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Medicare Cost Report - Audit & Reimbursement Update

Minnesota HFMA

November 2024

Introduction

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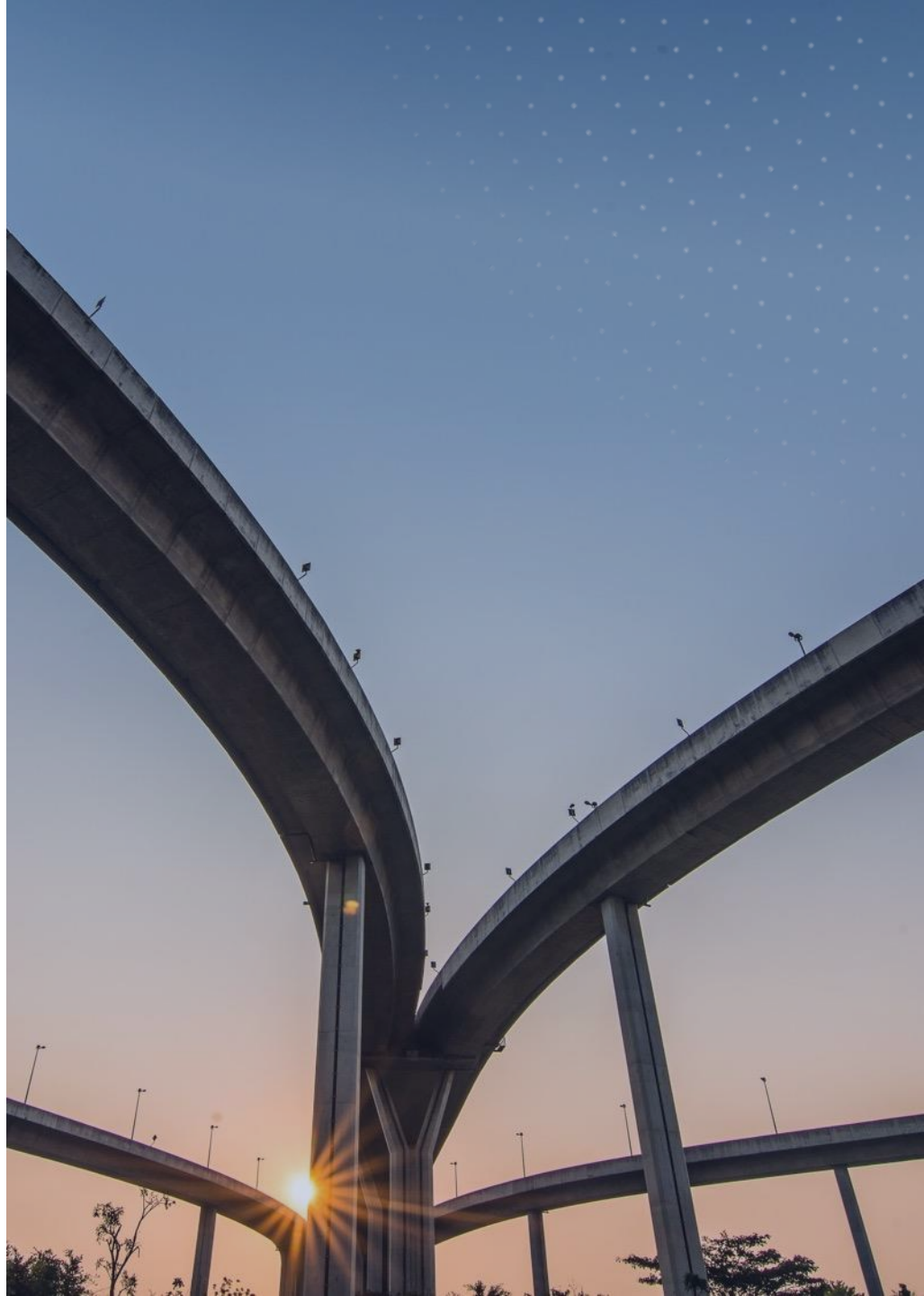

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Cost Report Acceptance And Supporting Documents

Cost Report Reminder Letters and Contact Information

- Cost report reminder letters are sent 60 days prior to the due date
- Letters will include the FYB and FYE dates for the reporting period
- Letters addressed to the contact we list for A&R correspondence
  - Requests for contact updates may be emailed to J6_Cost_Report_Filing@anthem.com and must come from the Authorized Official or Delegated Official from the provider's current PECOS enrollment record
  - Any changes in Authorized Official or changes in operational or managing control must be reported to NGS within 30 days, by either logging into and updating the PECOS record or by submitting a paper 855A change of information application to our Provider Enrollment department. They can be reached at 1-855-593-8047. Additional information is also available on our website, ngsmedicare.com, under Enrollment

Checking Cost Report Status in MCReF

- Cost report status is available to providers in the MCReF system once received by NGS

Submission Process Status	Scenario
None	Provider has not submitted a Cost Report for the FYE
Received	Provider has submitted at least one Cost Report that is pending acceptance and no submissions have been accepted.
Accepted	At least one CR for the FYE has been accepted
Rejected	All submitted CRs have been rejected
Not Required	FYE has been closed prior to the receipt of an acceptable submission

Cost Report Supporting Documentation Requirements

Supporting documentation requirements:

- Effective for cost reports with FYB 10/1/2018 and after, when a provider files the cost report, NGS will ensure required supporting documentation is also submitted. Failure to include the supporting document could result in the rejection of the cost report.
  - IRIS Files – new XML format
  - Bad Debt Listings – amounts correspond to submitted cost report
  - DSH Listings supporting number of days – days correspond to submitted cost report
  - Charity Care Listings – amounts correspond to submitted cost report
  - Verify totals-multiple tabs, subunits, transposed numbers

- **Home Office Cost Reports** – we will ensure Home Office cost report was submitted (with NGS or other MAC)

Medicare Bad Debt

- Bad debt write off amounts must consist only of Medicare Part A coinsurance plus deductible amounts, minus any payments received before a claim is deemed worthless/before write off
- Bad debt is to be reported during the reporting period in which the claim was deemed worthless and written off; not when service was rendered
- Fee schedule services and Medicare Advantage/HMO claims may not be reported on the cost report
- Payments received from a beneficiary or from secondary insurance should be tracked and subtracted from the coinsurance and deductible amounts on the bad debt listing-the remaining uncollected amount is the bad debt write off amount
- The write off amount on the bad debt listing should be easily traceable through the columns, i.e. (A + B) – C = D

A	B	C	D
DEDUCTIBLE	CO-INSURANCE	PAYMENTS RECEIVED BEFORE WRITE OFF	TOTAL WRITE OFF
	2,723.00	5.00	2,718.00
100.00	5,446.00	-	5,546.00
-	1,167.00	-	1,167.00
-	600.00	-	600.00
-	2,600.00	2,068.00	532.00
-	5,600.00	-	5,600.00
-	4,400.00	1,152.00	3,248.00

Medicare Bad Debt Payments vs Recoveries

- Payments received from a beneficiary or from secondary insurance should be tracked and subtracted from the coinsurance and deductible amounts on the bad debt listing-the remaining uncollected amount is the bad debt write off amount
- Recoveries are payments received ***after*** a claim is written off (Date deemed worthless), not before
- Recoveries must be reported on the cost report for the year in which the recovery payment was received. If received in a subsequent year cost reporting period, it must be reported as an offset in that subsequent cost reporting period.
- Please report recoveries and any reprocessed Medicaid claims separately from current year write offs, on a separate tab or listing
- Each line on the bad debt listing should represent one single Medicare claim, not a range or aggregate of claims

CMS Exhibit 2A - Medicare Bad Debt Listing

- CMS has published a new template for Medicare Bad Debts, exhibit 2A, for cost reporting periods beginning on or after October 1, 2022
- Complete separate exhibits for bad debts resulting from inpatient services and outpatient services
- A hospital healthcare complex claiming bad debts for multiple components must complete separate exhibits for each CCN
- Report dates in MM/DD/YYYY format
- Spreadsheet template and related instructions at the below link or in CMS Pub 15-2 (at the end of the WS S-2 section, 4004.2)
    - https://www.cms.gov/medicare/audits-compliance/part-a-cost-report/electronic-cost-report-exhibit-templates

CMS Exhibit 2A - Medicare Bad Debt Listing

4004.2 (Cont.) FORM CMS-2552-10 03-23

EXHIBIT 2A

TITLE	MEDICARE BAD DEBTS
PROVIDER NAME	
CCN	
SUBPROVIDER CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
INPATIENT / OUTPATIENT	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMN 23	
TOTAL DUAL ELIGIBLE	

PATIENT NAME LAST	PATIENT NAME FIRST	DATE OF SERVICE: FROM	DATE OF SERVICE: TO	PATIENT ACCOUNT NUMBER	MBI OR HICN	MEDI-CAID NUMBER	PROVIDER DEEMED INDI-GENT	MEDI-CARE REMIT-TANCE ADVICE DATE	MEDI-CAID REMIT-TANCE ADVICE DATE	SEC-ONDARY PAYER RA RE-CEIVED DATE	BENE-FICIARY RESPON-SIBILITY AMOUNT	DATE FIRST BILL SENT TO BENE
1	2	3	4	5	6	7	8	9	10	11	12	13

A/R WRITE OFF DATE	SENT TO COLLEC-TION AGENCY (Y/N)	RETURN FROM COLLEC-TION AGENCY DATE	COLLEC-TION EFFORT CEASED DATE	MEDI-CARE WRITE OFF DATE	RECOVER-IES ONLY: AMOUNT RECEIVED	RECOVER-IES ONLY: MCR FYE DATE	MEDI-CARE DE-DUCTIBLE AMOUNT	MEDI-CARE CO-INSUR-ANCE AMOUNT	PAYMENTS RECEIVED PRIOR TO WRITE-OFF	ALLOW-ABLE BAD DEBTS AMOUNT	COMMENTS
14	15A	15	16	17	18	19	20	21	22	23	24

Disproportionate Share and Low-Income Patient Listings

- If a provider wishes to change the method used to capture Medicaid/Title XIX days reported on Worksheet S-2 line 24 and/or 25 (date of admission, census days, or date of discharge) from the method previously reported on line 23, written notice must be submitted to the MAC at least 30 days before the beginning of the cost reporting period in which the change would apply
- Requests for retroactive changes will not be approved
- CMS will issue the approval for the change in methodology.
- Providers are to submit any correspondence from CMS approving or denying a change to the MAC. The method will apply to the entire cost reporting period and will apply to future reporting periods unless the provider submits a new request to the MAC and obtains another approval to change the methodology

42 CFR §412.106(b)(4)(iv), "If a hospital seeks to change its methodology for reporting days in the numerator of the fraction in the second computation, the hospital must notify CMS, through its fiscal intermediary or MAC, in writing at least 30 days before the beginning of the cost reporting period in which the change would apply. The written notification must specify the methodology the hospital will use, the cost reporting period to which the requested change would apply, and the current methodology being used. Such a change will be effective only on the first day of a cost reporting period."

CMS Exhibit 3A – DSH and LIP Listings

- CMS has published a new template for DSH and LIP, exhibit 3A, for cost reporting periods beginning on or after October 1, 2022
- Complete separate exhibits for each CCN
- Report dates in MM/DD/YYYY format
- Spreadsheet template and related instructions at the below link or in CMS Pub 15-2 (at the end of the WS S-2 section, 4004.1)
  - https://www.cms.gov/medicare/audits-compliance/part-a-cost-report/electronic-cost-report-exhibit-templates

CMS Exhibit 3A – DSH and LIP Listings

4004.1 (Cont.) FORM CMS-2552-10 12-22

EXHIBIT 3A

TITLE	MEDICAID ELIGIBLE DAYS FOR A DSH ELIGIBLE HOSPITAL
PROVIDER NAME	
CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
WS S-2, PT. I, LINE #	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMNS 10 &12	
TOTAL COLUMN 11	

PATIENT CLAIM INFORMATION							
PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATIENT ACCOUNT NUMBER	MEDICAID NUMBER	STATE ELIGIBILITY CODE	PATIENT POPU-LATION CODE
1	2	3	4	5	6	7	8

MEDICAID DAYS				INSURANCE OR OTHER PAYER NAME		MEDICARE ELIGIBILITY			
WKST S-2, PART I COLUMN NUMBER	ELIGIBLE DAYS	LABOR & DELIVERY ROOM DAYS	NEWBORN BABY DAYS	PRIMARY	SECONDARY	A/B INDICATOR	START DATE	END DATE	COMMENTS
9	10	11	12	13	14	15	16	17	18

Other Helpful Supporting Documents

- Census Reports
  -Support statistical data reported on Worksheet S-3 Part I column 8

  -Include Medicare patient days and discharges, Medicaid patient days and discharges, total patient days and discharges for each component of the hospital

- Working Trial Balance in Excel

- PS&R/Revenue Crosswalk or .mcp file

- Per-entity consolidation/detail schedules
  -Expand on consolidated financial statements

- Home office or related party reconciliation
  -Support for amounts reported on Worksheet A-8-1 columns 4 and 5

Other Helpful Supporting Documents

- Protested or Self-Disallowed Items

  -Documentation must include estimated reimbursement amounts for each protested or self-disallowed item.

  -A separate worksheet for each specific disallowed item must be submitted with the cost report that explains why the provider self-disallowed the specific item and a description of how the provider calculated the estimated reimbursement amount for each specific disallowed item

Home Office Cost Allocation and Hospital Cost Report Worksheet S-2

- If a home office furnishes services to a provider related to patient care, the reasonable costs of those services are included in the provider's cost report and are reimbursable as part of the provider's costs.
- The hospital (or other provider type) cost report cannot be accepted if the home office cost statement for the same/overlapping period is not received
- If home office costs are allocated the home office number is to be reported on the hospital cost report Worksheet S-2 line 140
- Report the **current, correct** home office number; email J6_Cost_Report_Filing@anthem.com for assistance
- If the home office number is not yet set up with NGS, complete the Home Office Form at ngsmedicare.com under Resources-Cost Reports, Home Office Cost Statements and email it to J6_Cost_Report_Filing@anthem.com

Home Office Cost Statement Submission

- New CMS Home Office Cost Statement Form 287-22 is required for FYB 10/1/2022 and later
  - EC and PI files required
  - E-signature is available, mailed ink signature no longer needed with electronic filing
  - May be submitted entirely through MCReF
  - Please submit a copy of Worksheet A groupings or a roll-up schedule that contains working trial balance account numbers to support any Worksheet A-8-1 column 5 amounts identified as “already included in Worksheet A”

IRIS File Requirements

Teaching hospitals – changes to IRIS files

- FY 2022 IPPS Final Rule – 8/13/21 FR, Vol. 86, No. 154, pages 45311-45313
- New .XML format for cost reports beginning on/after 10/1/2021. CMS has finalized cost report instructions and specifications for the new format
- Approved XML IRIS Vendors:
    - Besler – iRotations
    - HFS – HFSSoft IRIS
    - MyEvaluations.com – MyGME
    - New Innovations

Effective for cost reports beginning on/after 10/1/2022, IRIS IME and GME FTEs must correspond to what is reported on the cost report

Amended Cost Reports

Submitting an Amended Cost Report

- Include a cover letter with the amended filing that indicates what items were originally submitted on the as-filed cost report, what changed, and the reason for the change
- Amended cost reports must be received prior to the start of the desk review-see further details and exceptions at www.ngsmedicare.com under Resources > Cost Reports > File an Amended Cost Report
- Once received we will review the amended cost report for acceptability, subject to the same requirements for the as-filed cost report-verify bad debt, DSH and Charity Care amounts
- It may not be necessary to resubmit all the original supporting documentation if no changes were made from the original filing

MAC-Provider Communication

Cost Report Filing Resources

Questions:

J6_cost_report_filing@anthem.com

Manager:

Bobbi.Jo.Luciano@elevancehealth.com

PS&R or Pass Through Payments:

PSR@anthem.com

MCReF System Login:

https://mcref.cms.gov

Cost Report Mailing Addresses

Cost Report Address

Street Address (FedEx/Courier)

National Government Services, Inc
Attn: Cost Reporting Unit
220 Virginia Ave
Indianapolis IN 46204

USPS Mailing Address

National Government Services, Inc
Attn: Cost Reporting Unit
PO Box 7040
Indianapolis IN 46207-7040

Check Address

Street Address (FedEx/Courier)

US Bank Lockbox Services – J6 A
Attn: Lockbox 809199
5635 South Archer Ave
Chicago IL 60638

USPS Mailing Address

National Government Services
US Bank Lockbox Services – J6 A
PO Box 809199
Chicago IL 60680-9199

As-Filed Cost Report Overpayment and Extended Repayment Plans (ERS)

Providers wishing to request an Extended Repayment Schedule for an as-filed cost report overpayment:

- Indicate intent to apply for ERS in cover letter submitted with cost report
- Submit check copy and ERS Request to ERS mailbox, noting that the request relates to an As-Filed Cost Report
  - j6A.ers.requests@anthem.com
- When the cost report is accepted, A&R will include cover letter with the overpayment submission to Finance
- Demand letter will still generate, but payments will not be withheld while ERS request is being reviewed

NGSConnex A&R Inquiries

NGSConnex A&R Inquiries

- NGS A&R sends correspondence through the A&R Inquiries feature in NGSConnex. Auditors and providers use this area of Connex to send/receive desk review documentation requests, final settlements, tentative settlements, interim rate review documents, and detailed PS&R reports. Multiple contacts can be designated to receive A&R correspondence per provider.
- **If responding to an inquiry from NGS, please search for it by PTAN or Inquiry ID. Do not initiate a new inquiry**
- It is very important to maintain your access to NGS Connex to receive this correspondence. It is also very important to review the documents upon receipt.
- We have a dedicated shared email mailbox for inquiries related to using NGSConnex A&R Inquiries: ARConnex@Anthem.com. Please use this email address to update your contacts for A&R NGSConnex, such as when associates leave or when you have new associates.

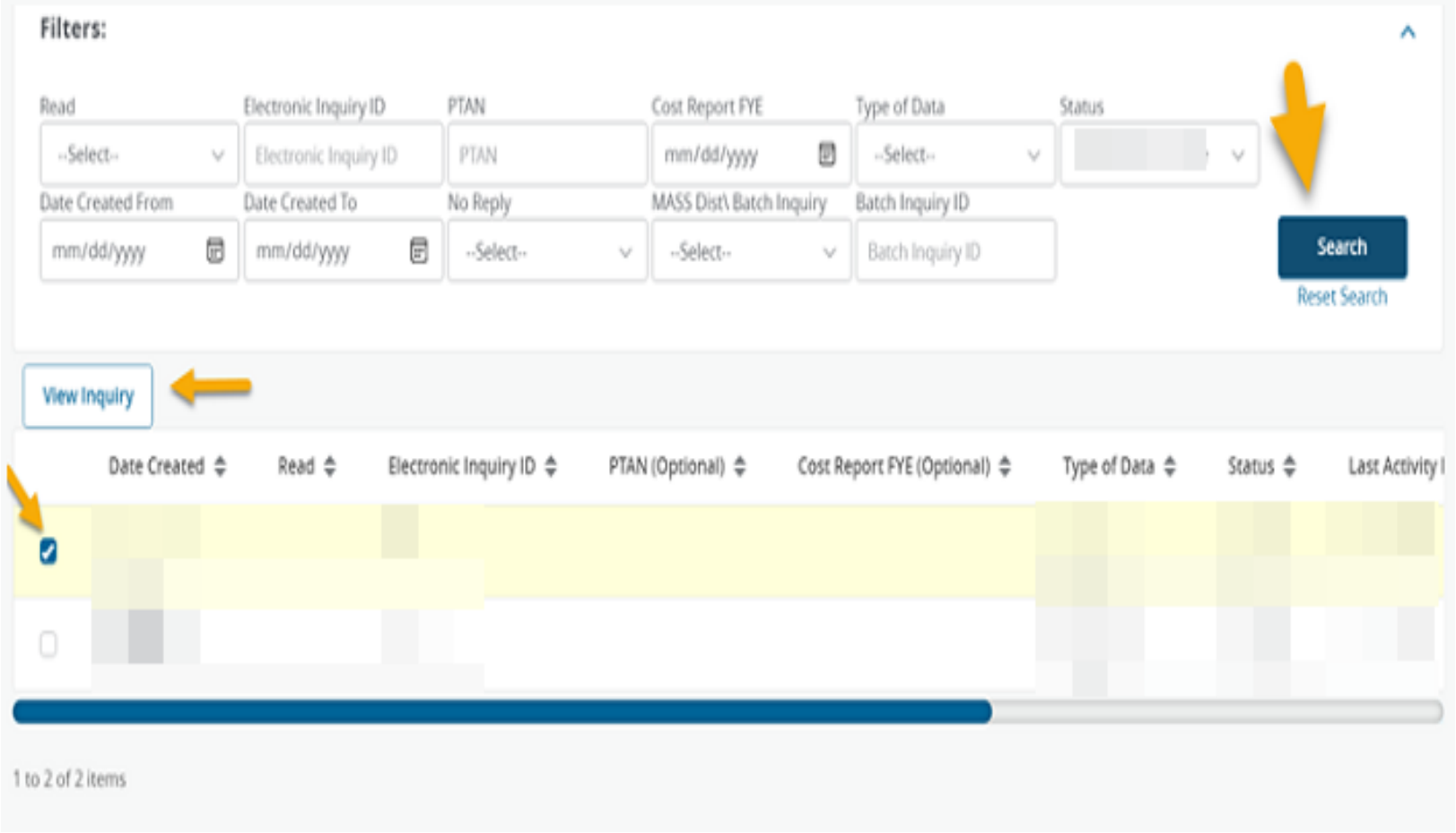
NGSConnex A&R Inquiries

- To have a new NGSConnex contact set up for A&R Inquiries, send an email to ARConnex@anthem.com including the information below. A&R will establish an ID for them.
  - Designated Contact Name
  - Title
  - Phone Number
  - Mailing Address
  - Email Address
  - Provider Numbers Impacted
  - NGSConnex User ID if already assigned
- The primary contact (to whom the letter is addressed) must be either the Authorized or Delegated Official from the current PECOS enrollment record, or a person designated by the Authorized/Delegated Official. To designate an alternate primary contact, an email request must be sent by the Authorized Official or Delegated Official of the facility.
- To add a CPA or consultant to the distribution, the provider should send an email to ARConnex@anthem.com requesting the consultant's NGSConnex ID be added for their provider number. This request must come from the provider, not the consultant. We must have at least one provider contact if including a consultant in the distribution.

Using Connex to Respond to NGS

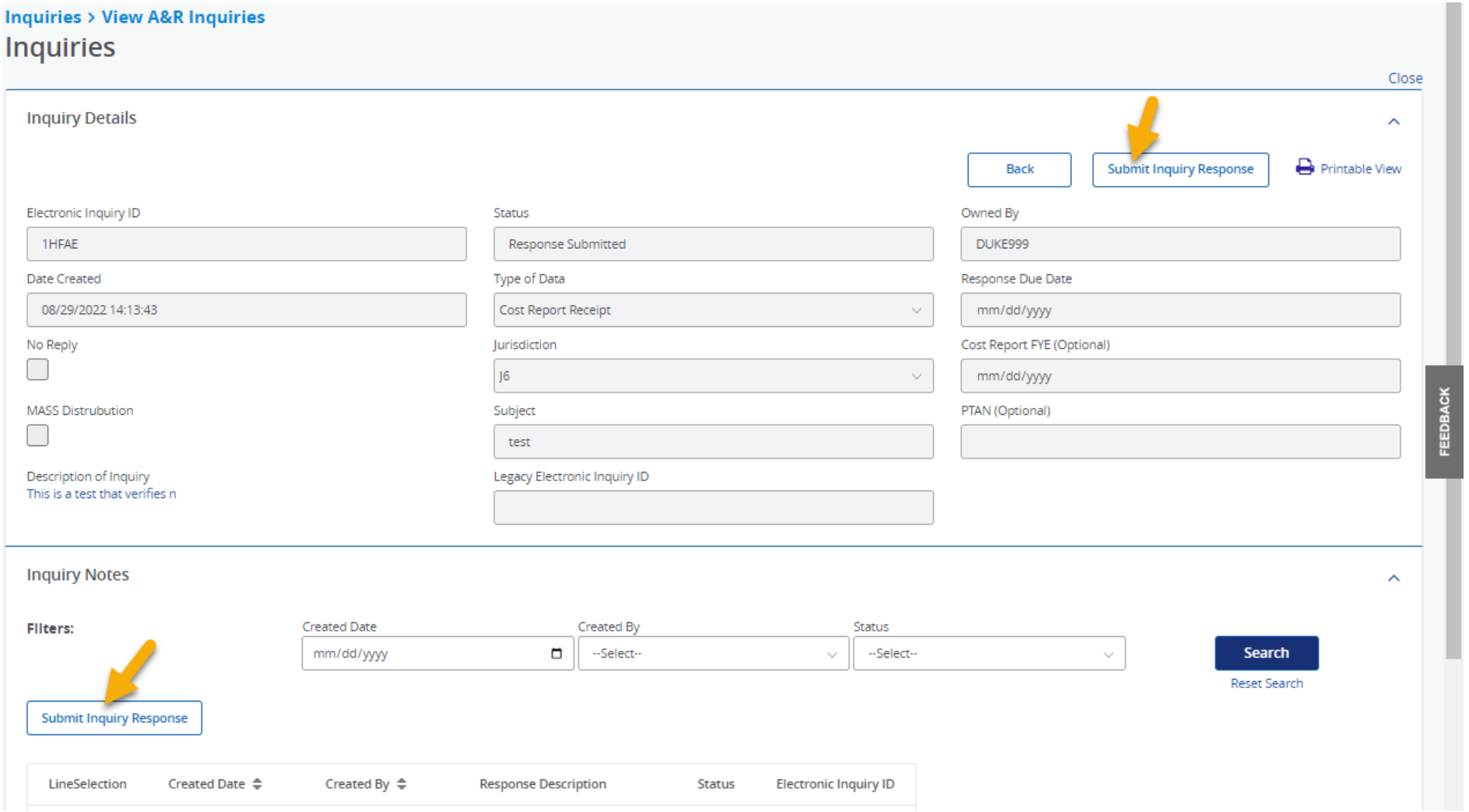
Use Connex to find and respond to an inquiry from NGS

- Log into Connex and perform a search
- Click the checkbox and then “View Inquiry” to open it and respond, add attachments
- https://www.ngsmedicare.com/web/ngs/ngsconnex-user-guide



Using Connex to Respond to NGS Continued

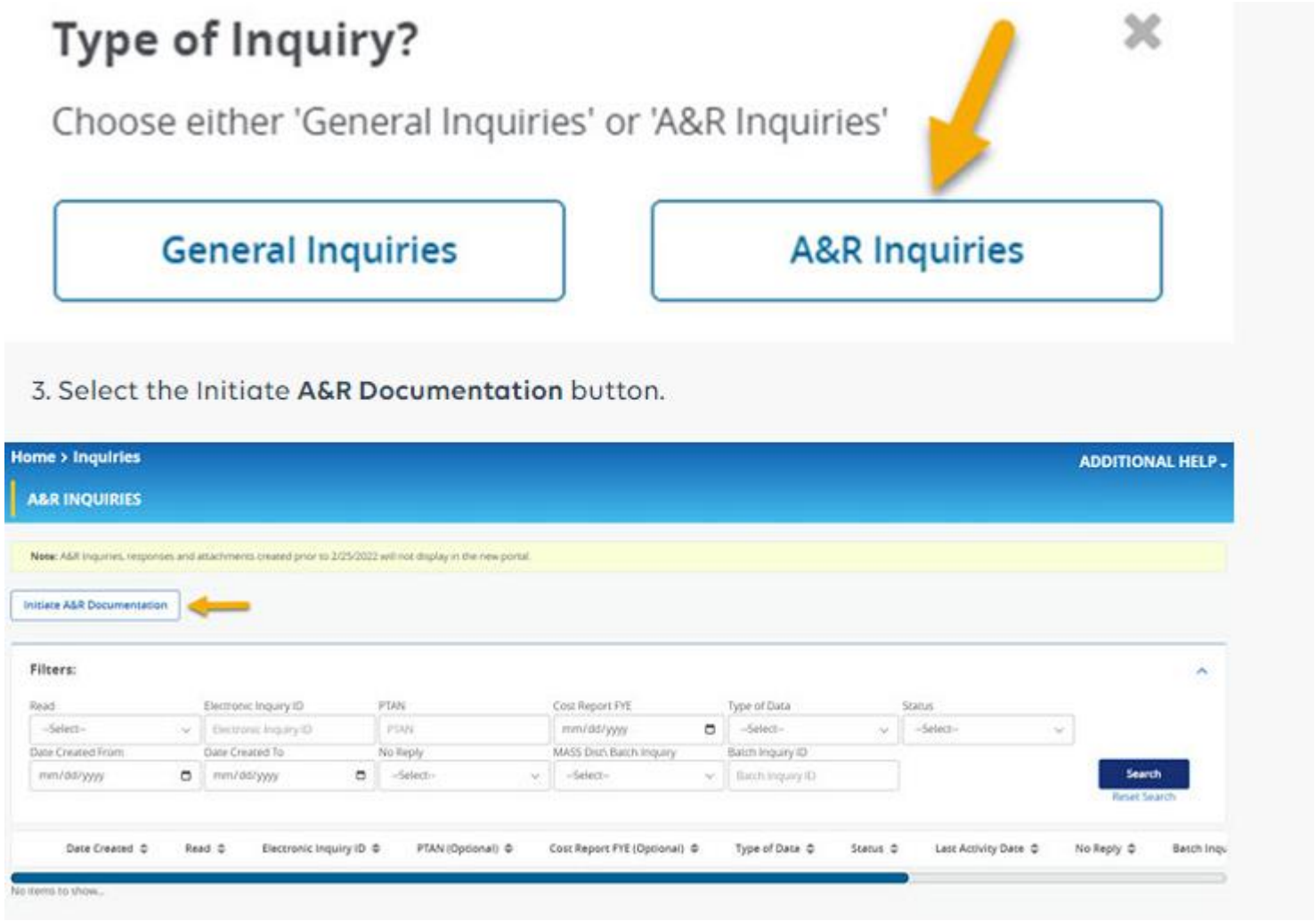
From the Inquiry Details screen find the Submit Inquiry Response button to add a response and add attachments if requested



Initiating a New Inquiry in Connex

Connex can also be used to start a <u>new</u> inquiry to submit files to NGS not requested by an auditor

- Inquiries may be sent to A&R by selecting the ‘Inquiries’ button on the NGSConnex homepage
- For ‘Type of Inquiry’ select ‘A&R Inquiries’
- https://www.ngsmedicare.com/web/ngs/ngsconnex-user-guide



S-10 Audits

S-10 Audits: 2024

- All providers qualifying for DSH again selected for S-10 Audit in 2024
  - FFY beginning 2022 data will be reviewed
- NGS has 187 audits to complete in J6 using CMS developed Audit Program
  - 44 MN providers being audited this year.
  - Figliozzi & Co. is being utilized again as a subcontractor to complete 42% of the audits with NGS staff completing the other 58% in total.
  - NGS letters were emailed to all providers during February and March 2024.
  - Audit exit conferences will be more evenly spread out throughout the year, with some much earlier in the year, which should alleviate pressure on providers.

S-10 Audits

Audits will focus mainly on Lines 20, 22 and 26 of W/S S-10

- **Line 20 – Charity Care Charges will be reconciled between cost report and submitted listings**
  - Review providers Query Logic for Line 20
  - Review Charity policies and/or Financial Assistance Policies (FAPs) – Providers must be following their policy, and the policy must be for the cost reporting period
  - Recommending providers to submit one excel spreadsheet with one tab that reconciles to line 20 or that we will adjust to at audit
  - Review for transaction codes/adjustment codes to ensure charity codes
  - Bad debts claimed on the Medicare Settlement Worksheets cannot be included on S-10 Line 20. The write-off to the GL account determines if the Medicare bad debt can be claimed as a Medicare Settlement bad debt or a Medicare charity write-off.
  - Ensure all charity claims were written off in the current year

S-10 Audits

Line 20 – Charity Care Charges will be reconciled between cost report and submitted listings (continued):

- Ensure no physician/professional fees have been included (listings should contain columns for Rev codes unless physician/professional fees are captured in a separate system then the attestation is required to be submitted).
- Review for duplicates within the listing
- Review the insurance description if a reclassification is needed to uninsured. Descriptions that are Self-Pay, uninsured or any description that is uninsured will be reclassified from insured to uninsured.
- HRSA/COVID payments cannot be included on Line 20. HRSA for COVID would have paid for services from 02/04/2020 if the claim was submitted to HRSA prior to 03/22/2022. All HRSA claims must have been submitted prior to 03/22/2022.

S-10 Audits

Line 22 – Payments Received from patients will be reconciled between cost report and submitted listings

- Payments should be for amounts previously written off as charity care during prior year(s).
- If recovery occurs in current year, it should be offset and only remaining balance claimed on Line 20 in the current year

Line 26 – Total Bad Debt Expense will be reconciled between cost report and submitted listings

- Review providers query logic
- Recommending providers to submit one excel spreadsheet with one tab that reconciles to line 26 or that we will adjust to
- Settlement Medicare bad debts are to be included in the line 26 listing
- Recoveries should be netted

S-10 Audits

Line 26 – Total Bad Debt Expense (continued)

- No Physician or professional fees should be included
- Only amounts owed by patients should be included-no 3rd party liabilities should be included
- All claims are to be written off in the current year
- No duplicates

S-10 Audits: CMS 2552-10 Transmittal 20 (Updated by Transmittal 18) - Impact to Uncompensated Care

- Please note that this does not impact our current year under review (i.e., it may for FFY23 and beyond).
- S-10 Worksheet Part I now includes the UCC for the entire hospital complex only. S-10 Worksheet Part II includes inpatient and outpatient services billable under the hospital's CMS certification number (i.e., provider number).
- Unknown at this time if this new Worksheet will be used in future rulemaking to calculate a hospital's UCC payment.
- When a provider accepts an amount from an insurer as a payment (or partial payment) an inferred contractual relationship between the insurer and provider will exist.
- S-10 PT II Exhibits 3B (charity care charges) and 3C (total bad debts) – This information may be subject to audit starting in 2025, NGS is waiting on instructions to be furnished by CMS.

Desk Reviews, Audits, and Final Settlements

J6 Hospital Cost Report Inventory – Minnesota

- 125 Minnesota hospitals
  - 45 Prospective Payment System Hospitals
  - 76 Critical Access Hospitals
  - 1 Long Term Care Hospitals
  - 0 Rehabilitation Hospitals
  - 1 Psychiatric Hospitals
  - 2 Childrens Hospitals

J6 Desk Review/Audit/Final Settlement Workload

OPTION YEAR 4: 8/1/2024 – 7/31/2025

Medicare Cost Report Workload

- Desk Reviews (~1,600 targeted)
  - Hospital (~460 targeted; 140 Minnesota)
  - Non Hospital (~1,140; 78 Minnesota)
- Audits (~82 targeted; 14 Minnesota)
  - Complete (~62 targeted; 10 Minnesota)
  - Additional starts (~20 targeted; 4 Minnesota)
- All other final settlement timeframes
  - Generally to be final settled within 16-18 months from initial cost report acceptance*

**Unless going to audit, on a currency plan, or on hold*

Wage Index/Occupational Mix

FY 2026 Wage Index

- **November 15, 2024** - Deadline for MACs to complete all desk reviews for hospital wage data and transmit revised Worksheet S-3 wage data and occupational mix data to DAC. Worksheet S-3 wage data must be sent to DAC in electronic format (HCRIS hdt format). Occupational mix data must be sent to DAC on the Excel spreadsheet provided by DAC for specific use by MACs.

- **January 31, 2025** - Release of revised FY 2026 wage index and occupational mix files as PUFs on the CMS Web site. These data will have been desk reviewed and verified by the MACs before being published. Also, a file including each urban and rural area's average hourly wages for the FYs 2025 (final) and 2026 (preliminary) wage indexes will be provided on the CMS Web site.

- **February 18, 2025** - Deadline for hospitals to submit requests (including supporting documentation) for:
    1. Corrections to errors in the January PUFs (wage index S-3 wage data and occupational mix) due to CMS or MAC mishandling of the wage index data, or
    2. Revisions of desk review adjustments to their wage index and occupational mix data) as included in the January PUFs (and to provide documentation to support the request).

    MACs must receive the requests and supporting documentation by this date. No new requests for wage index and occupational mix data revisions will be accepted by the MACs at this point, as it is too late in the process for MACs to handle data that is new in a timely manner.

FY 2026 Wage Index

- **March 21, 2025 -** Deadline for the following:
  - 1. MACs to transmit final revised wage index data (in HCRIS hdt format) to DAC for inclusion in the final wage index. Worksheet S-3 wage data must be transmitted in HCRIS hdt format. Occupational mix data must be sent to DAC on the electronic Excel spreadsheet provided by DAC for specific use by MACs. All wage index data revisions must be transmitted to DAC by this date.

  - 2. MACs must also send written notification to hospitals regarding the status of the hospitals' February 18, 2025, correction/revision request(s) by this date.

FY 2026 Wage Index

- **April 4, 2025**
  - Deadline for hospitals to appeal MAC determinations and request CMS' intervention in cases where the hospital disagrees with the MAC's determination. It should be noted that during this review, CMS does not consider issues such as the adequacy of a hospital's supporting documentation, as CMS believes that the MACs are generally in the best position to make evaluations regarding the appropriateness of these types of issues (which should have been resolved earlier in the process). The request must include all correspondence between the hospital and MAC that documents the hospital's attempt to resolve the dispute earlier in the process. Data that was incorrect in the preliminary or January wage index data PUFs, but for which no correction request was received by the February 18, 2025, deadline, will not be considered for correction at this stage.

  - Hospitals must submit appeals with all supporting documentation for the FY 2026 wage index cycle via the Wage Index Appeals (WIA) module in the Medicare Electronic Application Request Information System (MEARIS) at https://mearis.cms.gov. To ensure compatibility with MEARIS, supporting documentation shall preferably be PDF or Word files and spreadsheets shall be in Excel.

  - Note: These appeals for FY 2026 will NOT be accepted via email.

FY 2026 Wage Index

- **April 30, 2025**
  - Release of final FY 2026 wage index and occupational mix data PUFs on CMS Web page. Hospitals will have approximately 1 month to verify their data and submit correction requests to both CMS and their MAC to correct error due to CMS or MAC mishandling of the final wage and occupational mix data.
- **May 30, 2025**
  - Deadline for hospitals to submit correction requests to both CMS and their MAC to correct errors due to CMS or MAC mishandling of the final wage and occupational mix data as posted in the April 30, 2025, PUF. Changes to data will be limited to situations involving errors by CMS or the MAC that the hospital could not have known about before review c the final April PUFs. CMS and the MACs must receive all requests by this date.

FY 2026 Wage Index

- **May 30, 2025**
  - Hospitals must submit corrections with all supporting documentation for the FY 2026 wage index cycle via the Wage Index Appeals (WIA) module in the Medicare Electronic Application Request Information System (MEARIS) at https://mearis.cms.gov. To ensure compatibility with MEARIS, supporting documentation shall preferably be PDF or Word files and spreadsheets shall be in Excel. Note: These appeals for FY 2026 will NOT be accepted via email.

- **August 1, 2025**
  - Approximate date of issuance of the FY 2026 final rule; wage index includes final wage index data corrections

- **October 1, 2025**
  - Effective date of FY 2026 wage index

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IRIS Overlap Duplicate FTE Reviews

IRIS Overlap FTE Review

- In 2023, Myers and Stauffer LC (M&S) was awarded a contract directly with CMS to provide support for Quality Assurance, IRIS, and Training (QITS). As part of their QITS contract, M&S is to conduct a review of Intern and Resident overlap/duplicate FTEs on a national level (Starting with FFY 17 cost reports).
  - M&S has a Joint Operating Agreement with all Medicare Administrative Contractors (MACs) defining roles between each party.

- Hospitals involved in this first round of IRIS overlap reviews were contacted late last summer.

- Upon completion of the review, any adjustments to the cost report that were identified by M&S are transferred to the servicing MAC to incorporate into the cost report and for payment processing (As part of the initial final settlement or reopening).

- All questions, comments, concerns regarding these reviews should be directed to M&S.

- Latest Status
  - M&S completed their review on all FFY 17 cost reports. M&S transferred the results to the Medicare Administrative Contractors in September. NGS will be incorporating adjustments through the reopening process since all impacted cost reports have already been final settled.
  - FFY 18 and 19 reviews are in process by M&S.

Medicare Cost Report Reopenings & Appeals

Reopenings

- NGSMedicare.com – Cost Reports – Submitting a Cost Report Reopening
  - Includes guidance on what to include in the request
  - Includes guidance on how NGS evaluates reopening request
- Preferred Method of sending Reopening requests or Reopening inquiries: cost.report.reopenings@anthem.com
- Closing out aged inventory
  - If any hospitals have pending Reopenings with NGS and you need a status or have not heard from us in some time; please reach out with an email to the Reopening mailbox - cost.report.reopenings@anthem.com

Reopenings

Reopening guidance:

- **The cover letter or the body of the email should contain:**
  - Medicare provider name, six-digit provider number and cost report fiscal year end.
  - Clearly specify the issue requested to be reopened, the reason, and why it is believed to meet the conditions to qualify for a reopening.
  - Include the estimated reimbursement dollar impact.
  - Include the specific requested adjustments to the cost report (i.e. worksheet, line, column and amount for each adjustment.
- **Be prepared to supply any supporting documentation within 30-60 days from initial request**
  - **Failure to do so could result in a denial of the reopening**

Reopenings

- **CR 13413 – Instructions for Processing Requests for SSI Realignment for Cost Reporting Periods Starting Before October 1, 2013**

  - NGS issued notifications to the hospitals they service that the pre-FY 2014 cost reporting period SSI ratios have been posted
  - Instructions included in the letter on the process to submit a new SSI realignment request or confirm an existing request
  - Existing requests need to be confirmed to proceed: cost.report.reopenings@anthem.com
  - All requests must include cost report begin date and cost report end date
  - MACs shall issue a revised NPR within 24 months of the Final Information Received Date (FIRD). The FIRD is the receipt date of the provider's new or confirmed realignment request.

Appeals

- On February 21, 2024, CMS issued Change Request (CR) 13294 to provide guidance to the Medicare Administrative Contractor's (MAC's) on how to address Medicare cost reports on hold as a result of court challenges to the fiscal year (FY) 2004 inpatient prospective payment system (IPPS) Proposed Rule (68 FR 27208) about whether patient days associated with patients enrolled in a Medicare Advantage (MA) plan (then called a Medicare+Choice (M+C) plan) should be counted in the Medicare fraction or the Medicaid fraction of the disproportionate patient percentage (DPP) calculation.

- Impact on cost reports with pending appeals before the Provider Reimbursement Review Board (PRRB) and/or remands impacting DSH:
    - BR 13294.6 addresses pending PRRB appeals and remands for DSH-related issues for cost reporting periods starting before 10/1/2004.
    - BR 13294.7 addresses pending PRRB appeals and remands for DSH-related issues for cost reporting periods beginning on/after 10/1/2004 and before 10/1/2013.
    - All pending PRRB appeals and remands under BRs 13294.6 and 13294.7 shall have RNPRs issued within the later of 12 months from the date of this CR (due 2/21/2025) if the remand has already been issued or six months from the date of the remand for remands received after the issuance of this CR.

Appeals

- After issuing CR 13294, CMS issued CMS Ruling 1498-R3 on 3/4/2024. It provides notice CMS is revoking CMS Ruling 1498-R2, which allowed hospitals to elect their supplemental security income (SSI) ratios based on either “total days” or “covered days” for cost reporting periods with discharges that pre-dated 10/1/2004. Since CMS Ruling 1498-R2 was revoked, all SSI ratios will be based on “total days” for all RNPRs issued under CR 13294.

- With the issuance of CR 13294, the PRRB has resumed scheduling of previously postponed hearing dates. We encourage Providers to submit DSH listings and any other documentation needed to potentially resolve these issues prior to scheduled hearing.

Appeals

- Current hot topic in Appeals: Substantive claim - 42 C.F.R. § 405.1873 dated 11/13/2015
  - Effective for cost reports beginning on or after 1/1/2016, in order to document dissatisfaction with a final determination, the Provider must document its dissatisfaction through a substantive claim on the cost report associated with the appeal.
  - A substantive claim is similar to a protested item, in that the Provider must claim an estimated reimbursement amount related to an issue that the MAC has no authority to grant relief (i.e. SSI%, Part C, IPPS Standard Discharges, Outliers, ATRA, etc.), in order to show its dissatisfaction related to that particular issue.
  - For Providers, it is important to note the requirements of 42 C.F.R. § 413.24(j) in order to properly self-disallow a specific item.
    - The Provider must include an estimated reimbursement amount for each specific self-disallowed item in the protested amount(s) on the Provider's cost report.
    - The Provider must provide a separate explanation explaining why the Provider self-disallowed each item.
    - The Provider must include an explanation of how the estimated reimbursement amount for each of the item(s) self-disallowed was calculated.
  - It is also important to note that documentation supporting the above noted requirements of 42 C.F.R. § 413.24(j) must be submitted with the Provider's most recently submitted and accepted cost report.

Miscellaneous Contact Information

Standard Mailboxes and Contact Info

J6 Provider Contact Center: 1-877-702-0990

Other Contact Information on our website:

www.ngsmedicare.com

Standard Email Boxes for JK Medicare Part A Audit & Reimbursement:

Cost Report Filing: J6_Cost_Report_Filing@anthem.com

Cost Report Reopenings: cost.report.Reopenings@anthem.com

Cost Report Appeals: NGSCostReportAppeal2@anthem.com

Wage Index: J6WageIndex@anthem.com

J6 Desk Review/Audit Inquiries: J6Leads@anthem.com

PS&R: PSR@Anthem.com

Hospice Caps: selfreportedhospicecap@anthem.com

Provider Based Determinations: ngsprovbaseddeterminations@anthem.com

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Appeals Manager
Mark Hudak
Mark.Hudak@elevancehealth.com

Subcontractors

Figliozzi & Company, PC – Cost Report Audits and S-10 Audits

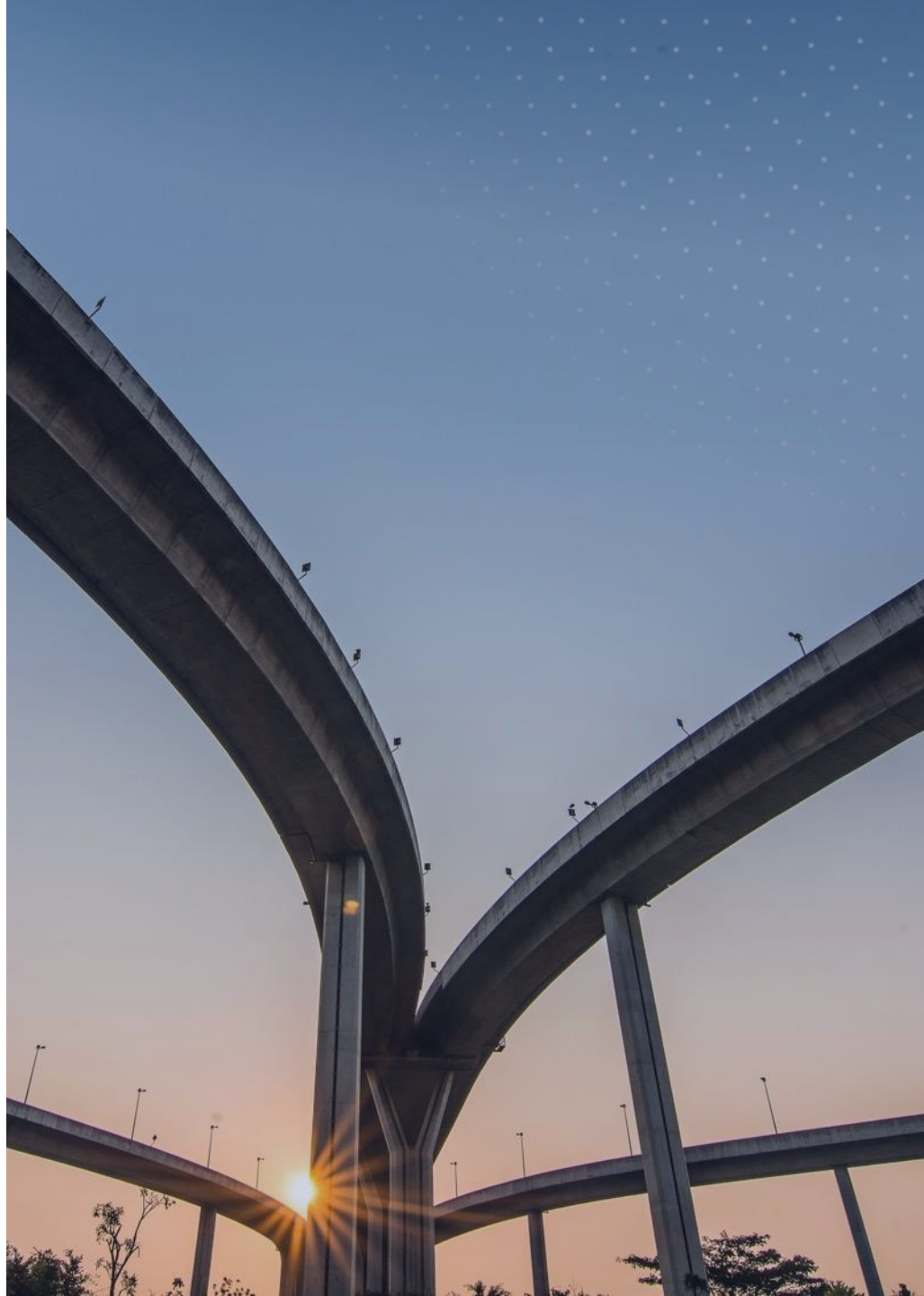
Pete Figliozzi – pfigliozzi@figliozzi.com

Kujawa & Batteau, PC – Cost Report Desk Reviews

Steve Kujawa - skuwaja@kandb-cpa.com

Systematic Medical Billing & Credentialing Services, Inc. – NGS subcontracts to complete MSP Audits

Alex Zeruto - azeruto@gmail.com



national government SERVICES

Other Miscellaneous Contact Information

Credit Balance Fax

1-315-442-4287

National Government Services, Inc.

Part A ORU/Credit Balance Reports

P.O. Box 6474

Indianapolis, IN 46207-6474

ERS Mailbox

j6A.ers.requests@anthem.com

National Government Services, Inc.

ATTN: ORU Part A – ERS Requests

P.O. Box 809199

Chicago, IL 60680-9199

MAC Customer Experience (MCE) Audit & Reimbursement Surveys

We're looking for ways to improve your Audit and Reimbursement experience.
Please take a few minutes to share your thoughts with us!

Beginning in April 2022, NGS has been including links to a survey at the completion of certain workloads:

- Notice of Program Reimbursement (NPR) review
- Revised NPR review
- S-10 Audit
- Interim Rate Review

We encourage you to navigate to the link in the letter you receive for the above workload completion and provide us feedback on your experience. Thank you in advance!