Program Memorandum Intermediaries

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1369

SUBJECT: Changes to FY 2001 and FY 2002 Graduate Medical Education (GME) Policies as Required by the Medicare, Medicaid, and State Child Health Insurance Program Balanced Budget Refinement Act of 1999 (BBRA), P. L. 106-113, and the Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement and Protection Act (BIPA) of 2000, P. L. 106-554

The BBRA, enacted on November 29, 1999, contained many provisions affecting inpatient hospital payment policies. The BBRA required that numerous provisions were to be implemented retroactively, while other provisions were to become effective shortly after enactment. Previous program memoranda (including Program Memorandum (PM) A-00-17, Change Request 1129, dated April 2000, and PM A-00-86, Change Request 1379, dated November 22, 2000) provided implementation instructions for these provisions. However, that PM did not include instructions for implementing §311 of the BBRA, Use of National Average Per Resident Amount Methodology in Computing Direct Graduate Medical Education (GME) Payments.

The BIPA, enacted on December 21, 2000, contained additional provisions regarding inpatient hospital payment policies, including one that modified §311 of the BBRA. This PM notifies you of the actions you are to take to implement §311 of the BBRA and §511 of the BIPA. Section 311 is effective for cost reporting periods beginning on or after October 1, 2000, and §511 is effective for cost reporting periods beginning on or after October 1, 2001.

USE OF NATIONAL AVERAGE PER RESIDENT AMOUNT METHODOLOGY IN COMPUTING DIRECT GME PAYMENTS

Section 311 of the BBRA amended §1886(h)(2) of the Social Security Act to establish a methodology for the use of a national average per resident amount (PRA) in computing direct GME (DGME) payments for cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005. Generally, using FY 1997 data, §311 establishes a "floor" and a "ceiling" based on a locality-adjusted, updated, weighted average PRA. Section 511 of the BIPA increased the floor that was established by §311 of the BBRA. Each hospital's PRA is compared to the floor and ceiling to determine whether its PRA should be revised.

The weighted average per resident amount for cost reporting periods ending during FY 1997 is $68,464. For cost reporting periods beginning on or after October 1, 2000, and on or before September 30, 2005, the national average PRA is applied using the following three steps:

Step 1: Update the weighted average PRA for inflation. Update $68,464 (the weighted average PRA) from October 1, 1996 to the midpoint of each individual hospital's cost reporting period beginning on or after October 1, 2000 using the Consumer Price Index-Urban (CPI-U). (The CPI-U factors needed for updating the weighted average PRA have been distributed by HCFA on October 31, 2000 as part of the list of annual update factors that are issued to the intermediaries by the Regional Offices).

Example: (**Note**: The CPI-U factors used are for illustrative purposes only.)

Hospital	Cost Reporting Period	Update $68,464 from	to Midpoint of Cost Reporting Period in FY 2001	Using CPI-U factor of	Equals National Average PRA
A	October-September	October 1, 1996	April 1, 2001	1.11723	$76,490
B	January-December	October 1, 1996	July 1, 2001	1.12028	$76,699
C	July-June	October 1, 1996	January 1, 2001	1.11006	$75,999

The starting point for updating $68,464 is the same date for all hospitals, (October 1, 1996), but the ending date is different because it is dependent upon the cost reporting period for each hospital.

Step 2: Adjust for locality. Adjust the updated weighted average PRA, now the national average PRA, to calculate a locality-adjusted national average PRA for each hospital. This is done by multiplying the national average PRA by the calendar year (CY) 1999 Geographic Adjustment Factor (GAF), (as specified in the October 31, 1997 **Federal Register** (62 FR 59257)), for the fee schedule area in which the hospital is located. (The CY 1999 GAFS are to be used for the duration of this policy, for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2005).

Example: Assume Hospitals A, B, and C are located in Alabama.

Hospital	National Average PRA	Multiplied by the CY 1999 GAF for All Counties in Alabama	Equals Locality-Adjusted National Average PRA for FY 2001
A	$76,490	0.930	$71,136
B	$76, 699	0.930	$71,330
C	$75,999	0.930	$70,679

Step 3: Determine possible revisions to the base-year PRA. For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005, the locality-adjusted national average PRA, as calculated in Step 2, is then compared to the hospital's individual PRA. Each hospital's PRA is revised, if appropriate, according to the following categories:

Floor – For cost reporting periods beginning in FY 2001 (per the BBRA): To determine which PRAs (primary care and non-primary care separately) of each hospital are below the 70 percent floor, each hospital's locality-adjusted national average PRA is multiplied by 70 percent. This resulting number is then compared to each hospital's PRA that is updated for inflation to FY 2001. If the hospital's PRA would be less than 70 percent of the locality-adjusted national average PRA, the individual PRA is *replaced* by 70 percent of the locality-adjusted national average PRA for that cost reporting period and the new PRA would be updated for inflation in future years by the CPI-U.

There may be some hospitals with both primary care and non-primary care PRAs that are below the floor, and are thus, replaced by 70 percent of the locality-adjusted national average PRA. In these situations, the hospitals would receive a single PRA; a distinction between PRAs would no longer be made for differences in inflation (see 42 CFR §413.86 (e)(3)(ii)) as of cost reporting periods beginning on or after October 1, 2000. Alternatively, hospitals may have primary care PRAs that

are above the floor, and non-primary care PRAs that are below the floor. In this case, only the non-primary care PRAs would be revised to equal 70 percent of the locality adjusted national average PRA, and the prior year primary care PRAs would be updated for inflation as usual by the CPI-U.

Example: Assume Hospitals A, B, and C have the following primary care and non-primary care PRAs:

Hospital	Locality-Adjusted National Average PRA for FY 2001	FLOOR—Multiply .70 by the Locality-Adjusted National Average PRA for FY 2001	Primary Care PRA for FY 2001	Non-primary Care PRA for FY 2001
A	$71,136	$49,795	$47,000	$45,000
B	$71,330	$49,931	$50,000	$48,000
C	$70,679	$49,475	$110,000	$108,000

Using the chart, compare each hospital's FY 2001 PRAs to each hospital's corresponding locality-adjusted national average PRA for FY 2001. Hospital A has a primary care FY 2001 PRA of $47,000 and a non-primary care FY 2001 PRA of $45,000. Both of these PRAs are below their floor of $49,795. Therefore, for Hospital A in FY 2001, both the primary care and non-primary care PRAs are replaced by the $49,795 floor. Thus, $49,795 is the amount that should be used to determine Hospital A's DGME payments for both primary care and non-primary care residents on its cost report beginning in FY 2001, and the $49,795 PRA should be updated for inflation by the CPI-U thereafter.

Hospital B's primary care PRA exceeds the floor, and is, therefore, not affected by the 70 percent floor. However, Hospital B's non-primary care PRA of $48,000 is below its locality-adjusted national average PRA floor of $49,931. Therefore, for FY 2001, Hospital B's non-primary care PRA is replaced by the $49,931 floor. Hospital B's primary care PRA of $50,000, and its non-primary care PRA of $49,931 are the amounts that should be used to determine Hospital B's DGME payments on its cost report beginning in FY 2001, and they should be updated for inflation by the CPI-U thereafter.

Hospital C's PRAs are each above the 70 percent floor, and are, therefore, not affected by the 70 percent floor. If the PRAs do not exceed the ceiling, they would be adjusted for inflation by the CPI-U as usual. If the PRAs exceed the ceiling, they would be affected as described below.

Floor – For cost reporting periods beginning in FY 2002 (per the BIPA): To determine which PRAs (primary care and non-primary care separately) of each hospital are below the 85 percent floor, each hospital's locality-adjusted national average PRA for FY 2002 is multiplied by 85 percent. This resulting number is then compared to each hospital's PRA that is updated for inflation to FY 2002. If the hospital's PRA would be less than 85 percent of the locality-adjusted national average PRA, the individual PRA is *replaced* by 85 percent of the locality-adjusted national average PRA for that cost reporting period. The new PRA would be updated for inflation in future years by the CPI-U.

There may be some hospitals with both primary care and non-primary care PRAs that are below the floor, and are thus, replaced by 85 percent of the locality-adjusted national average PRA. In these situations, the hospitals would receive a single PRA; a distinction between PRAs would no longer be made for differences in inflation (see 42 CFR §413.86 (e)(3)(ii)) as of cost reporting periods beginning on or after October 1, 2001. Or, hospitals may have primary care PRAs that are above the floor, and non-primary care PRAs that are below the floor. In this case, only the non-primary care PRAs would be revised to equal 85 percent of the locality adjusted national average PRA, and the prior year primary care PRAs would be updated for inflation as usual by the CPI-U.

Example: Assume Hospitals A, B, and C have the following primary care and non-primary care PRAs:

Hospital	Locality-Adjusted National Average PRA for FY 2002	FLOOR—Multiply .85 by the Locality-Adjusted National Average PRA for FY 2002	Primary Care PRA for FY 2002	Non-primary Care PRA for FY 2002
A	$72,136	$61,316	$50,795	$50,795
B	$72,330	$61,481	$51,000	$50,931
C	$71,679	$60,927	$109,000	$107,000

Using the chart, compare each hospital's FY 2002 PRAs to each hospital's corresponding locality-adjusted national average PRA for FY 2002. Hospital A has a primary care and a non-primary care FY 2002 PRA of $50,795. Both of these PRAs are below their floor of $61,316. Therefore, for Hospital A in FY 2002, both the primary care and non-primary care PRAs are replaced by the $61,316 floor. Thus, $61,316 is the amount that should be used to determine Hospital A's DGME payments for both primary care and non-primary care residents on its cost report beginning in FY 2002, and the $61,316 PRA should be updated for inflation by the CPI-U thereafter.

Hospital B's primary care PRA and non-primary care PRA are both below the locality-adjusted national average PRA floor of $61,481. Therefore, for FY 2002, both Hospital B's primary care PRA and non-primary care PRA are replaced by the $61,481 floor. The amount of $61,481 should be used to determine Hospital B's DGME payments on its cost report beginning in FY 2002, and it should be updated for inflation by the CPI-U thereafter.

Hospital C's PRAs are each above the 85 percent floor, and are, therefore, not affected by the 85 percent floor. If the PRAs do not exceed the ceiling, they would be adjusted for inflation by the CPI-U as usual. If the PRAs exceed the ceiling, they would be affected as described below.

Ceiling - For cost reporting periods beginning in FY 2001 through FY 2005, calculate a ceiling that is equal to 140 percent of each locality-adjusted national average PRA, and compare it to each individual hospital's PRA. If the hospital's PRA is greater than 140 percent of the locality-adjusted national average PRA, the PRA would be adjusted (depending on the fiscal year) as follows:

A. FY 2001 - For cost reporting periods beginning in FY 2001, each hospital's PRA from the *preceding* cost reporting period (that is, the PRA used to calculate the hospital's DGME payments in FY 2000) is compared to the *FY 2001* locality-adjusted national average PRA. If the individual hospital's FY 2000 PRA exceeds 140 percent of the FY 2001 locality-adjusted national average PRA, the PRA is frozen at the FY 2000 PRA, and is not updated in FY 2001 by the CPI-U factor.

There may be some hospitals with both primary care and non-primary care PRAs that are above the ceiling, and thus, they are both frozen at FY 2000 and not updated to FY 2001. Alternatively, hospitals may have primary care PRAs that are above the ceiling, and non-primary care PRAs that are below the ceiling. In this case, only the primary care PRAs would be frozen, and the non-primary care PRAs would be updated for inflation using the CPI-U.

Example: FY 2001:

Hospital	Locality-Adjusted National Average PRA for FY 2001	CEILING—Multiply 1.40 by the Locality-Adjusted National Average PRA for FY 2001	Primary Care PRA for FY 2000	Non-primary Care PRA for FY 2000	PRAs used for payment in FY 2001	
A	$71,136	$99,590	$46,000	$44,000	$49,795	
B	$71,330	$99,862	$49,000	$47,000	$50,000	$49,931
C	$70,679	$98,951	$109,000	$107,000	$109,000	$107,000

Using the chart, compare each hospital's FY 2000 PRAs to each hospital's corresponding locality-adjusted national average PRA ceiling for FY 2001. Hospital A's FY 2001 PRAs were already determined to be below the 70 percent floor for FY 2001, so their FY 2000 PRAs clearly do not exceed the ceiling in FY 2001. Hospital B's FY 2000 PRAs also do not exceed the ceiling in FY 2001, so its primary care PRA is updated as usual to FY 2001 with the CPI-U for the January-December cost report, (and its non-primary care PRA is replaced by the locality-adjusted national average PRA floor for FY 2001). However, both of Hospital C's FY 2000 PRAs exceed the FY 2001 ceiling. Therefore, for FY 2001, Hospital C's primary care PRA is frozen at $109,000 and is not updated with the CPI-U for FY 2001, and its non-primary care PRA is frozen at $107,000 and is not updated with the CPI-U for FY 2001.

B. FY 2002 - For cost reporting periods beginning in FY 2002, the methodology used to calculate each hospital's individual PRA would be the same as described above for FY 2001. Each hospital's PRA from the *preceding* cost reporting period (that is, the PRA used to calculate the hospital's DGME payments in FY 2001) is compared to the *FY 2002* locality-adjusted national average PRA. If the individual hospital's FY 2001 PRA exceeds 140 percent of the FY 2002 locality-adjusted national average PRA, the PRA is frozen at the FY 2001 PRA, and is not updated in FY 2002 by the CPI-U factor.

Example: FY 2002:

Hospital	Locality-Adjusted National Average PRA for FY 2002	CEILING—Multiply 1.40 by the Locality-Adjusted National Average PRA for FY 2002	Primary Care PRA for FY 2001	Non-primary Care PRA for FY 2001	PRAs Used for Payment in FY 2002	
A	$72,136	$100,990	$49,795	$49,795	$61,316	
B	$72,330	$101,262	$50,000	$49,931	$61,481	$61,481
C	$71,679	$100,351	$109,000	$107,000	$109,000	$107,000

Using the chart, compare each hospital's FY 2001 PRAs to each hospital's corresponding locality-adjusted national average PRA ceiling for FY 2002. Hospital A's and Hospital B's FY 2001 PRAs do not exceed the ceiling in FY 2002 (they were replaced by the 85 percent floor for FY 2002). However, both of Hospital C's FY 2001 PRAs exceed the FY 2002 ceiling. Therefore, for FY 2002, Hospital C's primary care PRA is frozen at $109,000 and is not updated with the CPI-U for FY 2002. Its non-primary care PRA is frozen at $107,000 and is not updated with the CPI-U for FY 2002.

C. FY 2003, FY 2004, FY 2005 - For cost reporting periods beginning in FY 2003, FY 2004, and FY 2005, if the hospital's PRA for the *previous* cost reporting period is greater than 140 percent of the locality-adjusted national average PRA for that same previous cost reporting period, (e.g., for the cost reporting period beginning in FY 2003, compare the PRA used to calculate the hospital's DGME payments in FY 2002 to the locality-adjusted national average PRA from FY 2002), then the hospital's PRA is updated for inflation, except that the CPI-U applied for a 12-month period is reduced (but not below zero) by 2 percentage points.

Example: FY 2003:

Hospital	**Locality-Adjusted National Average PRA for FY 2002**	**CEILING—Multiply 1.40 by the Locality-Adjusted National Average PRA for FY 2002**	**Primary Care PRA for FY 2002**	**Non-primary Care PRA for FY 2002**	**PRAs Used for Payment in FY 2003**	
A	$72,136	$100,990	$61,316	$61,316	$62,316	
B	$72,330	$101,262	$61,481	$61,481	$62,481	$62,481
C	$71,679	$100,351	$109,000	$107,000	$109,436	$107,428

Hospital A's and B's PRAs for FY 2002 are not above the ceiling for FY 2002. Therefore, their PRAs are updated with the CPI-U of their respective cost reporting period to FY 2003. However, Hospital C's FY 2002 PRAs are above the FY 2002 ceiling of $100,351, and thus, for FY 2003, Hospital A's PRAs are updated with the FY 2003 CPI-U minus 2 percent. If, in this scenario, the CPI-U for FY 2003 for a July-June cost report is 1.024, (Hospital C has a July-June cost report), Hospital C would update its PRAs in FY 2003 by 1.004 (the CPI-U minus 2 percent). Specifically, 1.004 x $109,000 = $109,436, and 1.004 x $107,000 = $107,428.

If the CPI-U factor for FY 2003 would have been 1 percent, and subtracting 2 percent would yield a negative percent, the PRAs for FY 2003 would not be updated (they would remain at $109,000 and $107,000), because the CPI-U cannot be reduced below zero for purposes of updating PRAs that exceed the ceiling.

For cost reporting periods beginning in FY 2004 and FY 2005, the methodology would be identical to the one applied in FY 2003, except that for FY 2004, compare the PRA used to calculate the hospital's DGME payments in FY 2003 to the locality-adjusted national average PRA from FY 2003. Similarly, for FY 2005, compare the PRA used to calculate the hospital's DGME payments in FY 2004 to the locality-adjusted national average PRA from FY 2004. If the hospital's PRA for the *previous* cost reporting period is greater than 140 percent of the locality-adjusted national average PRA for that same previous cost reporting period, then the hospital's PRA is updated for inflation, except that the CPI-U applied for a 12-month period is reduced (but not below zero) by 2 percentage points.

General Rule for Hospitals That Exceed the Ceiling - For cost reporting periods beginning in FY 2001 through FY 2005, if a hospital's PRA exceeds 140 percent of the locality-adjusted national average PRA, and it is adjusted under any of the above criteria, the current year PRA cannot be reduced below 140 percent of the locality-adjusted national average PRA.

For example, to determine the PRA of Hospital D in FY 2003, assume that Hospital D has a FY 2002 PRA of $100,001 and the FY 2002 locality-adjusted national average PRA ceiling is $100,000. For FY 2003, applying the CPI-U factor minus 2 percentage points to $100,001 (for example, 1.024 - .02 = 1.004), would yield an updated PRA of $100,401. Applying the full CPI-U factor of 1.024 to the locality-adjusted national average PRA (before calculation of the ceiling) would result in an increase in the FY 2003 ceiling from $100,000 to $102,400. Consequently, applying the CPI-U minus 2 percentage points to Hospital D's PRA would result in a PRA of $100,401, which is *under* the ceiling of $102,400 for FY 2003. In this situation, for purposes of the FY 2003 cost report, Hospital D's PRA equals $102,400.

If the hospital's PRA does not exceed 140 percent of the locality-adjusted national average PRA, the PRA is updated by the CPI-U for the respective fiscal year. If a hospital's PRA is updated by the CPI-U because it is less than 140 percent of the locality-adjusted national average PRA for a respective fiscal year, and once updated, the PRA exceeds the ceiling for the respective fiscal year, the updated PRA would still be used to calculate the hospital's DGME payments. Whether a hospital's PRA exceeds the ceiling is determined *before* the application of the update factors. If a hospital's PRA exceeds the ceiling only because of the application of the update factors, the hospital's updated PRA would still reflect the CPI-U factors.

For example, if, in FY 2001, the locality-adjusted national average PRA *ceiling* for Area Y is $140,000, and if, in this area, Hospital E has a FY 2000 PRA of $139,000, then for FY 2001, Hospital E's PRA is updated for inflation for FY 2001 because the PRA is below the ceiling. However, once the update factors are applied, Hospital E's PRA is now $142,000 (that is, above the $140,000 ceiling). In this scenario, Hospital E's inflated PRA of $142,000 would be used to calculate its FY 2001 DGME payments because Hospital E's PRA has only exceeded the ceiling after the application of the inflation factors.

The CPI-U Inflation Factors – For cost reporting periods from FY 2001 through FY 2005, once the actual update factors for a cost reporting period (as opposed to the projected update factors) have been issued by HCFA, each hospital's PRAs and its locality-adjusted national average PRA must be compared again to determine whether the PRAs should be revised.

PRAs Greater Than or Equal to the Floor and Less Than or Equal to the Ceiling - For cost reporting periods beginning in FY 2001 through FY 2005, if a hospital's PRA is greater than or equal to 70 percent during FY 2001 (or 85 percent during FY 2002) and less than or equal to 140 percent of the locality-adjusted national average PRA, the hospital's PRA is updated using the existing methodology specified at 42 CFR §413.86(e)(3)(i).

Updating PRAs After FY 2005 - For cost reporting periods beginning in FY 2006 and thereafter, a hospital's PRA for its preceding cost reporting period would be updated using the existing methodology at 42 CFR §413.86(e)(3)(i).

Determining PRAs for New Teaching Hospitals in FY 2001 through FY 2005 – When calculating the weighted mean value of PRAs of hospitals located in the same geographic area or the weighted mean value of the PRAs in the hospital's census region (as specified in 42 CFR §412.62(f)(1)(i)), the PRAs used in the calculation must not be less than the floors for cost reporting periods beginning during FYs 2001 or 2002, or, if they exceed the ceiling, they must either be frozen for FYs 2001 and 2002, or updated with the CPI-U minus 2 percent for FYs 2003 through 2005. In addition, the regulations at 42 CFR §413.86(e)(5) provide that the PRA for a new teaching hospital is based on the *lower of* the hospital's actual costs incurred in connection with the GME program . . . or the weighted mean value of PRAs. In the case where a hospital's actual costs of the GME program during its cost reporting period beginning during FYs 2001 or 2002 are *less* than the floors, the hospital's PRA would *not* be based on the actual costs, but instead would be equal to 70 percent in FY 2001, or 85 percent during FY 2002, of the locality adjusted national average PRA. The floor applies to hospitals with existing PRAs in FYs 2001 and 2002, or to hospitals that are establishing new base year PRAs in FYs 2001 and 2002.

The *effective date* for this PM is cost reporting periods beginning on or after October 1, 2000 for §311 of the BBRA, and cost reporting periods beginning on or after October 1, 2001 for §511 of the BIPA.

The *implementation dates* are specified in this PM for each provision.

For §311 of the BBRA, the *implementation date* is May 5, 2001., *OR* by the first biweekly payment for a hospital's cost reporting period beginning during Federal FY 2001, whichever date is later.

For §511 of the BIPA, the first biweekly payment for a hospital's cost reporting period beginning on or after October 1, 2001.

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 1, 2002.

If you have any questions, contact Tzvi Hefter, 410-786-4487.