Program Memorandum
Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal A-03-043 **Date: MAY 23, 2003**

CHANGE REQUEST 2692

SUBJECT: **Changes to Fiscal Year (FY) 2001 Nursing and Allied Health Education Payment Policies**

The Benefits Improvement and Protection Act (BIPA), P.L. 106-554, enacted on December 11, 2000, contained numerous provisions affecting inpatient hospital payment policies. Some of these provisions became effective either prior to the passage of the BIPA, or shortly after its passage. This Program Memorandum (PM) is to notify you of the actions you are to take to implement §512 of the BIPA. It also implements §541 of the Balanced Budget Refinement Act (BBRA) of 1999 (P. L. 106-113) regarding Medicare+Choice nursing and allied health payments for portions of cost reporting periods occurring on or after January 1, 2000.

Medicare+Choice Nursing and Allied Health Education Payments

Section 541 of the BBRA of 1999 provides for additional payments to hospitals for costs of nursing and allied health education associated with services to Medicare+Choice enrollees. Hospitals that operate approved nursing or allied health education programs and receive Medicare reasonable cost reimbursement for these programs would receive additional payments. Section 541 limits total spending under the provision to no more than $60 million in any calendar year (CY). (In this document, we refer to the total amount of $60 million or less as the payment "pool".) Section 541 also provides that direct Graduate Medical Education (GME) payments for Medicare+Choice utilization will be reduced to the extent that these additional payments are made for nursing and allied health education programs.

Section 512 of the BIPA of 2000 changed the formula for determining the additional amounts to be paid to hospitals for Medicare+Choice nursing and allied health costs. Under §541 of the BBRA, the additional payment amount was determined based on the proportion of each individual hospital's nursing and allied health education payment to total nursing and allied health education payments made to all hospitals. However, this formula did not account for a hospital's specific Medicare+Choice utilization. Section 512 of the BIPA revised this payment formula to specifically account for each hospital's Medicare+Choice utilization.

The regulations at 42 CFR §413.87 were revised to reflect this change. This provision is effective for portions of cost reporting periods occurring in a calendar year (CY), beginning with CY 2001.

A. Qualifying Conditions for Payment

For portions of cost reporting periods occurring on or after January 1, 2001, a hospital that operates a nursing or allied health education program in accordance with 42 CFR §413.85 (as revised in 66 FR 3358, dated January 12, 2001) may receive an additional payment amount if it meets the following three conditions:

1. The hospital must have received reasonable cost Medicare payment for a nursing or allied health education program(s) in its cost reporting period(s) ending in the Federal FY that is two years prior to the current calendar year. For example, if the current calendar year is CY 2001, the FY that is two years prior to CY 2001 is FY 1999. In this example, if a hospital did not receive reasonable cost payment for approved nursing or allied health education programs in FY 1999, but first establishes these programs and receives such payment as specified in §413.85 after FY 1999, the hospital will be eligible to receive an additional payment amount beginning in the calendar year that is two years after the respective FY. For example, if the hospital establishes a nursing or allied health program in FY 2000, it will first be eligible to receive an additional payment amount in CY 2002.

2. The hospital must be receiving reasonable cost payment for its nursing or allied health education program(s) in the current calendar year.

3. The hospital must have had Medicare+Choice utilization greater than zero in its cost reporting period(s) ending in the fiscal year that is two years prior to the current calendar year.

B. Calculating the Additional Payment Amount

For portions of cost reporting periods occurring on or after January 1, 2001, an eligible hospital will receive the additional payment amount calculated according to the following steps:

Step 1: Determine for each eligible hospital the—

- Total 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. (In general, use the sum of the payment amounts from the Medicare cost report, CMS-2552-96, on Worksheet D, Part III, line 101, column 8—Total Medicare Part A inpatient routine other pass through cost including subproviders, and Worksheet D, Part IV, line 101, column 7—Total Medicare Part A ancillary other pass through costs including subproviders. However, if a provider has an amount greater than zero in column 1 of Worksheet D, Part III and/or Worksheet D, Part IV (for non-physician anesthetist cost), then, for purposes of this step 1, remove all non-physician anesthetist cost from column 1, and re-run the cost report to determine total Medicare nursing and allied health payments excluding any pass-through costs associated with non-physician anesthetists).

- Total inpatient days (excluding M+C inpatient days) for that same cost reporting period. (Use the sum of line 1, lines 6 through 10, and lines14 and 14.01 of column 6 from Worksheet S-3, Part I); and

- Total Medicare+Choice inpatient days for that same cost reporting period. (If applicable, obtain the number of Medicare+Choice inpatient days from the Provider Statistics and Reimbursement Report (PS&R), report type 118. Medicare+Choice encounter days associated with providers and units excluded from the IPPS issued by CMS may be added to the inpatient days from report type 118. However, subject to the rules concerning time limitation for submitting provider claims at §3600.2 of the Intermediary Manual, additional documentation to revise the FI's determination may be submitted by the provider, but will be subject to audit by the FI).

For example, if the current calendar year is 2001, determine the hospital's total nursing or allied health education payments made in its cost reporting period ending in FY 1999. Also, determine the hospital's total inpatient days and total Medicare+Choice inpatient days for its cost reporting period ending in FY 1999. If a hospital has more than one cost reporting period ending in that fiscal year, the fiscal intermediary (FI) will add the nursing and allied health payments made to the hospital over those cost reporting periods. The inpatient days and Medicare+Choice inpatient days for the cost reporting periods would be added, as well.

If the actual total amount of the hospital's Medicare nursing or allied health education payment or the actual total amount of the Medicare+Choice inpatient days has not been finalized at the time the determination of the additional payment amount is being made because the hospital's relevant cost report(s) has not as yet been settled, then the additional payment should be made based on an

estimate of the total amount of Medicare nursing and allied health payments and Medicare+Choice inpatient days for that year. When the actual total amounts are determined upon settlement of the cost report(s), the additional payment amount should be recalculated, and any overpayments or underpayments should be reconciled.

Step 2: Using the data in step 1, 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.

Step 3: CMS will determine the following:

- 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.

- The total of all inpatient days from those same hospitals for those same cost reporting periods.

- The total of all Medicare+Choice inpatient days from those same hospitals for those same cost reporting periods.

(See section D below for these amounts).

Step 4: CMS will use the data in step 3 to 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 for those hospitals from that cost reporting period. CMS will multiply this ratio by the total of all Medicare+Choice inpatient days for those hospitals from that cost reporting period.

Step 5: Calculate the ratio of the product determined in step 2 to the product determined in step 4.

Step 6: Multiply the ratio determined in step 5 by the Medicare+Choice nursing and allied health payment "pool". (Each CY, CMS estimates the Medicare+Choice nursing and allied health payment "pool", not to exceed $60 million. The "pool" is used for determining the additional payments for nursing and allied health education). The result is the additional payment amount for the current calendar year for an eligible hospital. (Report this additional payment amount on line 11.01 of Worksheet E, Part A).

EXAMPLE: In its cost reporting period ending in FY 1999, Hospital A received $100,000 in total Medicare payments for approved nursing and allied health education programs. Hospital A's total inpatient days were 28,000. Total Medicare+Choice inpatient days were 2,800.

For all cost reporting periods ending in FY 1999, assume Medicare paid $250,000,000 in total nursing and allied health education program payments. The total number of inpatient days across those hospitals in that year was 142,000,000, and the total number of Medicare+Choice inpatient days was 14,200,000.

Assume the CY 2001 Medicare+Choice nursing and allied health payment "pool" is $26,000,000. Thus, Hospital A's Medicare+Choice nursing and allied health education payment for CY 2001 will be calculated as follows:

$$\left(\frac{\frac{\$100{,}000}{28{,}000 \text{ inpatient days}} \times 2{,}800 \text{ M+C inpatient days}}{\frac{\$250{,}000{,}000}{142{,}000{,}000 \text{ inpatient days}} \times 14{,}200{,}000 \text{ M+C inpatient days}} \right) \times \$26{,}000{,}000 = \mathbf{\$10{,}400}$$

C. Proportional Reduction to Medicare+Choice 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 Medicare+Choice enrollees will be reduced by an estimated percentage in each CY. Specifically, the law provides that the estimated reductions in Medicare+Choice direct GME payments must equal the estimated total additional Medicare+Choice nursing and allied health education payments.

D. Calculation of Amounts for CY 2001

1. The additional payment amount:

- The Medicare+Choice nursing and allied health education payment "pool" for CY 2001 is **$43,663,043.**

- The total amount of nursing and allied health education payments made to all hospitals for cost reporting periods ending in FY 1999, that is, 2 FYs prior to CY 2001, is **$204,780,092.**

- The total inpatient days for all hospitals with an approved nursing or allied health education program for cost reporting periods ending in FY 1999 is **56,794,990.**

- The total of all Medicare+Choice inpatient days for all hospitals with an approved nursing or allied health education program for cost reporting periods ending in FY 1999 is **1,701,313.**

- (total nursing and allied health payments/total inpatient days) x total Medicare+Choice inpatient days = **$6,134,256.**

- The ratio of (a) each hospital's Medicare nursing and allied health education payments to its inpatient days multiplied by its Medicare+Choice inpatient days from its cost reporting period(s) ending in FY 1999, to (b) **$6,134,256** is multiplied by (c) **$43,663,043** (the "pool") to determine each hospital's additional payment amount (as described in section B) for CY 2001.

EXAMPLE: In its cost reporting period ending in FY 1999, Hospital A received $100,000 in total Medicare payments for approved nursing and allied health education programs. Hospital A's total inpatient days were 28,000. Total Medicare+Choice inpatient days were 2,800. Its total additional payment amount for portions of its cost reporting period that occur in CY 2001 would be determined as follows:

$$\frac{\frac{\$100{,}000}{28{,}000 \text{ hospital inpatient days}} \times 2{,}800 \text{ M+C inpatient days}}{\$6{,}134{,}256} \times \$43{,}663{,}043 \text{ "pool"} = \mathbf{\$71{,}179}$$

NOTE: If Hospital A's FY 1999 cost report is not settled at the time the fiscal intermediary calculates the additional payment amount for CY 2001, and, later, upon settlement, it is determined that $100,000 is not the actual total amount that Hospital A received for FY 1999, then the FI will recalculate the additional payment amount with the accurate total and reconcile any overpayments or underpayments to Hospital A.

2. Reduction to Medicare+Choice direct GME Payments:

The proportional reduction to Medicare+Choice direct GME payments for CY 2001 is **14.13 percent**. Accordingly, for portions of cost reporting periods occurring in CY 2001, all hospitals that receive Medicare+Choice 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 **14.13 percent.** (This percent reduction occurs on lines 6.05 and 6.08 of Worksheet E-3 Part IV).

EXAMPLE[1]: In CY 2001, teaching Hospital A has a per resident amount (PRA) of $50,000, 75 FTE interns and residents, and a Medicare+Choice utilization of 15 percent. Teaching Hospital A's calculation for Medicare+Choice direct GME payment for CY 2001 is:
($50,000) x (75) x (.15) x $(.80)^2$ = 450,000
450,000 x .1413 = 63,585
450,000 – 63,585 = $386,415.

Each hospital with a calendar year cost reporting period that is receiving Medicare+Choice direct GME payments will have those payments reduced by **14.13 percent** for the period of January through December 2001. If a hospital does not have a calendar year cost reporting period, then the reductions to its Medicare+Choice 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 Medicare+Choice direct GME payments from October through December 2000 will be reduced by 10.5 percent, as determined for portions of CY 2000. However, the hospital's Medicare+Choice direct GME payments from January through September 2001 (from its FY 2001 cost reporting period), and its Medicare+Choice direct GME payments from October through December 2001 (from its FY 2002 cost reporting period), will be reduced by 14.13 percent. Ultimately, its Medicare+Choice direct GME payments for the remainder of its FY 2002 cost reporting period, which extends from January through September 2002, will be reduced by the applicable percentage for CY 2002. Similarly, if a hospital has a July through June cost reporting period, its Medicare+Choice direct GME payments from July through December 2000 will be reduced by 10.5 percent as determined for portions of CY 2000. However, its Medicare+Choice direct GME payments from January through June 2001, and its Medicare+Choice direct GME payments from July through December 2001, will be reduced by 14.13 percent. Its Medicare+Choice direct GME payments for the remainder of its cost reporting period, which extends from January through June 2002 will be reduced by the applicable percentage for CY 2002.

E. Payment

For CY 2001 payments:

1. Calculate each provider's total Medicare+Choice nursing and allied health payment for portions of cost reporting periods that occur within CY 2001.

   - If the provider previously received payments for Medicare+Choice nursing and allied health (either on an interim basis in CY 2001 or on the settled cost report), offset the amount calculated in this step 1 by any amounts previously paid.

2. For purposes of reducing the Medicare+Choice direct GME payments by 14.13 percent, identify the providers that have residency programs and received Medicare+Choice direct GME payments in portions of cost reporting periods occurring in CY 2001.

   - If the provider's Medicare+Choice direct GME payments received (either on an interim basis or at cost report settlement) were already reduced to account for a percent reduction for CY 2001, the percent reduction of 14.13 percent in this step 2 should be offset by any reduction already made to the provider's Medicare+Choice direct GME CY 2001 payments.

3. Using steps 1 and 2, determine each provider's net payment amount.

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[1]For purposes of this example, the Medicare+Choice direct GME payment calculation has been simplified.

[2]The Balanced Budget Act of 1997 provided for a 5-year phase-in of payments to teaching hospitals for the direct costs of GME associated with services to Medicare+Choice enrollees. Eligible teaching hospitals receive 20 percent of these payments in CY 1998, 40 percent in CY 1999, 60 percent in CY 2000, 80 percent in CY 2001, and 100 percent in CY 2002 and subsequent years.

- Note: The payments for providers that operate both GME and nursing or allied health education programs are the net of (1) the additional amount from step 1, and (2) the percent Medicare+Choice direct GME reduction from step 2.

4. Make the net payment from step 3 to each provider. If the provider's cost report ending in CY 2001 has not been tentatively settled, make the additional payment as part of the tentative settlement for that cost report. If the provider's cost report ending in CY 2001 has been tentatively settled, make the additional payment at the time of final settlement. If the provider's cost report ending in CY 2001 has already been settled, do not reopen the cost report if the adjustment is less than $5,000, unless the provider requests the reopening. Otherwise, reopen the cost report to make the additional payment using normal reopening procedures.

   The FI should make sure that the additional payment reflects all portions of cost reporting periods that occur during CY 2001. For example, if a provider's fiscal year end (FYE) is June 30, then, for the additional payment for CY 2001, the intermediary would report half of the additional payment amount on the provider's cost report for the year ending June 30, 2001 (to reflect the second 6 months of the FYE 6/30/01), and half of the additional payment on the provider's cost report ending June 30, 2002 (to reflect the first 6 months of FYE 6/30/02).

For CY 2002 payments:

1. Determine that each provider qualifies for the additional payment amount in CY 2002, using the criteria in section A of this PM.

2. Until a transmittal addressing the additional payment amounts for CY 2002 is issued, the intermediary should make the additional payment amount for portions of cost reporting periods that occur within CY 2002 based on the amount calculated for each provider for CY 2001.

   - If the provider previously received payments for Medicare+Choice nursing and allied health (either on an interim basis in CY 2002 or on the settled cost report), offset the payment made in this step 2 by any amounts previously paid.

   - If the provider's Medicare+Choice direct GME payments received (either on an interim basis or at cost report settlement) were already reduced to account for a percent reduction, the amount owed by the provider should be offset by any reduction already made to the provider's CY 2002 Medicare+Choice direct GME payments.

3. Make the payment (net of the additional amount for Medicare+Choice nursing and allied health and the percent reduction for Medicare+Choice direct GME) from step 2 to each provider. If the provider's cost report ending in CY 2002 has not been tentatively settled, make the additional payment as part of the tentative settlement for that cost report. If the provider's cost report ending in CY 2002 has been tentatively settled, make the additional payment at the time of final settlement. If the provider's cost report ending in CY 2002 has already been settled, do not reopen the cost report. Please wait for a separate transmittal addressing CY 2002 payments.

   The intermediary should make sure that the additional payment reflects all portions of cost reporting periods that occur during CY 2002. For example, if a provider's fiscal year end (FYE) is June 30, then, for the additional payment for CY 2002, the intermediary would report half of the additional payment amount on the provider's cost report for the year ending June 30, 2002 (to reflect the second 6 months of the FYE 6/30/02), and half of the additional payment on the provider's cost report ending June 30, 2003 (to reflect the first 6 months of FYE 6/30/03).

For CY 2003 interim payments:

At your next scheduled semi-annual rate review:

1. Determine that each provider qualifies for the additional payment amount in CY 2003, using the criteria in section A of this PM.

2. Estimate each provider's total Medicare+Choice nursing and allied health payment for portions of cost reporting periods that occur within CY 2003. (Until a separate transmittal is issued addressing CY 2003 payments, as an estimate, use the total amount the hospital received for Medicare+Choice nursing and allied health based on the most recently issued transmittal, in this case, the transmittal for CY 2001).

3. Make a lump sum payment to each eligible provider to account for the portion of CY 2003 that has already past. (If a provider has a cost reporting period that ended between January and the time of your rate review, include a portion of the lump sum payment applicable to that cost reporting period in the tentative settlement of that cost report). If interim payments for Medicare+Choice nursing and allied health have already been made to a provider for January through the date of your rate review, reduce the lump sum amount to account for interim payments already made. If the provider also receives Medicare+Choice direct GME payments, reduce the lump sum payment by the percent GME reduction (use 14.13 percent from CY 2001).

4. Begin making interim payments for subsequent months to reflect (1) the additional amount for Medicare+Choice nursing and allied health, and/or (2) for providers that receive Medicare+Choice direct GME payments, the percent GME reduction (14.13 percent).

5. Continue making interim payments as applicable for portions of periods after December 31, 2003. In general, in your interim rate calculations, include an adjustment for Medicare+Choice nursing and allied health and an offset for Medicare+Choice direct GME, using the best available data based on most recently issued transmittal related to Medicare+Choice nursing and allied health education payments.

The *effective date* for this PM is January 1, 2001.

The *implementation date* for this PM is:

For tentative and final settlements of 2001 and 2002 cost reports, include payment amounts as part of the normal tentative and final settlement process.

For reopenings of 2001 cost reports, determine payment amounts and notify providers by July 1, 2003 of your intention to reopen. Reopenings should be completed within their normal timeframes.

For interim rate adjustments for 2003, reflect the change in payment in your next semi-annual rate review.

These instructions should be implemented within your current operating budget.

This PM may be discarded after May 23, 2004.

If you have any questions, contact Miechal Lefkowitz at (410) 786-5316.