North Carolina HFMA Medicare Workshop

Novant Health Conference Center
January 22, 2025

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Building Up with Audit & Reimbursement Part A

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Disclaimer

The content in this presentation is intended for Jurisdictions J and M Medicare providers and is current as of December 1, 2024. Any changes or new information superseding this information is provided in articles with publication dates after December 1, 2024, 2024, at https://palmettogba.com.

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What Is Provider Audit and Reimbursement?

Provider Audit and Reimbursement

- Provider Audit and Reimbursement (PARD) is responsible for ensuring payments to Medicare providers are proper according to the Medicare law, regulations and interpretative guidelines published by the Centers for Medicare and Medicaid Services (CMS).
- Palmetto GBA determines the accuracy of payments to the provider through review of information furnished by the provider, including the annual Medicare Cost Report and supporting documentation.

PARD Responsibilities

- Cost Report Receipt and Acceptance/Rejection
- Issuance of Tentative Settlements
- Cost Report Reviews (Desk Reviews/Audits/Wage Index/S-10 Audit)
- Cost Report Reopenings
- Cost Report Appeals
- Interim Rate Reviews
- Accuracy of Provider Specific File
- Computation of Hospice Payment Cap
- Provider-Based Determinations
- Review Request for Special Payment Status
- And more….

Medicare Cost Report

- On an annual basis, providers are required to submit a Medicare Cost Report to their designated MAC. The instructions and policies the provider must adhere to in completing the cost report are found in the Provider Reimbursement Manuals (PRM) Parts I and II.
- All providers participating in the Medicare program, whether they are paid on a reasonable cost basis, or a system of prospective payment are required under 42 CFR 413.20 (a) to maintain sufficient financial records and statistical data for proper determination of costs. MACs review the records and data because the data from the cost report is used for payment reimbursement and various rate setting and payment refinement activities.

Cost Report Filing

- Medicare cost reports are required to be filed each year. A cost report normally covers a 12-month period and must be submitted within five months of the end of provider's cost reporting period.
- The Medicare Cost Report e-Filing (MCReF) system is provided by CMS to simplify the process of submitting a Medicare Cost Report
- Providers are required to obtain their own PS&R report(s) for use in preparing the cost report
- For cost reporting periods beginning on or after October 1, 2022, hospital cost reports must be filed with listings that support Medicaid Eligible Days (Exhibit 3A), Medicare Bad Debts (Exhibit 2A), Charity Care (Exhibit 3B), and Total Bad Debts (Exhibit 3C)

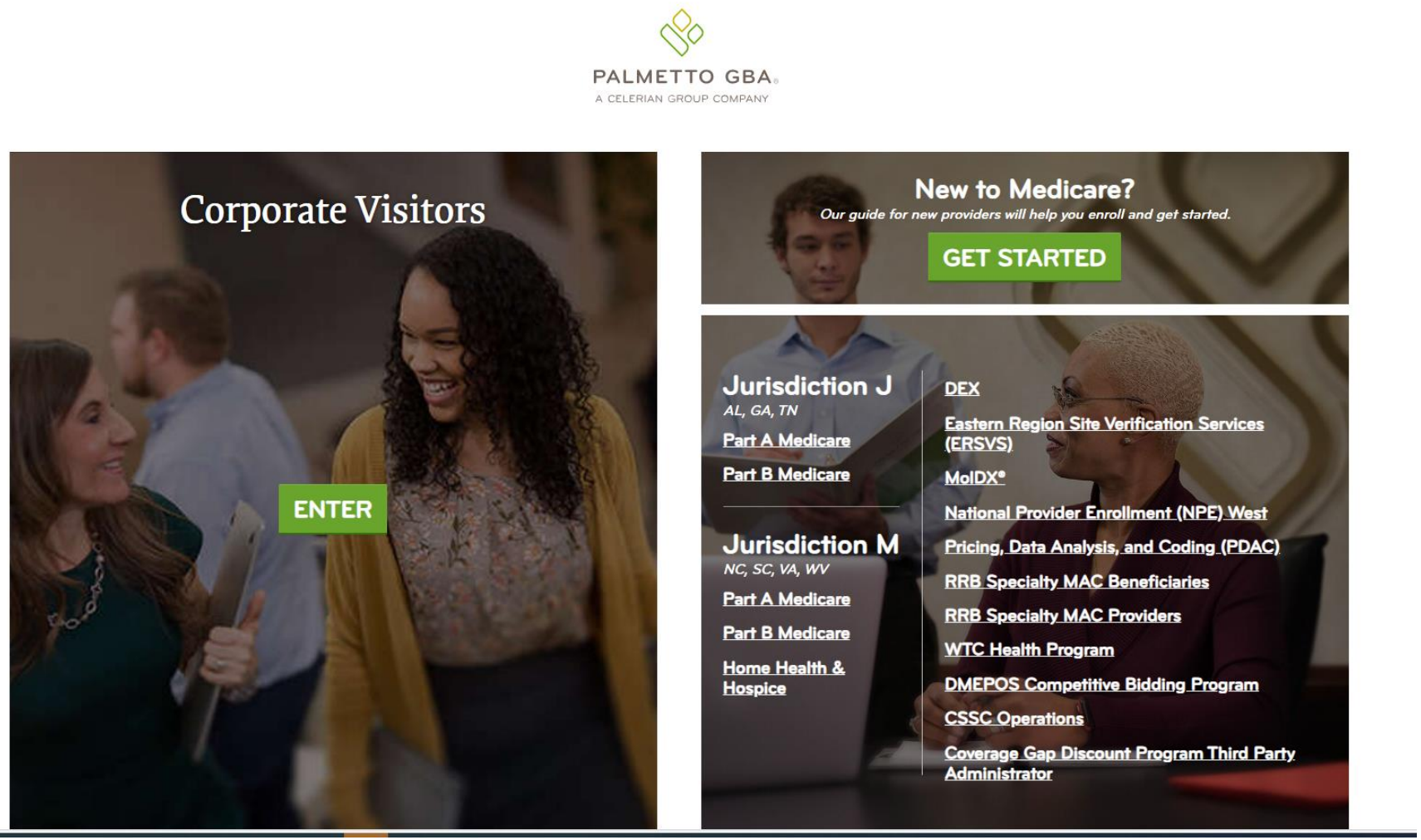
MCReF and Cost Report Correspondence

- Palmetto GBA strongly recommends providers utilize MCReF to file the cost report. Benefits include:
  - **Electronic signature**
  - **Eliminates postage expense**
  - **PHI is secure**
  - **Confirmation of receipt is received immediately**
  - **Tracking of cost report process via MCReF Dashboard**
  - **Access to Tentative Settlement and Notice of Program Reimbursement packages**

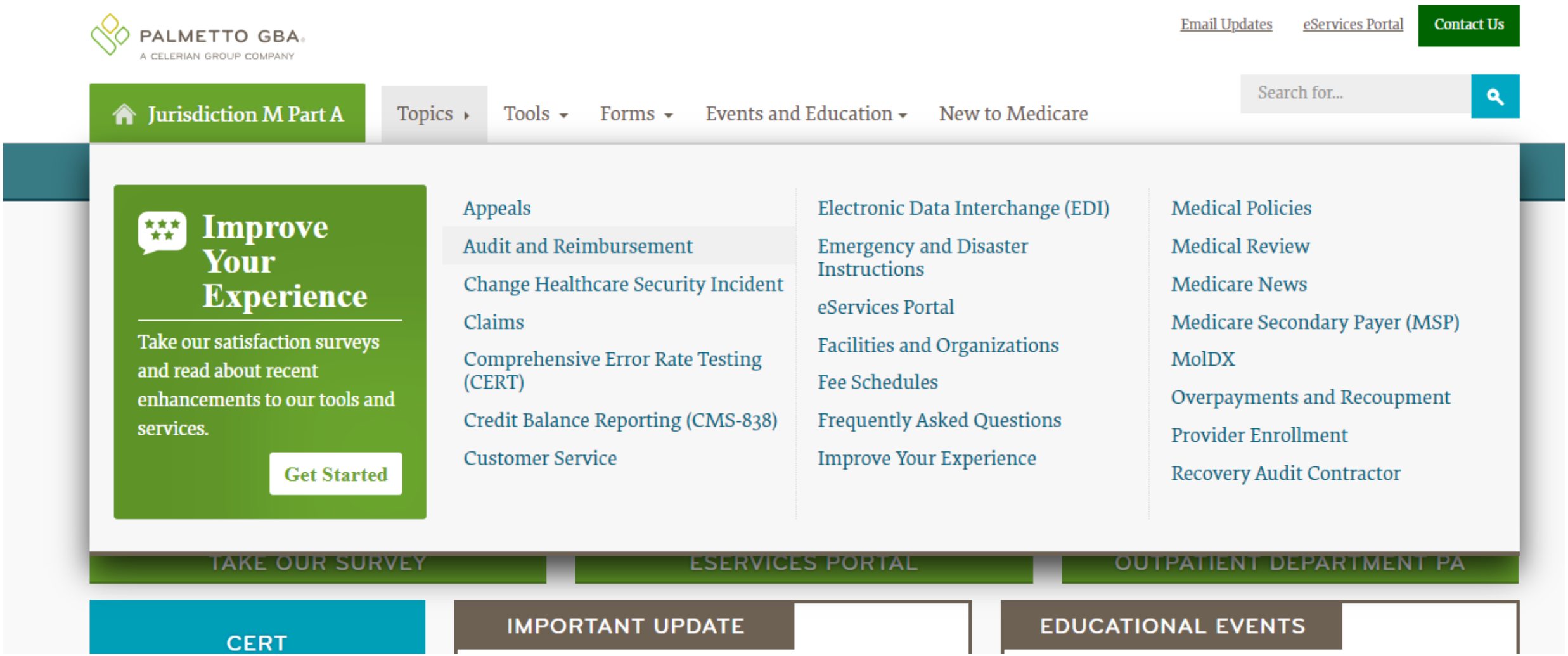
MCReF and Cost Report Correspondence

- Palmetto GBA strongly recommends providers utilize the CMS provided electronic versions of key cost report exhibits now required for hospital cost reports. Benefits include:
  - **A reduced need for follow-up communication regarding the cost report submission**
  - **When filing using MCReF, a provider will receive preemptive feedback about potential issues with their exhibits**

Palmetto GBA Website



Palmetto GBA Website



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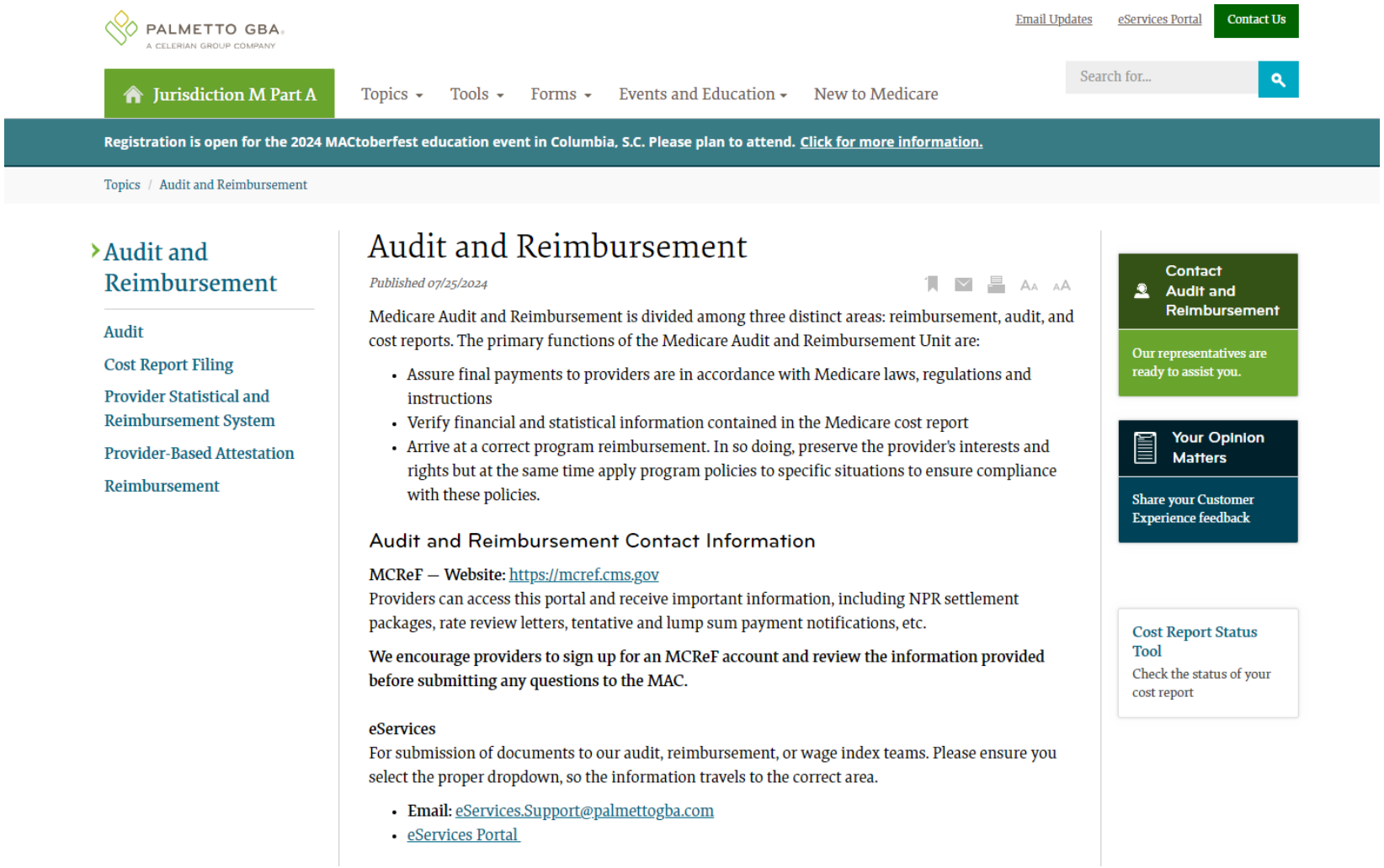

What's Happening in PARD?

Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage

- On June 9, 2023, CMS issued the final rule: Medicare Program; Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage. This final rule establishes a policy concerning the treatment of patient days associated with persons enrolled in a Medicare Part C (also known as ''Medicare Advantage'') plan for purposes of calculating a hospital's DPP for cost reporting periods starting before FY 2014. (88 FR 37772)

Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage

- The Secretary therefore determined that, in order to comply with the statutory requirement to make DSH payments and to address any potential statutory gap, it was necessary for CMS to engage in retroactive rulemaking to establish a policy to govern whether individuals enrolled in MA plans should be included in the Medicare fraction or in the numerator of the Medicaid fraction, if dually eligible, for fiscal years before 2014. After considering comments from the public, CMS finalized its proposal that a patient enrolled in an MA plan remains entitled to benefits under Medicare Part A and will be counted in the Medicare fraction of the DPP and not counted in the numerator of the Medicaid fraction for cost reporting periods that include discharges before October 1, 2013.

Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage

- The final rule took effect August 8, 2023, and will require MACs to calculate and recalculate the DPP and to issue Notices of Program Reimbursement (NPR) or revised NPRs for all cost reports previously placed on hold due to CMS instructions or CMS Ruling 1739-R and for cost years remanded to MACs pursuant to court orders or pursuant to CMS Ruling 1739-R. The RNPRs (or NPRs for those providers who never received an NPR for the cost year at issue) shall set forth a DSH payment adjustment that accounts for Part C patient days in the calculation of the DPP in the manner set forth in the final Part C days rule.

Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage

- Please note that **CMS has re-published SSI fractions** for discharges before FY 2014 to reflect the Part C days policy adopted through notice-and-comment rulemaking, and for cost reports from that period held for issues relating to the SSI fraction, MACs are required to use the republished SSI fractions to issue NPRs and revised NPRs.

Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage

- Since the final rule is the controlling policy for fiscal years before FY 2014, any previously issued instructions related to the inclusion of Part C days in the Medicaid fraction for any of those fiscal years are no longer valid. Consistent with §405.1885(c)(2), the final rule retroactively adopting the policy at §412.106(b)(2)(i) for fiscal years before FY 2014 is not a basis for reopening final settled cost reports.
- Providers do not need to take any action to initiate the processing of the required NPR or RNPR
- The majority of RNPR's have been processed
- The remands will continue to be processed through the first quarter of 2025

SSI Realignment for Cost Reporting Periods Starting Before Oct. 1, 2013

- On June 9, 2023, in response to the Supreme Court's ruling in Azar v. Allina Health Services, 139 S. Ct. 1804 (2019), the Centers for Medicare & Medicaid Services (CMS) issued a final rule (CMS-1739-F) that established a policy on the treatment of Part C days for purposes of calculating a hospital's disproportionate patient percentage (DPP) for cost reporting periods starting before October 1, 2013 (that is, for cost reporting periods starting before Federal fiscal year (FY) 2014) (88 FR 37772). Under the policy articulated in this rule, CMS will calculate a hospital's DPP by including Part C days in the Medicare fraction and excluding them from the numerator of the Medicaid fraction.

SSI Realignment for Cost Reporting Periods Starting Before Oct. 1, 2013

- 42 CFR 412.106(b)(3) allows a hospital the opportunity to request to have its SSI ratio realigned based on its cost reporting period (as opposed to the Federal fiscal year). Under this regulation, a realignment will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official SSI ratio for that period.
- After the Supreme Court's Allina decision, CMS held processing of requests for SSI ratio realignment for cost reporting periods starting before FY 2014. With the issuance of the final rule (CMS-1739-F), processing of realignment requests for cost reporting periods starting before FY 2014 will resume.

SSI Realignment for Cost Reporting Periods Starting Before Oct. 1, 2013

- All active providers should have received a letter with instructions on how to confirm or request an SSI realignment for cost reporting periods beginning before October 1, 2013. Notification would have been sent to the current primary contact on file for each provider.
- **Existing Realignment Requests:** For any realignment requests for cost reporting periods starting before October 1, 2013, that the provider submitted to its MAC prior to July 31, 2024, providers **must** confirm these existing requests with their MAC before they can be processed.
- **New Realignment Requests:** Providers may also request realignments for other cost reporting periods starting before October 1, 2013, in accordance with CMS regulations.

SSI Realignment for Cost Reporting Periods Starting Before Oct. 1, 2013

Information to Send to MACs for Existing or New Realignment Requests:

- To confirm an existing request or make a new request for cost reporting periods starting before October 1, 2013, the provider must send a written notification to the MAC which contains the following information:
  - **Cost report begin date**
  - **Cost report end date**
  - **Should indicate new or confirmed**
  - **One provider number per request, multiple years for same provider can be included in one request**

SSI Realignment for Cost Reporting Periods Starting Before Oct. 1, 2013

- Requests should be emailed to the applicable reopenings address:
  - **Jurisdiction J: JJAudit.Reopening@palmettogba.com**
  - **Jurisdiction M: JMAudit.Reopening@palmettogba.com**

SSI Realignment for Cost Reporting Periods Starting Before Oct. 1, 2013

- Note that, in accordance with the existing rules regarding realignment requests (42 CFR 412.106(b)(3)), once a hospital has confirmed its request for realignment of cost reporting periods starting before October 1, 2013, (in the case of requests made prior to July 31, 2024) or made a new request for such a reporting period, that request may not be withdrawn. The realigned ratio for the cost reporting period (posted on the CMS DSH website) will be the hospital's ratio, regardless of whether the ratio is higher or lower than the Federal fiscal year ratio.

SSI Realignment for Cost Reporting Periods Starting Before Oct. 1, 2013

- Cost reporting period-based SSI ratios for cost reporting periods starting before October 1, 2013, are available on the CMS website. Providers should review the final cost report percentage to the realigned DSH percentage on the CMS website at: https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/dsh.
- Due to the expected volume of the realignment requests CMS has allowed additional time to complete these reviews. MACs have 24 months from the confirmation of the existing or new requests to complete them.
- Providers are responsible for reviewing prior cost reports and making the determination of whether to request a realignment

Nursing and Allied Health Education (NAHE)

- 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 education (NAHE) programs are those that are, in part, operated by a provider, and meet State licensure requirements, or is recognized by a national accrediting body.

Nursing and Allied Health Education (NAHE)

- In 2018, CMS provided clarification regarding provider-operated programs. CMS stressed that in all cases, the burden of proof is on the hospital to demonstrate that its program is meeting the five 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.

Nursing and Allied Health Education (NAHE)

- **Criteria for identifying programs operated by a provider 42 CFR 413.85(f)(1)**
  - Directly incur the training costs
  - Have direct control of the program curriculum
  - Control the administration of the program
  - Employ the teaching staff
  - Provider and control both classroom instruction and clinical training (where classroom instruction is a requirement for program completion)

Nursing and Allied Health Education (NAHE)

- Provider Operated. “Provider” means the Medicare CCN that was issued to the facility under review. A home office is not a provider. A related party is not a provider.
- In summary, the provider must manage and control all aspects of the NAHE program operation (classroom instruction, clinical training, tuition, management, diplomas/certificates, etc.). 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.

Nursing and Allied Health Education (NAHE)

- 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.
- If costs are incurred at the home office/related org level that are not primary direct expenses essential for NAHE program operation, those costs may be disallowed instead of disallowing the entire NAHE program

Nursing and Allied Health Education (NAHE)

- **Helpful Supporting Documentation**
  - Copy of Program Accreditation/Approval
  - Organizational Charts with description/responsibilities of staff
  - Working Trial Balance
  - Copy of a sample of certificate/diploma issued to individuals who completed program
  - Payroll Reports
  - Policy/Procedures directing the program(s), including but not limited to describing the process of making changes to the program curriculum, how tuition is collected, supervision of instructional staff, etc.
  - Copy of program catalog and/or curriculum including location and instructor of classroom and clinical training
  - Copy of agreements between hospitals and colleges/universities detailing roles and responsibilities

Wage Index — CMS Focus Areas

- **Contract Labor Reviews**
  - The minimum support required is a signed and valid contract. If the contract does not indicate costs/hours claimed for the period, staff will review invoices in addition to the contract. Without a valid contract, costs will not be allowed.
  - When a contract reflects an all-inclusive rate, Palmetto requires original, unaltered documentation supporting actual amounts related to labor vs. non-labor costs

Wage Index — CMS Focus Areas

- **Home office Reviews**
  - Home office costs included on the wage index worksheets must be allowable for wage index purposes. Providers must submit detailed documentation to support the original cost. Documentation must allow audit staff to trace costs claimed through all allocation sheets. If there are multiple home office financials, or central/regional home offices, providers must submit all documents in order to properly trace the totals back to origination.
- **Management Salaries**
  - Providers must submit a valid contract or time studies to support Part A vs. Part B split of management salaries. Without support of the division of time, all salaries will be reported as Part B.

Accuracy of the Provider Specific File (PSF)

- October 1, 2024, Updates — Inpatient Prospective Payment System and Long-Term Care Hospital (LTCH) PPS Changes
- January 1, 2025, Updates — Hospital Outpatient Prospective Payment and Medicare Ambulatory Surgical Center payment system for calendar year 2025
- Low Volume Adjustment Requests
- CRNA Certification — Critical Access Hospitals — December 31, 2024

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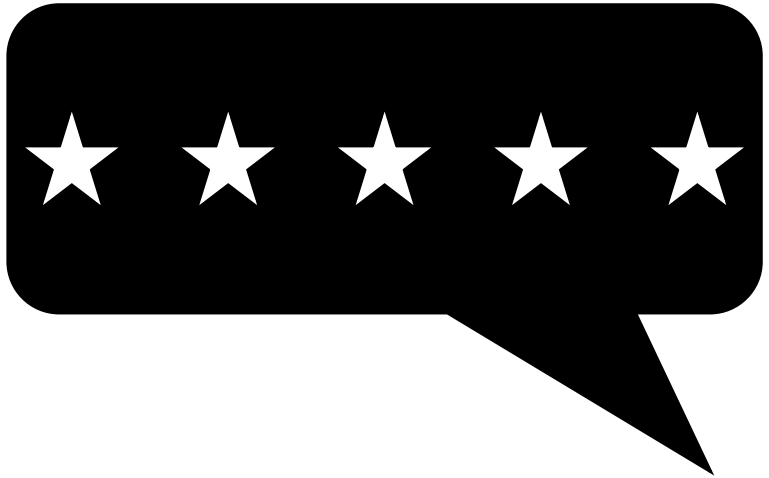
Customer Experience Survey

How likely are you to recommend our education to a colleague or peer?

Customer Experience Survey

FEEDBACK



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THANKS FOR ATTENDING!