Reimbursement Advisor

JUNE 2018 • VOLUME 33, NO. 10
EDITORS: CHRISTOPHER KENNY AND MARK POLSTON

Emerging Issues in Reimbursement for Allied Health Education

Scrutiny of N&AH programs ramps up

By Daniel Hettich and Michael LaBattaglia

A recent wave of scrutiny has emerged in Medicare administrative contractor (MAC) audits of nursing and allied health (N&AH) education programs. N&AH education programs that have been receiving pass-through cost reimbursement without issue for decades are now, suddenly, receiving disallowances from their MACs.

In many instances, the MACs have cited standards that simply do not exist in the regulatory text. Recently, for example, after receiving pass-through cost reimbursement for 17 years, a provider challenged the Centers for Medicare and Medicaid Services' (CMS) new standard requiring that records maintained by the provider be created "contemporaneously" to the costs incurred. In that case, *William Beaumont Hosp.-Royal Oak v. Price*, a federal court held that "[s]uch a requirement does not appear in the text of the regulations, is contrary to the Secretary's longstanding practice, and—unless voided—would result in [an] 'unfair surprise'" that may not be afforded the deference generally granted. [No. 16-13528, 2018 WL 1556241, at *7 (E.D. Mich. March 29, 2018).]

This article discusses four key areas of N&AH education programs that are likely to be scrutinized during an audit. These four areas are:

- Meeting the provider-operator requirement in order to be eligible for pass-through reimbursement of N&AH education program costs;
- Distinguishing what activities qualify for pass-through costs versus normal operating expenses;
- Understanding the principles community support and redistribution of costs to determine whether a provider may be barred from N&AH education program reimbursement; and
- Understanding the meaning of "net cost" reimbursement for N&AH education program

INSIDE THIS ISSUE

Wolters Kluwer

to determine whether a provider's actual reimbursement is fully accounting for those costs.

Although this article discusses N&AH programs generally, it is important to recognize that N&AH programs are often unique and require an individualized assessment.

Background

The Medicare statute requires the Department of Health and Human Services (HHS) secretary to share in the costs of approved N&AH education programs. [*See* 42 U.S.C. § 1395x(v); *see also* 42 C.F.R. § 413.85(d)(1).] N&AH education programs are designed to help providers maintain an adequate workforce by incentivizing the training of nonphysician professionals.

N&AH education program costs are separately identified as "passed through" costs and reimbursed by CMS on a reasonable cost basis.

Common N&AH education programs include training for dietetic interns, nurse anesthetists, occupational therapists, pharmacy residents, X-ray technologists and hospital chaplains. A provider's costs for these programs are excluded from inpatient operating cost definitions and the payment rate calculations under the prospective payment system. Instead, N&AH education program costs are separately identified as "passed through" costs and reimbursed by CMS on a reasonable cost basis. [*See* 42 U.S.C. § 1395x(v)(1)(a).] These costs typically include the salaries of teachers and stipends paid to residents.

The Medicare regulations set forth the key requirements for N&AH programs. To be approved, a program's educational activities must be recognized by a national approving body, enhance quality of inpatient care at the provider, and be "operated" by the provider. [42 C.F.R. § 413(d)(1)(i).] In addition, the program must lead to the ability to perform in a specific specialty.

Programs that merely enhance an individual's overall expertise or allow the individual to operate a specific piece of equipment, for example, would be considered continuing education and would be excluded from pass-through treatment. [*See* 68 Fed. Reg. 45356, 45425 (August 1, 2003).] CMS will not pay for normal operating costs, patient care costs, costs incurred by a related organization, or costs that constitute a redistribution of costs from an educational institution to a provider or costs that have been or are currently being provided through community support. Medicare will pay the "net cost" of approved nursing and allied health education activities. [42 C.F.R. § 413.85(h), (d).]

The "Operator" Requirements

To be considered the operator of an approved N&AH program, a provider must meet five regulatory requirements. [*See* 42 C.F.R. § 413.85(f)(1).] The five requirements assess the degree to which the provider controls all aspects of the program.

A provider and a university may be related organizations, but the provider must demonstrate that it directly incurs the training costs.

These requirements are the compliance pillars for an "operator" audit. The following subsections discuss each requirement and also identify areas of risk where MACs have been known to focus in their audits on this topic.

1. *Directly incur the training costs [42 C.F.R. § 413.85(f)(1)(i)]*

   The provider must incur the costs associated with the clinical training and classroom instruction portions of the programs if the classroom instruction is a requirement for completion of the program. For example, the provider must incur the costs for books, supplies and faculty salaries, where such costs are applicable.

   A unique wrinkle to N&AH education programs is that Medicare will not recognize the

Emerging Issues in Reimbursement…, *page 7*

The Inevitability of Hospital Price Transparency?

Move to transparency raises questions, complexity

By Christopher Kenny

Deep within the Fiscal Year 2019 Inpatient Prospective Payment System (IPPS) Proposed Rule is a discussion of an important proposal—and likely a harbinger of future rulemakings—regarding hospital price transparency.

The Centers for Medicare and Medicaid Services (CMS) proposal is straightforward enough: beginning Jan. 1, 2019, hospitals must "make public" their "standard charge" for inpatient hospital services on the internet in a machine readable format. [83 Fed. Reg. 20164, 20548-49 (May 7, 2018).] But the many questions this proposal raises—indeed, many of them raised by CMS itself in the rulemaking—coupled with other developments elsewhere in the hospital industry portend a marked shift toward making hospital prices public.

Though a laudable goal, the move is fraught with complications and collateral considerations that have made chargemaster reform and price transparency difficult to achieve. CMS's proposal is an attempt to break that logjam, and providers should be engaging with CMS early and often to shape the process as much as possible.

Statutory Background

CMS's latest proposal has its roots in a provision of the Patient Protection and Affordable Care Act (ACA) that requires hospitals to "make public" their "standard charges for items and

Reimbursement Advisor

Editorial Inquiries:
Mark Polston, Esq.
Phone: 202-626-5540
Email: *mpolston@kslaw.com*

Christopher Kenny, Esq.
Phone: 202-626-9253
Email: *ckenny@kslaw.com*

To subscribe: Call 800/638-8437.

For customer service: Call 800/234-1660.

Reimbursement Advisor (ISSN: 0884-2795 USPS 770-190) is published monthly for $869 per year by Wolters Kluwer at 76 Ninth Avenue, New York, NY 10011.

POSTMASTER: Send address changes to *Reimbursement Advisor*, 7201 McKinney Circle, Frederick, MD 21704.

Subscription price: $869 per year plus postage, handling, and appropriate state sales tax. Single issue price: $109.

Business and circulation: Fulfillment Operations, Wolters Kluwer, 7201 McKinney Circle, Frederick, MD 21704.

Permission requests: For information on how to obtain permission to reproduce content, please go to the Wolters Kluwer Web site at *www.WoltersKluwerLR.com/policies/permissions-reprints-and-licensing.*

Purchasing reprints: For customized article reprints, please contact *Wright's Media at 1-877-652-5295* or go to the *Wright's Media* Web site at *www.wrightsmedia.com.*

services provided by the hospital, including for diagnosis-related groups" (DRGs). [42 U.S.C. § 300gg-18(e).] The statute states that hospitals must make such charges public "in accordance with guidelines developed by the Secretary." [*Id.*] CMS did not issue any such guidelines for several years until the agency stated in the fiscal year (FY) 2015 IPPS final rule that hospitals could comply with the statute by either making public "a list of the standard charges (whether that be the chargemaster itself or in another form of their choice), or their policies for allowing the public to view a list of those charges in response to an inquiry." [79 Fed. Reg. 49854, 50146 (Aug. 22, 2014).]

A hospital's "standard charge" is a fluid concept.

CMS's light touch in this instance made sense. As any hospital finance professional knows, a hospital's "standard charge" is a fluid concept. There is, of course, the line item charge for each item and service in the chargemaster. Arguably, this is what Congress intended hospitals to make public, but the statute is not clear on that point. Throwing open a hospital chargemaster could also have the effect of creating—rather than resolving—confusion.

When a grocery shopper asks for the price of a gallon milk, the customer is asking because he wants to know how much he will be paying for it: No one has insurance coverage for supermarket purchases. But patients' individual financial responsibility for hospital services is not easily determined from simply reviewing the hospital chargemaster. For insured patients, individual liability is determined by many factors, such as any negotiated discounts or contractual allowances between the hospital and the patient's insurance plan, as well as the amount of the patient's deductible and coinsurance obligations, out-of-pocket maximums, and how much of any such obligations have been paid year to date.

Complicating matters more is the issue of grouping of hospital items and services. By including a reference to DRGs, Congress appears to have recognized the fact that many patients do not incur a coinsurance or other out-of-pocket expense for each and every item that is included with a chargemaster amount on an inpatient or outpatient claim. Rather, these services are grouped into either DRGs or ambulatory payment classifications (APCs) based on the items and services that appear on the claim. A patient may receive additional items and services that another patient with the same underlying diagnosis and treatment does not receive, but both admissions would be grouped into the same DRG or APC classification.

Those payors that mirror Medicare by paying fixed amounts for each DRG will not increase or reduce payment rates for items and services appearing on a claim that do not affect the classification. (Outlier payments and stop-loss provisions are a potential exception to this rule, but the effect on patient out-of-pocket expenses is probably minimal as a particularly costly patient will likely hit his/her maximum amount relatively quickly.) Complicating matters further, however, is the reality that not all payors use Medicare's DRG classification system and may instead establish their own groupings or only use a subset of Medicare's.

The average patient is not aware of these variances and may conclude based on a review of raw chargemaster data that his/her financial obligation will be much higher than it actually is. Allowing hospitals to only post their policies for reviewing charge data was a possible way to avoid such confusion. Hospitals could require that a patient review such data with a patient navigator or other patient accounting professional who can review the charges with the patient's insurance information at hand, as well as with all of the hospital's charity care and financial assistance policies that may also affect total obligations for both insured and uninsured patients.

CMS's Latest Proposal

CMS is now sending very clear signals that the agency expects hospitals to do more. The obvious indication is the agency's proposal to expressly require hospitals to make such information public "via the internet in a machine readable format and to update this information at least annually, or more often as appropriate." [88 Fed. Reg. at 20549.]

The rest of CMS's discussion in the proposed rule is spent on how, if at all, CMS should expand upon these "guidelines" and the extent to which

such guidelines should become requirements. Indeed, CMS stated its intent to enforce compliance with these rules, potentially through an attestation process and with the potential consequence of civil monetary penalties and public announcement of such sanctions for noncompliance. [*Id.*]

The agency seeks input from hospitals and other stakeholders regarding what "standard charges" should mean. Specifically, CMS asked if the amount published should be the hospital's raw chargemaster amount, or some combination of average rates it receives from or discounts it offers to commercial payors for each item and service or for each common grouping of items and services (*i.e.*, DRGs and APCs). [*Id.*]

Average payment rates and average discounts—whether listed individually or grouped—do not expressly and plainly tell patients what they want to know: how much will they owe?

In the succeeding paragraphs, CMS acknowledged that hospitals likely will need additional tools to make this information useful to patients. Even average payment rates and average discounts—whether listed individually or grouped—do not expressly and plainly tell patients what they want to know: how much will they owe?

CMS asked stakeholders whether hospitals should be responsible for "inform[ing] patients how much their out-of-pocket costs for a service will be before those patients are furnished that service?" [*Id.*] If so, CMS also asked "[w]hat changes would be needed to support greater transparency around patient obligations" and "how can CMS and providers help third parties create patient-friendly interfaces" to review such data. [*Id.*]

Providers should use this invitation to push CMS to also require commercial insurance plans to improve the technology available to determine a patient's current cost-sharing responsibilities so that, if CMS does adopt a requirement that standard charge should include some better estimate of each patient's out-of-pocket expenses, hospitals can comply with the statute. Requiring hospitals to act as benefits managers without the tools to give patients meaningful information will be setting all parties up for failure.

Perhaps in the interest of robust debate, CMS asked: "Should health care providers play any role in helping to inform patients of what their out-of-pocket obligations will be?" [*Id.*] The question is worth serious consideration as the agency's prior attempts to require hospitals to provide such information was met with great difficulty—and resistance—from providers. When the provider-based regulation was first promulgated, CMS required hospitals to provide Medicare patients with their expected coinsurance obligations for services furnished in off-campus departments. The original regulation required that hospitals must provide written notice of the "amount of the beneficiary's potential financial liability (that is, of the fact that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, *and of the amount of that liability*)." [*See* 42 C.F.R. § 413.65(g)(7) (2000) (emphasis added); *see also* 65 Fed. Reg. 18434, 18540 (April 7, 2000) (emphasis added).]

Only four months later, CMS backed off of this requirement. Providing Medicare beneficiaries with the amount of their out-of-pocket liability for a given service is complex for the reasons stated above. Each beneficiary will have met different portions of his/her deductible, and such estimates may be further complicated by differing benefit structures for beneficiaries enrolled in Medicare Advantage and those patients with Medigap plans. (Hospitals also faced great difficulty predicting patient out-of-pocket expenses for a particular patient encounter—not just particular services—when the items and services a patient may receive are unknowable in advance. A patient may present to a provider-based clinic with a headache and could simply receive aspirin or advanced diagnostic imaging, with wildly differing coinsurance obligations.) Providers would be wise to remind CMS of its prior experience with requiring hospitals to provide such estimates and to note the exponential difficulty that would stem from providing those estimates to patients with different commercial plans.

Price Transparency Is Likely an Inevitability

Absent better tools that can assist hospitals and patients calculate expected out-of-pocket

expenses for Medicare and commercial patients alike, any requirement to do so will be fraught with difficulty. Some form of price transparency, however, is already here and the push for greater transparency will increase in the future.

Some form of price transparency is already here and the push for greater transparency will increase in the future.

Part of CMS's impetus for expanding the existing ACA requirement was increasing concern "that challenges continue to exist for patients due to insufficient price transparency. Such challenges include patients being surprised by out-of-network bills for physicians, such as anesthesiologists and radiologists, who provide services at in-network hospitals, and patients being surprised by facility fees and physician fees for emergency rooms visits." [83 Fed. Reg. at 20549.]

One could certainly argue that state laws regarding notice of out-of-network physician billing and better enrollee education of provider networks by commercial insurance plans would be more effective ways to address these concerns than posting hospital charges on the internet. It appears CMS believes, however, it has a responsibility to do something to respond to public outcry, and the tools the agency has been given by the ACA are likely viewed within CMS as the most convenient option.

Whether CMS acts or not, others are forcing hospitals' hand. A recent decision by the Supreme Court of Texas required a hospital to produce to an uninsured patient its contracted reimbursement rates with commercial payors in order to determine whether the full chargemaster amounts charged to a patient treated in a hospital's emergency room were "reasonable" under state law. [*See In re North Cypress Med. Ctr. Op. Co., Ltd.*, No. 16-0851 (Tex. Apr. 27, 2018).] The defendant hospital in this case is a for-profit provider that is not subject to section 501(r) of the Internal Revenue Code that require hospitals to limit charges to uninsured patients to "amounts generally billed" to commercial plans, but the case highlights that what a hospital may once have been able to keep protected as proprietary may be subject to greater scrutiny.

Indeed, some members of Congress are scrutinizing hospital prices and proposing policy changes to discourage price increases. One senator is calling for radically reforming the Medicare hospital wage index system by capping a hospital's annual share of payments in order to reduce alleged incentives to raise hospital employee wages and offset the increases with a bigger share of the wage index pie and higher prices to insurers and patients. [*See* "Ideas to Make Health Care Affordable Again," Sen. Bill Cassidy (R-LA) (May 29, 2018), available at *https://www.cassidy.senate.gov/imo/media/doc/Dr%20Bill%20Cassidy%20-%20Make%20Health%20Care%20Affordable%20Again.pdf.*] Simply posting hospital charges is almost certainly a preferable alternative.

When considering the various options available to hospitals, posting raw chargemaster data alone may end up being the least risky option available to hospitals. Indeed, posting average discounts or average payment rates may be misleading to those patients whose plans receive discounts below the average. Other payors that pay percentage of charge contracts may use the data to demand that hospitals lower their charges in future contract negotiations so that they pay rates closer to those payors who use DRGs or other systems. Reducing charges in this manner, of course, could also have the effect of reducing the hospital's Medicare outlier payments or prompt an outlier payment reconciliation. None of these outcomes is especially desirable.

Posting raw chargemaster data online in a machine-readable format is all that CMS proposes to require of hospitals in the short term. The proposal is not a dramatic departure from current practices, and hospitals can still post disclaimers regarding individual patient liability, links to or summaries of financial assistance policies, and an invitation to discuss such information with patient navigators. They can also use this directive to demand better tools from commercial payors during contract renegotiations. But the time for forward thinking is here. ■

About the Author

Christopher Kenny is a partner in King & Spalding LLP's health care industry practice group in Washington, D.C. He may be reached at *ckenny@kslaw.com.*

Emerging Issues in Reimbursement…, *from page 2*

"related organizations" principle within the "operator" context. In determining whether a provider is the operator of a program, the fact that a provider and a college or university are related organizations under 42 C.F.R. §413.17 ("Cost to related organizations") is, standing alone, insufficient for the provider to claim those costs. In other words, a provider and a university may be related organizations, but the provider must demonstrate that it directly incurs the training costs.

Some MAC audits have zeroed in on the term "directly" to mean the hospital must incur the cost in the first instance and cannot simply directly reimburse a related party for its costs. For example, a hospital that arranges to reimburse a college or university for the salaries of its preceptors rather than pay those preceptors from the hospital's payroll may run afoul of this strict interpretation. However, nowhere in regulation, rulemaking or program guidance is the term directly defined so narrowly. Instead, we believe (and have argued before the Provider Reimbursement Review Board (PRRB)) that the better reading of the word directly is that it merely indicates that the typical rule applicable to related parties, whereby a provider can claim a cost that was only incurred by a related party, does not apply in the allied health context. Instead, that related-party cost must appear on the provider's own books.

More specifically, the typical rule for related parties is that a cost incurred by a related party is treated "as if" incurred by the hospital itself: "The intent [of the related-party rule] is to treat the costs incurred by the [related party] *as if* they were incurred by the provider itself." [Provider Reimbursement Manual, Chapter 10, § 1005 (emphasis added).]

In other words, usually a provider need not directly incur a related-party cost on its own books but may treat the cost incurred by the related party "as if" incurred by the provider. By stating that allied health costs must instead be directly incurred by the provider, the allied health regulation is making clear that the general related-party rule does not apply and that a provider must itself directly incur the cost itself by, for example, reimbursing the related party for its expense so that the cost appears on the provider's own "books and records."

This interpretation is further bolstered by a CMS preamble in which CMS stated that "our policy has been that the provider, rather than the related organization, must directly incur the costs **on its books** and records **before** the costs will be recognized for Medicare payment purposes." [66 Fed. Reg. 3358, 3367 (January 12, 2001).] The use of the word "before" bolsters the contention that the cost does not have to appear on the provider's books first, it merely most appear on the provider's books before it will be allowed.

There are good arguments that a provider has directly incurred a cost where it has reimbursed a related party for the cost so that the cost appears on the provider's books before it is claimed for reimbursement.

These arguments notwithstanding, providers would be wise to incur the allied health costs in the first instance whenever possible to avoid this argument altogether. If, however, the argument is unavoidable, we believe there are good arguments that a provider has directly incurred a cost where it has reimbursed a related party for the cost so that the cost appears on the provider's books before it is claimed for reimbursement.

2. *Have direct control of the program curriculum [42 C.F.R. § 413.85(f)(1)(ii)]*

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, the regulations specifically allow a provider to enter into an agreement with a college or university to provide the basic academic course requirements leading to a degree, diploma or other certificate. The provider, however, must be 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.

In preamble guidance, CMS contemplated certain situations where providers' arrangements with colleges and universities result in the provider having representation on a joint committee with certain oversight responsibilities. Under these provider/college educational arrangements, the provider must demonstrate that it nonetheless maintains direct responsibility for the curriculum of the training programs. [*See* 66 Fed. Reg. 3358, 3362 (January 12, 2001).]

Under provider/college educational arrangements, the provider must demonstrate that it nonetheless maintains direct responsibility for the curriculum of the training programs.

In other situations where there is a sequential operation of a program by an educational institution and a provider, the provider may create a program leading to a degree in which instruction in general academic requirements is provided by a college or university and subsequent specialized classroom instruction and clinical training are given by the provider, as long as the provider establishes and controls the curriculum and requirements for graduation. [*Id.*] However, no costs incurred by the college may be claimed as provider costs.

3. *Control the administration of the program [42 C.F.R. § 413.85(f)(1)(iii)]*

The provider must control the administrative duties relating to the program. These duties include the collection of tuition (where applicable), maintaining payroll records of the teaching staff or students/residents or both (where applicable), and being responsible for the day-to-day operation of the entire training program. The regulations allow a provider to contract with another entity to perform some administrative functions, but the provider must maintain control over all aspects of the contracted functions.

Providers should be aware that MACs have recently been interpreting the requirement that providers maintain control over the curriculum and administration of allied health programs strictly and narrowly and are questioning whether those standards are met whenever there is substantial collaboration with a college or university. Although such a narrow reading of the control requirement is at odds with the collaboration that is clearly contemplated in the regulation, providers should organize their programs to avoid this dispute as much as possible.

4. *Employ the teaching staff [42 C.F.R. § 413.85(f)(1)(iv)]*

Providers are required to employ the teaching staff of the N&AH program such as preceptors, residency directors and other program faculty. Here, the regulations do not define the term "employ" and, therefore, offer little guidance. Given this ambiguity, having teaching staff appear on a provider's payroll is clearly the most unambiguous proof of employment.

Nonetheless, there is a good argument that the provider's ability to exercise control over the teaching staff while they are operating in their capacity as teachers for the allied health program is sufficient to meet the common legal definition of employ. The PRRB has previously adopted this wider definition. [*See Barberton Citizens Hospital v. Blue Cross and Blue Shield Association/Community Mutual Insurance Company* PRRB No. 94-D61 (July 28, 1994) (finding "the ability to remove faculty members together with the fact that the faculty members were governed by the Provider's employees policies and procedures, and were covered under the Provider's liability insurance policy" was sufficient to meet the employment standard).]

Nonetheless, some MACs have applied this provision as requiring that all teaching staff be formal employees of the provider. This position is antithetical to both the broader definition of employee endorsed by the PRRB and the regulation's recognition that at least some teaching staff need not be employees of the provider as providers are explicitly allowed to use outside organizations to provide "basic academic courses." [*See* 42 C.F.R. § 413.85(f)(1)(ii).]

5. *Provide and control both classroom instruction and clinical training [42 C.F.R. § 413.85(f)(1)(v)]*

   The hospital must provide and control classroom instruction and clinical training to be considered the operator of the N&AH education program. Notably, this requirement applies only when classroom instruction is a requirement for the completion of the program.

   Many N&AH educational programs train residents in a clinical setting with little or no classroom component. Similar to the second requirement, the regulations allow a provider to enter into an agreement with a college or university to provide the basic academic course requirements leading to a degree, diploma or other certificate. The provider remains 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 Importance of the Diploma

The regulation states that a provider is assumed to be the operator of the N&AH program when it issues the diploma for the program: "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 ... to be the operator of the program." [42 C.F.R. § 413.85(f)(2).] Though the regulations make clear that a hospital may enter into an agreement with an educational institution, some MACs have determined that a hospital was not the operator simply because the provider's name appeared alongside the name of an educational institution on the diploma associated with completion of the N&AH program.

Some MACs have determined that a hospital was not the operator simply because the provider's name appeared alongside the name of an educational institution on the diploma.

This position is confounding for at least two reasons. First, the regulation states that the provider that issues the degree, diploma or other certificate is assumed to be the operator of the program, yet nowhere does it require that the provider be the only name listed on the diploma. Second, even assuming that the name of the educational institution being listed alongside that of the provider was enough to overturn the assumption that the provider was the operator of the program, the MAC still would be required to assess the five regulatory requirements. In other words, failure to satisfy the diploma assumption cannot be used to show that the provider is *per se* not the operator of the N&AH program.

Nonprovider Operated N&AH Education Programs: "Grandfathered" Status

The N&AH regulation contemplates that some providers may be eligible for pass-through cost reimbursement for nonprovider operated programs under what is known as the "grandfathering" provision. Payment for training costs will be allowed even when the provider does not operate the program if:

- Training occurs on the provider's premises;
- The provider claimed and was reimbursed for such costs during the most recent cost reporting period that ended on or before October 1, 1989;
- The provider cannot "expand" proportion of cost, meaning the percentage of total allowable provider cost attributable to allowable clinical training cost does not exceed the percentage of total cost for clinical training in the provider's most recent cost reporting period ending on or before October 1, 1989;
- The hospital incurs costs and receives a benefit for the support it furnishes; and
- Costs do not exceed the costs it would have incurred had it operated the program. [42 C.F.R. § 413.85(g)(2).]

Therefore, a provider with a longstanding N&AH education program that suddenly encounters audit challenges regarding its status as operator of a program should consider whether it independently satisfies the grandfathering requirements. At the same time, providers should be aware that MACs have recently been demanding proof from providers that have long been grandfathered that they were, in fact,

reimbursed for their allied health programs during 1989.

Pass-through Costs Versus Continuing Education Costs

A provider may be rightly considered the operator of the N&AH program (or grandfathered) yet still not be entitled to pass-through cost reimbursement for all of its costs associated with its program. In the regulation, CMS distinguishes between costs that are necessary as part of the N&AH training and normal continuing education costs.

CMS stated that Medicare would generally provide reasonable cost payment for "programs of long duration designed to develop trained practitioners in a nursing or allied health discipline, such as professional nursing or occupational therapy." [66 Fed. Reg. at 3370.] The costs of continuing education training programs, however, are not classified as pass-through educational costs. [*Id.*] Instead, continuing education costs are hospital-operated costs covered by prospective payment system rates for most hospitals.

CMS distinguishes between costs that are necessary as part of the N&AH training and normal continuing education costs.

CMS has stated that programs "that do not lead to any specific certification or the ability to perform in the specialty" are classified as continuing education. [68 Fed. Reg. 45356, 45425 (August 1, 2003).] According to CMS, this distinction is to ensure that Medicare pass-through payments are only provided for programs that enable an individual to be employed in a capacity that he or she could not have been employed without having first completed a particular education program. [*Id.*]

Pharmacist training programs provide a good example of this distinction. CMS initially proposed to treat both years of a pharmacy residency program as continuing education under the premise that the training was not generally required to be a hospital pharmacist. However, based on comments received to the proposed rulemaking, CMS acknowledged that the "industry norm" was for hospitals to generally hire only pharmacists who have completed one year of pharmacy practice residency to work directly in patient care. Accordingly, the first year of pharmacy practice residency training programs may be eligible for Medicare reasonable cost pass-through payment, but the second year is continuing education. [*Id.* at 45428–29.]

Because the industry norm is an evolving target, a provider may have reasonable grounds to challenge an audit finding by the MAC that identifies all or some of the years of an N&AH education program as continuing education if a majority of hospitals now require the training as a prerequisite for employment in that area. In other words, if what was previously merely continuing education is now generally required for practice, there may be a chance to apply for allied health funding.

The Principles of Community Support and Redistribution of Costs

The community support principle is based on the idea that Medicare will pay for N&AH education costs on a pass-through basis until the community has assumed those costs. For example, if a university undertakes the classroom education of the students, including the collection of the tuition, the employment of the faculty, the control of the curriculum, and the awarding of the degree, the community has undertaken the responsibility for training nurses and allied health personnel and has relieved the hospital of these costs. [66 Fed. Reg. at 3363.]

A provider is well advised to perform due diligence, to determine the extent to which the program is, or ever was, financially supported by an academic institution.

Redistribution of costs means "an attempt by a provider to increase the amount, or to expand the types, of the costs of educational activities that are allowed for Medicare payment purposes by claiming costs that previously were not claimed by the provider and were considered costs of an educational institution." [42 C.F.R. § 413.85(c).]

In preamble guidance, CMS has stated, for example, that costs for a school of nursing or allied health education that were incurred by an educational institution are not allowable costs in subsequent fiscal years. [66 Fed. Reg. at 3374.] In addition, if there was a time in which a program was entirely supported by non-hospital resources, that program will forever be precluded from Medicare reimbursement eligibility. Therefore, a provider is well advised to perform due diligence, especially if undertaking the operation of an N&AH program, to determine the extent to which the program is, or ever was, financially supported by an academic institution.

Net Costs

Medicare purports to pay providers the "net costs" of their approved N&AH programs. The net cost of approved educational activities is determined by deducting the revenues that a provider receives from tuition and student fees from the provider's total allowable educational costs that are directly related to approved educational activities. [42 C.F.R. § 413.85(d)(2).] These calculations are done in the provider's Medicare cost report.

A provider may have reasonable grounds to challenge an audit finding by the MAC that identifies all or some of the years of an N&AH education program as continuing education if a majority of hospitals now require the training as a prerequisite for employment in that area.

A provider's total allowable educational costs are those costs incurred by the provider for trainee stipends, compensation of teachers and other costs of the activities as determined under the Medicare cost-finding principles in § 413.24. Under Medicare's cost-finding methods, providers commonly use the "step-down method" in the Medicare cost report to allocate costs of nonrevenue producing cost centers to the other cost centers that they serve.

For example, during step-down, a portion of a hospital's general and administrative (A&G) costs can be allocated to the cost of the N&AH program, which represent expenses such as facilities, human resources and executive salaries that are costs of the program. The amount of A&G costs that can be allocated to the N&AH program is based on the accumulated cost of the N&AH program.

Providers must offset the direct expenses of their N&AH program by their tuition before the provider is able to allocate the A&G costs to the N&AH program.

For those providers that must make adjustments for tuition (not all N&AH programs charge tuition and fees), CMS and contractors require hospitals to make this adjustment as a reduction from expenses prior to the step down and allocation of indirect cost, including A&G costs. In other words, providers must offset the direct expenses of their N&AH program by their tuition before the provider is able to allocate the A&G costs to the N&AH program. The result is that net expenses for the N&AH program are understated because it does not include the full amount of A&G costs attributable to the N&AH program.

The cost reporting instructions, in effect, seem to contravene the principles of cost-finding and reasonable cost reimbursement. Under the reasonable cost statute, CMS is required to take into account both direct and indirect costs of providers of services. [*See* 42 U.S.C § 1395x(v)(1)(A).] The regulatory definition of reasonable cost "take[s] into account both direct and indirect costs of providers of services." [42 CFR § 413.9.]

Additionally, the purpose of cost-finding is to allow a provider "to recover both the direct and indirect costs of treating Medicare beneficiaries." [*Genesis Health Ventures Inc. v. Sebelius*, 798 F. Supp. 2d 170, 174 (July 22, 2011).] "[F]or the purpose of proper matching of revenue and expenses, the cost of the revenue-producing centers includes both its direct expenses and its proportionate share of the costs of each nonrevenue-producing center (indirect costs) based on the amount of services received." [*Id.*] Therefore, providers would have reasonable grounds to challenge

such an audit adjustment and the authors of this article are currently pursuing such an appeal on behalf of hospital clients.

MACs Must Provide "Fair Notice" of New Interpretations

In many of the instances discussed in this article, MACs are announcing new, stricter standards and interpretations than those that were previously employed. For example, they have announced in some instances that providers must incur a cost first for it to be allowable, that providers must be the direct and formal employer of all faculty, and that providers must be the sole issuer of the program diploma. Even if these standards were not specifically contrary to the regulation (as they are in many instances), they still should not be applied retroactively because providers lacked "fair notice" of them.

The question of "fair notice" does not ask whether the agency's determination "is 'plainly erroneous,' but whether that interpretation is 'ascertainably certain.'" [S*ee, e.g., Fabi Constr. Co. v. Sec'y of Labor*, 508 F.3d 1077, 1085 (D.C. Cir. 2007) ("[e]ven if the Secretary's interpretation were reasonable, announcing it for the first time in the context of this adjudication deprives Petitioners of fair notice").] Clearly, these standards were not ascertainably certain, which is why many providers may not have previously complied with them despite the ability to do so. MACs, therefore, should not, years after the residency training has taken place, announce the application of new standards and threaten recoupment of many years' worth of payments.

Conclusion

A provider's best defense against ramped-up scrutiny in N&AH program audits is knowledge of the requirements discussed in this article. A provider should also be on guard for an MAC's attempt to create standards that are plainly not in the text of the regulation—such as the narrow meaning of the term directly, that a provider is *per se* not the operator if its name appears alongside an academic institution on the program's diploma, or that net costs apply only to direct program expenses.

MACs, should not, years after the residency training has taken place, announce the application of new standards and threaten recoupment of many years' worth of payments.

The fact-specific nature of the payment rules allow there to be an opportunity for intervention immediately following the audit, prior to the issuance of a Notice of Program Reimbursement, to resolve any issues that the MAC identifies. If not resolved with the MAC, the recent developments in *William Beaumont Hosp.-Royal Oak* show that the HHS secretary's discretion in interpreting the N&AH requirements is not unlimited, making many of these issues ripe for appeal. ■

About the Authors

Daniel (Dan) J. Hettich is a partner in King & Spalding LLP's health care industry practice group in Washington, D.C. He may be reached at *dhettich@kslaw.com*.

Michael LaBattaglia is an associate in King & Spalding LLP's health care industry practice group in Washington, D.C. He may be reached at *mlabattaglia@kslaw.com*.