

that there has been some confusion and we have had adverse court decisions, we do not anticipate this clarification would have a significant impact on payments. We do not have data available that would enable us to identify those hospitals that have not been applying this policy and, therefore, would be required to change their policy. Consequently, we are unable to quantify the impacts of this clarification.

5. Labor, Delivery, Recovery, and Postpartum Beds and Days

Similarly, in the case of labor, delivery, recovery, and postpartum rooms, we would clarify that it is necessary to apportion the days and costs of a patient stay between the labor/delivery ancillary cost centers and the routine adults and pediatrics cost center on the basis of the percentage of time during the entire stay associated with these various services. Because this is a clarification of existing policy, we do not anticipate this proposed change would have a significant payment impact. However, we do not have data available that would enable us to identify those hospitals that have not been applying this policy and, therefore, would be required to change their policy. Consequently, we are unable to quantify the impacts of this clarification.

6. Days Associated With Demonstration Projects Under Section 1115 of the Act

Some States have demonstration projects that provide family planning or outpatient drug benefits that are limited benefits that do not include Medicaid coverage for inpatient services. In this proposed rule, we also would clarify that any hospital inpatient days attributed to a patient who is not eligible for Medicaid inpatient hospital benefits either under the approved State plan or through a section 1115 waiver must not be counted in the calculation of Medicaid days for purposes of determining a hospital's DSH percentage.

We estimated the potential impact of the proposed clarification to our policy of excluding days associated with inpatients who are eligible only for Medicaid outpatient benefits. We identified the percentage of individuals receiving only outpatient family planning benefits under Medicaid compared to all Medicaid-eligible beneficiaries (this is currently the only outpatient-only category for which we have numbers of eligible beneficiaries). These percentages were calculated on a statewide basis for each State with a family planning benefit. Based on these percentages, assuming family planning beneficiaries use inpatient services at the same rate as all other Medicaid beneficiaries, we estimated the amount of total Medicare DSH payments for each State that may be attributable to family planning beneficiaries' use of inpatient services.

For example, in Alabama, total Medicare DSH payments in 1999 (the latest year for which a complete database of cost reports from all hospitals is available) were \$97.1 million. Because the percentage of family planning beneficiaries to total Medicaid eligible beneficiaries is 11.24 percent, we estimated 11.24 percent of \$97.1 million in Medicare DSH payments, or \$10.9 million, is the maximum amount of Medicare DSH that may currently be attributable to the inclusion

of inpatient days for individuals who are only eligible for outpatient family planning Medicaid benefits. Based on this analysis, we have identified the potential impact upon hospitals to be as much as \$290 million in reduced DSH payments from the Medicare program to those hospitals in FY 2004. Of this amount, \$170 million is attributable to California. This amount is not an impact on State programs nor does it require States to spend any additional money. We also note that we are not aware of any specific hospitals that are including inpatient days attributable to individuals with no inpatient Medicaid benefits. Therefore, this estimate reflects the maximum potential impact, but the actual impact is very likely to be much less.

We are unable to estimate the effect of this clarification on specific hospitals because we are not aware of specific hospitals that are presently including those inpatient days in their calculation of Medicaid days for purposes of determining their Medicare DSH percentage. However, we expect the impact on any particular hospital would be minimal (with no impact on the level of beneficiary services), because the days attributable to patients receiving these limited benefit programs should be only a small portion of the overall Medicaid days at any particular hospital. No other provider types would be affected.

7. Dual-Eligible Patient Days

We are proposing to change our policy for counting days for patients who are Medicare beneficiaries and also eligible for Medicaid, to begin to count in the Medicaid fraction of the DSH patient percentage the patient days of these dual-eligible Medicare beneficiaries whose Medicare coverage has expired. Our current policy regarding dual-eligible patient days is they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient has no Medicare Part A coverage or coverage has been exhausted. However, we recognize it is often difficult for fiscal intermediaries to differentiate the days for dual-eligible patients whose Part A coverage has been exhausted. We believe the impact of this proposed change would be minimal, both because situations where dual-eligible patients exhaust their Medicare benefits occur infrequently, and because, due to the administrative difficulty separately identifying these days, in many cases they are already included in the hospital's Medicaid fraction. Accordingly, we do not have data available to allow us to quantify the impact of this proposed change precisely.

8. Medicare+Choice (M+C) Days

We have received questions whether patients enrolled in a Medicare+Choice (M+C) Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation. The questions stem from whether M+C plan enrollees are entitled to Medicare Part A because M+C plans are administered through Medicare Part C. We are proposing to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient

percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for an M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.

We do not have data readily available to assess the impacts of this proposed change. In particular, it appears likely that there is some variation in how these days are currently being handled from one hospital and fiscal intermediary to the next. Nonetheless, we believe there should not be a major impact associated with this proposed change.

B. Costs of Approved Nursing and Allied Health Education Activities

1. Continuing Education

In section IV.E. of the preamble of this proposed rule, we are proposing to clarify further the distinction between continuing education, which is not eligible for pass-through payment, and approved educational programs, which are eligible for pass-through payment. An approved program that qualifies for pass-through payment is generally a program of long duration designed to develop trained practitioners in a nursing or allied health discipline, such as professional nursing, in which the individual learns "value-added" skills that enable him or her to work in a particular capacity upon completion of the program. Such a program is in contrast to a continuing education program in which a practitioner, such as a registered nurse, receives training in a specialized skill or a new technology. While such training is undoubtedly valuable in enabling the nurse to treat patients with special needs, the nurse, upon completion of the program, continues to function as a registered nurse, albeit one with an additional skill. We are proposing to clarify our policy concerning not allowing pass-through payment for continuing education because it has come to our attention that certain programs, which in our view constitute continuing education, such as pharmacy or clinical pastoral education, are inappropriately receiving pass-through payment.

To the extent that Medicare would no longer pay for such programs as pharmacy and clinical pastoral education, Medicare payments would be reduced. We believe that these two programs comprise a small fraction of the approximately \$230 million that are paid for all nursing and allied health education programs under Medicare.

2. Nonprovider-Operated Nursing and Allied Health Education Programs With Wholly Owned Subsidiary Educational Institutions

As discussed in section IV.E.3. of this proposed rule, we are proposing that Medicare would not recoup reasonable cost payment from hospitals that have received pass-through payment for portions of cost reporting periods occurring on or before October 1, 2003 (the effective date of finalizing this proposed rule) for costs of nursing or allied health education program(s) where the program(s) had originally been operated by the hospital, and then operation