MAY 2001

REPORT TO THE CONGRESS

Medicare Payment for Nursing and Allied Health Education

MEDPAC
Medicare Payment Advisory Commission

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Executive summary

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The Medicare Payment Advisory Commission was required by the Balanced Budget Refinement Act of 1999 to examine Medicare's payments to hospitals for educating nonphysician health professionals. The Commission believes that the principles laid out in our August 1999 report to the Congress regarding Medicare's payments to hospitals that operate approved medical residency programs also apply here. In particular, additional payments to hospitals that educate nonphysican health professionals should be made only if such hospitals incur higher patient care costs and those costs are associated with additional value to Medicare beneficiaries. However, no data are available on the extent of providers' involvement in clinical training of nonphysician health professionals and its impact on patient care costs. We therefore recommend that the Secretary collect the data needed to determine whether adjustments to Medicare payments would be appropriate. The Commission continues to believe that federal policies intended to influence the number, mix, and distribution of health care professionals should be made through specific targeted programs supported by general revenues rather than through Medicare.

Medicare Payment for Nursing and Allied Health Education

RECOMMENDATIONS

1 If the Congress wishes to influence the number, mix, and geographic distribution of health care professionals, it should do so through specific targeted programs supported with general revenues rather than through Medicare payment policies.

*** YES: 12 • NO: 1 • NOT VOTING: 1 • ABSENT: 2**

2 The Secretary should collect data on the number and types of nonphysician health professionals receiving training in clinical settings and study whether providers that participate in such training have higher patient care costs and provide measurably enhanced patient care.

YES: 12 • NO: 1 • NOT VOTING: 1 • ABSENT: 2

***COMMISSIONERS' VOTING RESULTS**

Medicare seeks to ensure access for its beneficiaries to high-quality, medically necessary care in an appropriate setting. To achieve this end, the Medicare Payment Advisory Commission (MedPAC) believes that payments should:

- induce providers to supply care efficiently,
- account for differences in the intensity and complexity of care provided,
- recognize the value of enhanced patient care provided in settings where health professionals train by paying more when the added value justifies higher costs, and
- not intentionally distort the supply of health professionals.

The Balanced Budget Refinement Act of 1999 (BBRA) required MedPAC to study Medicare payments for the clinical training of nonphysician health professionals (such as nurses, nurse practitioners, allied health professionals, physician assistants, and psychologists) and the basis for any difference in treatment among them. The report language accompanying the BBRA noted that the Congress desired additional information on Medicare's role in financing such training beyond what MedPAC considered in our August 1999 report.

The Congress asked the Commission to examine this issue in part because not all hospitals participating in training nonphysician health professionals receive support from Medicare for these activities. In particular, Medicare's payments for nursing and allied health education generally are limited to training programs operated by hospitals. Because most nursing and allied health education programs are instead operated by academic institutions, providers do not receive education payments from Medicare for these programs, even though substantial clinical training may occur in the hospital or other clinical sites. In addition, because certain types of training programs, such as those for clinical psychologists and social workers, are almost never based in hospitals, hospitals do not receive education payments for these programs even though extensive clinical training may take place.

In our August 1999 report on Medicare's payments to teaching hospitals, the Commission concluded that:

- Residents bear the cost of training.
- The direct costs of operating approved medical residency programs are, in fact, payments for patient care. Therefore, it would be appropriate to fold inpatient graduate medical education (GME) costs into base prospective payment system (PPS) rates.
- The higher costs of care observed in teaching hospitals are associated with enhanced value to Medicare beneficiaries and should continue to be paid through a separate add-on to base PPS rates.

What do these conclusions mean for Medicare payments for the training of nonphysician health professionals?

- As with physician training, the direct costs of operating a program are borne by trainees, either through tuition payments or lower salaries than they would otherwise receive.

- If hospitals or other providers operating or participating in training programs for nonphysician health professionals have higher costs—and those costs are associated with enhanced value to Medicare beneficiaries—it is appropriate for Medicare to pay those costs through an add-on to base payment rates.

Developing policies based on these conclusions would present two problems, however. First, limited information is available on how much clinical training of nurses and allied health professionals takes place in hospitals and other settings. We know which hospitals receive Medical education payments, but we do not know which hospitals participate in clinical training or how much clinical training takes place in hospitals or other settings. Second, we have only limited data on whether hospitals that participate in such training have higher patient care costs and whether those higher costs are associated with higher-quality care or added services that enhance the value of the care provided to Medicare beneficiaries.

The Commission needs more information before endorsing either an enhanced patient care adjustment or a specific payment add-on for the clinical training of nonphysician health professionals.

Historical context

Since Medicare's inception, the program has reimbursed certain educational costs for nursing and other allied health professionals. These costs were recognized as allowable expenses for providers because the Congress believed that educational activities enhance the quality of care in an institution and that the Medicare program had a responsibility to share in these costs until the community covered them in some other way. When Medicare began in 1965, most training for nonphysician health professionals was hospital operated. For example, over 80 percent of training for registered nurses (RNs) historically took place in hospital-based diploma training programs (Coffman et al. 1999). Over the past three decades, however, the environment in which nurses and allied health professionals are trained has changed substantially, with the emphasis shifting from a hospital-based apprenticeship model to an academic model. Only 7 percent of basic registered nurse graduates currently come from hospital-based diploma programs. Similarly, most education programs for nonphysician health professionals are operated by academic institutions, such as universities and community colleges. Despite this shift in sponsorship, training programs continue to rely on hospitals, clinics, nursing homes, and other settings for clinical training sites.

The Medicare program also has always recognized as allowable patient care expenses the costs of clinical training incurred by providers for students in approved educational activities operated by entities other than the provider, such as universities. Classroom costs incurred by the provider for these programs were also allowable if they did not entail a shift in financial responsibility from the educational institution to the provider, the provider clearly benefited from these activities, and the incurred costs were less than if the provider were the legal operator of the program.

Current payment policies

When the Health Care Financing Administration (HCFA) implemented prospective payment for inpatient hospital services, it excluded the costs of provider-operated training programs from the base payment rate.[1] HCFA paid providers for these costs separately, through a so-called education pass-through. Although these payments are labeled as education, they go to providers along with other payments for patient care services; Medicare does not provide separate payments to educational institutions or programs operated by a hospital. In contrast, the costs of clinical training in hospitals—for students enrolled in programs operated by academic institutions—were considered normal operating costs and included in prospective payments (consistent with MedPAC's view about these expenses). These costs were folded into base PPS rates because HCFA (and the Congress) believed that hospitals benefited from participating in clinical training through services provided by trainees, potential recruitment of trainees, and lower training costs for new employees when trainees were hired.[2] Policymakers also believed that the shift in health professions education from hospital-operated programs to programs operated by universities and community colleges was recognition that the community was undertaking the role of supporting education expenses, and therefore separate Medicare support was no longer required.

To be eligible to receive payment for costs associated with its nursing or allied health education program, a provider must:

- directly incur the training costs;
- directly control the program curriculum;
- control the administration of the program, including collecting tuition;
- employ the teaching staff; and
- provide and control both classroom instruction and clinical training (where classroom instruction is a requirement for program completion).

In addition, the training program also must be recognized by a national approving body or state licensing organization.[3]

In some circumstances, hospitals that do not directly operate a health professions training program may receive payments for the net costs of training they incur if they received payment for these services in 1989 and if several other conditions are met.[4] Net costs are determined by deducting tuition, student fees, and state and local grants from a provider's total education costs. Net costs are then apportioned to reflect Medicare's share of these expenses. Costs of related organizations are not recognized in the definition of net costs.

[1] These costs are also excluded from the target amount calculations for hospitals and hospital units exempt from the prospective payment system.

[2] When the PPS was first implemented, the Congress did not explicitly address this issue. However, in the Omnibus Budget Reconciliation Act of 1990 the Congress essentially concurred with HCFA and tightened payment policies so that hospitals would receive pass-through payments only for provider-operated programs (with an exception for some nonprovider-operated programs).

[3] HCFA once kept a list of approved nursing and allied health profession training programs that qualified for pass-through payments. Recent regulations eliminated this list and replaced it with a broader principle requiring that the program be an organized course of study licensed by state law, or if state licensing is not required, that it be accredited by the relevant recognized national professional organization (HCFA 2001a).

[4] This exception came about because of inconsistencies between the regulations implementing the inpatient prospective payment system and the Provider Reimbursement Manual, which was not revised to reflect changes in the regulations on the treatment of educational expenses. Regulations take precedence over the reimbursement manual, but some providers continued to follow the manual and received education pass-through payments for clinical training costs of programs they did not directly operate. The Congress allowed hospitals that made this error to continue to receive pass-through payments as long as certain criteria were met.

Licensed health care professionals may be reimbursed under Medicare Part B for the services they furnish in the course of training others. Services provided by trainees generally are not reimbursable under Part B, even though licensed health professionals may supervise the services.[5] For example, physical therapists may not receive reimbursement for the time a student provides therapy to a patient, even when an instructor supervises the student. If care is provided jointly by the instructor and student, however, services may be reimbursed. A provider's participation in health professions training, therefore, may lead to lower Part B reimbursements. Hospital-operated training programs may claim these costs as part of the education pass-through, but in nonprovider-operated programs the services may go unreimbursed. Alternatively, these payment rules may lead to more joint care than supervised care, with the same reimbursement but less learning. The Commission will explore Part B reimbursement issues for nonphysician providers further as part of a mandated report due in 2002.

Medicare funding and hospitals receiving payments

Medicare's current pass-through payments for costs associated with training nursing and allied health professionals total about $260 million, approximately three times the amount spent on training programs for nurses and allied health professionals administered by the Bureau of Health Professions (see text box, page 7). About 700 hospitals receive Medicare pass-through payments; roughly two-thirds of these hospitals also receive payments for residency training programs. A relatively large proportion of hospitals with residency training programs receive payments for training nurses and allied health professionals—about one-half of major teaching hospitals and two-fifths of other teaching hospitals.

Only a fraction of facilities that provide clinical training for nurses and allied health professionals receives the education pass-through from Medicare. In 1997, fewer than 300 hospitals received nursing education payments, representing less than one-fifth of all registered nurse training programs in the country. The average pass-through payment for these hospitals was about $600,000. Almost twice as many hospitals (about 550) received payments for allied health education training programs, with an average pass-through payment of around $150,000.

MedPAC's views on Medicare's support for health professions education

Many in the health professions education community have noted that Medicare's education pass-through payments support only a limited number of nursing and allied health training programs, and that hospital-based training programs are no longer the norm for health professions training. They advocate redirecting (and possibly expanding) Medicare funding to support clinical training costs in hospitals for academic-based training programs, providing support for other clinical training sites, and potentially directing funding to academic institutions rather than providers.

[5] The exception is for services furnished by residents. Supervising physicians may be reimbursed for services provided by residents as long as they provide appropriate supervision and documentation.

Programs sponsored by the Bureau of Health Professions to support training of nonphysician health professionals

In fiscal year 2001, the Bureau of Health Professions and the Bureau of Primary Health Care devoted almost $100 million to education programs for nursing and allied health professionals—just more than 20 percent of approximately $460 million devoted to health professions education, including scholarship and loan repayment funds from the National Health Service Corps. Titles VII and VIII of the Public Health Service Act authorize competitive grants to organizations that train and educate the health care workforce. Under these titles, the Bureau of Health Professions administers about 40 grant programs for educating and training physicians, nurses, dentists, allied health professionals, and public health practioners at about 1,700 institutions. Title VII programs support physician, dentist, and allied health profession training, with most of the funding dedicated to training in primary care medicine and dentistry and medical student diversity. Title VIII programs support nursing education.

Title VII programs

- Allied health projects ($8.4 million)—to help eligible entities expand or establish programs to increase the number of individuals trained in allied health professions.
- Physician assistant training in primary care ($4.0 million)—to help accredited schools of allopathic or osteopathic medicine and other accredited public or private nonprofit training programs meet the costs of planning, developing, operating, or maintaining projects to train physician assistants, and to train teachers for such programs.
- National Health Service Corps scholarships ($8.4 million)—provides scholarships to physician assistants, nurse practitioners, and certified nurse midwives in exchange for service in recognized Health Professional Shortage Areas.

Title VIII programs

- Advanced nursing education ($59.0 million)—to support accredited programs in advanced nursing education, including master's degree programs, post-master's certificate programs, and nurse-midwifery certificate programs. Graduates serve as nurse practitioners, clinical nurse specialists, nurse midwives, nurse anesthetists, nurse educators, nurse administrators, and public health nurses.
- Basic nursing education and practice ($12.8 million)—to strengthen programs that provide basic nurse education.
- Nursing workforce diversity ($4.7 million)—to increase opportunities for individuals from disadvantaged backgrounds, including racial and ethnic minorities underrepresented among registered nurses.
- Nursing loan repayment ($2.3 million)—provides 85 percent loan repayment for entry-level registered nurses and advanced practice nurses who agree to work for at least two years in health facilities with a critical shortage of nurses. ■

In MedPAC's August 1999 report to the Congress on Medicare payments for graduate medical education and teaching hospitals, the Commission concluded that residents bear the cost of their training by receiving lower wages than they might otherwise and, therefore, that Medicare payments for direct GME costs should be considered patient care expenses (MedPAC 1999). The Commission subsequently recommended folding costs for inpatient direct GME into PPS rates through a revised adjustment to teaching hospital payments (MedPAC 2000).

Although the Commission's report focused on residency training for physicians, we noted that the same reasoning applies to training for nonphysician health professionals. The Commission therefore recommended that payment adjustments be developed in settings where nonphysician health professionals train when the added value of patient care justifies its higher costs. We noted, however, the lack of available data showing which providers train specific categories of health professionals and that such data would need to be collected before determining whether these providers have higher patient care costs that might warrant a payment adjustment. The Commission also recommended that federal policies intended to affect the number, specialty mix, and geographic distribution of health care professionals be implemented through specific targeted programs rather than through Medicare payment policies.

Given the Commission's earlier conclusions, the following questions arise for Medicare's payments for nursing and allied health education.

- Is care in hospitals that provide clinical training in nursing and allied health professions more costly than in other hospitals after controlling for current payment system parameters?
- Does such training contribute to enhanced patient care in these settings?
- Is training for nonphysician health professions different from residency training?
- Should a shortage of nurses and other health care professionals affect Medicare's role?
- Can hospitals' involvement in nonphysician health professional training be quantified to permit adjustments to the payment rates?
- Should payment rates for patient care be adjusted to reflect the extent of hospital participation in training programs?
- Should Medicare payment policies for clinical training be consistent across all types of nonphysician providers?

Are costs higher for hospitals that train nonphysician health professionals?

We lack the data to analyze thoroughly the relationship between nonphysician training and Medicare costs per case. The only available information is Medicare pass-through payments for hospital-operated nursing and allied health profession training programs. These data can determine only whether the presence of a hospital-operated training program is associated with higher patient care costs; they do not help us assess the relationship between a hospital's level of involvement in these training programs and costs per case or whether hospitals that participate in clinical training but do not receive pass-through payments have higher patient care costs than the average for all hospitals.

Our analysis shows that when education pass-through payments for nursing and allied training programs are added back into base operating costs, per case costs for these hospitals are 1.8 percent higher than average, after controlling for other cost-related payment system factors including case mix, wage index, and resident intensity (as measured by the ratio of residents to hospital beds).[6] Although this analysis provides some indication that hospitals that participate in nonphysician health profession training have higher costs, it has serious limitations. First, the magnitude of the cost difference is potentially understated because facilities that participate in nursing and allied health training but receive no pass-through payments are in the comparison group and counted as not participating. If their costs were higher, the observed difference would understate the actual difference. Second, the observed cost effect may partially reflect classroom costs that nonhospital-operated programs do not incur and that are not fully offset by tuition payments from students. In addition, cost-based pass-through payments provide little incentive for hospitals to produce services efficiently and may result in hospitals shifting education costs from students to the Medicare program. Finally, the analysis cannot discern the relationship between the level of involvement in nursing and allied health education and costs per case.

The actual relationship between teaching and costs per case thus remains unknown. To provide a more thorough analysis of the relationship, additional data would need to be collected on the number and types of nonphysician trainees involved in clinical training in programs operated by both providers and nonproviders.

Does training contribute to enhanced patient care?

MedPAC has assumed that residency training enhances the quality of patient care in a facility. We note, however, that Medicare buys a different product in teaching hospitals: more complex cases, more sophisticated technologies, and extra services. More research is needed to determine whether a parallel assumption can be made for the different types of nonphysician health profession training. Establishing that enhanced care exists is an essential element for determining whether Medicare should recognize the potentially higher costs of facilities participating in the clinical training of nonphysician health professionals. A separate payment adjustment would be warranted only if it could be established that costs were higher and that those costs were associated with additional value to Medicare patients.

[6] These higher patient care costs are observed only when pass-through costs for nursing and allied health profession training programs are added back into PPS operating costs. In other words, there is no indirect cost effect similar to what is seen with hospitals that train residents.

Is training for nonphysician health professionals different from residency training?

Training for nonphysician health professionals differs from residency training in two respects. First, nursing and allied health education are pursued before degrees and licenses to practice are issued.[7] The education consists of both classroom and clinical education. In contrast, residency training is pursued after a medical degree is conferred and consists almost exclusively of clinical training. This difference in the level of educational attainment may be relevant to whether extra care provided in teaching settings is of higher value.

Second, residents receive a stipend during their clinical training, whereas most nurses and other nonphysician health professionals pay tuition. Although this is consistent with the Commission's view that students pay for the cost of their training, the tuition may not reflect the actual cost of training because academic institutions often charge uniform tuition across fields. The potentially higher costs of nursing and other health professions education therefore are frequently subsidized by other parts of educational institutions. A further subsidy is provided when patient care facilities furnish clinical training to students without charging the school or the student for the net costs of such training. Generally, providers have not charged for such training, which means either that they receive a net benefit or are willing to subsidize training because education is one of their missions. Anecdotal evidence suggests that training programs for nursing and allied health professionals are having some difficulty finding facilities willing to provide clinical training because of the potentially higher costs and decreased productivity associated with such training, although hospital-based programs are able to claim some of these higher costs as part of the Medicare's pass-through payment. Providers that participate in clinical training but that do not directly operate the program either need to absorb training costs, charge education institutions or students a fee for providing clinical training, or stop providing clinical training.

Should a shortage of nurses and other health care professionals affect Medicare's role?

A well-trained supply of health care professionals is essential to providing quality care for Medicare beneficiaries. Recent reports of potential shortages of nurses and other health care professionals have focused attention on ways to combat an impending shortage of health care workers. Medicare's pass-through payments for nursing and allied health professions education are often cited as a potential source of support, although the Commission views these payments as support for patient care, not education.

RECOMMENDATION 1

If the Congress wishes to influence the number, mix, and geographic distribution of health care professionals, it should do so through specific targeted programs supported with general revenues rather than through Medicare payment policies.

[7] Although registered nurses pursuing advanced practice degrees are licensed (like residents), they generally are not eligible to receive separate Part B payments for the services they provide until they complete their degrees and receive certification.

In our August 1999 report, the Commission concluded that Medicare payment policy is too blunt an instrument to rely on to achieve specific workforce goals. The ability of Medicare to address workforce shortages through the education pass-through is limited and these payments do not necessarily provide resources where they are most needed. In addition, the program should focus on whether payment rates for its various services are adequate to ensure beneficiaries' access to care.

Can hospitals' involvement in training be quantified?

To establish hospitals' involvement in training nurses and allied health professionals, and whether facilities that provide training produce a different patient care product that might warrant higher payments, we need data on the number and types of trainees in different clinical settings, on whether facilities that participate in clinical training have higher costs, and on whether products in these facilities are of higher value. Currently, these data do not exist.

RECOMMENDATION 2

The Secretary should collect data on the number and types of nonphysician health professionals receiving training in clinical settings and study whether providers that participate in such training have higher patient care costs and provide measurably enhanced patient care.

Because data would need to be collected on the number and types of trainees in different clinical settings, the process of answering questions about training costs and benefits could be complex and time consuming. Providers, for instance, may not be fully aware of the number of trainees in their facilities, particularly if they do not directly operate the program. Individual training programs, for credentialing and other reasons, likely keep better track of where and how long their students train at different clinical sites and thus may be better sources for these data. However, the number of training programs that would need to be surveyed is potentially large, and the process would likely be complicated by the fact that training programs likely use multiple clinical sites which may change over time. Therefore, it might be necessary to limit the types of health professions examined.

Should payment rates be adjusted?

Until data are collected on the number of nonphysician trainees in different clinical settings, a specific payment adjustment cannot be developed to reflect the potentially higher patient care costs of these facilities. Ultimately, the Medicare program should adjust payment rates for patient care to reflect the actual relationship (if any) between providers' involvement in clinical training and the costs of caring for patients if the added costs are commensurate with the added value of the care received.

The current pass-through payment provides no incentive for efficiency; if expanded to cover all clinical training, it might encourage a reallocation of costs from education institutions to providers, with a potentially large effect on Medicare payments. Despite the problems with the current education pass-through, the Commission is not recommending any specific changes in the payment until more information is available. Given the current shortage of certain health care personnel, we are reluctant to recommend eliminating pass-through payments without alternative programs that might take the place of the current payment. Medicare payment policies, though, are not the appropriate vehicle for promoting such alternative programs.

Should Medicare payment policies for clinical training be consistent across all types of nonphysician providers?

The Congress also asked the Commission to examine the basis for any differences in the treatment of nonphysician health professions in Medicare's payment policies for clinical training. Certain types of training programs, such as those for clinical psychologists and physician assistants, are almost never recognized for pass-through payments, possibly because many health professions were not included on HCFA's original list of approved education programs. However, HCFA has eliminated this list and replaced it with a consistent set of standards that hospitals and the training programs they support must meet to claim education pass-through payments. With this change, HCFA will treat health profession programs more equally, although programs operated by providers and nonproviders will still be treated differently. Many health professions will continue to be disadvantaged by this policy because their programs are almost never provider-operated and thus will never receive pass-through payments.[8] As discussed above, if the presence of a particular type of health profession training results in higher patient care costs and there is added value commensurate with these higher costs, payment rates should be adjusted to reflect this relationship. The various nonphysician health professions should be treated equally with regard to this standard. ■

[8] A proposed rule issued by HCFA (consistent with the conference agreement language accompanying the Balanced Budget Act of 1997) would allow hospitals to be paid their reasonable cost for clinical training costs of psychologists if they operate the clinical training portion of the program (HCFA 2001b).

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Commissioners' voting on recommendations

In the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), the Congress required MedPAC to call for individual Commissioner votes on each recommendation, and to document the voting record in its report. The information below satisfies that mandate.

Recommendation 1

If the Congress wishes to influence the number, mix and geographic distribution of health care professionals, it should do so through specific targeted programs supported with general revenues rather than through Medicare payment policies.

Yes:	*Braun, Hackbarth, Loop, Nelson, Newhouse, Newport, Raphael, Reischauer, Rosenblatt, Smith, Stowers, Wilensky*
No:	*Wakefield*
Not voting:	*DeBusk*
Absent:	*Johnson, Rowe*

Recommendation 2

The Secretary should collect data on the number and types of nonphysician health professionals receiving training in clinical settings and study whether providers that participate in such training have higher patient care costs and provide measurably enhanced patient care.

Yes:	*Braun, DeBusk, Loop, Nelson, Newport, Raphael, Reischauer, Rosenblatt, Smith, Stowers, Wakefield, Wilensky*
No:	*Hackbarth*
Not voting:	*Newhouse*
Absent:	*Johnson, Rowe*

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