CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2133	**Date: August 17 2018**
	Change Request 10552

SUBJECT: Clarification of Policies Related to Reasonable Cost Payment for Nursing and Allied Health Education Programs

I. SUMMARY OF CHANGES: This CR clarifies policies related to payment for approved provider-operated and certain non-provider-operated nursing and allied health education programs.

EFFECTIVE DATE: August 17, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 19, 2018

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: Under section 1861(v) of the Social Security Act, Medicare has historically paid providers for the program's share of the costs that providers incur in connection with approved educational activities. Approved nursing and allied health (NAH) education programs are those that are, in part, operated by a provider, and meet State licensure requirements, or is recognized by a national accrediting body. The costs of these programs are excluded from the definition of inpatient hospital operating costs and are not included in the calculation of payment rates for hospitals or hospital units paid under the Inpatient Prospective Payment System (IPPS), Inpatient Rehabilitation Facility (IRF) PPS, or Inpatient Psychiatric Facility (IPF) PPS, and are excluded from the rate-of-increase ceiling for certain facilities not paid on a PPS. These costs are separately identified and "passed through" (that is, paid separately on a reasonable cost basis). Existing regulations on NAH education program costs are located at § 413.85. The most recent rulemaking on these regulations was in the January 12, 2001 final rule (66 FR 3358) and in the August 1, 2003 final rule (68 FR 45423—45434).

Payment for Provider-operated Programs

A program is considered to be provider-operated if the hospital meets the criteria specified in § 413.85(f), which means the hospital directly incurs the training costs, controls the curriculum and the administration of the program, employs the teaching staff, and provides and controls both classroom and clinical training (where applicable) of the NAH education program.

Payment for Certain Non-provider-operated Programs

Section 4004(b)(1) of Pub. L. 101-508 provides an exception to the requirement that programs be provider-operated to receive pass-through payments. This section provides that, if certain conditions are met, the costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) for clinical training conducted on the premises of the hospital under an approved NAH education program that is <u>not</u> provider-operated by the hospital are treated as pass-through costs and paid on the basis of reasonable cost. Section 4004(b)(2) of Pub. L. 101-508 sets for the conditions that a hospital must meet to receive payment on a reasonable cost basis under section 4004(b)(1). These provisions are codified in the regulations at § 413.85(g).

B. Policy: I. Clarification Regarding Provider-Operated Programs

The regulations regarding provider-operated programs at § 413.85 are as follows:

(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.

We have received questions about §413.85(f)(2), which states, "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." We are clarifying our existing policy below; we are not changing policy on this matter.

As the accreditation requirements have evolved and the trend in nursing and allied health education has grown toward degree-issuing programs from colleges or universities, hospitals have tried to restructure their programs and make arrangements with colleges or universities in order to simultaneously provide a degree to their graduates, and meet the provider-operated criteria. However, successfully satisfying the provider-operated criteria in order to qualify for Medicare pass-through payment while simultaneously meeting current accreditation requirements has become extremely difficult, if not impossible, in certain circumstances. 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.* The MAC shall not assume that because the hospital issues the degree, diploma, or certificate of completion, either individually, or jointly with a college/university, that that is sufficient to meet the provider-operated criteria. It is not sufficient. As §413.85(f)(2) states, "**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" (emphasis added). This bolded language, "absent evidence to the contrary," indicates that the hospital *must first demonstrate that there is <u>no</u> evidence showing that the program is not provider-operated.* The MAC shall review the evidence provided, and be satisfied that all provider-operated criteria at §413.85(f)(1) are met first, and only then shall the MAC approve pass-through payment to the hospital for the program. *MACs shall not rely on a degree/diploma/certificate issued by the hospital as evidence that a program is provider-operated.*

We have also received questions about the meaning of the parenthetical statement at §413.85(f)(1)(ii), which states "(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.)" We are clarifying our existing policy

below; we are not changing policy on this matter.

Regarding arrangements between hospitals and colleges or universities that could be acceptable, the January 12, 2001 Federal Register (66 FR 3363-4) states:

"…sequential operation of a nursing and allied health education program involves providers that enter into agreements with a college or university in which instruction in general academic requirements leading to a degree is provided by the educational institution, and subsequent specialized didactic and clinical training is given by the provider. The provider may receive pass-through payment for the costs of the program that the provider incurs if the provider meets *all of the criteria for operating the program*, including the requirement at . . . (§413.85(f)(1)(ii) of this final rule) that the *provider must directly control the curriculum.* We note that under this section of the regulations, there is a provision (also cited at § 413.85(f)(1)(v) of this final rule) which states that 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 related 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. No costs incurred by the college or university may be claimed as provider costs (emphasis added)."

That is, the hospital is always responsible for meeting the provider-operated criteria; hospital staff, not staff from an educational institution, must be responsible for controlling, managing, and operating the program financially and administratively on a daily basis, such as, but not limited to, enrollment, collection of tuition, human resources matters, and payroll. While §413.85(f)(1)(iii) states that a provider may contract with another entity to perform some administrative functions of day to day operations, the provider must maintain control over all aspects of the contracted functions. The hospital cannot have an arrangement with an educational institution where there are certain functions for which the hospital has no involvement and no oversight. If educational institution personnel are involved, hospital staff must have final decision making authority. In addition, the hospital may contract with an educational institution to provide basic courses required for a degree (e.g., English 101), but the hospital must teach all the courses related to the theory and practice of the particular nursing or allied health specialty.

The January 12, 2001 final rule provides additional guidance on what "direct control" of the curriculum means. Although the accrediting agency often dictates which courses and the order of the courses that must be completed by each student, to the extent where there is some flexibility provided by the accrediting body, it must be the hospital, not another educational institution deciding upon the order of the coursework, and the manner its students will accomplish the coursework that will allow the program to be accredited. In addition, there may be certain courses that are unique to the hospital, and the hospital decides what those courses are and when they are taught. Furthermore, control of the curriculum means the hospital actually provides all of the courses, or, with respect to the basic courses required for completion of the program (e.g., English 101), the hospital arranges for an outside organization to provide those academic courses necessary to complete the course work. (See 66 FR 3364).

II. Clarifications Regarding Payment for Certain Non-provider-Operated Programs

Sections 413.85(g)(1) and (2) specify that pass-through payment for the clinical costs (not classroom costs) of certain nonprovider-operated programs may be made to a hospital if, in part, the hospital claimed and was paid for clinical training costs on a reasonable cost basis during its most recent cost reporting period that ended on or before October 1, 1989. We note that section 4004(b) of Pub. L. 101-508 was intended to apply only to NAH programs which were not provider-operated in 1989, but for which hospitals erroneously claimed and received pass-through payment from Medicare in 1989. We emphasize that this provision allows the hospitals to receive pass-through payment after 1989 for the clinical costs of only those programs that were already not provider-operated in 1989; this provision is not intended to allow for the payment of the clinical costs of programs that became non-provider-operated after 1989. That is, after 1989, hospitals cannot receive pass-through payments under this provision for any other non-provider operated NAH program if the hospital did not receive pass-through payment in 1989. *Clinical training costs* are defined at

§413.85(c) as “costs of training for the acquisition and use of the skills of a nursing or allied health profession or trade in the actual environment in which these skills will be used by the student upon graduation. Clinical training may involve occasional or periodic meetings to discuss or analyze cases, critique performance, or discuss specific skills or techniques; it involves no classroom instruction.”

We have received questions about the proper way to determine the allowable clinical costs to be paid for the applicable nonprovider-operated programs. We are providing instructions to implement our existing policy below; we are not changing policy on this matter.

§413.85(g)(2)(iii) states:

In any cost reporting period, 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.

To determine whether the limit described in § 413.85(g)(2)(iii) applies to any non-provider operated program claimed in the current cost report and, if so, to compute the appropriate payment for such program or programs, the MAC shall:

1. Obtain the hospital’s most recent cost report ending on or before October 1, 1989 (for ease of reference, we will refer to this cost report as the “1989” cost report).
2. For each current year’s non-provider operated program, determine whether this same program was reported in the 1989 cost report (i.e., Form HCFA-2552-89), Worksheet A, Line 20 and subscripts (nursing school(s)) and lines 23 and 24 and subscripts (Allied Health programs), Column 7).It is important to ensure in this step that the 1989 NAH non-provider operated program is the same as the non-provider program in the current year.For example, the programs would not be the same in 1989 and the current year if the hospital reported a Radiology Technologist non-provider operated program and no other Radiology-type programs in the 1989 cost report but in the current year’ cost report the provider reported only a Nuclear Medicine Technology non-provider operated program.As mentioned in the first paragraph of this section, the hospital is not entitled to receive pass-through payment in the current year for the Nuclear Medicine Technology program because this program does not meet the requirements of § 413.85(g)(2) .
3. For each non-provider operated program found to have been reported in both the current and the 1989 cost reports in Step 2, determine whether the program was not operated by the hospital in 1989 but the hospital received pass-through payment for it in that year.(See § 413.85(g)(2))ii).)
4. Only for each non-provider operated NAH program reported on Worksheet A, Line 20 and subscripts and Line 23 and subscripts of the current cost report for which the hospital received pass-through payment in 1989 (as determined in Step 3), compute the “1989 percentage” using steps 5 through 7 and the “Current Year Percentage” using steps 8 through 10.Do not complete Steps 5 through 11 for any current year’s non-provider operated NAH programs if the hospital did not receive pass-through payments for the program(s) in 1989 (see Step 3). 1989 Percentage Computation if Required by Step 4
5. Numerator - For each program individually, from Form HCFA-2552-89, determine the sum of the costs on lines 20 and 23, 24 and subscripts as applicable, column 7, of Worksheet A.
6. Denominator - determine total allowable hospital costs from the amount on Form HCFA-2552-89, Worksheet A, line 95 Subtotals, column 7.(We note that Worksheet A, Line 95 of the 1989 cost report contains only the “allowable” total provider cost since the non-reimbursable cost centers’ costs are not included on this line.Per § 413.85(g)(2)(iii), the “percentage” is “the percentage of total allowable cost…”)
7. Percentage from 1989 - For each program individually, divide the NAH cost amount from Step 5 by the total allowable hospital cost from Step 6.In accordance with Provider Reimbursement Manual-2 (PRM-2), Section 4000.1, percentages are rounded to 2 decimal places. Current Year Percentage
8. Using the current year cost report under review, only for programs that were nonprovider-operated in 1989 and are still nonprovider-operated in step 3, refer to Form CMS-2552-10, Worksheet A, line 20 (Nursing School) and line 23 and subscripts (paramedical education programs as applicable),

column 7.Numerator –For each program individually, use the amounts from Worksheet A, lines 20 and subscripts and 23 and subscripts, Column 7.For each program individually, verify that the amount on Worksheet A, line 20 or its subscripts and/orLine 23 or its subscripts, Column 7 relate only to the "clinical costs" of the NAH program.If so, use the amount from this specific line.If the amount in Column 7 for any of the programs contains "clinical training cost and classroom costs", subtract the "classroom costs" and use the net amount.(We note that for cost reporting periods beginning on or after October 1, 1990, PRM-2, Section 3610 (Form CMSA-2552-96) and Section 4013 (Form CMS-2552-10), specify that "classroom costs" related to non-provider operated NAH programs under § 413.85(g)(2) are not to be reported on Lines 20, 24 (Form CMS-2552-96) and 23 (Form CMS-2552-10).)

9. Denominator - determine total allowable hospital costs from the amount on Form CMS-2552-10, Worksheet A, line 118 Subtotals, column 7.(We note that Worksheet A, Line 118 of the current cost report contains only the "allowable" total provider cost since the non-reimbursable cost centers' costs are not included on this line.Per § 413.85(g)(2)(iii), the "percentage" is "the percentage of total allowable cost…").
10. Clinical Percentage from the Current Cost Report – For each program individually, divide the NAH clinical cost amount from step 8 by the total allowable hospital cost from step 9.In accordance with PRM-2, Section 4000.1, percentages are rounded to 2 decimal places.
11. For each program individually, compare the 1989 Percentage (step 7) to the Clinical Percentage from the Current Cost Report (step 10).If for any program, the current year percentage is greater than the 1989 year percentage, do not use the current year percentage; compute the current year's allowable clinical pass-through payment for the program by using the 1989 percentage.Proceed to pay the Medicare pass-through to the hospital in the current year for the clinical costs. For example, if the 1989 clinical percent was 30 percent, and the current year percent is 40 percent, only 30 percent of the hospital's current year clinical costs are allowable for Medicare pass-through payment.If for any program, the current year percentage is equal to or less than the 1989 percentage, then 100 percent of the hospital's current year clinical costs are allowable for Medicare pass-through payment; use the current year percentage.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10552.1	The MACs shall note that the policies contained in this notice are clarifications; no changes in policy are being made. These clarified policies shall be applied by hospitals as they file the cost reports and by the MACs during the normal desk review/audit process.	X								
10552.2	The MAC shall not assume that because the hospital issues the degree, diploma, or certificate of completion, either individually, or jointly with a college/university, that that is sufficient to meet the provider-operated criteria.	X								
10552.3	MACs shall not rely on a degree/diploma/certificate	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	issued by the hospital as evidence that a program is provider-operated.									
10552.4	The MAC shall review the evidence provided, request additional documentation as necessary, and be satisfied that all provider-operated criteria at §413.85(f)(1) are met first, and only then may the MAC approve pass-through payment to the hospital for the program.	X								
10552.5	The MAC shall follow the 11 steps under section II of this CR to determine whether the limit described in § 413.85(g)(2)(iii) applies to any non-provider operated program claimed in the current cost report and to compute the appropriate payment for such program or programs.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10552.6	CR as Provider Education: Contractors shall post this entire instruction, or a direct link to this instruction, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the entire instruction must be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Renate Dombrowski, renate-rockwell.dombrowski@cms.hhs.gov , Miechal Kriger, 646-842-2766 or miechal.kriger@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0