Medicare pass-through dollars for paramedical education are one way hospitals can still get reimbursed on the basis of their costs under the prospective payment system. To qualify, a hospital must demonstrate that it has some involvement in the operation of the nurse anesthesia program. Establishment of a cost center for school-related expenses can help maximize reimbursement.

In this time of shrinking hospital operating margins caused by increasing costs and a reimbursement system that does not keep pace with inflation, the pressures are increasing for all programs within hospitals to financially justify their existence. Hospital paramedical education programs, such as nurse anesthesia education programs, are often viewed as "nice" programs to have. But because they cannot generate revenue, they are sometimes among the first programs to be abolished in attempts to balance budgets and maintain bottom lines. This reality is forcing many program directors to justify the existence and costs of their programs.

Program justification can be accomplished in a number of ways, including:

1. A reduction in CRNA staff costs.
2. A stable source of new CRNAs for the hospital.
3. A reduction in recruitment costs to obtain these CRNAs.
4. The value of the Medicare pass-through dollars.

The concept of Medicare pass-through dollars will be explored to provide an explanation of how the reimbursement is calculated and offer suggestions to hospitals on how to implement measures to maximize pass-through dollars.

History of pass-through reimbursement

Paramedical education costs, like medical education costs, were recognized as exempt from the prospective payment system (PPS) when Congress created it. A portion of the rationale for their exemption from the diagnosis-related group (DRG) rates can be found in the Provider Reimbursement Manual (PRM), Part I, Section 404.2, which states:

"the responsibility for operating and supporting approved educational programs which are necessary to meet the community's needs for nursing and paramedical programs should be borne by the community. Where the community has not yet recognized and accepted this responsibility, the Medicare program does participate appropriately in the support of such approved programs as they are operated by providers in conjunction with their patient care activities."

Section 402.1 of the manual outlines the qualifications for approved educational activities as follows:

"Approved educational activities being formally organized or planned programs of study operated or supported by an institution, as distinguished from 'on-the-job inservice,' or similar work learning programs. To be an allowable cost, the educational activity must be: A. designed to enhance the quality of or improve the administration of the institution. B. where required, licensed by state law. C. where licensing is not required, approved by the recognized professional organization for the particular activity."

Nurse anesthesia programs meet these requirements and are listed in the PRM as approved programs.
Program operation versus support

Even though the above regulation states that the program may be operated or supported by a provider, the Health Care Financing Administration (HCFA) has attempted to disregard the word "supported" and focused on "operated by an institution." Some fiscal intermediaries have interpreted this as meaning the program's license or accreditation must be in the hospital's name, as opposed to the educational institution's name.

There is currently debate between hospitals and various government entities concerning the application and interpretation of what constitutes operating a program. As was stated in the February 1989 issue of Reimbursement Advisor:

"prior to the enactment of PPS, HCFA has held that the cost of medical education for nurses in programs not operated by the hospital were not reimbursable Medicare costs. However, the Provider Reimbursement Review Board (PRRB) disagreed with the administrator in cases where the hospital contracted with educational institutions to participate in nursing programs. Although the administrator overturned the PRRB decisions, the federal courts agreed with the PRRB and the providers (hospitals) and overruled the administrator."

Cases such as this suggest that the interpretation of what the regulations originally intended will not be agreed upon for some time.

To eliminate any potential difficulties with HCFA's interpretation of this regulation, all hospital programs should be set up so that their operation can be claimed solely by the hospital provider or jointly by the hospital and the educational institution. This can most often be accomplished in a contract between the two entities stating that the program is a joint one and listing the responsibilities of each party in its operation. The interrelationships between the parties should be listed, as well as the roles both play in program accreditation and education of students.

Again, because different intermediaries in various parts of the country are interpreting these regulations, it is difficult to give one set rule for ensuring the operations criteria will be met. However, as indicated above, there appears to be a weakening in HCFA's stand that a hospital must be the operator of the program, and it may be possible to obtain reimbursement solely on the basis of support of a program.

Reimbursable costs

For programs already recognized by HCFA as pass-throughs and for new programs seeking Medicare pass-through reimbursement, it is important that all costs be properly classified to maximize the reimbursement potential. This is best done through having a separate cost center for the school and discussions with all appropriate department heads and/or supervisors to insure that all costs related to the school are properly classified and identified within its cost center.

Costs that are considered allowable for reimbursement purposes are as follows:

A. Costs incurred in a provider-operated program, including the costs of classroom and clinical training.
B. Support of a non-provider program that has contracted with the hospital for its joint operation. This should include all costs related to clinical training at the provider site. Costs incurred that are related to the classroom portion of training are allowable if the following three criteria are met:
1. The provider's support does not constitute a redistribution of non-provider costs to the provider. This distinction is important because the underlying principle of reimbursement for educational activities is that it is not intended that Medicare should participate in increased cost resulting from a redistribution of cost from educational institutions or units to patient care institutions or units.
2. The provider is receiving a benefit for the support it furnishes.
3. The provider's support is less than the cost the provider would be expected to incur with a program of its own.

Some practical examples of allowable costs are stipends and benefits paid by the hospital to the students, office supplies, educational supplies and other directly related expense items. Costs that are not directly identified or consumed by the school are just as important and reimbursable as direct costs. Indirect costs include such things as building depreciation, utilities, accounting support, payroll support, personnel support and other administrative functions of the hospital. These costs are normally assigned to the nurse anesthesia education cost center through the Medicare stepdown report. Coordination between the program director and the hospital department responsible for the completion of the Medicare cost report can insure that the indirect expenses are maximized in the stepdown report, thereby maximizing the reimbursement. Here are two examples of ways this can be done:
1. Because most institutions allocate depreciation and other capital costs on a square-foot basis, it is important that all space utilized by the program be identified. This includes classrooms, conference rooms, office space for program directors and secretarial support, as well as innovative means such as percentages of locker rooms and/or lounge areas shared by CRNAs and students.
2. Personnel-related statistics, such as hours, salaries and FTE counts, should include the faculty and students associated with the program. This is important, because in many hospitals students may not be counted as FTEs, and their work hours may not be reflected in hospital reports. But because they may receive benefits from the personnel department, it is important that the statistics in the stepdown report reflect these factors, so dollars can be allocated to the program.
The key factor in allocating these costs to the CRNA school is documentation. Obviously, the goal is to allocate as many costs to the program as possible. However, because this is one of the few areas where its audit can save Medicare money, these areas are typically audited much more closely.

If the program director and reimbursement department have properly documented the reasons and justifications for allocating various costs to the program, their documentation can be presented to the Medicare auditors upon request, enhancing the likelihood that these costs and allocations will be allowed. This in no way implies that the documentation should be misleading or that costs not reasonably related or allocated to the program be included. It simply states that clean documentation provided before an audit process will usually insures a better result than if the justification or reasoning behind the allocations is hidden or is not clear. The Medicare program will attempt to insure that it is not paying for costs either presently or formerly incurred by the educational institution.

**Calculation of reimbursement**

The number of pass-through dollars that the Medicare program will reimburse a school are calculated on the basis of the annual cost report. Important schedules on the cost report with which the program director should at least be familiar include:

- **Worksheet A**, Summary of Expenses
- **Worksheet A-6**, Reclassification of Expenses
- **Worksheet A-8**, Adjustment to Expenses
- **Worksheet B-1**, Stepdown of Indirect and Overhead Costs
- **Worksheet B-Part I**, Stepdown Statistics
- **Worksheet D**, Determination of Costs

The following example shows how some hypothetical figures flow through a cost report to determine how many pass-through dollars will be paid. In the following example, the direct costs for the program are $200,000, the indirect costs are $90,000 and the total pass-through reimbursement is $100,000.

**Example**

Listed on Worksheet A as direct costs for the school are student stipends, compensation of teachers and other direct costs amounting to $200,000.

Listed on Worksheet A-6 is $10,000 to be added to the school’s cost for 50% of secretarial time shared with the anesthesia department. This number must be documentable by some method, such as quarterly time studies.

Listed on Worksheet A-8 is a negative adjustment of $50,000 for tuition revenues received by the provider.

The sum of all costs from the A worksheets is $160,000.

On worksheets B-1 and B Part-1, an additional $90,000 of indirect and overhead costs is allocated to the school. This amount represents an appropriate allocation of costs, such as depreciation, housekeeping, utilities, payroll, accounting, etc.

The fully allocated cost of the program is now $250,000.

The portion of these costs that will be reimbursed by Medicare is determined on the D worksheet by multiplying the Medicare percentage of total anesthesia charges by the fully allocated program cost. For instance, if total anesthesia charges for the hospital are $5,000,000, and $2,000,000 (or 40% of these charges) were for Medicare patients, then the Medicare reimbursement for the period will be 40% of the $250,000 total cost, or $100,000.

**Summary**

For the time being, Medicare pass-through dollars provided for a paramedical education program are still considered to be reimbursed on a cost basis. It has been the pattern of Congress over recent years to eliminate or reduce those areas of cost-based reimbursement, such as it has done with direct medical education costs, CRNA labor costs and capital costs.

While paramedical education costs have not yet been reduced or eliminated by Congress, hospitals should not base their entire program’s justification on pass-through reimbursement. Simply because this reimbursement exists today and can be included in a cost-benefit analysis is no guarantee that Congress will not reduce or eliminate this reimbursement in future years.

To maximize Medicare pass-through reimbursement, it is important that the operation of the program be proven on behalf of the hospital. The hospital must be able to show that the program is not incurring expenses that have been previously incurred or should be incurred by the educational institution. And finally, the hospital should ensure that all direct and indirect costs that can reasonably be classified or allocated to the educational cost center are properly documented.

By paying attention to these concerns and the other regulations identified in chapter four of the *Provider Reimbursement Manual*, program directors and hospital reimbursement personnel can become better equipped to capitalize on the pass-through reimbursement afforded by Medicare regulations and thereby improve the value of their program to the supporting hospital institution.