Agenda

• Cost Report Settlements
• Status of 2016 SSI Settlements
• WPS Audit Plan
• Physician Compensation in an Emergency Room
• DSH
• Nursing and Allied Health Education Programs
• Related Party Cost – A&G
• Worksheet S-10 Audits
• Related Party Costs
• Cost Report Electronic Filing
• Cost Center/Stat Changes
• Reopenings
• WPS Medicare Website
Cost Report Settlements

- CMS requirement – for non-audited cost reports, the FI/MAC must complete a Notice of Program Reimbursement (NPR) within 365 days from cost report acceptance.

- Temporary modification - for cost reports with FYE May 1, 2017 through April 30, 2018, contractors have 18 months from the accept date to issue an NPR.

- Acute and rehab hospitals that use the SSI ratio aren’t subject to these requirements.
Status of 2016 SSI Settlements

- WPS is settling cost reports that use the 2016 SSI ratio i.e. acute and rehabilitation hospitals with cost reporting periods beginning on or after 10/1/15 and before 10/1/16

- Unless the 2016 SSI ratio cost report is scheduled for audit, we will issue final settlements for at least 90% of these cost reports by 02/29/20

- The remaining 10% of cost reports will be final settled by 4/30/20
WPS Audit Plan

• 11 cost reports for Iowa hospitals (4 acute care and 7 critical access) are scheduled for audit

• All other cost reports will be settled with a desk review

• Paramedical education programs, especially a hospital’s accreditation and legal operator status, will be a point of emphasis at audit for acute care hospitals

• Physician compensation in the emergency room and related party costs will be a point of emphasis at audit for CAHs
Critical Access Hospitals - Physician Availability Services in an Emergency Room

• Need a signed agreement between the hospital and the physician(s) reflecting the allocation of physician time between services provided to individual patients and availability services

• Allocation agreement must be supported by adequate documentation

• Two of the most common forms of documentation: 1) ER time logs, 2) physician time study
Critical Access Hospitals - Issues with Physician Availability Services in an Emergency Room

• No allocation agreement or the agreement is unsigned – required by 42 CFR §415.60 and must be signed by the department head of physician

• Time study isn’t concurrent with the cost reporting period

• Professional services only include face to face time with the patient – these services should also include charting and dictation time

• Emergency room physician is seeing patients at a rural health clinic and is only on call at the ER
When auditing DSH payments, WPS auditors will be focusing on whether hospitals included unallowable categories of patient days, e.g. S-CHIP, State-only, spenddown, dual eligible, in their DSH Medicaid patient day count.

The intent is to identify days for which the patient wasn’t eligible for full Medicaid benefits.

The OIG has been or will be reviewing DSH payments for unallowable days in Indiana, Missouri, and Kansas:
- Looking for non-Title XIX programs, dual eligible patients, otherwise ineligible patients, etc.
Nursing and Allied Health Care Programs

Provider-Operated Programs

• 42 CFR §413.85(f)(1) sets forth five criteria for identifying programs as provider-operated. The provider must:
  – i) directly incur the training costs
  – ii) have direct control of the program curriculum
  – iii) control the administration of the program
  – iv) employ the teaching staff
  – v) provide and control both classroom instruction and clinical training

• 413.85(f)(2) – Absent evidence to the contrary, the provider that issues the degree, diploma...is assumed to meet all of the criteria set forth in (f)(1) and to be the operator of the program
Nursing and Allied Health Care Programs

Provider-Operated Programs

• WPS will be evaluating all 5 criteria at 413.85(f)(1) and not relying on the degree, diploma, or certificate

• Are colleges or universities actually operating these programs?

• Hospitals must be in control of the programs and not just paying another entity, e.g. a university or college, to train the students

• Eleven Iowa hospitals with nursing and/or allied health programs
Related Party Costs - A&G

• A CAH receives administrative services (management, accounting, etc.) from an acute care hospital

• To calculate the cost of the services, the acute care hospital records the CAH’s costs (generally A&G) on a nonreimbursable cost center line of their cost report and allocates A&G to this cost center using the accumulated cost statistic

• This calculated cost (the A&G allocation from the acute care hospital) is then claimed on the CAH cost report
Related Party Costs - A&G

- CMS position: “If the provider [acute care hospital] did not maintain the proper documentation they cannot support a cost allocation [to the CAH]. Accumulated costs is not acceptable as this [acute care hospital] is NOT a home office cost statement.”
Cost Report Electronic Filing

- CMS hired a contractor to build a portal for the submission of cost reports and related documentation (Mcref)
  - Similar to filing taxes electronically
  - Cost report and related documentation will be stored in CMS’ STAR system

- Not mandatory to file through the portal because of the impact to small providers

- Current J5 provider utilization of the Mcref system is 35%
Worksheet S-10 Audits

- CMS selected J5 hospitals (no Iowa) for Worksheet S-10 audits of federal fiscal year 2015 data

- Many controversies regarding the proper reporting of S-10 data

- Audited hospitals will have adjustments made to their cost reports that may affect the amount of uncompensated care reimbursement they receive

- Next year?
Cost Center/Stat Changes

- Providers must use standard cost centers and standard statistical bases unless request and approval for changes in either

- Standard Cost Centers (generated by default in cost reporting software)
  - Not subscripted

- Standard statistical bases (at the top of B-1)
Cost Center/Stat Changes

- The provider can elect to change the order of allocation and/or allocation statistics, as appropriate, for the current cost reporting period if a request is received by the contractor, in writing, 90 days prior to the end of that reporting period.

- The contractor has 60 days to make a decision and notify the provider of that decision or the change is automatically accepted.

- The change must be shown to more accurately allocate the overhead or should demonstrate simplification in maintaining the changed statistics.

- If a change in statistics is requested, the provider must maintain both sets of statistics until an approval is made. If both sets are not maintained and the request is denied, the provider reverts back to the previously approved methodology.

- The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. (see CMS Pub. 15-1, chapter 23, §2313)
Reopenings


• Per §2931.2, a reopening request determination will be dependent upon whether the following criteria have been met:
  • New and material evidence has been submitted
  • A clear or obvious error has been made
  • The determination has been found to be inconsistent with the law, regulations, and rulings, or general instructions.
Reopenings

These situations will result in the denial of a reopening request:

- A request that is submitted more than three years after the NPR date
- A request that is incomplete (does not contain the necessary documentation to support the initial request)
- A request for reopening that results in an immaterial revision to the cost report settlement
- A request for reopening where an open appeal already exists. The appeal must first be closed before a reopening may be considered.
- Alert 11 from PRRB Rules
- A request that does not meet the §2931.2 criteria for reopening
Reopenings

- Once a reopening request has been denied, such denial cannot be rescinded. A new reopening request can only be submitted if the three year reopening timeframe has not yet expired, and if there is new evidence available that would address the original reason for denial. If a reopening request that has been denied is resubmitted without any additional evidence to address the original denial reasons, the second reopening request will be denied for the same reason.
**WPS Portal/Website**

- Separate from CMS MCREF portal discussed earlier
- Can NOT be used for initial cost report submissions
- Only use for subsequent documentation
  - Desk Review, Audit, Appeal, or Reopening issues
  - Wage Index
  - Rate Reviews
  - Misc. Requests
- Allows for attachments, as well as option to send it to specific audit contacts.
- This allows for alternative to “secure email.”
MAC J5 Contract

- WPS’ 5-year J5 (Iowa, Missouri, Kansas, and Nebraska) contract with CMS expires July 31, 2017
- CMS has extended the contract to July 31, 2019 at which time it will go out to bid
- Anticipated award date is August 29, 2019
• Any Questions?