We refer readers to the CMS Direct Graduate Medical Education (DGME) website at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME.html*. Hospitals should access this website for a list of additional section 5506 guidelines for the policy and procedures for applying for slots, and the redistribution of the slots under sections 1886(h)(4)(H)(vi) and 1886(d)(5)(B)(v) of the Act.

H. Reasonable Cost Payment for Nursing and Allied Health Education Programs (§§ 413.85 and 413.87)

1. General

Under section 1861(v) of the Act, Medicare has historically paid providers for Medicare's share of the costs that providers incur in connection with approved educational activities. Approved nursing and allied health (NAH) education programs are those that are, in part, operated by a provider, and meet State licensure requirements, or are recognized by a national accrediting body. The costs of these programs are excluded from the definition of "inpatient hospital operating costs" and are not included in the calculation of payment rates for hospitals or hospital units paid under the IPPS, IRF PPS, or IPF PPS, and are excluded from the rate-of-increase ceiling for certain facilities not paid on a PPS. These costs are separately identified and ``passed through'' (that is, paid separately on a reasonable cost basis). Existing regulations on NAH education program costs are located at 42 CFR 413.85. The most recent rulemakings on these regulations were in the January 12, 2001 final rule (66 FR 3358 through 3374), and in the August 1, 2003, final rule (68 FR 45423 and 45434).

b. Medicare Advantage Nursing and Allied Health Education Payments

Section 541 of the Balanced Budget Refinement Act (BBRA) of 1999 provides for additional payments to hospitals for costs of nursing and allied health education associated with services to Medicare+Choice (now called Medicare Advantage (MA)) enrollees. Hospitals that operate approved nursing or allied health education programs and receive Medicare reasonable cost reimbursement for these programs would receive additional payments from MA

organizations. Section 541 of the BBRA 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 of the BBRA also provides that direct graduate medical education (GME) payments for Medicare+Choice utilization are reduced to the extent that these additional payments are made for nursing and allied health education programs. This provision was effective for portions of cost reporting periods occurring in a CY, on or after January 1, 2000.

Section 512 of the Benefits Improvement and Protection Act (BIPA) of 2000 changed the formula for determining the additional amounts to be paid to hospitals for MA nursing and allied health costs. Under section 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 MA utilization. Section 512 of the BIPA revised this payment formula to specifically account for each hospital's MA utilization. This provision was effective for portions of cost reporting periods occurring in a calendar year, beginning with CY 2001, and was implemented in the August 1, 2001 IPPS final rule (66 FR 39909 and 39910).

The regulations at 42 CFR 413.87 codified both statutory provisions. We first implemented the BBRA NAH MA provision in the August 1, 2000 IPPS interim final rule with comment period (IFC) (65 FR 47036 through 47039). In that IFC, we outlined the qualifying conditions for a hospital to receive the NAH MA payment, how we would calculate the NAH MA payment pool, and how a qualifying hospital would calculate its ``share'' of payment from that pool. Determining a hospital's NAH MA payment essentially involves applying a ratio of the hospital-specific NAH Part A payments, total inpatient days, and MA inpatient days, to national totals of those same amounts, from cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year. The formula is as follows:

(((Hospital NAH pass-through payment/Hospital Part A Inpatient Days) *

Hospital MA Inpatient Days)/((National NAH pass-through payment/
National Part A Inpatient Days) * National MA Inpatient Days)) * Current Year Payment Pool.

With regard to determining the total national amounts for NAH pass-through payment, Part A inpatient days, and MA inpatient days, we note that section 1886(l) of the Act, as added by section 541 of the BBRA, gives the Secretary the discretion to ``estimate'' the national components of the formula noted previously. For example, section 1886(l)(2)(A) of the Act states that the Secretary would estimate the ratio of payments for all hospitals for portions of cost reporting periods occurring in the year under subsection 1886(h)(3)(D) to total direct GME payments estimated for the same portions of periods under section 1886(h)(3) of the Act. Accordingly, we stated in the August 1, 2000 IFC (65 FR 47038) that each year, we would determine and publish in a final rule the total amount of nursing and allied health education payments made across all hospitals during the fiscal year 2 years prior to the current calendar year We would use the best available cost reporting data for the applicable hospitals from the Hospital Cost Report Information System (HCRIS) for cost reporting periods in the fiscal year that is 2 years prior to the current calendar year (65 FR 47038).

To calculate the pool, in accordance with section 1886(l) of the Act, we would ``estimate'' a total amount for each calendar year, not to exceed $60 million (65 FR 47038).

To calculate the proportional reduction to Medicare+Choice (now MA) Direct GME payments, we stated that the percentage is estimated by calculating the ratio of the Medicare+Choice nursing and allied health payment ``pool'' for the current calendar year to the projected total Medicare+Choice direct GME payments made across all hospitals for the current calendar year. We stated that the projections of Medicare+Choice direct GME and Part A direct GME are based on the best available cost report data from the HCRIS (for example, for calendar year 2000, the projections are based on the best available cost report data from HCRIS 1998), and these payment amounts were increased using the increases allowed by section 1886(h) of the Act for these services (using the percentage applicable for the current calendar year for

Medicare+Choice direct GME and the Consumer Price Index (CPI-U) increases for Part A direct GME). We also stated that we would publish the applicable percentage reduction each year in the IPPS proposed and final rules (65 FR 47038).

Thus, in the August 1, 2000, IFC, we described our policy regarding the timing and source of the national data components for the NAH MA add-on payment and the percent reduction to the direct GME MA payments, and we stated that we would publish the rates for each calendar year in the IPPS proposed and final rules. While the rates for CY 2000 were published in the August 1, 2000, IFC (see 65 FR 47038 and 47039), the rates for subsequent CYs were only issued through Change Requests (CRs) (CR 2692, CR 11642, CR 12407). After recent issuance of the CY 2019 rates in CR 12407 on August 19, 2021, we reviewed our update procedures, and were reminded that the August 1, 2000 IFC states that we would publish the NAH MA rates and direct GME percent reduction every year in the IPPS rules. Accordingly, for CY 2020 and CY 2021, we proposed and finalized the NAH MA add-on rates in the FY 2023 IPPS/LTCH PPS proposed and final rules. We stated that for CYs 2022 and after, we would similarly propose and finalize their respective NAH MA rates and direct GME percent reductions in subsequent IPPS/LTCH PPS rulemakings (see 87 FR 49073 August 10, 2022).

In this FY 2024 IPPS/LTCH PPS proposed rule, we are proposing the rates for CY 2022. Consistent with the use of HCRIS data for past calendar years, we are proposing to use data from cost reports ending in FY 2020 HCRIS (the fiscal year that is 2 years prior to CY 2022) to compile these national amounts: NAH pass-through payment, Part A Inpatient Days, MA Inpatient Days.

For this proposed rule, we accessed the FY 2020 HCRIS data from the fourth quarterly HCRIS update of 2022. However, to calculate the ``pool'' and the direct GME MA percent reduction, we ``project'' Part A direct GME payments and MA direct GME payments for the current calendar year, which in this final rule, is CY 2022, based on the ``best available cost report data from the HCRIS'' (65 FR 47038). Next, consistent with the method we described

previously from the August 1, 2000 IFC, we increased these payment amounts from midpoint to midpoint of the appropriate calendar year using the increases allowed by section 1886(h) of the Act for these services (using the percentage applicable for the current calendar year for MA direct GME, and the Consumer Price Index-Urban (CPI-U) increases for Part A direct GME. For CY 2022, the direct GME projections are based on the fourth quarterly update of CY 2020 HCRIS, adjusted for the CPI-U and for increasing MA enrollment.

For CY 2022, the proposed national rates and percentages, and their data sources are set forth in this table. We intend to update these numbers in the FY 2024 final rule based on the latest available cost report data.

CY 2022 NAH MA Rates	CY 2022	SOURCE
NAH Pass-Through	$289,890,999	Cost reports ending in FY 2020 HCRIS
Part A Inpatient Days	67,427,704	Cost reports ending in FY 2020 HCRIS
MA Inpatient Days	11,865,080	Cost reports ending in FY 2020 HCRIS
Part A Direct GME	$2,673,355,222	CY 2020 HCRIS + CPI-U
MA Direct GME	$1,836,860,771	CY 2020 HCRIS + CPI-U
Pool (not to exceed $60 million)	$60,000,000	((MA DGME /Part A DGME) * (NAH Pass-through))
Percent Reduction to MA DGME Payments	3.27%	Pool/MA direct GME

Section 4143 of the CAA 2023 (enacted December 29, 2022), called "Waiver of Cap on Annual Payments for Nursing and Allied Health Education Payments," amends section 1886(l)(2)(B) of the Act to state that for portions of cost reporting periods occurring in each of CYs 2010 through 2019, the $60 million payment limit, or payment "pool," *shall not apply* to the total amount of additional payments for nursing and allied health education to be distributed to hospitals that, as of the date of enactment of this clause, are operating a school of nursing, a school of allied health, or a school of nursing and allied health. As noted previously, section 541 of the BBRA limited total spending under the NAH MA provision to no more than $60 million in any calendar year. Under CR 11642 issued on November 19, 2020, CMS instructed MACs to recalculate historical payments to hospitals consistent with the $60 million limit per calendar year, and make applicable adjustments to NAH MA payments. In this section, we propose a method for the MACs to implement section 4143 in the absence of the $60 million limit on the pool.

In addition, section 541 of the BBRA 1999 also provides that direct GME payments for MA utilization will be reduced to the extent that these additional payments are made for nursing and allied health education programs. However, section 4143 of the CAA 2023 also provides that in not applying the $60 million limit for each of 2010 through 2019, the Secretary shall not take into account any increase in the total amount of such additional payment amounts for such nursing and allied health education for portions of cost reporting periods occurring in the year. We propose to interpret this to mean that, pursuant to the requirement set out at section 4143(b) of CAA 2023, MACs shall not change the DGME MA percent reduction amounts specified in CR 11642 for CYs 2010 through 2018, and CR 12407 for CY 2019 (and CR 12596 which corrected the DGME MA percent reduction related to CY 2018 specified in CR 11642).

The following table shows the recalculated pool amounts for CYs 2010 through 2019. We propose that MACs would first determine whether hospitals that received revised payments under CR 11642 were still receiving NAH MA payments on an interim basis as of December 29, 2022. For example, if a hospital's payments for a NAH program(s) were adjusted under CR 11642, but that hospital since closed all of its NAH programs, that hospital would not be eligible under section 4143 to receive adjusted payments for CYs 2010 through 2019, even if the hospital itself has remained operational.

Second, we propose that MACs would use the table in this section of this rule to recalculate an eligible hospital's NAH MA payment for portions of cost reporting periods occurring in CY 2010 through CY 2019 that are still within the 3-year reopening period. The formula is specified previously in this section.

Third, we propose that the MACs would subtract the payment amount determined under CR 11642 (or CR 12596 or CR 12407 as applicable) for a CY from the recalculated amount in the second step, as previously detailed.

Fourth, we propose that the MACs would determine the amount owed to a hospital in a CY as the amount calculated in the third step plus the difference, if any, between that amount

and the amount previously recouped under CR 11642 (or CR 12596 or CR 12407 as applicable) or the amount that would have been recouped under CR 11642 (or CR 12596 or CR 12407 as applicable) if not for the enactment of Section 4143 of the CAA 2023, if such difference for a CY is greater than $0. We note that by adding this difference to the amount calculated in the third step, the amounts previously recouped under CR 11642 (or CR 12596 or CR 12407 as applicable) will be returned to hospitals, and recoupments that would have occurred under CR 11642 (or CR 12596 or CR 12407 as applicable) if not for the enactment of Section 4143 of the CAA 2023 will not occur.

CALCULATION TABLE FOR SECTION 4143 OF CAA OF 2023						
	Section 4143 CAA POOL	**FFS NAH PAYMENTS**	**FFS INPATIENT DAYS**	**MA INPATIENT DAYS**	**(FFS NAH/FFS INPT DAYS) X MA INPT DAYS**	**PERCENT REDUCTION TO MA DGME PAYMENTS**
CY 2010	$62,997,033	$213,862,393	45,409,814	3,114,194	$14,666,631	9.77%
CY 2011	$66,438,422	$226,645,225	49,217,935	3,825,354	$17,615,494	7.85%
CY 2012	$76,035,672	$240,958,503	55,551,047	4,376,532	$18,983,667	7.16%
CY 2013	$84,753,118	$245,304,017	54,965,956	4,945,724	$22,071,952	6.41%
CY 2014	$93,598,893	$248,506,989	54,405,730	5,360,315	$24,484,107	5.86%
CY 2015	$102,448,386	$247,076,161	55,223,064	5,907,933	$26,432,967	5.32%
CY 2016	$110,412,962	$253,272,740	55,717,901	6,376,818	$28,986,630	4.99%
CY 2017	$119,165,456	$249,546,528	58,599,068	7,241,576	$30,838,548	4.44%
CY 2018	$130,335,289	$267,714,849	61,066,487	7,888,809	$34,584,457	4.12%
CY 2019	$140,589,366	$262,043,840	62,649,285	8,481,459	$35,475,490	4.07%

We are not proposing any changes to the regulations text at 42 CFR 413.87.