



VA-DC HFMA 2025 Spring Conference

Cost Report Considerations

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Agenda:

- Spending Reform Options
 - Considerations
 - Status – Extended through 9/30/2025
- Provider-based and 340B issues
- Medicare DSH Trends
- Other Reimbursement issues

Spending Reform Options

Spending Reform Update

- On March 14, 2025, the U.S. Senate passed a Continuing Resolution stopgap spending bill that was signed by President Trump on March 15, 2025.
- The Continuing Resolution put a stop to Healthcare spending cuts being analyzed by both the House and the Senate, however the current administration wants to cut taxes, so we expect the following spending cuts to resurface in the coming months.

Federal Budget Reconciliation

- Federal Spending on Health Programs and Services Accounted for More Than One Fourth of Net Federal Outlays in FY 2024
 - Total federal outlays on health programs and services amounted to \$1.9 trillion in FY 2024
 - Total federal outlays in FY 2024: \$6.9 trillion
- Medicare (12%), Medicaid (8%), ACA Marketplace (2%), Veterans hospital and medical care (2%), global health (0.1%), and other health spending (2%): \$1.9 trillion (27%)
- Social Security (21%)
- National defense (13%)
- Net interest (13%)
- Income Security (11%)
- Other (15%)

Spending Reform – The List

1. **STRENGTHEN MEDICARE FOR SENIORS (\$479B)**
 - *Site Neutral – \$146B*
 - *Uncompensated Care – \$229B*
 - *Bad Debt – \$42B*
 - *BCA Mandatory Sequester Extension - \$62B*
2. **MAKING MEDICAID WORK FOR THE MOST VULNERABLE (\$2.3T)**
 - *Per Capita Caps - up to \$918B*
 - *Equalize Medicaid Payments for Able Bodied Adults - up to \$690B*
 - *Limit Medicaid Provider Taxes - \$175B*
 - *Lower FMAP Floor - \$387B*
 - *Special FMAP Treatment for DC – \$8B*
 - *Repeal American Rescue Plan FMAP Incentive – \$18B*
 - *Medicaid Work Requirements - \$120B*
3. **REIMAGINING THE AFFORDABLE CARE ACT (ACA) (\$151B)**
 - *Recapture Excess Premium Tax Credit – \$46B*
 - *Limit Health Program Eligibility Based on Citizenship Status - \$35B*
 - *Repeal the Prevention Public Health Fund – \$15B*
 - *Appropriate Cost Sharing Reductions - \$55B*

Potential Program Changes

Uncompensated Care

- House Ways and Means Healthcare Committee "menu" of potential program changes as options for an upcoming reconciliation bill.
- **Eliminate Medicare Coverage of Bad Debt Up to \$42 billion 10-year savings**
 - Medicare currently reimburses hospitals at 65 percent of bad debt (uncollected cost-sharing that beneficiaries fail to pay), while private payers nor Medicare HMO's do not typically reimburse providers for bad debt.
 - CMS has done everything possible to eliminate the Medicare bad debt process, however many hospitals receive millions annual in Medicare bad debt reimbursement.
 - Elimination of payment for Medicare bad debt would increase the cost of Uncompensated care.
 - **Continuing Resolution (CR) extends funding through September 30, 2025, with no cuts.**
- **Improve Uncompensated Care Up to \$229 billion in 10-year savings**
 - This policy reforms uncompensated care payments by removing the payment from the Medicare Trust Fund and establishing a new uncompensated care fund that will equitably distribute payments to providers based on their true share of charity care and non-Medicare bad debt.
 - **Continuing Resolution (CR) extends funding through September 30, 2025, with no cuts.**

Potential Program Changes

Citizenship

- **Limit Federal Health Program Eligibility Based on Citizenship Status Up to \$35 billion 10-year savings**
 - Currently, many non-citizens who entered the country illegally are eligible for federal health care programs including advance premium tax credits as Medicaid. This policy would remove specified categories of non-citizens from eligibility for federal health care programs.
 - **Continuing Resolution (CR) extends funding through September 30, 2025, with no cuts.**
- **\$6 billion in 10-year savings**
 - In May 2024, the Biden Administration finalized a rule that would allow DACA recipients to enroll in subsidized marketplace and basic health program (BHP) plans. The rule expands eligibility by modifying the definition of “lawfully present” to include DACA recipients.
 - **Continuing Resolution (CR) extends funding through September 30, 2025, with no cuts.**



Potential Program Changes

Physicians

- **Reform Medicare Physician Payments Up to \$10 billion in 10-years**
 - Reform Medicare's physician payment system to encourage more predictability and certainty.
 - **Continuing Resolution (CR) extends funding through September 30, 2025, with no cuts.**
- **Medicare Site Neutrality Up to \$146 billion in 10-year savings**
 - Currently, Medicare and beneficiaries pay more for the SAME health care service furnished in hospital outpatient departments (HOPDs) than in physician offices. The budget supports Medicare site neutral payments by equalizing Medicare payments for health care services that can be safely delivered in a physician's office.
 - **Continuing Resolution (CR) extends funding through September 30, 2025, with no cuts.**

Potential Program Changes

Reimbursement

- **Prevent Dual Classification for Hospitals Under Medicare Up to \$10 billion in 10-year savings**
 - Prevent dual reclassifications for hospitals under Medicare to eliminate double dipping of benefits.
 - **Continuing Resolution (CR) extends funding through September 30, 2025, with no cuts.**
- **Geographic Integrity in Medicare Wage Index Up to \$15 billion in 10-year savings**
 - Enact geographic integrity in Medicare's Wage Index calculations to reduce overpayments to urban hospitals.
 - (Wage index changes are budget neutral. I am not sure how this saves the government any money)
 - **Continuing Resolution (CR) extends funding through September 30, 2025, with no cuts.**

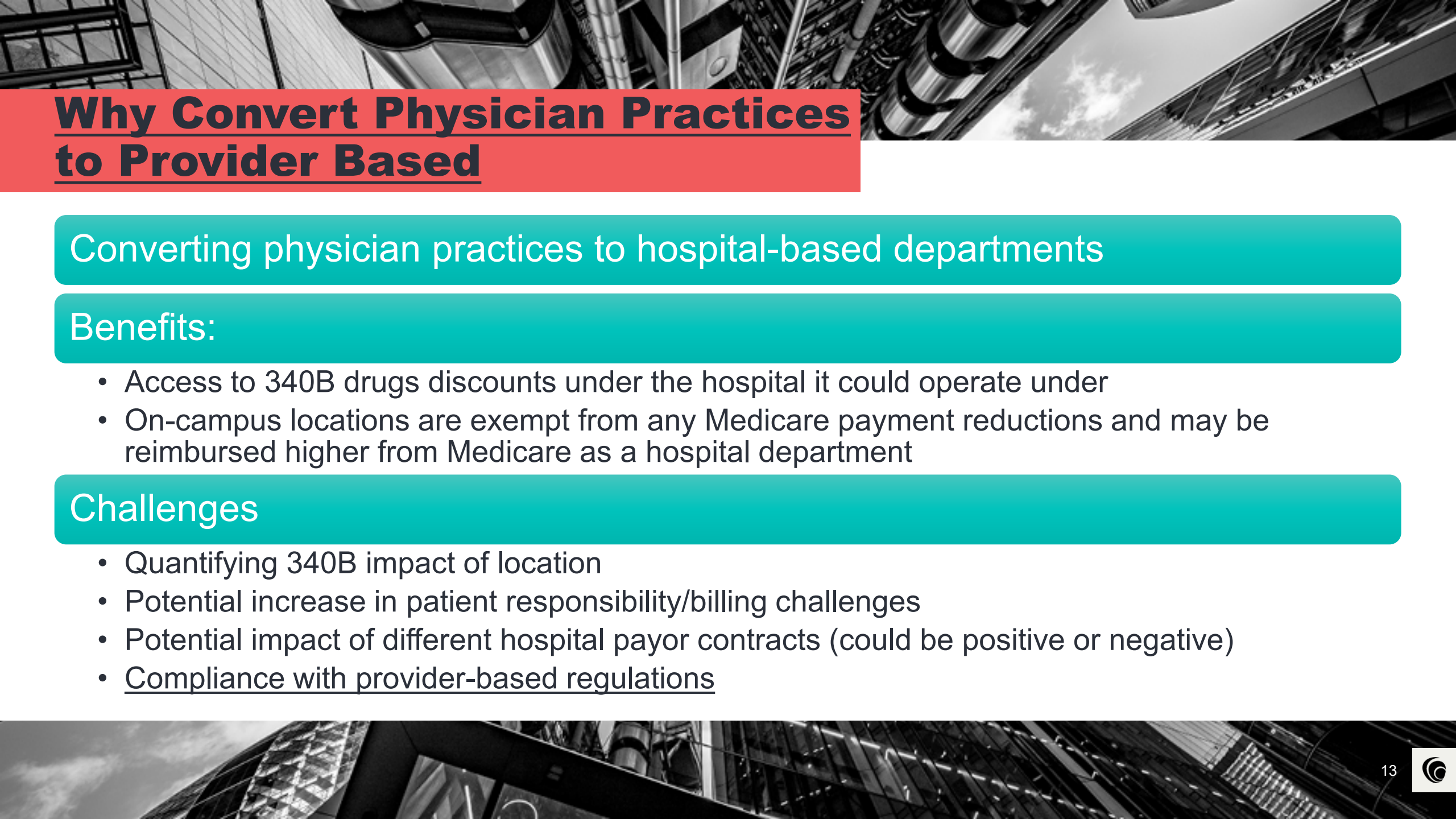
Potential Program Changes

Reimbursement

- **Eliminate Inpatient-only List Up to \$10 billion in 10-year savings**
 - Eliminate the inpatient-only list so more same-day surgeries and procedures can be performed in lower cost, outpatient settings. (Lower Medicare Payment) (This is the 2nd time. Trump did this in the first Administration, but had to reverse due to safety issues)
 - **Continuing Resolution (CR) extended funding through September 30, 2025, with no cuts.**
- **Recapture excess Affordable Care Act (ACA) subsidies Up to \$46 billion in 10-year savings**
 - Currently, an individual can receive advance payments of the premium tax credit to coincide when health insurance premiums are due each month, based on an estimate of income. If the tax credit is paid in advance, the taxpayer must reconcile the advance credit payments with actual income filed on the tax return and repay any excess tax credits. For individuals with incomes below 400 percent of FPL, any repayment amount is capped. The budget removes limits on repayments of excess premium tax credit payments so any individual who was overpaid in tax credits would have to repay the entire excess amount, regardless of income.
 - **Continuing Resolution (CR) extended funding through September 30, 2025 with, no cuts.**



Provider-based and 340B Issues



Why Convert Physician Practices to Provider Based

Converting physician practices to hospital-based departments

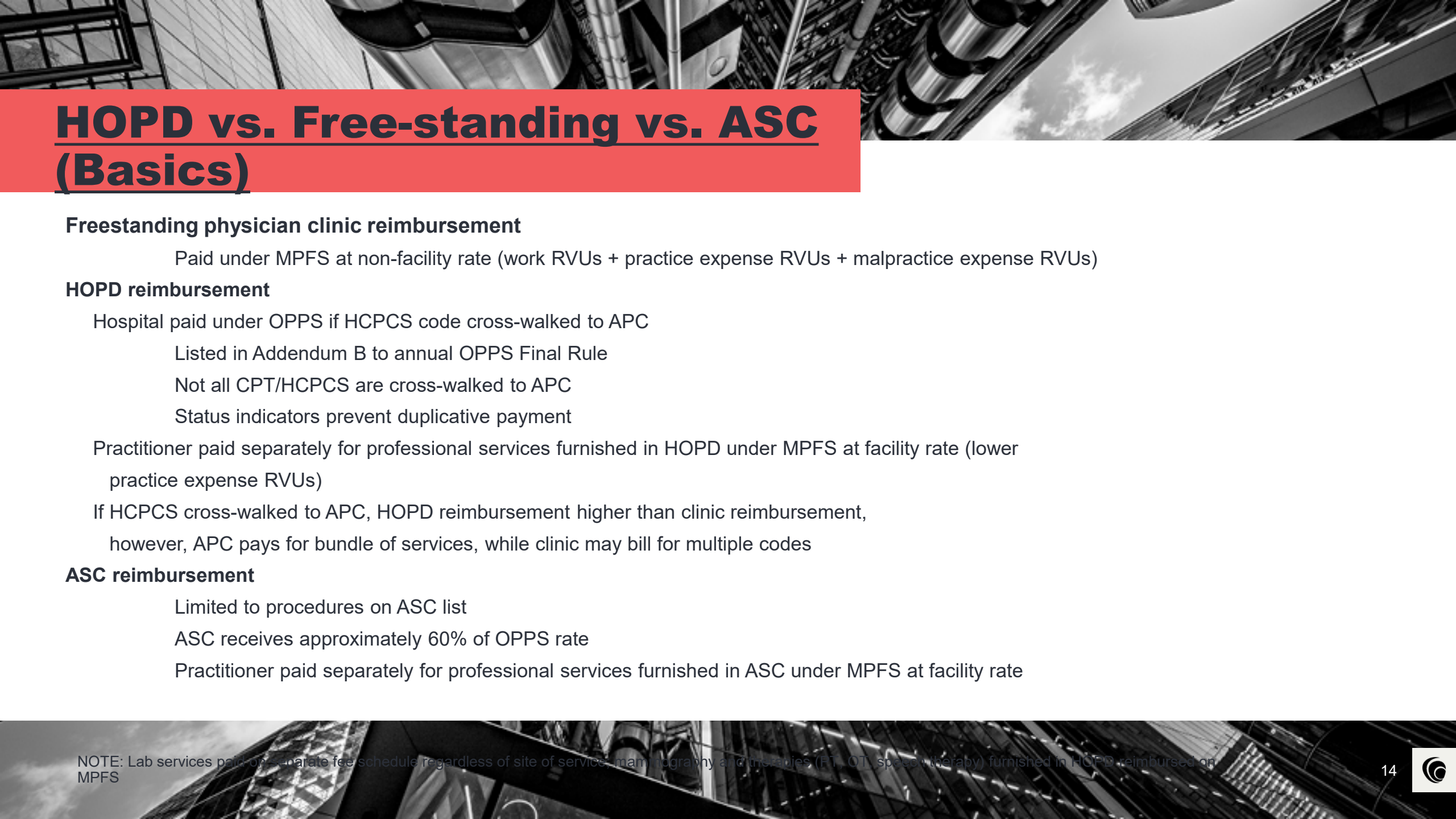
Benefits:

- Access to 340B drugs discounts under the hospital it could operate under
- On-campus locations are exempt from any Medicare payment reductions and may be reimbursed higher from Medicare as a hospital department

Challenges

- Quantifying 340B impact of location
- Potential increase in patient responsibility/billing challenges
- Potential impact of different hospital payor contracts (could be positive or negative)
- Compliance with provider-based regulations





HOPD vs. Free-standing vs. ASC **(Basics)**

Freestanding physician clinic reimbursement

Paid under MPFS at non-facility rate (work RVUs + practice expense RVUs + malpractice expense RVUs)

HOPD reimbursement

Hospital paid under OPPS if HCPCS code cross-walked to APC

Listed in Addendum B to annual OPPS Final Rule

Not all CPT/HCPCS are cross-walked to APC

Status indicators prevent duplicative payment

Practitioner paid separately for professional services furnished in HOPD under MPFS at facility rate (lower practice expense RVUs)

If HCPCS cross-walked to APC, HOPD reimbursement higher than clinic reimbursement, however, APC pays for bundle of services, while clinic may bill for multiple codes

ASC reimbursement

Limited to procedures on ASC list

ASC receives approximately 60% of OPPS rate

Practitioner paid separately for professional services furnished in ASC under MPFS at facility rate

NOTE: Lab services paid on separate fee schedule regardless of site of service, mammography and therapies (PT, OT, speech therapy) furnished in HOPD reimbursed on MPFS



Provider-based compliance

- Enrollment issues:
- Failure to complete Revalidation by the deadline.
 - This done once every 5 years. Failure to meet the deadline can result in deactivation of Medicare provider agreement and suspension of reimbursement
- **Not reporting Provider-Based Clinics to Section 4 of the Hospital CMS-855A Enrollment Record.**
 - Any provider-based clinics that are not within the “four walls” of the hospital need to be reported on the Hospital’s CMS—855A enrollment within 30-days of the effective date.

Provider-based compliance issues

Enrollment issues:

- On August 1, 2024, CMS implemented FISS edits that would cross reference service facility location information with the CMS-855A and data on the claim (2310E loop of the 837 institutional claim). The edits would confirm that the address on the claim ties to an approved address on the enrollment record.
- If clinics are NOT enrolled on the CMS-855A, it could result in either:
 - Claims Being Returned to Provider
 - If the address was not an exact match to an address on the approved CMS-855A enrollment record, the claim would be Returned to Provider, halting reimbursement.
 - Claims being overpaid
 - There are instances where hospitals did not put the address on the CMS-855A or the 2310 loop of the claim, which makes the claim appear to come from within the four walls of the hospital and not an off-campus provider-based clinic. This led the hospital to being overpaid, as there are reductions in OPPS payments for off-campus facilities.

Change in 340B Child Site Registration

- During the COVID-19 pandemic allowed hospital child sites that had not yet been registered could begin using 340B drugs right away if they were for eligible patients.
- On October 26, 2023, HRSA released a notice confirming that to continue purchasing 340B drugs,
 - Offsite, outpatient hospital facilities must
 - (1) be listed on the hospital's most recently filed Medicare Cost Report and registered with HRSA by the next 340B Program quarterly registration period, or
 - (2) the hospital must notify HRSA within 90 days of the publication of the Notice (January 24, 2024) that they have initiated the process of listing the outpatient facility on the hospital's Medicare Cost Report and registering it in OPAIS.
 - Following this 90-day grace period, non-compliant hospitals may be subject to audit and compliance action by HRSA.

Cost Reporting Best Practices for 340B Hospitals

Unique general ledger department(s) to record expense and charges on the financial statements

- Each department that will ultimately need to be registered as a child site
- Needed to trace departments to cost report line
- Hospitals that have multiple hospital campuses under the main hospital need to maintain separate departments as all departments in the remote location need to be registered as child site locations

These general ledger departments need to be mapped to a reimbursable cost report line to be eligible for 340B

- Cost report lines “above” line 190

Cleaner for 340B registration and OPA audit to have a subscribed cost report line for off-campus clinics

- Not required, and will create more work for cost report preparers

Need for constant collaboration between 340B team, hospital operations, cost report preparers to ensure departments are properly treated

- Critical to ensure cost reports remain compliant with federal regulations
- Consequences for filing improper cost reports can be significantly greater than the benefit that might be obtained for 340B purposes

Moving HOPD's to Different Hospital within System

Moving outpatient departments of a non-eligible 340B hospital to a hospital that has 340B

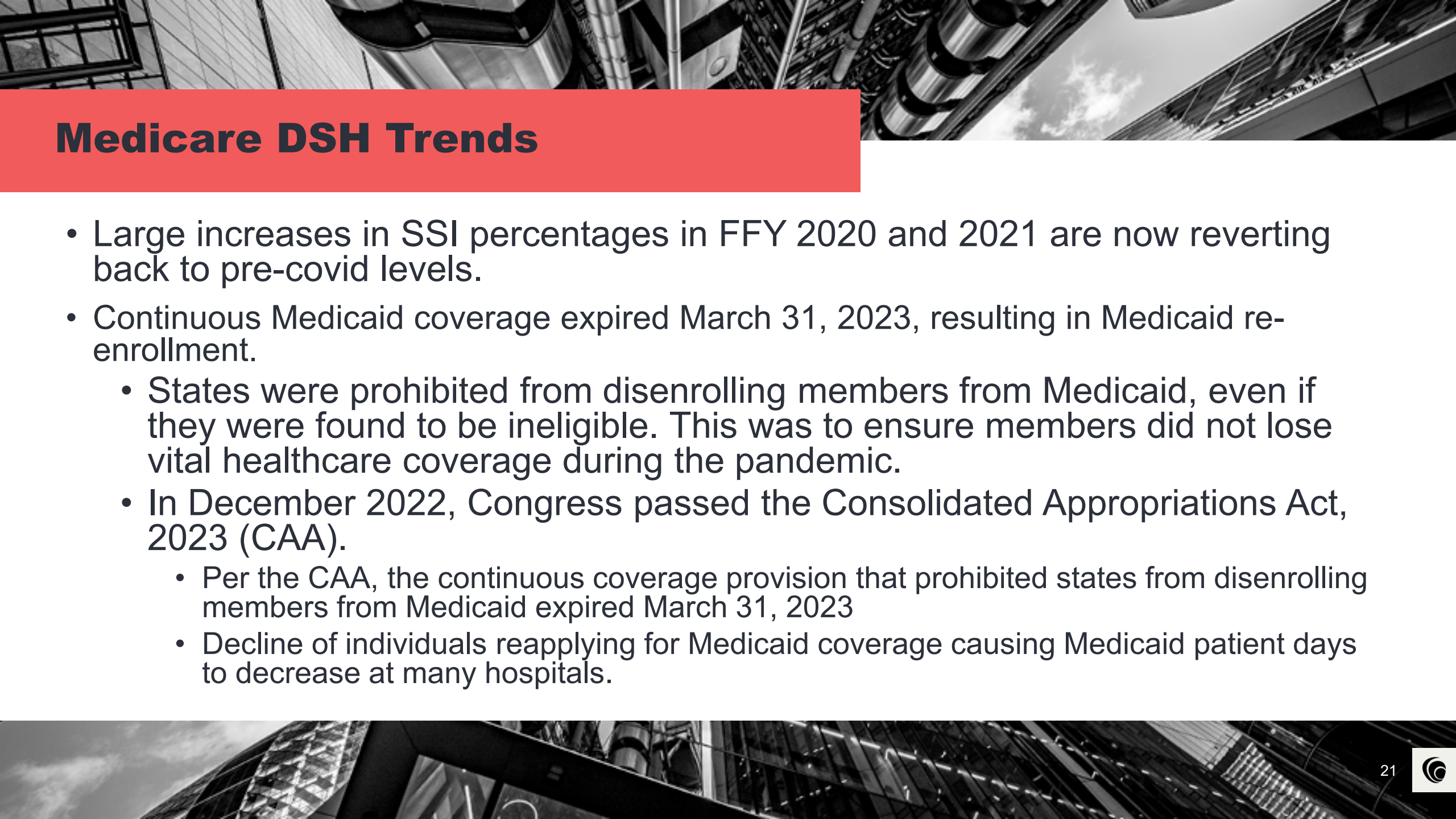
Benefits:

- Access to 340B drugs discounts under the hospital it could operate under
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Challenges

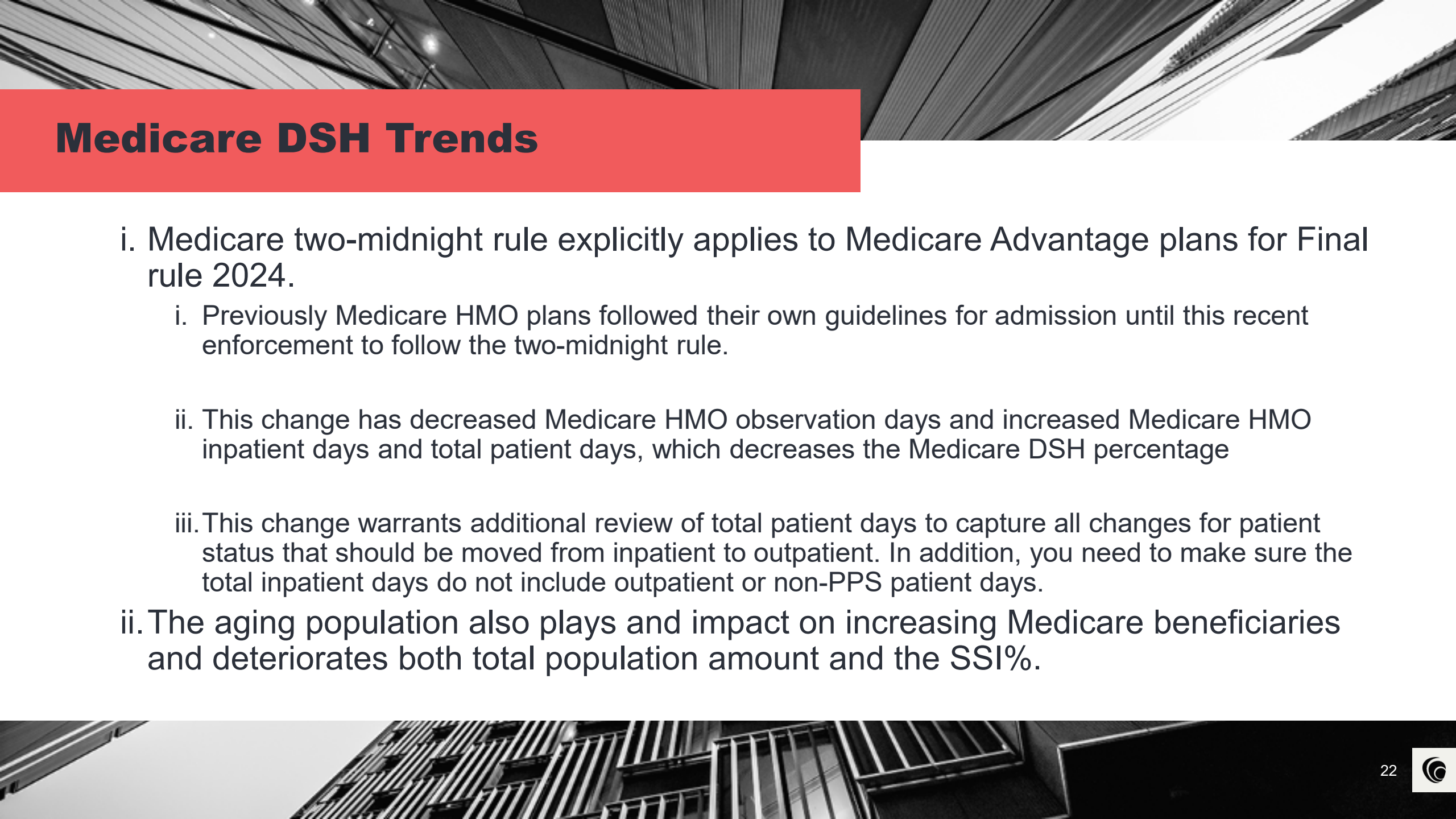
- Loss of Medicare excepted status causing Medicare payment reductions if the department is grandfathered and located off-campus:
- Potential impact of different hospital payor contracts (could be positive or negative)
- Compliance with provider-based regulations
- Internal politics

Medicare DSH Trends



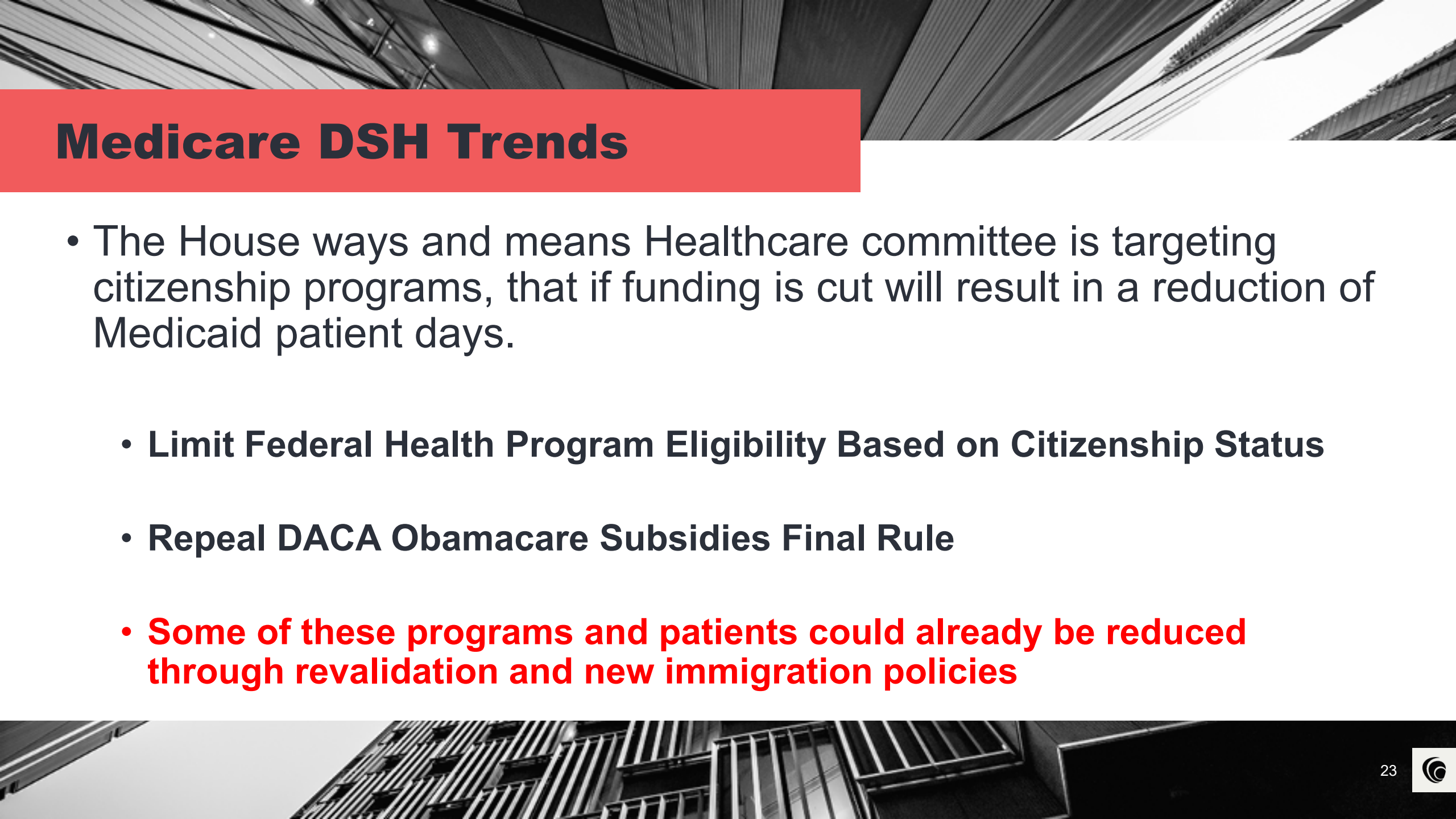
Medicare DSH Trends

- Large increases in SSI percentages in FFY 2020 and 2021 are now reverting back to pre-covid levels.
- Continuous Medicaid coverage expired March 31, 2023, resulting in Medicaid re-enrollment.
 - States were prohibited from disenrolling members from Medicaid, even if they were found to be ineligible. This was to ensure members did not lose vital healthcare coverage during the pandemic.
- In December 2022, Congress passed the Consolidated Appropriations Act, 2023 (CAA).
 - Per the CAA, the continuous coverage provision that prohibited states from disenrolling members from Medicaid expired March 31, 2023
 - Decline of individuals reapplying for Medicaid coverage causing Medicaid patient days to decrease at many hospitals.



Medicare DSH Trends

- i. Medicare two-midnight rule explicitly applies to Medicare Advantage plans for Final rule 2024.
 - i. Previously Medicare HMO plans followed their own guidelines for admission until this recent enforcement to follow the two-midnight rule.
 - ii. This change has decreased Medicare HMO observation days and increased Medicare HMO inpatient days and total patient days, which decreases the Medicare DSH percentage
 - iii. This change warrants additional review of total patient days to capture all changes for patient status that should be moved from inpatient to outpatient. In addition, you need to make sure the total inpatient days do not include outpatient or non-PPS patient days.
- ii. The aging population also plays and impact on increasing Medicare beneficiaries and deteriorates both total population amount and the SSI%.



Medicare DSH Trends

- The House ways and means Healthcare committee is targeting citizenship programs, that if funding is cut will result in a reduction of Medicaid patient days.
 - **Limit Federal Health Program Eligibility Based on Citizenship Status**
 - **Repeal DACA Obamacare Subsidies Final Rule**
 - **Some of these programs and patients could already be reduced through revalidation and new immigration policies**

340B Eligibility Trends

106 hospitals that qualified for 340B in 2019 no longer qualify in 2024

- 48 of these hospitals would have remained eligible if they had Rural Referral Center (RRC) status

Comparison: Latest vs. Prior Cost Report

- 94 hospitals that previously qualified for 340B are now ineligible
 - 43 of these would have qualified if designated as RRC
- 121 additional hospitals could have qualified under RRC criteria if approved by CMS
 - 93 of these were also eligible in the prior year
- 42 hospitals lost their 340B DSH designation but retained 340B eligibility through RRC status

Amended Cost Reports

Applying to Medicare for Rural Referral Center Status

Converting excluded Medicare sub-providers

Expand 340B savings to another hospital in a system

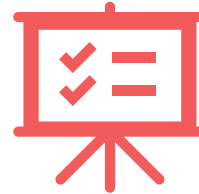
Contingency Plans
to maintain 340B
Medicare DSH
Qualification or
Qualify hospitals in
340B program

Early Detection of DSH and Potential 340B impact



Monthly internal DSH monitor

Utilize a monthly report to monitor Medicaid volume compared to Inpatient days comparing to previously file cost report



Hospitals in all states should monitor any revisions or new section 1115 waivers that are approved by their state to quantify the impact it may have on its ability to qualify or continue to qualify for the 340B program



Those that are close to losing 340B DSH and are not an RRC

Complete detailed DSH scrub based through 9 months to determine RRC application possibility in time

Converting Excluded Inpatient Units



One opportunity that hospital providers around the country have explored was to convert exempt Inpatient Psych Units (for Medicare purposes) to a non-exempt units.

Increase in DSH percentages allowing for qualification as 340B entity, or to maintain eligibility in 340B program

This would allow the Medicaid eligible days to be included in the Medicaid fraction of the DSH calculation

Medicare SSI days would be included in the SSI fraction of the DSH calculation

Medicaid and Medicare SSI volumes are high for inpatient psychiatric services



Some hospitals have converted the entire inpatient psychiatric unit to non-exempt, while others still maintain a small exempt Geriatric psychiatric unit in addition to a general non-exempt psych unit.



Full financial impact is needed to estimate the benefit especially the impact to Medical Education reimbursement for teaching hospitals because of adding beds to the acute care unit

Alert – Remember to decertify the DPU with a letter and through 855/PECOS. This can be a big issue if you use the same space for acute care patients without de-certification.

Other Reimbursement issues

Outlier update: fixed loss threshold (Settlement Issue)

Inpatient and Outpatient outlier amounts are reconciled to cost if 2 factors are met:

1. The Hospital received \$500,000 or more in Medicare outlier payments during the year, and
2. The cost-to-charge ratio (CCR) decreases or increases more than 10% from the % used to calculate and pay the outlier payments.
 1. Ex. Paid at 40% CCR and the cost report CCR is 32%. 8% decrease and greater than \$500,000 in outliers paid. (Medicare would not perform a reconciliation)
3. Medicare can go back to all open cost reports plus all reports within 3 years of settlement date.

Effective with Cost reports beginning on or after October 1, 2024 (CMS Change Request 13566):

1. The cost-to-charge ratio change becomes 10 percentage points or 20 percent fluctuation in the operation CCR.
2. In the example above the 20% fluctuation would have been triggered at 32% = $((40\% - (20\% \text{ of } 40\%))$. Medicare would perform a reconciliation under the new rules.

Low-volume payment (Prospective Issue)

The Consolidated Appropriations Act of 2024 extended temporary changes to low-volume hospital qualifying criteria and payment adjustment under the IPPS through Dec. 31, 2024.

- Current Criteria: Less than 3,800 discharges and located more than 15 road miles from the nearest IPPS hospital

Hospitals must submit written requests by 9/1/2024 to receive LVH adjustments for 10/1/2024-12/31/2024

- If deadline is missed, the effective date will be 30 days from the MAC determination

On December 21, 2024 Congress passed a Continuing Resolution to extend government funding through March 14, 2025

- Congress still needs to pass permanent legislation to extend the current low-volume payment beyond March 31, 2025

The Senate signed a Continuing Resolution through September 30, 2025, on March 14, 2025

- The Continuing Resolution extended Low-Volume from April 1, 2025, through September 30, 2025

Medicare dependent hospital payment (Prospective Issue)

The CAA, 2023 extended the MDH program through the end of CY 2024.

Starting Jan. 1, 2025, the MDH program will no longer be in effect, and all MDH hospitals will no longer have MDH status and will be paid based on the IPPS federal rate, without new legislation extending the program.

On December 21, 2024 Congress passed a Continuing Resolution to extend the government funding through March 14, 2025. New legislation needs to be passed prior to March 31, 2025 or the program is terminated.

The Continuing Resolution was passed by the Senate on March 14, 2025, to extend Medicare Dependent Status through September 30, 2025.

Current Status

Other Extended Programs:

- **Medicaid Disproportionate Share Hospital Relief.** The bill would eliminate the Medicaid DSH cuts through Sept. 30, 2025.
- **Medicare Rural Extenders.** The bill would extend the enhanced low-volume adjustment program through Sept. 30, 2025 and the Medicare-dependent hospital program through Oct. 1, 2025.
- **Medicare Telehealth and Hospital-at-home Extensions.** The bill would extend key telehealth waivers and the hospital-at-home program through Sept. 30, 2025.
- **Extension of the Work Geographic Index Floor under the Medicare Program.** The bill will extend a 1.0 floor on the work Geographic Practice Cost Index through Oct. 1, 2025.
- **Medicare Rural Ambulance.** The bill will extend add-on payments for ambulance services through Oct. 1, 2025. These add-on payments support rural, “super-rural,” and urban ambulance services.

Questions?

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Keith Hutcheson, CPA, Principal
140 East Town Street, Suite 1275
Columbus, Ohio 43215
O: +1 (304) 206-3302
E: keith.hutcheson@bakertilly.com

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