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Medicare Reimbursement:

Optimizing Your Medicare Cost Report

September 8, 2025

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About HORNE

We are a **professional services** firm founded on a cornerstone of public accounting.

Our Services

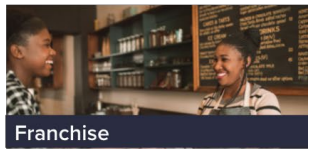
Our CPA heritage brings trust and discipline to our brand. Strategic choices brought us the talent, skills and mindset to solve our clients' biggest issues.

- Economic Recovery
- People Development
- Organization Growth
- Enhanced Productivity
- Technology
- Compliance
- Risk Management
- Building Wealth
- Cybersecurity

Industries We Serve


Construction

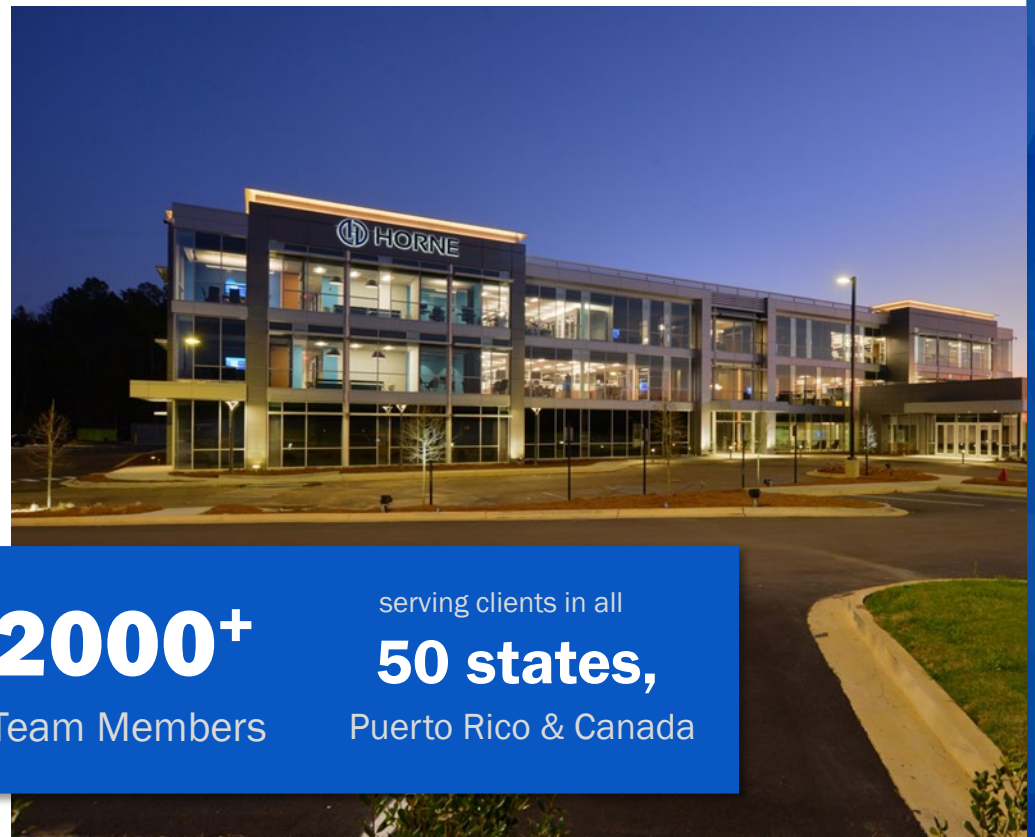

Financial Institutions


Franchise


Government


Healthcare


Public & Middle Market



2000+ Team Members

serving clients in all **50 states,** Puerto Rico & Canada

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Cost Report Timeline

- Generally, the cost report is due five months after fiscal year-end
- The cost report is submitted to the hospital's MAC
- Medicare filings are typically done via MCReF (Medicare Cost Report Electronic Filing)
- Failure to file cost report on time will result in reductions in payments
- Louisiana providers must also complete and submit a report specific to each Managed Care Organization (MCO) payor

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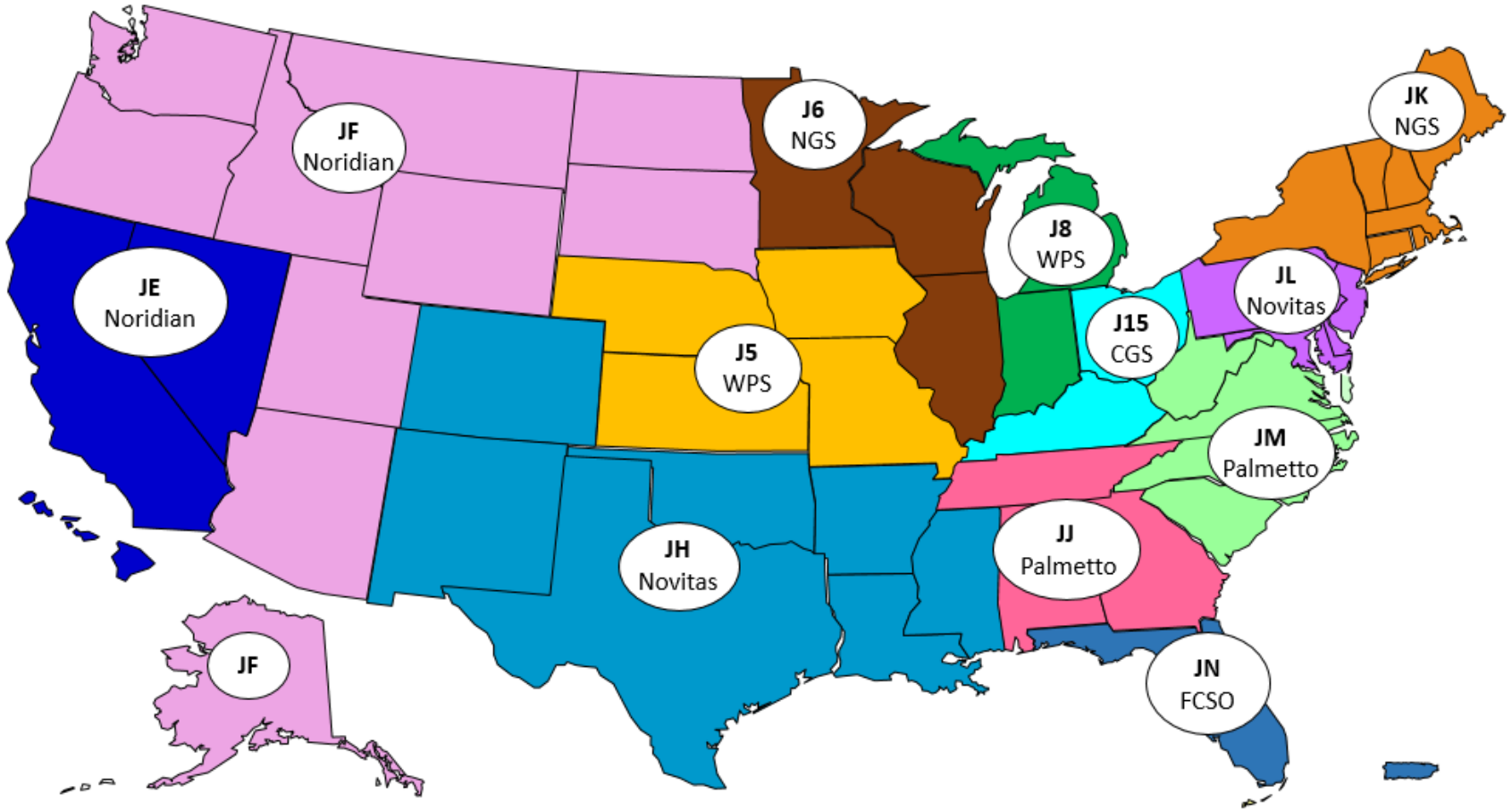
MAC Jurisdictions



Source: CMS Website

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Medicare Cost Report

- Medicare-certified institutional providers are required to submit annual cost reports. The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center (in total and for Medicare), Medicare settlement data, and financial statement data. CMS maintains the cost report data in the Healthcare Provider Cost Reporting Information System (HCRIS). Hospitals submit their cost report data to HCRIS using form CMS-2552-10.

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Patient Days

- Patient Days are a major driving factor of provider reimbursement

- However, Medicare reimbursement can be affected by other days such as:
  - Medicare Advantage Days
  - Medicaid Days
  - Total Patient Days

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Patient Days

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,295	3,876	24,783			1.00
2.00	HMO and other (see instructions)	7,991	10,162				2.00
3.00	HMO IPF Subprovider	2,989	4,459				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,295	3,876	24,783			7.00
8.00	INTENSIVE CARE UNIT	247	115	3,137			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT	0	560	1,567			12.00
13.00	NURSERY		7,570	7,890			13.00
14.00	Total (see instructions)	1,542	12,121	37,377	23.64	901.10	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	1,478	1,124	18,582	2.98	107.17	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			62			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				26.62	1,008.27	27.00
28.00	Observation Bed Days		397	2,540			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	1,083	1,160			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			361			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

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Medicare DSH & Uncompensated Care

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Medicare Disproportionate Share Hospital (DSH)

- Medicare Disproportional Share Hospitals serve a large percentage of low-income patients and thus receive additional payments from Medicare to help cover the associated cost of providing services.

- Medicare DSH hospitals will receive an Uncompensated Care (UCC) payment based on ratio of low-income days to total patient days.
  - The hospital will receive an upfront payment as an add-on to each Medicare inpatient claim, which is reported on the Medicare PS&R.
  - The cost report will calculate an actual DSH reimbursement amount.
  - The difference between these two is the cost report settlement amount.

Medicare Disproportionate Share Hospital (DSH)

- Hospitals must qualify for Medicare DSH each year to continue receiving these payments.

- Hospitals must qualify for Medicare DSH Payments to receive UCC payments.

- Medicare DSH payments are used to allocate the federal UCC pool to each Medicare DSH eligible hospital.
  - Each hospital's percentage is 'Factor 3' on the final rule DSH table.

Primary Method

- Hospitals that serve a significantly disproportionate number of low-income patients based on the Disproportionate Patient Percentage (DPP).
  - DPP = Medicare inpatient days + Percentage of total inpatient days attributable to patients eligible for Medicaid, but not entitled to Medicare Part A.
  - If DPP exceeds a specified threshold amount, the hospital qualifies for the Medicare DSH adjustment.

Medicare DPP

Medicare DPP	$\frac{\text{Medicare/Supplemental Security Income Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Patient Days}}$

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Medicare DSH Payment Adjustment Formulas

Medicare DSH Payment Adjustment Formulas for Hospitals Qualifying Under the Primary Method

Status/Location	Number of Beds	Threshold	Adjustment Formula
Urban Hospitals	0–99 Beds	≥15%, ≤20.2%	2.5% + [.65 x (DPP−15%)] **Not to Exceed 12%**
Urban Hospitals	0–99 Beds	≥20.2%	5.88% + [.825 x (DPP−20.2%)] **Not to Exceed 12%**
Urban Hospitals	100 or More Beds	≥15%, ≤20.2%	2.5% + [.65 x (DPP−15%)] **No Cap**
Urban Hospitals	100 or More Beds	≥20.2%	5.88% + [.825 x (DPP−20.2%)] **No Cap**
Rural Referral Centers	N/A	≥15%, ≤20.2%	2.5% + [.65 x (DPP−15%)] **No Cap**
Rural Referral Centers	N/A	≥20.2%	5.88% + [.825 x (DPP−20.2%)] **No Cap**
Other Rural Hospitals	0–499 Beds	≥15%, ≤20.2%	2.5% + [.65 x (DPP−15%)] **Not to Exceed 12%**
Other Rural Hospitals	0–499 Beds	≥20.2%	5.88% + [.825 x (DPP−20.2%)] **Not to Exceed 12%**
Other Rural Hospitals	500 or More Beds	≥15%, ≤20.2%	2.5% + [.65 x (DPP−15%)] **No Cap**
Other Rural Hospitals	500 or More Beds	≥20.2%	5.88% + [.825 x (DPP−20.2%)] **No Cap**

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DSH Reporting

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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in	7,971	4,177	32	8	10,095	1,083	24.00

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DSH Reimbursement

29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	1,700,596	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	17.68	30.00
31.00	Percentage of Medicaid patient days (see instructions)	60.63	31.00
32.00	Sum of lines 30 and 31	78.31	32.00
33.00	Allowable disproportionate share percentage (see instructions)	53.82	33.00
34.00	Disproportionate share adjustment (see instructions)	522,312	34.00

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Medicare DSH Payment Adjustment Formulas

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Urban Hospitals	0–99 Beds	≥15%, ≤20.2%	2.5% + [.65 x (DPP−15%)] **Not to Exceed 12%**
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Rural Referral Centers	N/A	≥20.2%	5.88% + [.825 x (DPP−20.2%)] **No Cap**
Other Rural Hospitals	0–499 Beds	≥15%, ≤20.2%	2.5% + [.65 x (DPP−15%)] **Not to Exceed 12%**
Other Rural Hospitals	0–499 Beds	≥20.2%	5.88% + [.825 x (DPP−20.2%)] **Not to Exceed 12%**
Other Rural Hospitals	500 or More Beds	≥15%, ≤20.2%	2.5% + [.65 x (DPP−15%)] **No Cap**
Other Rural Hospitals	500 or More Beds	≥20.2%	5.88% + [.825 x (DPP−20.2%)] **No Cap**

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Medical Education

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General Overview

- Medicare has participated in the costs of medical education since the program's inception in 1965.
- The IME add-on payment and DGME payment methodology were introduced in the 1980s and have been evolving through legislation ever since.
- BBA of 1997 had a major impact on the IME/DGME rules by setting "historic caps" based on residents training at the hospital in 1996, among other changes.
  - This has led to the delineation between "old" teaching hospitals and "new" teaching hospitals.

Medical Education

- Resident funding & reimbursement has two distinct payment types
  - Direct Graduate Medical Education
    - Main reimbursement drivers:
      - Medicare & Total Patient Days
      - Per Resident Amount
    - Offset the direct cost of residents
    - Bi-Weekly payment reconciled through the Medicare Cost Report
  - Indirect Medical Education
    - Main reimbursement drivers:
      - Number of Bed Days Available
    - Designed to cover additional costs of being a teaching hospital

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Direct Graduate Medical Education

		Title XVIII	Hospital	PPS	
				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			49.90	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			24.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			0.00	2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			2.23	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			11.47	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			0.00	3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			-25.29	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27			34.91	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			21.32	6.00
7.00	Enter the lesser of line 5 or line 6			21.32	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	11.23	9.43	20.66	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	11.23	9.43	20.66	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		3.98		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		5.30		10.01
11.00	Total weighted FTE count	11.23	13.41		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	10.38	27.29		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	11.52	24.89		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	11.04	21.86		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	11.04	21.86		17.00
18.00	Per resident amount	192,179.44	191,914.61		18.00
18.01	Per resident amount under §131 of the CAA 2021	0.00	0.00		18.01
19.00	Approved amount for resident costs	2,121,661	4,195,253	6,316,914	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			6,316,914	25.00

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Direct Graduate Medical Education

		Title XVIII		Hospital	PPS	
		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total	
		1.00	2.00	2.01	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	3,020	0	10,980		26.00
27.00	Total Inpatient Days (see instructions)	49,229	49,229	49,229		27.00
28.00	Ratio of inpatient days to total inpatient days	0.061346	0.000000	0.223039		28.00
29.00	Program direct GME amount	387,517	0	1,408,918	1,796,435	29.00
29.01	Percent reduction for MA DGME		3.27	3.27		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	46,072	46,072	30.00
31.00	Net Program direct GME amount				1,750,363	31.00
					1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)					
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				4,550,280	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)				0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
	Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)				7,467,392	37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)				0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)				0	39.00
40.00	Primary payer payments (see instructions)				23,447	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)				7,443,945	41.00
	Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)				4,567,377	42.00
43.00	Primary payer payments (see instructions)				12,205	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)				4,555,172	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)				11,999,117	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)				0.620374	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)				0.379626	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)				1,750,363	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)				1,085,880	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)				664,483	50.00

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Indirect Medical Education

		Title XVIII	Hospital	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			3,666,925	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			214,990	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0	1.04
2.00	Outlier payments for discharges. (see instructions)				2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)			0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			0	2.04
3.00	Managed Care Simulated Payments			16,334,452	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			163.61	4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			49.81	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)			0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			24.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			2.38	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			-26.98	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)			44.45	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			18.33	10.00
11.00	FTE count for residents in dental and podiatric programs.			5.30	11.00
12.00	Current year allowable FTE (see instructions)			23.63	12.00
13.00	Total allowable FTE count for the prior year.			36.32	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			38.86	14.00
15.00	Sum of lines 12 through 14 divided by 3.			32.94	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			32.94	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.201332	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.207389	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.201332	21.00
22.00	IME payment adjustment (see instructions)			404,150	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			1,700,596	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				

- Basic formula: **IME Multiplier x [(1+IRB ratio)$^{0.405}$ -1]**
- IME Multiplier – this is set by Congress. Currently it is 1.35.

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Indirect Medical Education

- 42 CFR § 412.105 - Special treatment: Hospitals that incur indirect costs for graduate medical education programs
- (b) ***Determination of the number of beds.*** For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period. This count of available bed days excludes bed days associated with—
  - (1) Beds in a unit or ward that is not occupied to provide a level of care that would be payable under the acute care hospital inpatient prospective payment system at any time during the 3 preceding months (the beds in the unit or ward are to be excluded from the determination of available bed days during the current month);
  - (2) Beds in a unit or ward that is otherwise occupied (to provide a level of care that would be payable under the acute care hospital inpatient prospective payment system) that could not be made available for inpatient occupancy within 24 hours for 30 consecutive days;
  - (3) Beds in excluded distinct part hospital units;
  - (4) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing-bed services, or inpatient hospice services.
  - (5) Beds or bassinets in the healthy newborn nursery; and
  - (6) Custodial care beds.

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Maximizing Reimbursement

- Properly state resident FTE & keep accurate records of schedules
- Fully understand rules, regulations, & calculations surrounding programs in the CAP building phase
- Reporting of Medicare Advantage activity
- Accurate bed days available & patient days
  - Swing Bed Days
  - Observation Days
  - Non-Distinct Hospice Days
  - Outpatient L&D Days
  - Temporary COVID-19 expansion beds

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Rural Health Clinics

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Rural Health Clinic

- Freestanding/Independent Rural Health Clinics (RHC)
  - Cost Report Form 222-17

- Provider-based Rural Health Clinics
  - Integrated into the existing owner Medicare cost report
    - Typically, broken out on HFS line 88 and use the M- series within the cost report

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Medicare Per Visit Payment Limit

- Starting 1/1/2021, Medicare pays the lower of the cost per visit vs the national all-inclusive rate (AIR) for newly enrolled RHCs.
  - 2021 - $100 per visit
  - 2022 - $113 per visit
  - 2023 - $ 126 per visit
  - 2024 - $ 139 per visit
  - 2025 - $ 152 per visit
  - 2026 - $ 165 per visit
  - 2027 - $ 178 per visit
  - 2028 - $ 190 per visit

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Maximizing RHC Rate

- Medicare Benefit Policy Manual Chapter 13
    - "In general, the AIR for an RHC is calculated by the A/B MAC by dividing total allowable costs by the total number of visits for all patients. Payment limits, and other factors are also considered in the calculation. Allowable costs must be reasonable and necessary and include practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of RHC services."

      Section 70.1 issued 03-20-25; Effective 01-01-25; Implemented 04-21-25

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Maximizing RHC Rate

- Review Overhead State allocation for accuracy
  - Cost Based Providers- what are the downstream reimbursement affects?
  - If another RHC is added to an organization, what are the reimbursement implications?

- Vaccine & Supplies accurately recorded and billed?
  - Starting July 1st, RHCs can now bill at the time of service for vaccines.

- Are bad debts being recorded and written off in accordance with CMS guidance?

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Maximizing Medicare Bad Debt Logs

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Knowledge

- **Recognize** the different causes for connectivity gaps between Medicare reimbursement owed to providers versus actual Medicare reimbursement claimed on cost reports
- **Identify** the changing Medicare Bad Debt Regulations and how the regulators' interpretations of these regulations are impacting the compilation of Medicare Bad Debt Logs and Fiscal Intermediary Audits across the country
- **Respond** to these Medicare Bad Debt Industry changes with proactive future planning relating to Medicare Bad Debt and other areas of the cost report

What are Medicare Bad Debts?

$1.12T (spent annual on Medicare)
The US Government is the biggest single payor to providers.

~68M (people on Medicare as of December 2024)
Due to their volume, Medicare negotiates very low payments to providers for rendering services.

~$31.7B (due from patients each year)
A large portion of Medicare patients are still unable to pay their deductibles & coinsurance of the bill to the provider.

~$3B (paid to hospitals for Medicare Bad Debts each year)
Medicare reimburses 65% of unpaid bills to keep providers incentivized to serve Medicare patients.

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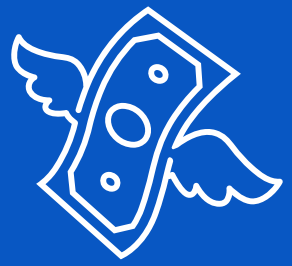

$1.9 – 2.2 Billion

(6-7% estimated as under-report each year)

Providers submit annual reports of unpaid bills (Medicare Bad Debts) for reimbursement from Medicare. Providers can also amend reports from previous underreported periods.

Louisiana's Traditional Medicare Statistics

Inpatient (Part A) & Outpatient (Part B)								
	2018	2019	2020	2021	2022	2023	2024	Grand Total
Deductibles & Coinsurance	$394,956,411	$393,090,764	$351,320,341	$336,628,225	$329,603,669	$336,261,518	$336,182,739	$2,478,043,667
Claimed Allowable Bad Debts	$98,462,563	$96,515,415	$84,281,339	$75,722,009	$68,577,211	$58,867,464	$49,354,185	$531,780,186
Unclaimed Deductibles & Coinsurance	**$296,493,848**	**$296,575,349**	**$267,039,002**	**$260,906,216**	**$261,026,458**	**$277,394,054**	**$286,828,554**	**$1,946,263,481**
Claimed Rate	**24.93%**	**24.55%**	**23.99%**	**22.49%**	**20.81%**	**17.51%**	**14.68%**	**21.46%**
Unclaimed Rate	**75.07%**	**75.45%**	**76.01%**	**77.51%**	**79.19%**	**82.49%**	**85.32%**	**78.54%**
Crossover Allowable Bad Debts	$64,281,754	$60,785,378	$50,431,371	$46,270,886	$40,101,297	$36,436,672	$28,149,977	$326,457,335
Crossover Allowable Bad Debts Percentage	**65.29%**	**62.98%**	**59.84%**	**61.11%**	**58.48%**	**61.90%**	**57.04%**	**61.39%**
Non-Crossover Allowable Bad Debts	$34,180,809	$35,730,037	$33,849,968	$29,451,123	$28,475,914	$22,430,792	$21,204,208	$205,322,851
Non-Crossover Allowable Bad Debts Percentage	**34.71%**	**37.02%**	**40.16%**	**38.89%**	**41.52%**	**38.10%**	**42.96%**	**38.61%**

$532M
Louisiana Medicare Bad Debts Claimed (7 years)

21.46%
Average Provider claimed rate in Louisiana

38.61%
Crossover Percentage of Medicare Bad Debt in Louisiana

$1.946B
Unclaimed Medicare Bad Debts in Louisiana

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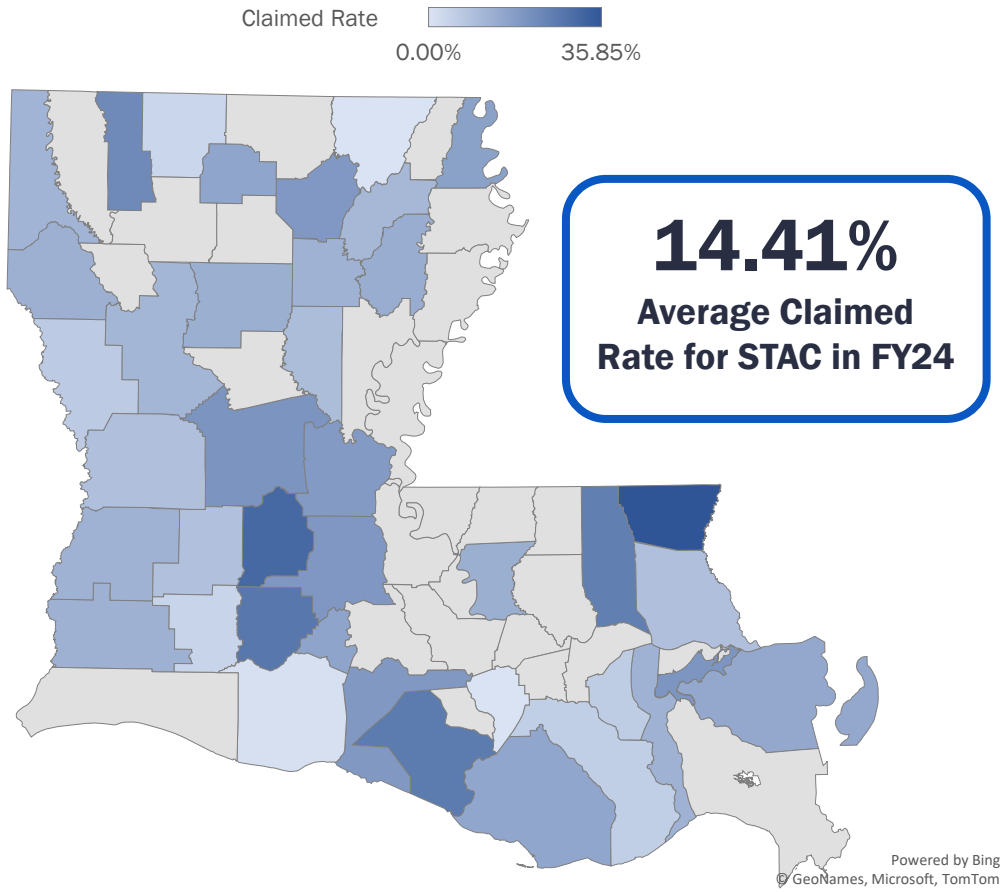
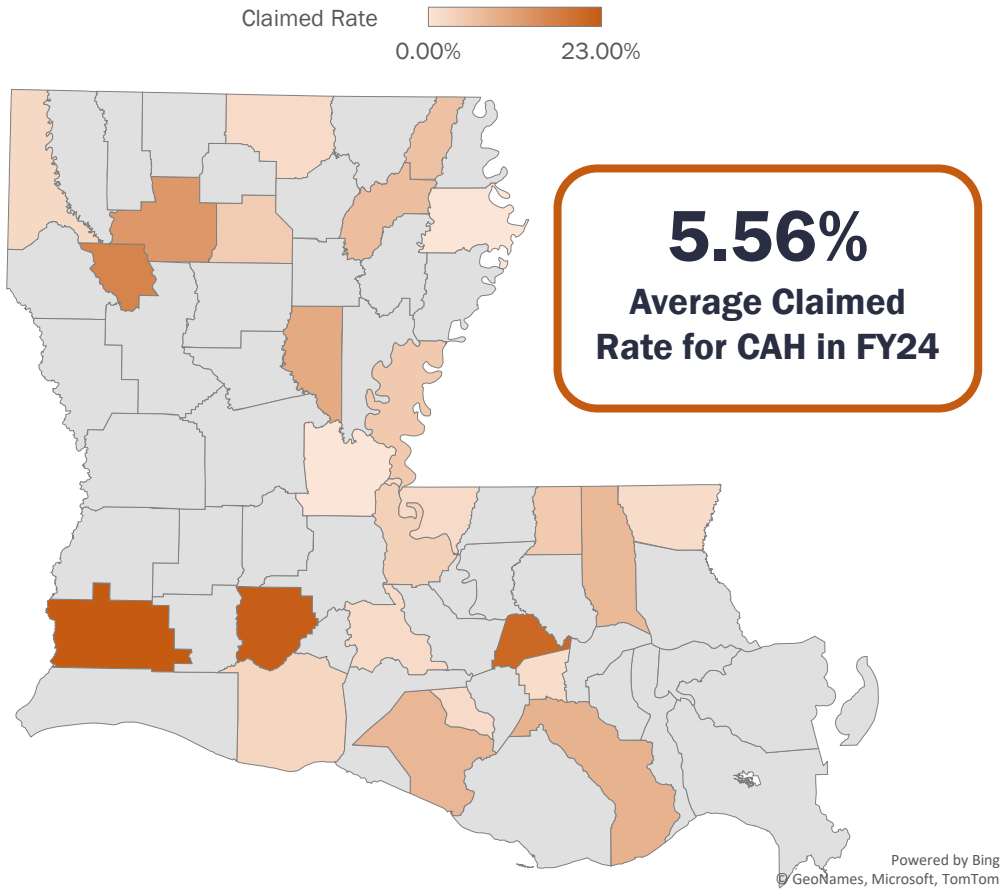
FY 2024 Claimed Rate by Parish

Short Term Acute Care Hospitals



14.41%
Average Claimed Rate for STAC in FY24

Critical Access Hospital



5.56%
Average Claimed Rate for CAH in FY24

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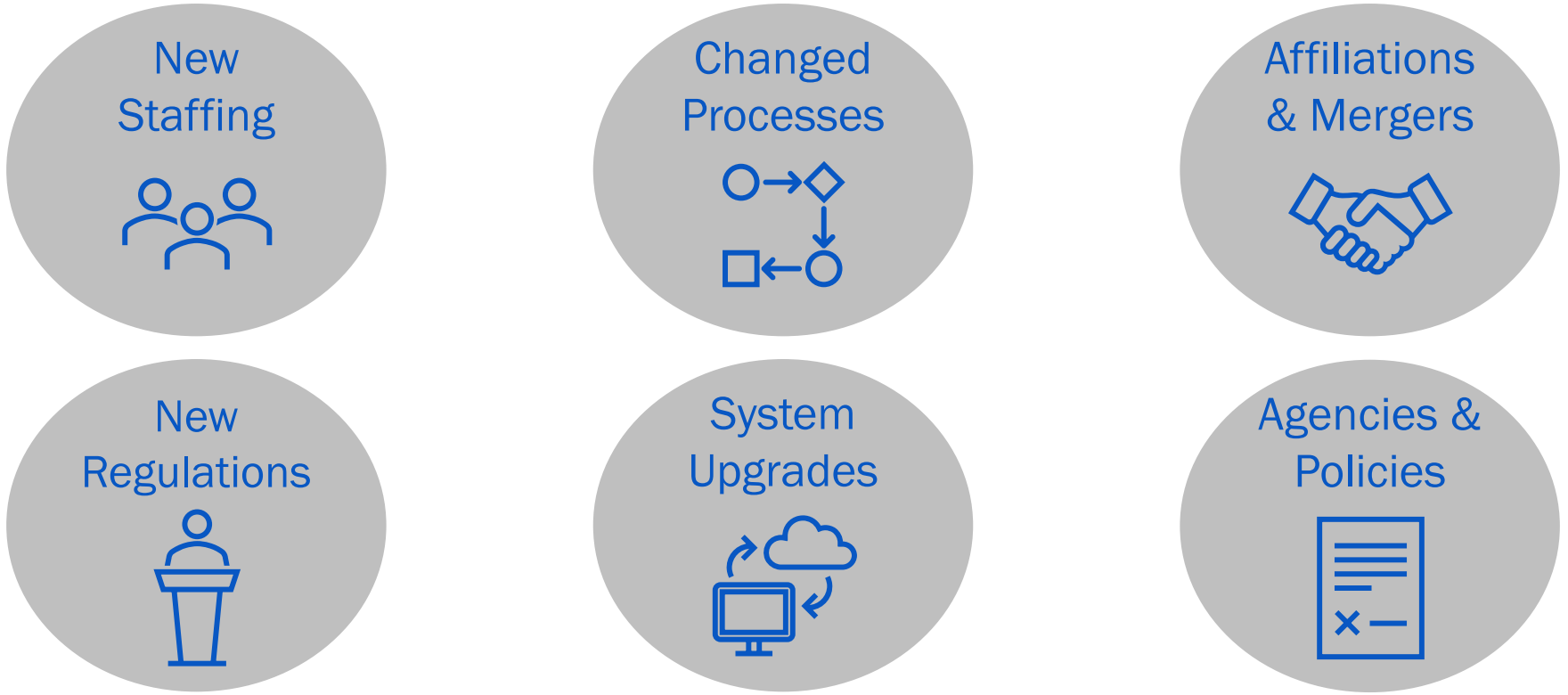
Medicare Advantage Patient Responsibility

- Medicare Advantage payments are an increasing percentage of “Medicare” and are projected to continue to rise.
- Many payers do allow for bad debts to be filed.
- Terms, if any, are payer and provider specific – all are different (typically even in a large system).
- Language varies by contract
  - Included
  - Excluded
  - Silent
- Reimbursement rates are similar to traditional Medicare Bad Debt.
- Typically, no limit on lookback periods; subject to a 50% penalty annually.

Are You Missing Value?

INDUSTRY CHANGES IMPACTON MEDICARE BAD DEBT

Below are some of the changes in your system that can create extended gaps in the connectivity of revenue cycle and reporting operations.



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Compilation vs. Analytics "Gap"

WHY IS VALUE OFTEN MISSED?

Expertise & Technology

PEOPLE & PROCESS

- ✓ Understanding the nuances
- ✓ Resolve the discrepancies
- ✓ Reconcile your agency files
- ✓ Identify the outlier data
- ✓ Advance to an outcome

Traditional Compilations

- Internal and/or vendor annual cost reporting process
- Historical reports and methodologies
- Consistent "same thing as last year" approach

Software Only Compilations

- Unique "outside-in" approach reconciles entire portfolio.
- Consider the impacts of dynamic changes.
- Account for every dollar: Paid, already claimed, etc.: all remaining deductibles and coinsurance should be analyzed.

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Changing Regulations

Crossovers | Indigent | Self Pay

- Final Rules - Primary driver of regulatory change at national level
  - October 1, 2020 (FY21 Final Rule): substantial
  - October 1, 2021, 2022, and 2023: less Medicare Bad Debt updates

- Varying, Retroactive, and Modified regulatory regulation implementation by Fiscal Intermediary.
  - Example: Zero-balance on Agency Accounts
  - Example: Crossovers written off to Contractual Allowances
  - Example: 1st bill within 120 days of Medicare payment
  - Example: Indigent vs Charity vs Presumptive Charity

Changing Regulations

Crossovers

- Crossovers must not be written off to a contractual allowance account; instead, they must be written off to an expense account for uncollectible accounts.
- Medicare bad debt must be treated as an implicit price concession and recorded as a reduction in net patient revenue.
- Current FASB guidance requires writing off implicit price concessions to a contra-revenue account instead of an expense account.
- Reasonable collection efforts will be met without a Medicaid RA if the following documentation is submitted as an alternative:
  - State Medicaid notification indicating the State has no obligation to pay
  - Documentation supporting the State's liability, or lack thereof, for the Medicare cost-sharing amount
  - Beneficiary's Medicaid eligibility documentation for date of service

Crossover Best Practice Recommendation: Crossovers are Dual Eligible Beneficiaries with valid supporting Medicare RA and Medicaid RA. Account balance is reduced to $0.00 when a valid Medicaid RA is received using a write-off code that is mapped appropriately to financial statements as a reduction in net patient revenue (i.e., no C/A and mapped to bad debt on GL).

Changing Regulations

Indigent | Clarifying Terms

- When referring to Medicare bad debts, the terms charity, indigence, financial assistance, presumptive charity, and similar have been historically used, often interchangeably, by providers and many in the healthcare field. Medicare has historically allowed providers to claim charity/indigent accounts on the MBD Logs as long as internal written policies are followed.
- CMS has determined that charity and indigence may not be used interchangeably in relation to Medicare. (CMS Publication 15-11, §4012 (Hospital Cost Reporting Instructions for Worksheet S-10) specifically states that "for Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as allowable bad debt."
- Charity, as defined by CMS in the bullet above, relates to the uncompensated charges given to uninsured patients (often called a self-pay discount). Medicare patient portion accounts, by nature of the patient being insured, cannot be considered as Charity when using this definition.
- Medicare does, however, allow Indigent accounts to be claimed as Medicare Bad Debt. Non-Crossover Indigent accounts are accounts that have been deemed indigent according to the Hospital's Financial Assistance Policy and the hospital has retained documentation to support the patient's determination of indigence (i.e., approved financial assistance application, bankruptcy documentation, deceased with no probate documentation, etc.).
- As noted, due to the interchangeable use of terms over a long period, this has generally been a gray area that providers need to address proactively. Clear distinction of terms across various aspects of the revenue cycle function is critical.

Changing Regulations

Indigent | Financial Assistance

Financial Assistance Best Practice Recommendations:

- Traditional financial assistance is defined as financial indigency granted based on a provider's Financial Assistance/Indigency Policy, which includes an approved Financial Assistance application, supported by proper supporting documentation, as outlined in the Provider's Financial Assistance/Indigency Policy (and follows regulatory requirements). All supporting documentation is maintained and available on demand.
  - Must perform both an asset and income test in determining indigency
  - May consider extenuating circumstances affecting indigency, which may include an analysis of liabilities and expenses
  - Must not use beneficiary's own declaration of indigency as sole proof of indigency
  - Must determine no other legally responsible party
- Providers should utilize one transaction code for true financial assistance when an approved application and proper documentation are on file.
- Categories on the log should be labeled as Indigent/Financial Assistance.
- If policies require more than the CMS Medicare requirements, adjustments to policies should be made to avoid disallowances/questions during audit. Auditors will review whether the provider followed their policy and whether the policy/supporting documentation align with the requirements. All Medicare and non-Medicare must be treated the same.
- CMS clarified through sub-regulatory guidance that providers may not use presumptive eligibility tools to evaluate whether a beneficiary is indigent.

Changing Regulations

Indigent | Bankruptcy and Deceased

Bankruptcy Best Practice Recommendations:

- Best practice for Bankruptcy Medicare Bad Debts is to retain proof of discharge from debtor (along with Chapter #, Case #, and File date), which is producible during audit, and transcribes discharge of debtor was confirmed before the account balance was written-off.

Deceased Best Practice Recommendations:

- The best practice for Deceased, No Estate Medicare Bad Debts, is to retain proof of no probate (a letter from the county), which is producible during audit and transcribes deceased no estate was confirmed before the account balance was written-off.

Changing Regulations

Indigent | Presumptive Charity

Presumptive Charity Best Practice Recommendations:

- CMS has clarified through sub-regulatory guidance that providers may not use presumptive eligibility tools to evaluate whether a Medicare beneficiary is indigent.
- As such, Medicare patient portion indigence cannot be solely supported with the use of presumptive eligibility tools. These accounts have the potential to be removed during the audit of the Medicare Bad Debt Logs.
- To avoid unnecessary audit adjustments, we recommend determining presumptive indigence after reasonable collection efforts have been made. In this model, reasonable 120-day efforts have occurred, and indigence is typically determined before further collection agency efforts are pursued in a Pre-Agency scoring process. When reasonable collection efforts have been made, these accounts can be categorized on the Medicare Bad Debt log as “Regular” self-pay accounts meeting valid collection efforts, and any reference to presumptive indigence is removed as not relevant to the account.
- Medicare and non-Medicare accounts must be treated the same in the above scenario.
- Further, and a likely necessary change, these regular (pre-agency scoring) accounts should have their own codes that clearly define the account as “Regular,” and any reference to presumptive eligibility should be removed from the codes that are used to avoid auditor confusion.

Changing Regulations

Self-Pay

Medicare Bad Debt is allowable for non-indigent beneficiaries only to the extent the provider complies with “reasonable collection efforts.” Reasonable collection efforts were not clearly defined before the FY21 IPPS Final Rule.

- Guarantor bill must be issued on or before 120 days after the latter of the following:
  - Medicare RA Date
  - 2nd Payer RA Date
  - Date of notification of 2nd payer that services are not covered
- Reasonable collection efforts must start a new 120-day collection cycle each time a payment is received.
- Emails and text messages are acceptable collection efforts as long as they are auditable and verifiable.
- Providers must put forth the same efforts to collect Medicare D&C amounts as they do in collecting comparable amounts from non-Medicare patients (which includes collection agency use).
- Documentation supporting reasonable collection efforts must be provided upon request:
  - Current bad debt collection policy (covering both Medicare and non-Medicare patients)
  - Patient account history, including all collection efforts
  - Beneficiaries file with copies of bill(s) and follow-up notices

Changing Regulations

Self-Pay

Self-Pay Best Practice Recommendations:

- Regular (No Agency) – Self Pay balances that have been through internal collections and based on the hospital's policy, do not meet the criteria to send to an outside collection agency.
- Bad Debt Collections Agency – Self Pay balances that have been through internal collections, have been sent to an outside collection agency, and have been returned from the Agency as uncollectible.
  - Best Practices when optimizing reimbursement from agencies
    - Review your agreement
    - Review your active inventory
- For both categories, the account balance is reduced to $0.00 when the account is deemed uncollectible after reasonable collection efforts have occurred (at least three collection attempts spanning over 120 days from the first bill to the patient, with collection efforts restarting after every payment). Medicare and non-Medicare accounts must be treated the same. I.E., Recommendation would be to write the account balance down to zero and have a transaction code, mapped to bad debt on the GL, that describes the write-off (for example: Reasonable Efforts, Terminal Bad Debt, Uncollectible).

Audit Observations

- New Medicare Bad Debt Submission Template in effect for 09/30/2023 FYE's and forward
- Indigent versus Charity versus Presumptive Charity
  - Remove any reference to "Charity" or "Presumptive" from Medicare Accounts.
  - Transaction Code(s) should reference "Financial Assistance" or "Indigent" for patients qualifying under the provider's Financial Assistance policy.
  - Transaction Code(s) should reference "Pre-Agency Scoring" for regular collections not going on to further bad debt collections.
- 1st Bill Within 120 days of Medicare Payment
  - New MBD Template calculates Timely Billing.
  - Audit Observations –first thing the auditors are looking at.
- Crossovers and Agency Written off Timely
  - We have anecdotally heard that some auditors are disallowing agency and crossovers accounts that are not written off "timely" after the Medicaid Payment for Crossovers or the Agency return for Agency accounts.
  - Not in regulations and is being applied inconsistently, and should be appealed.
- S-10 Audit/Review processes vs Medicare Bad Debt
  - It is imperative that the Medicare Bad Debt Log is compared to the S-10 Log and **ALL** Medicare Bad Debt Accounts are contained on Line 26 of the S-10 Log.
  - S-10 Logs are audited significantly earlier than Medicare Bad Debt Logs, so it is very hard to go back and "amend" an S-10 Log after the fact.
  - Auditors are starting to review the S-10 Log in comparison to the Medicare Bad Debt Log, and if the Medicare Bad Debt accounts are incorrectly on Line 20, it is becoming an issue in the MBD audit.

Industry Change

Future Planning in MBD+

- Crossovers recorded to contractual allowance codes (large scale vs ongoing issues)
- Indigent vs charity accounts (policies, procedures, MBD log labeling, transaction codes+)
- Presumptive “charity”/indigent accounts (tools, processes, transaction codes, timing (for regular treatment))
- New compliance regulations (1st bill < 120 days; date resets+)
- Integrated Policies, Procedures and Support (financial assistance, charity, indigent, MBD, agency+; best practices and compliance updates; supporting source data systems)
- Integrated MBD/S-10 (exception reports; integration across reporting, bucket cross-referencing++)
- Robotic Process Automation (RPA for MBD) Converting AI worklists into programmed corrections
- Legal pipeline (retroactive application; HC Alerts)
- Artificial Intelligence Solutions (AI for MBD)
  - Catch issues real-time with AI; getting things right and optimized first-time through
  - Crossovers – MCR + PA + transaction code
  - Indigent – MCR + transaction code
  - Presumptive/regular – MCR + codes/timelines

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Questions?

THANK YOU!

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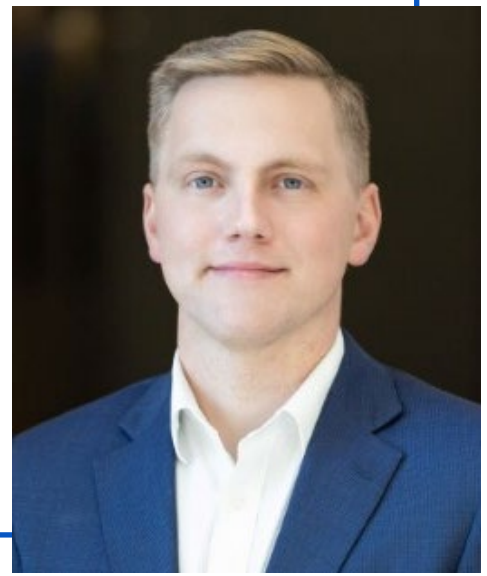

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