Were the MAC’s adjustments to disallow inpatient and outpatient pass-through reimbursement and the allied health Managed Care payment for the Providers’ Pharmacy Residency Programs appropriate and in accordance with 42 C.F.R. § 413.85?

# Facts

In reviewing the legal operator status of the Nursing Allied Health Education Program – Pharmacy Residency Program, the MAC determined that the program does not meet the requirements to be a provider operator program; therefore, costs associated with the Pharmacy Residency Program cannot be reimbursed as pass-through payment.

**Scottsdale Osborn Medical Center, 03-0038, 12/31/17**

The MAC adjusted to remove provider’s eligibility for pass-through payment with adjustments 5 and 24.

Adjustment 5 **(Exhibit C-2)** is to remove provider’s eligibility for pass-through payment for Pharmacy Residency Program by changing the response on the cost report worksheet S-2 part I line 60 from a “Y” to a “N”. Adjustment 24 eliminated passthrough treatment for the Pharmacy Residency Program costs on WS B-2 in accordance with 42 CFR 413.85.

The MAC’s review is documented on workpaper LD-1 which is included as **Exhibit C-3**. The audit adjustments were in accordance with Medicare Regulations 42 C.F.R. § 413.85 and CMS Pub. 15-1, Section 404.

**Scottsdale Shea Medical Center, 03-0087, 12/31/17**

The MAC adjusted to remove provider’s eligibility for pass-through payment with adjustment 27.

Adjustment 27 **(Exhibit C-4)** is reclassing Pharmacy Residency Program costs and B-1 allocation statistics from cost center line 23.00 to cost center line 5.00 in accordance with 42 CFR 413.85.

The MAC’s review is documented on workpaper L-D01 which is included as **Exhibit C-5**. The audit adjustments were in accordance with Medicare Regulations 42 C.F.R. § 413.85 and CMS Pub. 15-1, Section 404.

**John C. Lincoln Medical Center, 03-0014, 12/31/17**

The MAC adjusted to remove provider’s eligibility for pass-through payment with adjustments 5 and 10.

Adjustment 5 **(Exhibit C-6)** is to remove provider’s eligibility for pass-through payment for Pharmacy Residency Program by changing the response on the cost report worksheet S-2 part I line 60 from a “Y” to a “N”. Adjustment 10 is reclassing Pharmacy Residency Program costs and B-1 allocation statistics from cost center line 23.00 to cost center line 5.00 in accordance with 42 CFR 413.85.

The MAC’s review is documented on workpaper L-D01 which is included as **Exhibit C-7**. The audit adjustments were in accordance with Medicare Regulations 42 C.F.R. § 413.85 and CMS Pub. 15-1, Section 404.

**Background of Medicare Nursing School and Allied Health Education Program Cost Reimbursement**

From its inception in 1966, until 1983, Medicare paid for covered hospital inpatient services on the basis of "reasonable cost." Section 1861(v)(1)(A) of the Act defines "reasonable costs" as "the cost actually incurred," less any costs "unnecessary in the efficient delivery of needed health services." While Section 1861(v)(1)(A) does not prescribe specific procedures for calculating reasonable cost, it authorizes the Secretary to promulgate regulations setting forth the methods to determine reasonable cost and the items to be included in reimbursable services.

In addition, Medicare historically has paid a share of the net costs of "approved medical education activities" under the reasonable cost provisions. The regulations at 42 C.F.R. § 413.85(c) define approved educational activities as:

…formally organized or planned programs of study of the type that:

(1) Are operated by providers as specified in paragraph (f) of this section;

(2) Enhance the quality of health care at the provider; and

(3) Meet the requirements of paragraph (e) of this section for State licensure or accreditation.

The approved educational activities include approved training programs for physicians, nurses, and certain paramedical health professionals. Under the reasonable cost system, the allowable costs of the activities included: trainee stipends, compensation of teachers and other direct and indirect costs of the activities as determined under Medicare cost finding principles.

Medicare has consistently recognized programs operated by a provider, or jointly by a group of providers, as an allowable cost of the provider. As explained in the September 22, 1992 Federal Register, at pages 43661 – 43662, the Provider Reimbursement Manual (PRM) has stated since 1975 that an approved nursing or paramedical education program must be operated by a provider. Specifically, Section 404.2 stated in 1975 that:

However, it is not intended that Medicare should be responsible for expenditures by a provider in subsidizing such programs that are operated by other organizations. Under Medicare principles of reimbursement, an approved nursing or paramedical education program must be operated by a provider (or jointly by a group of providers) for Medicare to recognize the costs of the program as allowable costs of the provider(s).

Notably, the term "provider of services" means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility home health agency, or hospice program (Section 1861(u) of the Social Security Act (Act)). To be eligible for Medicare payments, an entity must be a "provider" with a provider agreement (42 U.S.C. §1395cc(a)(1)). Consequently, when CMS refers to a program jointly operated by a group of providers it is referring to a program operated by entities that meet the definition of a provider under the Act.

In 1982, Congress modified the Medicare program to provide hospitals with better incentives to render services more efficiently. Pursuant to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Congress amended the Act by imposing a ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital. Payments made pursuant to the TEFRA ceiling on the rate-of-increase are determined based upon the target amount which is derived from the hospital's allowable net Medicare operating costs in the hospital's base year. However, under § 1886(a)(4), approved medical education costs were excluded from the definition of inpatient operating costs for purposes of the TEFRA base year and, thus, were not included in the hospital's TEFRA base year for purposes of determining the hospital's target amount.

In 1983, Section 1886(d) of the Act was amended to establish the prospective payment system (PPS) for reimbursement of inpatient hospital services furnished to Medicare beneficiaries. Under PPS, providers are reimbursed their inpatient operating costs based on prospectively determined national and regional rates for each patient discharge, rather than on the basis of reasonable operating costs.

Under §§1886(a)(4) and (d)(1)(A) of the Act, the costs of approved medical education activities were specifically excluded from the definition of "inpatient operating costs" and, thus, were not included in the PPS hospital-specific, regional, or national payment rates or in the target amount for hospitals not subject to PPS. Instead, payment for approved medical education activities costs were separately identified and "pass-through," i.e., paid on a reasonable cost basis. Under PPS, all other costs that can be identified and categorized as costs of educational programs and activities are considered to be part of normal operating costs covered by the per case payments made under the PPS for hospitals subject to that system. This approach was similar to the treatment that these costs had received since 1979 for purposes of the cost limits.

The regulation implementing PPS at 42 C.F.R. § 412.113(b) provides that the costs of "approved education activities," including training programs for nurses and paramedical (allied health) professionals, will be paid on a reasonable cost basis, as defined in 42 C.F.R. § 413.85. In conjunction with the implementation of PPS, the regulations at 42 C.F.R. § 413.85 were amended. The regulation at 42 C.F.R. § 413.85 sets forth the applicable principles for reimbursing the reasonable cost of educational activities under the Medicare program, and explicitly defines the types of approved educational activities which are within the scope of these reimbursement principles.

The regulation at 42 C.F.R. § 413.85(h) lists several types of activities which CMS does not recognize as within the scope of approved educational activities. These activities are reimbursed on the inpatient side as normal operating costs and, thus, where applicable, through a provider's diagnosis-related group (DRG) payments, rather than as a pass-through cost. Specific to the facts in this case, 42 C.F.R. § 413.85(h)(6) excludes clinical training of students enrolled in an approved education program not operated by the provider.

In an effort to clarify the circumstances under which the costs of approved educational activities would be paid on a reasonable cost basis, and thus, eligible for pass-through reimbursement, HCFA (currently CMS) explained in the January 3, 1984 *Federal Register*, Final Rule, entitled "Medicare Program; Prospective Payment for Medicare Inpatient Hospital Services," that:

We believe that only the costs of those approved medical education programs *operated directly by a hospital* be excluded from the prospective payment system. If a program is operated by another institution, such as a nearby college or university, if [it] must be noted that by far the majority of the costs of that program are borne by that other institution, and not by the hospital. While it is true that the hospital may incur some costs associated with its provision of clinical training to students enrolled in a nearby institution, the hospital also gains in return.... We do not believe that this type of relationship was what Congress intended when it provided for a pass-through of the costs of approved medical education programs. Rather we believe that Congress was concerned with those programs that a hospital operated itself, and for which it incurs substantial direct costs.

*We are revising 42 C.F.R. §405.421(d)(6) [now 42 C.F.R. §413.85(h)(6)] to clarify that the costs of clinical training for students enrolled in programs, other than at the hospital, are normal operating costs*." (Emphasis added.) 49 FR 267 (Jan. 3, 1984).

Therefore, since October 1, 1983, only the costs of programs operated directly by a hospital are paid on a reasonable cost basis and excluded from PPS. Other allowable costs are reimbursed as normal operating costs.

CMS responded to a 1989 congressional directive, which instructed regulations to be issued by July 1, 1990 to clarify the criteria for reasonable cost reimbursement of nursing and allied health education costs, by issuing a proposed rule in 57 FR 43669 – 43670 (Sept. 22, 1992). CMS proposed the following five criteria that a nursing or allied health education program would have to meet to be considered provider-operated:

* The provider must incur the costs associated with the training, for example, the cost for books, supplies, and faculty salaries.
* The provider must directly control the program curriculum, that is, the provider must determine the requirements to be met for graduation. In meeting this requirement, a provider may enter into an agreement with a college or university to provide the basic academic course requirements leading to a degree, diploma, or other certificate, while the provider is directly responsible for providing the courses relating to the theory and practice of the nursing or allied health profession that are required for the degree, diploma, or certificate awarded at completion of the program.
* The provider must control the administrative duties relating to the program. These duties include the collection of tuition, maintaining payroll records for the teaching staff, and being responsible for the day-to-day operation of the entire training program.
* The provider must employ the faculty.
* The provider must provide and control both classroom instruction and clinical training.

This proposed rule was made final in 66 FR 3358 – 3376 (Jan. 12, 2001). This final rule restated that in order for a hospital to receive pass through payment for the nursing and allied health education costs it must meet the criteria outlined above. CMS provided further discussion and guidance about reimbursement for Nursing and Allied Health Education Programs in the August 1, 2003 Federal Register, specifically in 68 FR 45423 – 45434 (Aug. 1, 2003).

CMS recently published on August 17, 2018, a clarification of its reasonable cost payment policies for Nursing and Allied Health Education Programs. A comment pertinent to this case states:

It is a reality that many previously provider-operated programs are no longer compliant with all provider-operated criteria at §413.85(f)(1) and should not be receiving Medicare pass-through payments. We stress that *in all cases, the burden of proof is on the hospital to demonstrate that its program is meeting the 5 criteria listed at §413.85(f)(1) for provider-operated status*.

**Argument**

This appeal concerns a dispute involving the determination of provider operated status for the Nursing Allied Health Education program, a Pharmacy Residency Program. Provider contends that the program meets all the requirements of a provider operated programs and therefore is eligible for pass-through payment.

The MAC review and the adjustments posted to determine that the Pharmacy Residency Program does not meet the provider operated status were in accordance with 42 C.F.R. §§ 413.85, 413.20 and 413.24.

It is the Provider’s responsibility to provide adequate documentation to support its claim. Medicare regulation 42 C.F.R. § 413.20 states:

Financial data and reports.

(a) General. The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program.

Medicare regulation 42 C.F.R. § 413.24(c) states:

Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

It is the MAC’s position that the Provider’s programs do not meet the requirements of 42 C.F.R § 413.85(d) or (f). One of the payment components for an approved educational activity, as stated in 42 C.F.R. § 413.85(d)(1)(i)(B):

Meets the criteria specified in paragraph (f) of this section for identification as an operator of an approved education program.

The regulation at 42 C.F.R. § 413.85(f) states:

(f) *Criteria for identifying programs operated by a provider.*

(1) Except as provided in paragraph (f)(2) of this section, for cost reporting periods beginning on or after October 1, 1983, in order to be considered the operator of an approved nursing or allied health education program, a provider must meet all of the following requirements:

(i) Directly incur the training costs.

(ii) Have direct control of the program curriculum. (A provider may enter into an agreement with an educational institution to furnish basic academic courses required for completion of the program, but the provider must provide all of the courses relating to the theory and practice of the nursing or allied health profession involved that are required for the degree, diploma, or certificate awarded at the completion of the program.)

(iii) Control the administration of the program, including collection of tuition (where applicable), control the maintenance of payroll records of teaching staff or students, or both (where applicable), and be responsible for day-to-day program operation. (A provider may contract with another entity to perform some administrative functions, but the provider must maintain control over all aspects of the contracted functions.)

(iv) Employ the teaching staff.

(v) Provide and control both classroom instruction and clinical training (where classroom instruction is a requirement for program completion), subject to the parenthetical sentence in paragraph (f)(1)(ii) of this section.

(2) Absent evidence to the contrary, the provider that issues the degree, diploma, or other certificate upon successful completion of an approved education program is assumed to meet all of the criteria set forth in paragraph (f)(1) of this section and to be the operator of the program.

During its review of the Pharmacy Residency Program, the MAC determined that the Provider did not directly incur all the program training costs, did not have full control of the program administration, and did not employ the program teaching staff. See Exhibit C-3 for 03-0038, Exhibit C-5 for 03-0087 and Exhibit C-7 for 03-0014.

The MAC points to 68 FR 45433 (Aug. 1, 2003) that discusses related-entity rules, stating:

… for purposes of nursing or allied health education payment under § 413.85, it is not sufficient for a program to be operated by a related entity. Rather, the ‘‘related entity’’ principles do not apply under the agency’s nursing and allied health education payment policy because, as indicated in previous rulemakings, that policy requires that a program be directly operated by the provider itself. Requiring direct operation of a program by the provider ensures that, under § 413.85(c), costs borne by related organizations (that is, the community) are not redistributed to the hospital and claimed as a pass-through under the Medicare program.

The MAC argues that for a provider to qualify for a pass-through cost treatment they must meet the direct-operated standard. This standard is supported by the decisions reached in *Baptist Health v. Thompson*, U.S. Court of Appeals for the Eighth Circuit No. 05-4372 (August 15, 2006); *Community Care Foundation v. Thompson*, U.S. Court of Appeals for the District of Columbia Circuit No. 01-5295 (Feb. 7, 2003); and *Rapid City Regional Hospital v. BCBS Association/Wellmark*, CMS Administrator Decision, (May 24, 2000).

On page 13 of the Provider Preliminary Position Paper, The Provider states: “During the

MAC’s audit of the Programs, the Providers gave the auditors numerous documents and

information which fully demonstrated the Programs were controlled by the Providers and not the home office. However, this documentation was disregarded solely on the basis of the minor involvement of the home office for the processing of centralized payroll.”

The MAC has a different point of view related to the documentation provided. The documentation was reviewed, and it was determined that the requirements for passthrough treatment under 42 C.F.R. § 413.85(f) were not met. See Exhibit C-3 for 03-0038, Exhibit C-5 for 03-0087 and Exhibit C-7 for 03-0014.

The MAC’s determination is further supported by the Board’s recent decision in *St. Vincent Charity Medical Center vs. CGS Administrators*, PRRB Decision 2020-D16, August 14, 2020 (St. Vincent). (**Exhibit C-8**). In that appeal, *St. Vincent* asserted it was the operator of a clinical pastoral care education program (CPE Program). The MAC argued that the accreditation was held by the home office and *St. Vincent* did not meet each of the five criteria in 42 C.F.R § 413.85(f)(1). The Board stated:

In summary, while there is no question St. Vincent played a significant (if not dominant) role in the CPE Program during FYs 2010, 2011 and 2012, the evidence is clear that St. Vincent did not hold the accreditation for the CPE Program and did not meet all of the requirements as outlined in 42 C.F.R. § 413.85(f)(1) to be considered the “operator” of the CPE program.

The same is true in this case. While the Providers (03-0038, 03-0087 and 03-0014) may have “played a significant (if not dominant) role” in the Pharmacy Residency Program (PRP), the Provider “did not meet all of the requirements as outlined in 42 C.F.R. § 413.85(f)(1) to be considered the ‘operator’” of the PRP.

# Conclusion

The Pharmacy program in question is owned and operated by the home office. It does not meet the requirements as a provider operated program for pass-through payment. The MAC’s adjustments to remove the Pharmacy program from pass-through reimbursement on the cost report are correct and the Board should affirm these adjustments.

**IV. Law, Regulations, and Program Instructions**

**Other Sources:**

**SSA:**

§ 1861(v)(1)(A)

§ 1886(a)(4)

§ 1886(d)

§ 1886(d)(1)(A)

**Laws**:

42 U.S.C. §1395cc(a)(1)

Tax Equity and Fiscal Responsibility Act of 1982

**Regulations**: 42 CFR

412.106

412.113(b)

413.20

413.24

413.85

**Federal Register**

49 FR 266-267 (Jan 3, 1984)

57 FR 43661-43662 (Sept 22, 1992)

57 FR 43669-43670 (Sept. 22, 1992)

66 FR 3358–3376 (Jan. 12, 2001)

68 FR 45423–45434 (Aug. 1, 2003)

**Decisions**

*Community Care Foundation v. Thompson*, U.S. Court of Appeals for the District of Columbia Circuit No. 01-5295 (Feb. 7, 2003)

*Baptist Health v. Thompson*, U.S. Court of Appeals for the Eighth Circuit No. 05-4372 (August 15, 2006)

**Agency Decisions**

*Rapid City Regional Hospital v. BCBS Association/Wellmark*, CMS Administrator Decision, (May 24, 2000)

*HealthEast 2007 & 2008 Paramed Ed-CPE CIRP Groups v. NGS 2018-D6 (Nov. 21, 2017)*

*St. Vincent Charity Medical Center vs. CGS Administrators*, PRRB Decision 2020-D16, (August 14, 2020)

**Agency Instructions**

CMS Pub. 15-1, Section 404.

CMS Pub. 100-20, Transmittal 2133 – Clarification of Policies Related to Reasonable Cost Payment for Nursing and Allied Health Education Programs (August 17, 2018)

# V. EXHIBITS

C-1. Case Participants

C-2. 03-0038 Adjustments

C-3. 03-0038 WP LD-1

C-4. 03-0087 Adjustments

C-5. 03-0087 WP L-D01

C-6. 03-0014 Adjustments

C-7. 03-0014 WP L-D01

C-8. 2020-D16