 percent, for calendar year 2014. For example, per Research Medical Center’s (26-0027) (a participant of this appeal), FYE December 31, 2014, previous RNPR, MA DGME payments were $814,081 before reduction. The reduction was $115,030, 14.13 percent. With respect to Wesley Medical Center’s (WMC) (17-0123) (another participant of this appeal), FYE December 21, 2014, final settlement, MA DGME payments were $609,330 before reduction. The reduction was $86,098, 14.13percent.[[3]](#footnote-3)

WMC’s MA DGME reduction per the RNPR, which is under appeal, was $35,707. As noted above the reduction was $86,098, per the final settlement. Thus, the MA DGME reduction was lowered by $50,391. The RNPR reduced Wesley Medical Center’s from $61,524 to $23,969, a reduction of $37,532. WMC benefitted from the RNPR, which implemented Change Request 11642. They gained $12,859 ($50,391 – 37,532=$12,859).

**B. Argument**

The providers argue the CMS failed to promulgate Change Request 11642 through Notice-and-Comment Rule Making; CMS failed to publish the provisions of the Change Request through the Federal Register and Code of Federal Regulations; and the Change request was impermissibly retroactive. The MAC disagrees with the providers. It was not necessary for notice and comments and publication of the changes in the Federal Register and Regulations. In addition, it was permissible for CMS to publish the changes in Change Request 11642 (which was available to providers) and apply the changes to cost reports that currently open and cost reports that were subject to three-year cost report reopening period.

The providers acknowledge that CMS was required to annually update the inputs to be used to calculate the NAH MA payments. Specifically, CMS by regulations, was required to update the two components of the formula (1 - the denominator of the NAH MA ratio and 2 – the NAH MA payment pool). The initial components for calendar year 2000 were published in 65 F.R. 47025, 47036-38 (August 1, 2000). The updated components for CY 2001, were published in CMS Change Request 2511, Transmittal No. A-03-021 (March 28, 2003). The CMS did not again update the components until December 14, 2020, through Change Request 11642. The updates were for CY 2002 through 2018.

CMS was required to implement annual updates to the components. CMS was required to calculate the denominator of the NAH Part C ratio. 42 U.S.C. § 1395ww(*l*)(2)(A)-(B); 42 C.F.R. § 413.87(e)(3)-(4). In addition, CMS was required to calculate the NAH Part C payment pool for the year. 42 U.S.C. § 1395ww(*l*)(2)(C); 42 C.F.R. § 413.87(f). The provider’s focus on CMS’s means for the update for years 2002 – 2018 is nothing but a distraction. It is interesting the providers made no objection to CMS’s 2001 updates, which was through Change Request 2511, but objects to a similar means (Change Request 11642) to implement the updates for 2002 – 2018. The providers’ arguments with respect to the need to publish in the Federal register using a notice and comment process are without merit. CMS simply followed the regulations as they were required.

The providers’ argument that CMS was prevented from “retroactive rule making” is misplaced.

The statutes at 42 U.S.C. § 1395hh(e)(1)(A) allows CMS to make retroactive changes to the regulations.

(e) 1 Retroactivity of substantive changes; reliance upon written guidance

(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this subchapter shall not be applied (by extrapolation or otherwise) retroactively to

items and services furnished before the effective date of the change, unless the Secretary determines that—

(i) such retroactive application is necessary to comply with statutory requirements; or

(ii) failure to apply the change retroactively would be contrary to the public interest.

CMS did not previously update the components for the NHA MA for years 2002 through 2018. Therefore, the retroactive application of the 2002 – 2018 updates were necessary to comply with statutory and/or regulatory requirements. In addition, failure to apply the updates retroactively would be contrary to public interest. The obvious public interest is that providers are paid in accordance with the regulations. Again, it is interesting that the 2001 updates were issued on March 28, 2003, and retroactively applied to CY 2001 and the providers do not raise objections to the retroactive application.

The NAH MA Payment Pool is funded by payment reductions for Direct Graduate Medical Education (DGME). With the implementation of Change Request 11642, the DGME payment reduction factor was substantially lowered. Some of the providers of this appeal are paid for DGME costs in addition to their Inpatient Perspective Payment System (IPPS) payments. It seems the providers accept the lower reduction of their DGME payments, which was also published in Change Request 11642, but does not accept their claimed reduction in their NAH MA payments. As noted in the Facts section of this paper WMC benefitted from the RNPR. The increase in reimbursement for MA DGME was greater than the reduction of their MA NAH payment. The MAC will review the other provider results when made available by other MACs.

**C. Conclusion**

The providers are not entitled to additional NAH MA payments. The providers were properly notified of the reductions through Change Request 11642. In addition, the retroactive application of the reductions was in accordance with statutes and regulations. The burden of proof, which is upon the providers, has not been met. The Board must find that the MACs were not arbitrary and/or capricious and did in fact properly adhere to Medicare Law, Regulations and Policy.

**IV. LAWS, REGULATIONS, AND PROGRAM INSTRUCTIONS**

Laws:

42 U.S.C § 1395ww

42 U.S.C. 1395 § hhh(e)(1)(A)

Benefits Improvement and Protection Act § 512

Balanced Budget Refinement Act § 541

Regulations:

42 C.F.R. § 413.85 & 413.87

Federal Register:

65 F.R. 47025, 47036 – 38

Other Sources:

Program Memorandum A-03-043

Change Request 2511

Change Request 11642

**V. EXHIBITS**

**C-1.**  Schedule of Providers

**C-2.** Program memorandum A-03-043

**C-3.** Change Request 11642

**C-4.** Provider 17-0123, Previous Settlement and RNPR, Worksheets E Part A & E-4

1. Exhibit C-2 [↑](#footnote-ref-1)
2. Exhibit C-3 [↑](#footnote-ref-2)
3. Exhibit C-4 [↑](#footnote-ref-3)