

NWX-HRSA ORHP

**July 30, 2019
1:00 pm CT**

Coordinator: Good afternoon and thank you for standing by. At this time I would like to inform all participants that your lines have been placed on a listen-only mode until the question and answer session of today's call. Today's call is also being recorded. If anyone has any objections you may disconnect at this time. I would now like to turn the call over to Mr. Bill Finerfrock. Thank you and you may begin.

Bill Finerfrock: Thanks operator and I want to welcome all of our participants today. My name is, as she said, Bill Finerfrock and I'm the Executive Director of the National Association of Rural Health Clinics. I'll be your moderator for today's call. Today's topic is Rural Health Clinic Cost Reporting and Cost Reporting Issues. This series is sponsored by the Health Resources and Services Administration Federal Office of Rural Health Policy and is done in conjunction with the National Association of Rural Health Clinics.

We're supported by a cooperative agreement as you can see on your screen through the Federal Office of Rural Health Policy and that allows us to bring you these webinars free of charge. The purpose of the series is to provide RHC staff with valuable technical assistance and RHC specific information. Today's call is the 88th in the series which began in late 2004. During that time we've had over 23,000 combined participants on this series now being done as webinars. Some of you will remember they were originally done as conference calls. As, you know, there is no charge to participate and we encourage you to refer others who might benefit from the information to sign up to receive announcements regarding dates, topics, speakers, presentations and you can do that at the RHI hub Website. Or you can do it at the NARHC Website and follow the links for technical assistance forum and sign up for that.

We will have a Q&A period. You can either open up your phone line to ask your question via the phone line. Or we will open up the chat box which should be on the left-hand side of

your screen. You can enter your questions there and we will give them to our speaker through that mechanism.

If you have topics or questions that you'd like to ask for future calls or webinars, send them to bf as in my initials, b as in Bill, f as in Finerfrock @narhc.org and put RHC TA question or RHC TA topic in the subject line. At this point I would like to turn the call over, the webinar over to our speaker today, Mark Lynn who is with Healthcare Business Specialists a long-time rural health clinic consultant and he's going to talk to us today about rural health cost reports and some of the things you should keep in mind with regard to your cost report. Mark, appreciate your taking time to be with us today and look forward to your presentation.

Mark Lynn:

Thank you Bill. Hello everybody. This is Mark Lynn and thank you for the National Association of Rural Health Clinics and HRSA for sponsoring this. It is indeed very valuable, ```````` and we listen to them all the time. So, thank you guys for doing this. Today's session is going to be a management overview of the RHC cost reporting process. The agenda will be about 45 minutes of me talking and then we'll have hopefully 15 minutes or longer to answer your questions. We'll do an overview at first and then we'll put together some building blocks that will give you a foundation for a good clean cost report that will get you the right amount of reimbursement from Medicare when it's filed.

The objectives of today's webinar are going to be not to tell you guys how to prepare a cost report because I've been doing them 30 years and I'm still learning how to do those. In the amount of time that we have I couldn't really teach you a whole lot about it, but I can give you the whys. Why it's important. And then if you know why it's important then you can have the impetus to go out there and do what you need to do to get the information to whomever prepares your cost report so that it's done timely, that it's done correctly and accurately and that you do get that appropriate amount of reimbursement from Medicare.

As an overview of the process RHCs are required to prepare a Medicare cost report on an annual basis. It's typically a 12-month period of time. It serves basically as an invoice between Medicare and Medicaid between the RHC and Medicare and the RHC and Medicaid on the amount of monies paid and the amount of costs of the particular RHC. And there is a settlement process where Medicare in the past we've always received pretty much money

from Medicare. But things have changed in the recent years or in the last year and now there are occasionally paybacks. And we'll show you why that's happening in one of the slides in a few minutes.

Also from Medicaid if you guys are brand new as a rural health clinic it's very important that you get with somebody who knows the RHC process and knows the cost of reporting process for your particular state because there's 50 different states and there's 50 different ways for them to establish rates. And a lot of the RHC rate setting is based upon a law called BIPA 2000. The Medicaid rate setting process will typically use the first full-year cost report or the first two full year's cost reports to set a PPS rate that will pretty much stay with you forever unless you get a scope of practice changed and you really need someone who knows Medicaid in your particular state to help you with that so you know how to get the right amount from Medicaid.

Why is the cost report important? If you don't file, Medicare is not going to pay you and Medicare is going to take money away from you. They're going to want every single penny that was paid to you during that cost report year back. So, you're going to get a long letter that says you owe them \$200,000 or \$300,000 or half a million dollars whatever amount of money was paid the RHC from Medicare during the year. They're going to ask for that money back. So you really don't have much of a choice. You have to file this otherwise you owe the government a bunch of money.

And then also your interim rates from both Medicare and depending on how the base rates are done state and Medicaid rates are based upon these cost reports as well. So it's extremely important probably as 45 to 50% of your revenue is going to be Medicare and Medicaid. Thus 50% of your money is going to be tied to these cost reports. I think it's about \$200 billion worth of money is paid through Medicare cost reports in total per year.

You also receive money for your flu, pneumococcal, Medicare bad debt, even a little piece in there for to compensate the RHC for the loss of preventives copays and deductibles in there as well. I'll try and explain how they do that, but I can assure you there is a little bit of money in there for you for those lost copays and deductibles.

The RHC is responsible for preparing an accurate and a cost report that's in compliance with Medicare and Medicaid rules. The owner or authorized Medicare Part A official of your practice is going to be the one signing the cost report form. For this reason, it is important for you to attend meetings, webinars, like, to go the NARHC Spring Institute or the Fall Institute where you're learning what new regulations are out there about your cost reports so you guys can be aware and how to follow those regulations.

If you want to follow those regulations and review them yourself here is the link for you to review all 31 chapters of Medicare cost reporting regulations. There are thousands of pages of regulations and I think at one time I read them all. These are all in the Word files so you'll basically download a Word file and then read the regulation.

There are two types of RHCs that we're concerned about as far as cost reporting. There's an independent RHC that's typically owned by physicians, nurse practitioners and PAs and sometimes hospitals that are 50 beds or greater. There's also a provider-based RHC which is owned by a hospitals with 49 beds or less and are not subject to the RHC cap.

The cost of reporting form for the independents is the Form 222-17 which changed last year. And it got a little bit more complicated for us to do. And then the provider-based RHC is the Form 2552-10 which has been around for eight or nine years or so. Provider-based RHCs will be using the M series within the 2552-10 cost report. If you want to get a link to a PDF of the actual cost report forms the line below this has those. Here's the link to the independent cost report forms and here is the link to the provider-based forms.

When you do file your cost reports, you're going to have to use an electronic vendor because they have to be filed electronically instead of on paper. Cost Reports are electronically filed. There will be what's called an ECR or a PI (Print Image) which must agree with each other when you submit the documents to Medicare.

Right now there are four RHC vendors. Here is a list from Noridian of the approved vendors. As for the hospital cost report, I think we're down to two approved vendors. It's KPMG and then there's HFS. HFS is the one that most of your RHC cost report preparers will use. It's a pretty simple system and I have used it 25 years or so.

Here is a crosswalk between the forms, between the independent cost report and a provider-based cost report. There are 13 separate forms in the new independent RHC cost report. There are 10 different forms that are used in provider-based RHCs Cost Reports as well. The good news is most of the forms are exactly the same information whether you're independent or provider-base.

When you're listening to this session most of this information is going to apply to you whether you're independent or provider-based. There are a few things that are different depending on whether you are provider-based or independent, but for the most part it's going to be exactly the same information.

If you're an independent RHC the cap is \$84.70 cost per visit. When we talk about cost per visit it's your total expenses divided by your total visits. And most independent RHCs the cost per visit is well in excess of that. It's a \$120 range. It actually makes doing cost reports pretty easy and we can hit that cost per visit relatively easy. It's bad for you guys because your costs are running \$120 and you're getting paid \$84.70. Hopefully there will be a solution to that in the near future and we cross our fingers and hope it happens.

What does a Medicare cost report settle? Where are the pools of money coming from? Number one is the difference between your interim and your final rate. In the old days that really wasn't much of a difference. Medicare just paid your cap as an independent RHC and that's what you got. As a provider based there were big differences in that every year your interim rates changed and your settlements changed based upon what your cost per visit was running in that year.

Secondly, RHCs get additional money for flu and pneumococcal. You do not bill flu and pneumococcal on a Medicare UBO4 or 1500 form. And you actually roster bill it and put those on your cost report and you get settled through the cost report.

Also, Medicare will pay you for Medicare bad debts. Medicare will pay you 65% of anything that's on your UBO4. It can either be a copay or it can be a deductible. That's all that Medicare will reimburse you for but that can add up to quite a bit especially if you're in

a state where you have crossover bad debts or dual-eligibles and Medicaid does not pay you all the money owed to you. Those numbers can add up. I've seen them go up to \$75,000, \$100,000, \$150,000 or \$200,000 of Medicare crossover bad debt depending on which state you're in.

And then finally there's that little piece of copays and deductibles for preventive service. So those are the four pockets of money that you can get on the Medicare cost report.

Here's where all the crying has been. Most of the MACs (and a MAC is a Medicare Administrative Contractor) Noridian and Novitas in the years past have been paying more than the independent RHC rate of \$84.70. Palmetto GBA started doing it last year about July and we started seeing interim rates being set above the cap and the MACs started paying RHCs an interim settlement. I've seen some of the settlements be \$15,000 or \$16,000. We'll show you an example of one that's \$36,000. And those interim settlements have resulted in whenever we prepared a cost report in May your settlements were much lower. And unfortunately, a lot of RHCs end up having to pay money back to Medicare because between the interim rates being much higher and those interim settlements Palmetto overestimated that money on about 30% of the cost reports what we filed last year.

So, a lot of people are paying back money. I had one this morning where they were paying back \$9,000. It's a little bit painful and we've been having to do a lot of explaining on why in years past you never had to pay back money to Medicare but it's happening this year.

This is another reason it is good to have consultants who are familiar with these changes who always go to National Association of Rural Health Clinics meetings and learn things like this. RHCs need professional help when you're doing these cost reports. Your local CPAs are absolutely great at doing taxes and stuff which I cannot do to save my life. But doing cost reports is a niche that's very specialized and on this list, I know every single one of those people there. They go to every NARHC meeting and they all know RHC cost reporting really, really well.

So, get somebody if you meet them at the NARHC meeting that's probably a good place to start. You can tell I'm talking pretty fast. My Tennessee drawl doesn't usually go this fast.

But in 45 minutes I don't have a lot of time to explain everything about cost reports. But good friends at (Wipfli) were nice enough to put together four different presentations that are about 10 to 15 minutes each on cost reporting.

So, when you finish this session your homework is to go and watch. The Wisconsin Office of Rural Health was nice enough to pay for putting together these YouTube videos. So, you can watch those, listen to those and they're very good.

So, going into the building blocks of our cost report, again two different forms, 222-17 independents and 2552-10 the hospitals. They are going to cover a 12-month period of time with a few exceptions. You can go up to a 13-month cost report if you need to. If you sell your RHC on January 31 we can file a 13-month cost report. And that will be done with Medicare at that point instead of having to file a one-month cost report.

You will also have a short period. Whenever you become certified as a rural health clinic, either the state AAAASF or the Compliance Team will come out and you'll get a tie-in letter that will say a certain date. That is the date that you will begin as an RHC. And that's the date you begin your cost reporting. So you can have some short periods and you want to make sure you get those dates exact on that first cost report otherwise your cost report will get rejected by Medicare if those dates aren't exact.

We've had the first major change in independent RHC cost reports in 25 years. And I'm very adverse of change. It's very hard for me and the time it took to prepare cost reports was substantially higher than it was in previous years. So here is the new information if you want to get your hands on that. There's a link right there where you can go in. It's about 75 pages of regulations there that will explain what changed. And the reason for the change: number one is they're setting it up to where we can file cost reports by electronically filing. There's no wet signature required for RHCs anymore. So we can file electronically - and we filed a couple this year electronically. And it works beautifully. You just put a little X in the box and you email it to them and Palmetto accepted them.

But there's also this MCR eF system. MCR eF replaces all the different portals - each MAC had a different portal that they used to accept cost reports. All those 12 different portals are

gone now. There's one portal where you can electronically file your cost report and you have to assign somebody as your authorized cost preparer. And if you were to sign assign your cost report preparer that role they will be able to electronically file your cost report in the coming year. You have to use the CMS enterprise portal to do that. So just keep that as a to do is to get your cost report preparer set up so we can file your cost reports electronically next year.

It also eliminated a bunch of stuff related to FQHCs which use a different form now. And we no longer have a 339 Questionnaire that you guys have to have a wet signature on it and eliminates that. We do have to fill out the same information but it's a part of the cost report. So that makes it a whole lot simpler for you guys.

And then here's the regulations on the new cost report forms. I think that's the same link as I did before but it's there for you. And then for e-filings or to learn more about e-filing and the FAQs on that, there's some links for you guys to look at. If you're assigning your cost report -- authorized cost report preparer - look through that FAQ to see how to do that and that will help you do that. That's part of your homework.

So what are the timeframes that the MAC -- the Medicare Administrative Contractor - are required to work with? Well first off you're required to file a cost report within five months of year end. If you're a 12/31 year end your cost report is going to be due by May the 31st. If you don't get that thing postmarked by that May 31 then Medicare's going to cut off your money.

If you did get it filed by that May 31 Medicare has 30 days to look over the report and to accept it. That's why it's going to be very important for you guys to make sure to complete contact information forms with Palmetto and Novitas and Noridian where you can put your information. Who's your cost report preparer, what's your email address, what's your address, phone numbers on there.

Make sure that those things are up to date and make sure that if you have a change of office manager that you go in and get that updated as well because that way when they communicate to you on adjustments, on tentative settlements, everything is done via email. If

they have bad email addresses you're not going to get that information. So always update that information.

And then whenever there's an issue with cost reporting there will be invariably issues no matter who files your cost report. We have about probably four or five each year where something will go wrong. Diane from Palmetto will email me and say Mark something went wrong on this particular cost report and we will fix it and send it to them. But they have to have the correct information on how to contact me or whoever prepares your cost report.

And then the MAC has about 60 days from the date of acceptance to sending you guys a tentative settlement. And they will typically increase your interim rate based upon that information as well. And then sometimes they'll actually write you a check for the current year as well because they'll do a calculation of where they stand with you. Sometimes they'll take money away from you. What I got this morning they took away \$2,300 from them as well. So at that point they'll put together a tentative settlement for you guys within 60 days.

And then the MAC has one year from acceptance date to actually do what's called an NPR - Notice of Program Reimbursement. And that's your final settlement from Medicare. They will pay you out whatever additional money they owe you at that time. You want to hang onto this because a lot of states will come in - South Carolina for example - I got a request from them this morning wanting one from five years ago. So you want to hang onto your NPRs and save those where you can submit those to Medicaid or somebody asking for those.

And then here are the regulations from the MAC. That's Chapter 8 of the Healthcare Financial Management Manual. It's about a 132-page PDF for the rules for the MACs.

Your deadlines - this is what's important to you guys on getting a proper cost report done. If you're going to claim Medicare bad debts you have to write those off in the fiscal year that you're claiming the bad debt. So if you're 12/31 year end, if you don't have that account written off by 12/31 you cannot claim it on your next cost report.

So your homework is to go through your receivables and look for any Medicare bad debts. Let me explain what a Medicare bad debt is at the end of this session. You want to write those off during this fiscal year. If you're a 9/30-year end, it has to be done by 9/30 and you have to stop collection attempts.

If you're an independent RHC, you're going to have to use accrual basis accounting. If you're provider-based, your part of a hospital, you'll have accountants who already do accrual basis accounting. But if you're an independent RHC you probably use cash-basis accounting. And you need to convert to accrual basis accounting. And we can do that by making adjustments and making reclassifications on the cost report. But one of the big ones is if you accrue a bonus to an owner you have to liquidate that bonus within 75 days of your end.

So if you're giving the owner a \$25,000 bonus, you have to write them a check and you have to get them to cash that check within 75 days of your end or you cannot count it in that cost report period. And then if you have accruals for non-owners, like, you have a retirement plan and finally the pension people come back and say well you owe \$75,000 it's going to make our plan whole, you can actually as long as you liquidate that within one year of the cost report you're in you can actually put that in the year that money was for.

So that's an accrual basis accounting. That becomes very important especially in your Medicaid base years when you need to get the expense into the proper period of time. And there's typically a big lag in you guys getting money because you're a startup. And you can accrue those expenses for that proper period even though you don't quite have enough money to pay it on 12/31 you can get it accrued for that proper period of time.

And then all you guys will probably be using somebody to prepare your cost report for you. Make sure you get - everybody has a standard set of work papers that they ask for. And they'll typically be asking for them in November/December. You'll start hearing from your cost report people and they'll send you a checklist of stuff. Get that to them about two to three months after the fiscal year end. And that way there will be time to start working on your cost report and do it accurately for that May 31 deadline.

Finally on your to do list is this EIDM - the Enterprise Identity Management System. If you haven't been set up with it, it takes about two to three months. Go ahead and get started with that and remember to change your password every 60 days or they're going to kick you out. And you're going to have to start all over again. So that's going to be super important if you get started on that as soon as possible so that you have that ready for the next cost report.

Whoever is preparing your cost report is going to put together a table of contents. We're going to document to Medicare exactly how we came up with these numbers and these 13 forms that we submitted to them. We're going to have a trial balance of expenses. We'll tell Medicare how we came up with these expenses that we're claiming that we have. We're also going to put together support for any type of reclassification. A lot of times we'll ask for your W2s. And we're going to reclassify salaries to the proper place on the cost report.

And then we're going to make adjustments. We're going to look for if you have any related party transactions, if you bought a bunch of alcohol, if you made a bunch of contributions. Wherever you are on that spectrum, you know, we're going to have to disallow that on the Medicare cost report as a non-allowable expense.

And then total visits we're going to computer your visits - your total visits on there. And we'll have someone calculate to show Medicare how we came up with that number. There's going to be a provider FTE worksheet in there where we come up with an FTE - Full Time Equivalents. And there's something called productivity screens. And it can really hurt your reimbursement if you don't do those FTEs correctly your productivity screen's going to be over. We had a cost report yesterday where I reviewed it and we moved the FTEs down based upon doing those the way that they should be for Medicare. And it actually increased the rate by 20 bucks a visit. So important that you pay attention to these full-time equivalents.

Flu shot and pneumococcal logs there's big, big money. The average reimbursement is about \$270 or so for a pneumococcal shot nowadays. And for a flu shot it's about \$60 to \$66. So Medicare has figure out it's a lot cheaper to pay for a pneumococcal and a flu shot than it is for a hospital admission. So we need that information for that.

The PS&R report that is the one that gives us the settlement data. So we have a correct settlement with Medicare and we find out that we don't owe Medicare a bunch of money when we get all our settlement data from Medicare.

And then finally a Medicare bad debt listing in Excel. When we're doing these Medicare bad debts don't do them on paper. Palmetto will make you put them in Excel. We had some interns this summer and that was their summer job was putting these bad debt listings in Excel for some of our clients.

What is our allowable cost per visit? Basically you take your total allowable RHC cost and you subtract out the flu and pneumococcal and the cost report does that for you. And then you divide that by your total RHC visits. That's your Medicare visits, your Medicaid visits, your self-pay visits, your commercial visits. Medicare uses the total visits. You take your total expenses divided by your total visits. And then that will cover your RHC cost per visit. If your cost per visit is 200 bucks a visit, if you're an independent RHC, you're going to get \$84.70 as your capped rate.

If you're less than 49 beds or less, then you're going to get your full cost per visit. So that is your calculation of your what we call your AIR your All-Inclusive Rate. What are your allowable costs? They must be reasonable and necessary. So if you buy a Maserati and put it on your cost report, Medicare says you don't need a Maserati to do rural health clinic care.

But it's going to include your reasonable physician practitioner compensation overhead, equipment-based supplies, personnel. And one thing to remember for you guys that are provider based, sometimes it gets a little confusing because you're thinking of a provider-based clinic. And a provider-based clinic looks just, like, an emergency room where you have a facility bill and you have a physician bill where there's a bill for the physician compensation piece. And physician compensation is a non-allowable expense for a provider-based clinic.

But that doesn't apply to a provider-based rural health clinic. In that case there's just one bill and physician compensation is an allowable expense on that cost report. So keep that

straight. I had a question about that just last week. Somebody got confused by that. So keep that in mind if you're a provider-based RHC.

Here's some of the documents that we get as independent RHCs. We get financial statements. We get trial balances. We get tax returns. And that's where we can sort of delve in and get your expenses. For provider based it's a little difficult to delve through all the information the hospitals have. But you should have some type of departmental summary report. You should have some type of internal financials or they will have a trial balance as well for your particular RHC department. So you want to make sure that you capture that information and you can give to that whoever's preparing your cost report as well.

And then the hospital will have specific hospital cost report data as well. And you want to make sure that that information is accurate and you submit that to your cost report preparer.

This is what the trial balance portion of Worksheet A of the form 222-17 looks like. It's a little bit small and blurry on there so I won't go through and describe what all of these are. But when you do get your hands on one of these if you guys are new independent RHCs, look at these cost centers and you want to set up your cost accounting to be exactly, like, what these cost centers are.

That will make preparing the cost report much, much easier if you set up your cost centers because we're going to need information. You can't see it very well but pneumococcal and influenza you must have that cost showing up in this cost report. And it helps if you guys have your general ledger accounting set up to include this. So if you capture that information as you go through the year versus having to go back and try to find it at year-end when you're doing your cost report it will be much easier.

This is the second page of the cost report. There's 100 cost centers now in Form 222-17. There used to be an old version. The old version was 222-92. It only had 60 cost center lines in there. So make sure you get the new version. If you're a hospital this is the M-1. There's 32 different lines in here. And basically what CMS does is they sort of consolidate everything in here. If you look down here in the corner here you see 29 is your facility cost.

And if you look back on the RHC -- Form 222-17 -- if you look for cost centers 40 through 59 that's basically you want to explode all those costs and put that into facility costs. And then cost center 30 if you look through lines 60 through 74 on that RHC independent cost report form and put this in line 30 that's where the administrative costs are going to go. So sorry that was a little bit of detailed accounting. But they don't really give you a good explanation of what they want in there. That's just the best information I could give you on what goes in those particular areas of the provider-based cost report.

And for you guys that are provider based, there's going to be what's called a Worksheet B-1. The way the hospital cost report works is there's a stepdown function where they allocate tons of overhead to your rural health clinic. And when that CFO asks you for time studies and square footage and gross salaries and accumulated costs and pounds of laundry, remember it is super important that you get these numbers correct because the hospital is going to be allocating overhead to you guys.

Wipfli which is a big CPA firm out of Wisconsin and they're in Tacoma, Washington and a couple other places, Oklahoma and California. Steve Russo is out there. They do this benchmarking study for the National Association of Rural Health Clinics. If you're not a member of the NARHC, please consider joining so you have access to the free benchmarking service that (Wipfli) provides to you guys and the National Association of Rural Health Clinics.

According to this report, parent-provider overhead allocated with \$78.20 is the national average. So you can see how important it is to get these statistics correct. So you're talking about an extra \$78.20 per visit if you do these things directly. If you don't do them correctly you're probably going to get much, much less than that number. And here is how you can get ahold of NARHC and (Wipfli) to do these benchmark reports for you guys. And they're very important on physician compensation, visits, productivity, and those sorts of things you can really learn a lot from those. In fact this is I think one of (Jeff Bramschreiber) session that he did a few months ago on how to benchmark so it's really good.

And then here is if you're an independent RHC you can see you have a hard time seeing it because I can't see the numbers either. But you can see at the bottom here cost per influenza.

That's about \$66.41 for a flu shot. And that number for pneumococcal is \$273.32 or something, like, that for your pneumococcal shots. Again just shows the importance of capturing the correct information so you can capture the money that's important to you.

The new cost centers for pneumococcal and influenza vaccine were added to the CMS 222-17. There's also they added Telehealth as 79 and chronic management as 80. See those in red. Those are not allowable expenses. And so let's see this is a conversion sheet that we actually use. This is the old form 222-92 and then the new form 222-17 and this document converts the cost centers from the old form to the new form. A big thank you to Dani Gilbert, CPA who works for us at Healthcare Business Specialists for preparing this. Every time I do a cost report I use this form because it converts those old line numbers into the new line numbers for you. So if you guys are preparing cost reports get your hands on that. It will be a lifesaver when you're coding.

Here is how the cost report can be divided as far as expenses go. Healthcare costs are in the green area - Lines 1 through 39. The yellow that's a facility overhead. This may or may not be reimbursed based upon an allocation in the cost report. This green area you're going to get 100% of the medical costs. That's where you want your costs to be. If it's reasonable for it to be there.

And then finally non-RHC or non-reimbursable costs those are Lines 75 through 100. These are not reimbursed through the all-inclusive rate. So some of these items are reimbursed through the RHC but not the all-inclusive rate. That's the big difference. Things, like, chronic care management comes to mind. It's a non-allowable expense and goes there.

So here I sort of blew this up here so you can see Lines 1 through 39. These are the first - 10 lines are your salaries that you guys have. You put it on salary and then these are for contracted physician services, medical director and if you have a physician who's actually seeing patients using a contract you can put their costs there. And then here's some of your other basic supplies, medical healthcare supplies.

Here's your facility overhead. People, like, myself who prepare the cost report are going to be in accounting. Office supplies, office salaries, your rent will be in there as well. So these

are overhead. And then next section here is the red section. These are non-allowable expenses. Things, like, if you have a retail pharmacy, if you have Telehealth that's going to be a non-allowable expense, chronic care management.

And then 87, 88, 89 there's areas where we actually use for laboratory. Think about items that you bill to Medicare Part B and get paid fee for service if you're an independent laboratory or if you're a provider-based RHC and use the outpatient provider number and you're getting paid a fee for service for that, you're going to exclude those costs and put that in that non-reimbursable section.

It's going to be important that you keep up with your general ledger account so that we have a good clean number for your laboratory supplies, your license, and other lab supplies. We're going to disallow that expense. Your technical components you're going to bill those to fee for service in the same way you do laboratory. And we're going to keep up with those expenses as well and disallow them as well. Also, EKGs, technical components. Again you can bill those to Part B, Fee for service and for provider-based you would bill it using the hospital outpatient provider number.

Keep up with all of these. Chronic care management if you have an outside firm you're going to want to make sure you put the cost there. But you also want to adjust that cost out of the cost report. Your cost report preparer will know how to do that when they're preparing the cost report. But the main thing for you guys right now is keep up with these expenses through your accounting system so you have it whenever (Mark Lynn) or (David James) or (Julie Quinn) or whoever's preparing your cost report's working on it we will have those numbers and can put those in the right place.

And then now we're moving onto the visits. And I always say accounting visits are more of an art than a science but its super important. I know most people think that oh I want to have as many visits as possible because it's going to help me. So 99211 visits you don't count those. You don't count when you're just getting injections, lab procedures, hospital visits, non-RHC because that's your denominator. You want that denominator to be as low as possible. But make it accurate but make it as low as possible. You don't want to be counting these visits.

So let's go on here. And here's what the definition of an RHC visit is. Medically necessary, medical or mental health visit where we have a face-to-face encounter between a physician, nurse practitioner, PA, certified nurse midwife, clinical psychologist or a licensed clinical social worker where you provide an RHC service within the practitioner's scope of practice.

So that's the type of visit we're going to count. We're not going to count hospital visits because hospital visits are not covered under the RHC benefit as well. What we want to do is do a CPT frequency report. That's sort of the gold standard for this. Whomever is preparing your cost report they will be able to read that CPT frequency report. And they'll have a cheat sheet where whichever CPT code or (unintelligible) code is in there they will be able to determine what should be counted as an RHC visit or not.

And you want that broken down by provider from your computer system because on the RHC cost what we have to put in, how many visits the nurse practitioner saw, how many the physician saw, how many the PA saw. And if you have LCSWs or other types of provider types we need the visits for those particular provider types. If all you have are a manual count we will take that. But that's not the best thing as far as doing a cost report.

Additional requirements for independent RHCs only these are the new things that are required for you guys. So malpractice premiums they want a lot of information on malpractice. I'm not sure why. There's no settlement activity on this yet. I'm thinking down the road they may have an add-in for malpractice. I'm not sure what they're thinking. But right now they're just gathering information. Medical visits, mental health visits and visits by interns and residents. And then your payer mix. They want your payer mix as well.

So those are new requirements for independent RHCs. Provider based you do not have to do this yet. And there's a form that we use that breaks out the visit counts for you guys.

Here are the provider FTEs. This is super important because as a full-time physician if you were 52 weeks a year and you work 40 hours a week, you're going to have 2,080 working out. And you're going to be required to hit 4,200 visits or Medicare's not going to take your

RHC away from you. But they're going to use 4,200 visits as a part of that all-inclusive in count or calculation.

If you're a PA or a nurse practitioner, they're going to use 2,100 visits. So it's going to be really important that you keep up with your FTEs correctly. And you're going to have to do basically a time study. Let's see did I miss a slide here. I'll go back one. Okay a time study - a Medicare approved time study is one week per month for each month and then alternate your week as you go along through the year. And basically you want to have for each of your providers that have visits you want them to do this time study.

So here's a sample of a time study. I think it's from (David James') work paper set that looks really easy to get on here for you guys. So you're going to need to do it. And it's going to be very important that you do that. And also go back to this number here. This is in aggregate not just by provider.

So you can actually if you have a physician who's really lagging behind and your provider-based RHCs most of the ones I've seen they may hit 3,700, 3,800 visits versus the 4,200. But your PA or your nurse practitioner maybe seeing 3,100 visits. In aggregate you will be able to hit your productivity standard that way. So just keep that in mind it's in aggregate.

Influenza and pneumococcal (oh boy I'm running way over on time too). Influenza and pneumococcal what we're going to need for that is basically the patient's name, HIC number which is now it's the MBI number and the date of service. And that will come in very handy.

Also we're going to need a count of non-Medicare patients as well. So we need the full number of flue and pneumococcal shots. And we need your invoices to support as Medicare will ask us for that. So make sure you get your invoices and make sure you get the log. And then we can get your cost report information filed.

EIDM, just get started. Here is the website for getting started for the EIDM system. And make sure to change your password. That's going to be really important that you do that. And that'll get that PS&R report for us. When you do it you're going to ask for a 710 and a

71S. And then make sure you ask for the summary reports not the detailed reports because if you get the detailed it's going to be huge.

This is what PS&R reports will look like. They're basically one pagers. You have report type 710. And then a report type 71S will be here. And you'll actually add these numbers together when you're preparing your cost report. You guys won't have to do the cost report. Your cost report preparer will do it. But you'll add those numbers together and put that on the cost report.

And then this next slide this is the letter that you'll get saying this particular clinic got the rate increase of \$96.38. And Palmetto wrote them a check for \$36,798. Make sure this report gets in the hands of your cost report preparer because if we didn't include the \$36,000 in our payments, then we're going to have a big problem when Medicare finally gets around to tentatively settling your cost report. We under reported our payments by \$36,000. And that's going to be bad news.

Medicare bad debts. We're going to go super quick through Medicare bad debts as we always do. Here is a summary of the regulations from Noridian. I'm going to let you read those because we'll have a summary of those in a minute.

This is important. So this is something that has changed. Effective for cost reporting period beginning on or October 1, 2019, providers must comply with long-standing Medicare bad debt requirements that require you to write them off as an expense. And Palmetto has been doing weird things with hospitals, SNFS and HHAs recently. They haven't done this for RHCs yet but what they've done is adopted a zero-balance policy that requires the accounts receivable balance on Medicare bad debt accounts that equals zero prior to inclusion on the Medicare bad debt listing. If they don't equal the zero they're going to disallow them.

And number two is for Medicare crossovers and eligible bad debts. They must be written off to a bad debt adjustment code. In other words the bad debt must be written off into an expense account rather than a contractual adjustment. You guys need to start making this change now. And we'll work up some information on this for you guys. So we'll distribute

it to you guys so you know what to look for. They haven't started doing this with rural health clinics yet. But they have done it with hospitals, SNFS and HHAs.

Okay keep moving quickly. And here's the bad debt summary. It's only good for Medicare copays which is 20% of charges for the Medicare deductible - \$185 in 2019. They must be billed the Part A MAC. Nothing else will go on this bad debt report. You must try to collect for at least 120 days, treat everybody the same. You don't have to turn people over to the collection agency if you don't want to. It must be written off in the fiscal year of the cost report and then cost collection efforts must cease at this time. So that's going to be important that you do that. And then I think we just summarized that.

Here is the source document for some of this material here. Do look at this one here. The first bill must be within 45 to 60 days. I have seen some MACs will actually not let you claim a bad debt if you don't get your first bill out to that patient within 45 to 60 days of service. So that's one that some people miss. But that's very important that you do that. And then make sure you put it in the Excel spreadsheet. Don't have written ones and we have a separate spreadsheet for both regular and crossover bad debts.

And then here's what your bad debt - this thing looks like. And this is what's called a crossover or dual eligible bad debt. If Medicaid does not pay you the complete copay or deductible, you can include that on the Medicare cost report and Medicare will reimburse you for this bad debt. That's very important. A lot of people don't know that rule is out there. So go back and look at your Medicaid claims and make sure they're paying you everything they should. And if they're not you can claim that as a Medicare bad debt not a contractual adjustment. So keep that in mind.

Here are some of the spreadsheets that we use to claim bad debt. So you might want to look at those as well.

Electronic filing of cost reports. Remember it's not required that you do this. But we're going to try to get everybody on the MCR eF portal next year. And here again it's optional. The key to this thing is make sure that your cost report person can access MCR eF as that's how you're going to file your cost report. Make sure that you make a role for the MCR eF

authorized cost report filer. And if it's Mark Lynn or (Dani Gilbert) or (Julie Quinn) or (David James) or (Jeff Bramschreiber) whoever it is. Make sure you get their name in there so they can actually do this thing - they can actually file the cost report electronically for you.

Okay I wasn't too far over. I was only nine minutes over. That's who I am. If you need to get ahold of me you're more than welcome to call, email. (Dani Gilbert) she's smarter than I am by million times. And (Dani) there's her numbers and contact information. And then finally we're open - Bill if you want to open us up for questions be glad to take them.

Bill Finerfrock: Thanks Mark. Appreciate all that great information. Operator do you want to give the instructions if people want to ask a question through their phone line?

Coordinator: Sure. To ask a question over the phone please press Star followed by 1. Please ensure your phone is unmuted and record your name clearly when prompted. If you need to withdraw your request you can press Star 2. Again to ask a question please press Star followed by 1. One moment to see if we have any questions.

Bill Finerfrock: And you can also write your question in the chat box on the webinar page there. And while we're waiting to see if we get any on the phone line we'll go through some of these. (Marla Beatty) asked what about if we do chronic care management in-house? You mentioned that chronic care management was not an allowable cost. But it is reimbursable so can you make that clarification?

Mark Lynn: It is - it goes into that red section of being non-allowable. The reason why it's pulled out as non-allowable and Bill you had to convince me of this. I had a hard time believing it too. But because it's not a part of it all inclusive rate there's no visits required. There's no face-to-face encounters required with chronic care management.

As long as you hit that 20-minute mark then you have something that's a payable visit or a payable encounter. But the way the cost works is because there's no encounter with that it gets pulled out as a non-allowable expense. If you do it in-house you're...

((Crosstalk))

Mark Lynn: want people to put it on there.

Bill Finerfrock: If you get the 1500 or I'm sorry the UBO4 to bill for it but you get paid based on an average of what the fee for service rate is for that visit but it is the expenses for that don't go on the cost report. The idea is that Medicare says well you're going to get paid twice. Then those costs will be built into your all-inclusive rate. But yet we're paying you for that separate from your all-inclusive rate. So in order to prevent that from being double counted they only allow you to count your chronic care management. You can bill for it. But the cost of that cannot be captured on the cost report.

Next do RHCs -- this is from (Wanda Kelly) -- do RHCs get reimbursed for annual wellness visits on the cost report?

Mark Lynn: They are a part of that all-inclusive rate. And then if you do have an annual wellness visit that occurs with a regular visit, what will happen is there's a portion of that copay and actually what happens is there's a portion of that charge that gets built into the cost report. And they will actually - what happens is that rate you get, the \$68 that you get doesn't include the extra money if you had done it - and I have a hard time explaining this.

If you'd done an annual wellness exam by itself Medicare would have paid you. If you kept with \$84.70 they would have paid you the full \$84.70. But because you did that with that sick visit, Medicare only paid you \$68.75. So that difference between the \$68.75 and the \$84.70 goes - there's a piece where you actually get that money on the cost report. So that extra \$17.00 you will get there. And then the actual cost of doing it gets built into the all-inclusive rate. I know that was a convoluted explanation but that's the way it works.

Bill Finerfrock: Operator do we have any calls on the phone line?

Coordinator: There are no questions on the phone line. And just a reminder if you do want to ask a question on the phone that is Star followed by 1.

Bill Finerfrock: Okay. This one on the chat box is from (Marta Kelly). For Medicare bad debt can old debt from previous years be claimed on a cost report? For example debt from 2016 that is written off in 2018 be claim on the 2018 cost report?

Mark Lynn: The good news on that one is absolutely it can be. And I would highly recommend that you guys go through your accounts receivable and write everything off you possibly can. Bill knows this better than I do. Bad debt is always one of those things that's on the chopping block up in D.C. If they're looking for money to fund the \$110 rate, they may pull it out of Medicare bad debt. So the sooner you can capture that bad debt on this fixed cost report the better off you're going to be.

Bill Finerfrock: Okay. This one from (Joe McLong). As a new rural health clinic how long do we have to submit claims to be counted?

Mark Lynn: Bill do you know how to answer that? I'm not sure exactly how to answer that question.

Bill Finerfrock: I don't know either. (Joe) if you want to try and expand on that a little bit more. Your question isn't particularly clear. If you could elaborate on that we'll try and get back to it.

(Karen Robbins) do you only count visits reported with Modifier CG to ensure visits are not over counted? For example for provider codes in E&M visit procedure code and traditional care management on the same day is the charge of the modifier counted only? Is that one visit I guess they're asking.

Mark Lynn: Yes you would only count that as one visit even though - I mean there's two E&Ms there. That's where it becomes more of an art than a science on counting visits, like, that. You can't - you don't have a set rule that we only count things with CG modifiers because then there'll be other types of visits that you would still need to count. But that's why you need to send in that HCPCS code - the CPT frequency reports to your cost report preparer and they can look at each one of those individual items. But to answer your question on the one E&M visit I tried this in care management on the same day that's only going to count as one visit.

- Bill Finerfrock: Okay. This is from (Nina). Last year we had to include the date of birth for pneumo and flu. Do we have to continue to do that?
- Mark Lynn: According to Medicare rules you didn't have to do it last year. I'm not sure if you have an unusual MAC that would require that. But the Medicare regulations state they only want the HIC number or MBI number on there. The date the service and the patient's name on there. That's all that's required from Medicare.
- Bill Finerfrock: Okay. I'm assuming DOB means date of birth.
- Mark Lynn: That's right.
- Bill Finerfrock: Medicare - this is from (Holly McDonald). Medicare bad debt. If we write off in 2017 when we send to collection and then return from collections. And we have ceased all collection action at the end of 2018. We report as bad debt on 2018 but it was actually written off in the GL in 2017 when we sent it to collection.
- Mark Lynn: Yes the Medicare rules are very clear on this one. If you send over to collection you haven't written it off yet. You're still trying to collect money. Collection efforts have not ceased. So what happens is you probably need to put that account back on your books because you really didn't write it off. You were trying to collect it in 2017. Put it back on your books in 2018 when it was returned from collections. And at that point you're going to stop trying to collect that bill for that sorry Mark Lynn. He lives in a van down by the river. You're going to stop. And at that point you're collecting that and it will be truly written off. And then you can include it on the Medicare bad debt listing for 2018.
- Bill Finerfrock: Okay, all right. Would you clarify (Kelly Bergman) - would you clarify provider-based RHC? Can they have more than 49 beds or are they independent if the hospital that owns the RHC has more than 49 beds?
- Mark Lynn: That is a good question. I think at some point Medicare stopped making provider-based RHCs that were more than - that were 50 beds or more. They said you couldn't be provider based. You had to be an independent RHC. And what's confusing about it is you can have

more than 49 licensed beds. They don't use licensed beds. They use what's called available bed days. And what that definition is, is that how many beds can you set up and staff within a 24-hour period of time and treat patients. And that number will go into the cost report - the Form 2552. If it says 49 on there even though your license beds are 60 or 80 or 90 then you would be less than - you'd be 49 beds or less.

Bill Finerfrock: Okay we're going to have to probably take only one or two because I'm getting a message that there's another use of this room for another webinar to follow us on another.

Mark Lynn: Okay.

Bill Finerfrock: (Jim McClung) clarified we started a new EMR at the same time as RHC. So we're behind in submitting claims. Our fiscal year ends in June. We need to have all filed by what date?

Mark Lynn: I think this probably goes back to (Karen's) question. One of the problems that you have is when you become a new rural health clinic is you can't bill for the services from both Medicare and Medicaid initially. You have to hold your claims to get a rate set. You have to get a CCN number from Medicare. You have to get enrolled with Medicaid. So you tend to hold claims from the date that you're surveyed as an RHC.

And so what happens is the cost report ticker starts the date that you become surveyed as an RHC. Now what will happen is you want to get those claims filed as soon as possible so you can get those on the PS&R report. So the timely filing information still stays the same. I think its one year from the date of service you have to timely file those claims. So that's still in effect.

So that's where you're running into that catch 22 is the PS&R that you file initially will have a very low count. And the great thing about it is you're going to have an NPR that settles up in about a year, year and a half from now. And if you don't - and by then you should have everything in your NPR or onto your PS&R and then they will settle that money with you. And you should get your full reimbursement when you finally settle. The problem is you're going to be waiting a year and so before you finally settle with them.

Bill Finerfrock: Okay. This one is from (Kim Keating). How would your business be counted if a primary care provider sees a patient face to face and then calls in an LCSW for a warm handoff of a patient. Does the LCSW visit count as a separate visit?

Mark Lynn: The Medicare regulations...

((Crosstalk))

Mark Lynn...the way I read them and Bill you can correct me. That's two visits.

Bill Finerfrock: Right.

Mark Lynn: That's two AIRs. So if you got paid two AIRs on that then that would count as two visits.

Bill Finerfrock: Yes assuming that the purpose of the LCSW visit is, you know, medically necessary and meets the standards for a visit. But yes that would be counted as two visits.

Let's see this is going to have to be the last one. Can I ask for clarification on the statement I guess on Slide 6 where you must treat everyone the same versus 7 do not have to turnover to collections if our process is to send to collections after 120 days so we have to do the same with Medicare balances?

Mark Lynn: Yes the answer to that one is you have to treat everybody the same. So if you send Mark Lynn to a collection agency and I'm not on Medicare and Bill Finerfrock is on Medicare, then you have to treat us exactly the same. So we both would be sent to collection agency and then they'll go through their process and then you would write off. So the answer is you have to treat everybody the same. If you don't send people to the collection agency then obviously you're not going to be sending your Medicare patients on there.

And then a real quick answer on this cost report should we be included visits that are 99211. The answer is no, you do not count those as visits.

Bill Finerfrock: Okay. Thank you Mark. And I just want to for those of you who are listening for the Rural Health Certified Rural Health Clinic Professionals Certification, the CEU code for this presentation was P as in Paul, W as in William, 723 V as in voice, M as in man. That's pw723vm. I want to thank everybody on today's call and especially Mark Lynn for the presentation. And also the Office of Rural Health Policy for their RHCTA series.

Please again encourage others who may be interested to register. This was recorded and is available - should be available for download in a few days but at the RHI hub Web site. We welcome you to email us your thoughts and suggestions as I mentioned earlier at bf@narhc.org. And put RHCTA topic or question in the subject line.

The next scheduled call will be in August. We have not finalized the date yet. We will be getting something out on that soon. And so keep an eye out for that. Thank you again for your participation and this concludes today's call.

Coordinator: Thank you. That does conclude today's conference. All participants may disconnect. Thank you for your participation.

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