Hello everyone, thanks for being here today. We're going to give it just a few minutes for everyone to get logged in and then we will get started with today's webinar. Okay, hello everyone. Welcome to today's webinar.

My name is Sarah Holman and I am the Director of Government Affairs for the National Association of Rural Health Clinics and the moderator for today's call. Today's topic is RHC Cost Reporting 101. This webinar series is sponsored by HRSA's Federal Office of Rural Health Policy and done in conjunction with us here at 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 as always to bring these webinars to the entire RHC community free of charge. So we appreciate you being here with us.

The purpose of this series continues to be providing RHC staff and others in the RHC community with valuable technical assistance and RHC specific and up-to-date relevant information. So we encourage you to help us spread the word about these free webinars, encouraging others within your clinic to participate in the live sessions, to review the materials online after the fact, and just stay up-to-date with this important information for RHCs.

So the Q &A box is currently closed and will be throughout the presentation as our presenter is speaking given all of the information that she'll share throughout the presentation. But when we get to the Q &A period, we will open up that Q &A and we encourage you to submit your questions.

There we'll get to as many as we can today. As with all webinars, we're at the mercy of good bandwidth for all parties. We know that connectivity can go up and down. If you have issues or freezes, please just log out and come right back in. Hopefully that fixes the issue.

If you continue to have issues though, no fear. This webinar will be recorded and available on our website along with the slides after the fact. With that, I am pleased to introduce today's speaker. Katie Joe-Ribble is with us from Wipfley. Strong partners in the RHC community as always and we're thrilled that she's here to share her expertise and time with the RHC community.

With that, I'm going to turn it over to her for RHC Cost Reporting 101.

Thanks, Sarah. Thanks to all of you at NARC and your awesome team. I'm always thrilled to be a part of these presentations and any training that we can get out. Thank you for having me today.

Thanks, Sarah. Thanks to all of you at NARC and your awesome team. I'm always thrilled to be a part of these presentations and any training that we can get out. Thank you for having me today.

We will get to it. Again, my name is Katie. I'm a partner with Wipfley and excited to be here I have about 25 years of experience strictly in healthcare consulting. I'm passionate about rural health clinics as I actually grew up in a rural area.

My parents still live there and they get their care out of a critical access hospital and rural health clinic. I'm very passionate about rural health clinics. Today, we're going to talk about the exciting topic of rural health clinics cost reports.

Many of you likely do not prepare the cost reports. You might have a small component in gathering data for it or maybe you don't do anything for the cost report or you think what you do is not relevant to the cost report in your role. It likely is and...
that's what really the purpose of today's presentation is not necessarily to give you a 101 about all things you need to know in order to complete a cost report but really to give you a general overview of what the cost reports about, what the purpose of it is and the information that you gather for it or let's say how you provide services in your clinic and how it affects your rate in reimbursement.

Katie Jo Raebel 05:15
So we'll go over overview of the cost report today, kind of talk about the purpose, and then we'll dive in a little bit further into the key cost report drivers. How do we get to our cost per visit? And that's based on our allowable costs, our visits, we'll talk about productivity standards.

Katie Jo Raebel 05:33
And then we'll talk about the other two components of the cost report reimbursement in total. And that includes Medicare vaccine reimbursement for different vaccines, we'll talk about that. And Medicare bad debt. And then at the end, I have a couple of slides that refer back to the cost report flow and where you can get specific information from the cost report itself.

Katie Jo Raebel 05:56
All right, so let's dive in into cost report overview. So first things first, there's two different types of RHCs. Thus there's two types of cost reports for rural health clinics. First, we have the independent rural health clinics or they're oftentimes referred to as freestanding rural health clinics.

Katie Jo Raebel 06:17
And we have provider-based RHCs. These are rural health clinics that are provider-based to hospitals. You can also have a provider-based RHC to a nursing home. Typically it's a hospital. Both rural health clinics have to submit a cost report, it's required.

Katie Jo Raebel 06:35
And independent rural health clinics though have their own separate cost report where provider-based RHCs are really embedded into the hospitals cost report and have a separate subset of worksheets within the hospitals cost report.

Katie Jo Raebel 06:52
For the most part, the cost report is pretty much the same for both. We don't have hospital overhead that is allocated of course to our independent RHCs. That's a big component of provider-based RHCs. For the most part, it looks pretty much the same.

Katie Jo Raebel 07:12
What is, when does the cost report do? It's due five months after the close of the period covered. So if you are a 1231 fiscal year end, your cost report is due at the end of May. And it must be filed electronically.

Katie Jo Raebel 07:27
If you have a clinic that's terminating its enrollment, these are also due within five months of the fiscal year end or excuse me, the termination date. We've seen a lot of extensions that have been granted during the public health emergency and we're still seeing some extensions that are granted based off of request, but I think those are gonna be minimized in the future.

Katie Jo Raebel 07:53
So during the PHE, it was almost automatic that we were getting extensions. And prior to that, I can tell you in my 25 years of experience, prior to this public health emergency, these were very rarely granted. I've seen them in rare, rare occurrences that extensions have been granted.

Katie Jo Raebel 08:11
And I think we're gonna get there again. There's no indication of automatic extensions here on out. So just know that. What happens if you don't meet a cost report deadline? Your payments are gonna much really get cut off.

Katie Jo Raebel 08:27
So that's why it's important. If you don't have an extension in place, we wanna submit something so that your cost report, so your payments do not get cut off. So keeping track of information during and throughout the year is really important.
And being ready to submit that to your cost report preparatory timely, so that that cost report can be submitted is gonna be important really to your viability as a clinic to see those Medicare payments continue to come through.

Katie Jo Raebel 08:57
What's our purpose here of the cost report? I really like to refer to this as kind of a tie. You wanna think of it as a tax return for your clinic. What did you get paid during the year versus what should you have gotten paid during the year?

Katie Jo Raebel 09:14
And we either end up with a receivable or a payable at the end of the year. What's our goal? Just like a tax return. We wanna make sure that we don't have a big payable or receivable during the year. Sarah, can I verify that I'm still online here?

Katie Jo Raebel 09:32
Yes, yep, we can hear you and see. Okay, perfect, thank you. So we just wanna make sure again that we are, we're getting, and I wanna say maximizing, but I like to say optimizing reimbursement through our cost report.

Katie Jo Raebel 09:49
And that's through our all inclusive encounter rate. We'll dive into that a little bit further. So that's our first bullet on the bottom there. That's the Medicare all inclusive encounter rate. It's referred to as our AIR rate sometimes.

Katie Jo Raebel 10:04
It's our cost per visit rate. We're trying to get to the end game of what was our Medicare all inclusive encounter rate. And sometimes we're subject to certain taps. We're gonna talk about that. And we also have reimbursement then for our Medicare flu, pneumonia and COVID vaccinations as well as Medicare bad debt.

Katie Jo Raebel 10:22
So really those are the three components of our reimbursement. What did we get paid for? What did we get paid at under our all inclusive encounter rate? And we usually have an interim rate and what should we have gotten paid?

Katie Jo Raebel 10:35
That's part of our settlement on the cost report. We also then get settled up for Medicare influenza, pneumonia and COVID vaccinations. And we get settled up for Medicare bad debt on our Medicare cost report. So those are really the three components of the rural health clinic Medicare cost report that we're gonna dive into deeper today.

Katie Jo Raebel 10:55
As I mentioned, you may not have any hand or what you think you don't think you have any hand in your Medicare cost report. But I really feel like every person within the clinic, anything they do really has an effect on the Medicare cost report at your end.

Katie Jo Raebel 11:14
So whether you prepare the cost report, you're getting data for it. You compile one piece of information for that cost report preparation. Or again, you're providing medical services for the clinic. It's really important that you know how it affects your reimbursement and even billers.

Katie Jo Raebel 11:30
Billers and cost report preparers really need to be in sync. Are we billing for our services need to match how we're reporting services on the Medicare cost report? This is really important to our viability in the future. And it may affect your Medicaid rates in certain states.

Katie Jo Raebel 11:49
So although we're gonna be focusing on the Medicare component of your cost report, know that many states utilize the Medicare cost report and setting either an initial Medicaid rate or maybe some states rebase every couple of years and they look at finalized cost reports.

Katie Jo Raebel 12:05
And that's what your Medicaid rate is going to be based off of. So it's really important to know this isn't just a one and done. This can affect you into the future. And again, we'll talk about that a little bit further.

Katie Jo Raebel 12:17
Let's dig into key cost report drivers. So the first real component of our cost report, simple quick and dirty calculation is our all inclusive encounter rate. And it's basically allowable costs divided by RHC visits gets us to our RHC cost per visit.

Katie Jo Raebel 12:37
Our CPV sometimes it's referred to our AIR all inclusive encounter rate. It could be any of, referred to as any of those things. It's the same thing. What are we supposed to get paid based off of for our face-to-face medically necessary encounters with an RHC practitioner, right?

Katie Jo Raebel 12:55
Now, we may have certain maximum reimbursement limits that we'll talk about. Those are our caps. And we have some new ones that have been established as a result of the Consolidated Appropriations Act. So really focus on this.

Katie Jo Raebel 13:11
Our quick and dirty calculation of our all inclusive encounter rate is a simple fraction. Allowable costs divided by visits. And again, we're gonna dive into that a little bit further. So as a reminder, we had the Consolidated Appropriations Act which really set new limitations for independent RHCs that increase the caps that were in place at that time and really put freestanding RHCs and provider-based RHCs on kind of an equal playing level when it came to rates.

Katie Jo Raebel 13:45
So prior to the Consolidated Appropriations Act, we had caps that were lower. And until March 31st of 2021, we had a rate of 87.52. And after that, it was increased to $100 in April of that year. Since then, we haven't increased according to the Act of $13 every year until we get to 2028 and the cap will be $190.

Katie Jo Raebel 14:14
After that year, the rate will be increased by what's called the Medicare Economic Index, which is a very small inflationary factor. And maybe your Medicaid program in your state also increases your Medicaid RHC rate by that same inflationary factor. That 190 will be increased by the MEI that's in place for that year.

Katie Jo Raebel 14:35
So this is our freestanding RHC cap. And it's also in place for any newly certified RHCs that did not have an 855A submitted prior to the end of 2020. So really, there's going to be no difference between freestanding RHCs and provider-based RHCs that didn't apply for RHC status prior to the end of 2020.

Katie Jo Raebel 15:01
Now, let's talk about grandfathered RHCs really quickly. So our grandfathered RHCs were in place or were seeking certification prior to 1231, 2020, had an 855A submitted, and they really have a different cap in place.

Katie Jo Raebel 15:21
Their cap will be based off of their finalized Medicare Cost Report, which would either be based off of the 2020 fiscal year end or the first full year's cost report that contained that RHC. So let's say you had a clinic that submitted an 855A by 1231 of 2020, you were seeking certification, and therefore you're eligible for grandfathered status.

Katie Jo Raebel 15:48
You didn't get surveyed until June of 2021, and you are on a calendar fiscal year end. So your first full year's cost report, which will be your 2022 fiscal year-end cost report, will contain costs and visits for the entire fiscal year end. So 12 months of data, Medicare is going to set your grandfathered cap at that rate.

Katie Jo Raebel 16:16
So keep in mind, these caps that are listed here, again, are for freestanding or newly certified RHCs, but if you have a grandfathered rural health clinic, your rate is going to be different for every single clinic, every entity, every provider number, unless you had a consolidated rural health clinic on one line of the cost report.

Katie Jo Raebel 16:36
And again, it's based off of your 2020 cost report or your first full year's cost report that has been finalized from Medicare. Take note, if you have not reviewed your 2020 cost report or that first full year's cost report, and you think something's incorrect, you have the opportunity to go back and reopen a cost report, you want to make sure that that rate is justifiably as high as it possibly can be.
Again, we want to make sure it's correct, but if you've, let's say, incorrectly excluded costs from that calculation or maybe your visit count is too high, that's going to decrease your cost per visit. You want to go back and either reopen the cost report or if it's not finalized, make some changes and resubmit it.

So grandfathered RHCs, very important. All right, so let's go back to our quick and dirty calculation. Allowable cost divided by RHC visits gets us to our cost per visit. Let's say we come up with a $150 rate right here. Well, if we are newly certified or a freestanding RHC, it doesn't matter.

We have a rate of 126 and Medicare is going to pay us based on that rate. Medicare pays us 80% of the rate. Patient pays us 20% of total charges in total insurance, and that's kind of on the billing end. But just so you know, what you receive is not actually your rate. That is what you're paid based off of. So even if we have a $150 cost per visit, $200 cost per visit, if we're subject to these caps based on the slide, our cost report is going to be settled based on the caps that are in place.

All right, let's say you got paid though, based off of an interim rate of $100 and your cost per visit ends up to be $150. Well, the cap that's in place of 126 indicates that you got underpaid by about $26 per visit.

Therefore, you're going to have a receivable at the end of the year. So really important, our all inclusive and counterweight calculation that we're trying to get to. So let's dive into the numerator of the calculation. We're trying to get to allowable costs.

So the numerator of the calculation is those costs that are related to our rural health clinic services that we can bill and get paid for under our all inclusive and counterweight. So this would include practitioner compensation. Maybe we have overhead from the hospital. We have depreciation for equipment and our building supplies, personnel costs. All of those would be included in the numerator of the calculation.

Where do we get these as cost report preparers? Where does this information come from? Well, typically, if you're an independent RHC, you know, you have financial statements. Let's say it's a quick books report. Internally prepared accrual based financial statements is where that information would come from. Maybe we have the general ledger from your hospital.

Departmental summary reports for the rural health clinic or clinics is where we get that financial data. Tax returns depending on what type of ownership that you have for your clinic. So really, this is information that is prepared by the clinic and they submitted to the cost report preparer.

Compilation. We're not auditing it for correctness. We're compiling the data and putting it into an acceptable form. So the information is only as good and the cost report is only as good as the information that we get from the clinic itself.

Again, we're not auditing it. We can't verify the correctness of it. In fact, there has to be a representative from the clinic that's signing off on the cost report and validating that is correct. So as cost report prepares, we are not validating the correctness.

We're validating that we've submitted it appropriately based off of the data that we've received, but the clinic is signing off that the cost report is materially correct and the information is true.
So keep that in mind. So if we're missing costs based off of the data that we received, that's going to affect the cost per visit. We also have to separate some of those costs out that are related to RHD services based off of components of the cost report that are indicated according to cost center like health care staff costs.

We have to separate out our provider type salaries and benefits. We have overhead that's also indicated like office staff salaries, administrative expenses, billing, advertising, transcription, depreciation on the building, etc. And then we have costs that are other than RHD.

So even though we have certain services that we provide in the rural health clinic, not all of them are considered rural health clinic services. Even listed here, we have certain services that we have to have the ability to perform as a condition of participation in the program, but we actually don't get to bill them as rural health clinic services.

You actually have to bill and get paid for those differently. And if we're a freestanding rural health clinic, we get paid based on fee schedule. If we're a provider based RHD clinic, those get billed under the hospital and paid under the rate that the hospital would typically get paid if that service was performed in the laws of the of the hospital.

So for critical access hospital. We bill those under the hospital and we get paid based on the cost to charge ratio. So if we're not billing for services as a rural health clinic, we're not going to list it as a rural health clinic cost in our allowable cost center.

So it's really important that you as data gatherers and you're in charge of your general ledger and the cost data that's getting submitted to the cost report prepares. That we can easily see as cost report prepares where those costs take where those costs are located in your cost data.

So laboratory costs. You know, maybe you have those all in medical supplies, you have lab supply costs in medical supplies. It would be much easier if you could separate those out and show where your lab supplies are separately. Lab staffing salaries, same thing. Maybe you have one nurse or phlebotomist or other laboratory person that's providing services and it's all in other staff costs.

If you can separate those out and make it easier for your cost report preparer so that those can be put on the appropriate line, it makes it much more efficient. I also have radiology services listed here.

So the really the two services that are never billed under our RHC, all inclusive encounter rate is laboratory services and the technical component of diagnostic services. We can perform those within the walls of the RHC.

Medicare says that's fine, but Medicare always wants that billed to part B for a freestanding rural health clinic or billed under a hospital for a provider based. Rural health clinic. Therefore, we don't bill under the RHC.

Those costs should not be in our all inclusive encounter rate. And you may have other services provided outside the walls of the clinic that we can't bill as rural health clinic services like you have providers that perform ER services or they do outpatient surgeries in the hospital, not billed under our all inclusive encounter rate.
The cost for those services would also need to be carved out. We'll dive into telehealth in a second as well as some other services. I'm gonna take a sip of water and we'll talk about those non-RHC costs a little bit more. So we still want all of these costs to be indicated in the expense and cost data that you provide to your cost report preparer.

But again, we need to make sure that it's easily identifiable and we're as cost report preparers putting those costs on the appropriate lines. Matching principles, the Medicare cost report should include costs, visits and FTEs related to RHC services. We have to put those non-RHC services costs on different lines and the FTEs and visits are really excluded altogether. So we talked about lab. Again, these are paid a fee schedule if we're freestanding RHC and billed the Part B, which I have a lot of clinics that actually miss out on this all together.

They're not even billing for lab services. I find this out later. They think we didn't even know that we could bill fee for service for these. You can and these are not just point of care tests. So point of care tests and any lab services that you're providing in the RHC, freestanding rural health clinics, billed the Part B, paid under fee schedule, provider-based RHCs, billed under the hospitals, provider number and paid under their payment methodology.

The same is true again of the technical component of diagnostic services paid a fee schedule if we're freestanding RHC or billed out under the hospitals provider number. We have some other services that we are told we can again provide within our rural health clinic, but we don't get paid under our all-inclusive encounter rate.

One of those services is chronic care management. We've seen a lot of clinics that are implementing this program into their clinics and it's a great program, but really what you wanna think about is how do we get paid? If you're getting paid based on fee for service or you have to bill for services under the hospital, we need to make sure that we exclude those costs from our numerator of our calculation.

Chronic care management costs, if you pay another company to provide these services or let's say you have staffing that is just dedicated to chronic care management, we'll wanna know where those costs are or maybe you have certain nursing staff that have components of their time that are dedicated to chronic care management.

Maybe we say, okay, for each chronic care code that's being billed every 20 minutes of service, we're gonna allocate some of these particular nursing staff to chronic care services and their salaries are going to be removed on the cost report.

Maybe you provide a originating site telehealth services. So these are services where the patient comes in, into the clinic, you're basically hosting the patient. Medicare says, yes, clinics, you can provide that services, service, but again, how is it paid?

It's paid based on fee for service amounts. Therefore, we have to carve those costs out. So maybe you have equipment costs or building costs that you've identified in one room, just to providing these originating site telehealth services.

Maybe you have some staff that are helping set up for these services. We need to make sure that we remove those costs as well. And then during the pandemic, we were told that we as rural health clinics would now be able to temporarily provide distant site telehealth services and get paid, but again, not getting paid based on our all inclusive and counter rate paid based off of the lesser of the fee schedule amount or our charge amount.

So those services as well have to be removed and expenses removed from the cost report. So great that we can provide those services. And actually, that's been extended the the ability to provide those a distant site telehealth services through
the end of 2024.

Katie Jo Raebel 29:21
And again, get paid based off of the lesser of the schedule or our charge. So if you’re providing those services, it’s very important that you let your provider know your cost report, prepare or know so that they can remove those costs. And you come up with a calculation for removing telehealth and distant site service costs that are paid based off of fee schedule.

Katie Jo Raebel 29:46
So typically, how do we do that? So let’s just take the example of telehealth and we can apply this to lab services or chronic care management. Maybe we’ll ask the clinic. Okay. You provided distant site telehealth services. Let’s look at your CPT code report.

Katie Jo Raebel 30:01
You we should be able to to identify those G 205 services and other telehealth services that may have been billed differently to other commercial plans. And, you know, keep in mind. The all inclusive encounter rate is not just your Medicare costs and Medicare visits. It’s all your costs and all of your visits. So we have to apply this to all services that are performed.

Katie Jo Raebel 30:28
So we might, you know, come up with a plan of, okay, how many telehealth visits did you have during the cost report period? How much time is typically spent for those types of visits? And what’s the average hourly salary of those practitioners providing the service? And then we can come up with a good estimate that would be accepted by the intermediary for coming up with our salaries and benefits that are applicable to these non-RHC services.

Katie Jo Raebel 30:56
And then we’ll ask, as cost report prepares, did you have any other expenses related to providing these services? Do you have any other staff that provides services in relation to telehealth? What equipment costs do you have, etc? That may be related to these services. We need to remove those. So this could be applied to, again, lab services. We look at all of your lab CPT codes. What’s the average time to perform those lab tests?

Katie Jo Raebel 31:26
Who’s performing the services? We carve them in a chronic care management. Same thing. We can utilize this type of methodology to provide a carve out of costs. Diving into telehealth a little bit more.

Katie Jo Raebel 31:44
One thing we do know, yes, distance site services were able to provide through the end of 2024 currently and get paid based on our lesser of charge or fee for service amount. However, exciting in 2022, Medicare gave RHCs the permanent ability to provide distance site mental health services and get paid under our all inclusive encounter rate. So anything that’s paid under our all inclusive encounter rate, what do we want to do with costs and visits?

Katie Jo Raebel 32:19
Right? So again, think about that numerator. Think about proper matching principles for billing and cost report. Anything that’s paid based off of our all inclusive encounter rate, those related costs should be included in our numerator of our calculation and should stay on our cost reports.

Katie Jo Raebel 32:36
So mental health services, we get paid under our all inclusive encounter rate. We want to make sure that those costs are indicated in our numerator and therefore our visits should be included and we’ll dive into visits in a little bit. So this is another thing important to communicate to your cost report preparer.

Katie Jo Raebel 32:54
Yes, we provide mental health distance site telehealth services. These are where our costs are. These are the practitioners performing them. We want to make sure again we include those costs in our numerator.

Katie Jo Raebel 33:09
Alright, so we focus on our numerator of our calculation. Once we get to our and allowable costs, then we’re trying to get to all right. What should our denominator be in our calculation? And one component of that is actual visits.
So rural health clinics visits for the most part are those medically necessary face to face encounters with an RHC practitioner, right? That if looking at any patient regardless of payer type, if they were a Medicare patient, could you bill and get paid under the all-inclusive encounter rate? So again, we're not just looking at Medicare visits.

Katie Jo Raebel 33:48
We're looking at all visits provided during the cost reporting period. By a RHC recognized provider, would we be able to get paid under our all-inclusive encounter rate for that service? That's really what we want to be counting as a visits for our Medicare cost report.

Katie Jo Raebel 34:09
Again, these include all visits, not just Medicare visits during the RHC hours of operation, and these also include some visits outside the walls of the rural health clinic. So I mentioned hospital visits, ER visits. For the most part, our visits have to take place within the walls of the RHC.

Katie Jo Raebel 34:32
But Medicare is told us that we can provide certain services outside the walls of the RHC and still bill and get paid under our all-inclusive encounter rate. Those would include nursing home visits, home visits, swing bed visits, scene of an accident, assisted living visits because those are considered the patient's place of residence.

Katie Jo Raebel 34:55
We should be billing those and getting paid under our all-inclusive encounter rate. Therefore, those visits should also be included in our visit calculation. So for those of you that are gathering this visit data, go back and look. Are we counting nursing home visits?

Katie Jo Raebel 35:12
Are we counting swing bed visits? Are we billing for them properly? We want to make sure, again, we're properly matching how we're reporting and how we're billing. I have a lot of clinics that don't even know about nursing home visits or especially swing bed visits.

Katie Jo Raebel 35:28
That's a really great win under the RHC program. For us to have the ability to provide swing bed services and get paid under our all-inclusive encounter rate, and those particular providers don't even have to set foot in the RHC, they can be strictly providing nursing home services or swing bed services.

Katie Jo Raebel 35:48
If their costs are allocated to the Royal Health Clinic, if we're counting their visits in the cost per visit calculation and their FTEs are being reported, we can bill those out under our Royal Health Clinic billing number. We can bill them. We get paid on our all-inclusive encounter rate, and we have to make sure that we report it properly on our cost report.

Katie Jo Raebel 36:11
Little side note here, we do have the ability to provide visiting nurse services to the homebound if we're located in a home health shortage area. Now, during the PHE, Royal Health Clinics were provided a waiver to perform these services and bill under the all-inclusive encounter rate and get paid without a home health shortage area designation.

Katie Jo Raebel 36:40
Now that the PHE has expired, we have to go back to the original requirements. We have to be in a home health shortage area. There's nothing that tells clinics that you're in a home health shortage area. It's something that you have to basically plead your case to the state.

Katie Jo Raebel 36:58
The state makes a recommendation for approval to the regional CMS office, and the CMS regional office makes a final determination. With that determination, based of no other either home health agency being willing to come in and service your patients, or let's say there's an adequate coverage within your service area, you might be able to get a home health shortage area designation.

Katie Jo Raebel 37:23
If you do, you're able to bill those services and get paid under your all-inclusive encounter rate. Again, note that during the
PHE, you could have provided these services and bill and get paid under your all-inclusive encounter rate as well. It's important to let your cost report preparer know that if you did do this and that your counting visits, if you get paid under your all-inclusive encounter rate.

So, a little side note and an opportunity for rural health clinics to possibly go and get that home health shortage area if they think they're eligible. I've had hospitals that have shut down their home health shortage area and have been able to get a home health shortage area designation seamlessly from the CMS regional office in order to kind of continue providing services to their clinics under those visiting nurse services.

So, counting of visits is often easier said than done. Oftentimes, we'll get CPT code reports and we'll look at the bottom and we'll see all of the CPT code counts circled and that's pointed to and indicated as total visits. Well, that might include lab services, radiology services, nurse only visits, which nurses are not considered RHC practitioners, right?

So we only want to be including those services again that we're going to bill and get paid for if that patient was a Medicare patient. Could we get paid really an all-inclusive encounter, right? We're looking at really face-to-face medically necessary encounters and mental health at distant site services with our RHC practitioners.

If we had more than one service during an encounter, we're only counting that as one visit. So that's another thing. Sometimes we have an E &M and a procedure on the same day. If we're counting both CPT codes, we're counting two visits. What's our risk here? If we have an over-inflated denominator, our cost per visit goes down.

We want to make sure that we carve out as many visits as we can justifiably do, do so, and reduce our denominator so our cost per visit is as high as we can justifiably get it. Even over our cost per visit cap, in case, for example, maybe Medicaid uses that rate without a cap, and they say, okay, we're going to take your actual cost and update it every year or every couple of years as your updated prospective rate, or maybe your first, first Medicare cost report for a clinic is what's used to set your Medicaid permanent rate in your state.

Every state's different. So we really want to make sure that we're honing in on visits. If you are responsible for gathering data for your visits and giving it to your cost report repair, it's super important that you really hone in on this, that you're keeping track of it during the year, that you know what reports to use, and maybe you're using that CPT code report right now, and maybe there's another report like a scheduler report that would be much better because the CPT code report has all those codes, and we only need to know actual visits.

So think about that. That's something that you might want to take home from today's presentation is really going in and honing in on how you're counting visits. What we do know is that counting visits for our freestanding or a newly certified RHCs is going to be even more important as that cap continues to raise.

We've seen clinics that really haven't had to be too worried about, you know, if they're overstating visits because they have been tapped at a decreased amount for years. And now we're seeing clinics that are inching closer or maybe lower than that cap. And they really haven't honed in on counting visits.

So as that cap increases, we want to make sure, again, that we're really counting those visits correctly. Once we've honed in on our allowable cost and we're confident with that numerator amount, we really need to make sure that we're honing in on those visits and not overstating a visit.

Now the other component of our denominator. So what we just went through was counting actual visits. The second part of that is that's compared to what's called productivity standard visits. And the greater of the two is actually what's using our
That is driven off of full-time equivalent, full-time equivalents that we get from the clinic. And these are separated by practitioner type. You’ll see physician here, physician assistants, nurse practitioners, visiting nurse. If we’re in that home house shortage area, again, we can count our visits and get paid under our own inclusive and counter-rate.

Clinical psychologists, licensed clinical social workers, note those providers that are asterisk that are not subject to productivity standards. So we’re going to dig into productivity standards a little bit more. Know again that they are driven off of FTEs.

Again, we have had some exciting news with mental health services being able to be provided distantly and get paid under our own inclusive and counter-rate. What’s also exciting is that in 2024, not only are we able to provide again, distant site services for mental health and get paid under our own inclusive and counter-rate, we also have additional providers that can perform distant site services and services within the clinic and get paid under that AAR.

So licensed marriage and family therapists and mental health counselors are going to be recognized beginning next year as RHC provider. So super exciting. Kudos to NARC for moving that forward and we’re excited that these will be additional RHC-defined practitioners being able to get paid under that AAR.

All right. So let’s talk about FTEs and how do we... How do we calculate FTEs for a provider? What we want to be including is patient-related time or availability to see patients. So time spent in the clinic, time seeing, nursing home patients, swing bed patients, home visits, anything that we could bill as rural health clinic visits, that related time should be included in our FTE calculation.

This would also include charting time. What we don't want to include is time for providers where they're spending non-RHT time that’s billed differently, hospital time, inpatient or outpatient, ER coverage. Telehealth where we’re getting paid under fee for service, right?

Those G2025 codes, how much time is being spent for those? We want to carve that out of our FTE calculation. Maybe we have providers that are medical directors or they have a lot of administrative time that is not patient-related.

We want to make sure that we carve that out as well because they are not available to see patients at that time. We don't want their FTE to include that time. If we do have providers that are stepping in as quote, unquote, low-coms, maybe they're only, you know, a provider goes on vacation, their FTEs are really included in the FTE count.

We have another provider that's filling in for them. We don't need to include their time because it's really included in that low-com FTEs, or sorry, the permanent providers FTEs. These are our regular providers that are providing services on an ongoing basis.

That's the FTE that we want to be identified and reported on the cost report. A lot of times what we’ll get is the bottom line here. Yep, we have one physician FTE, they’re available full-time, and as we get the cost report done, we have a productivity standard problem, and what we do is we dig in a little bit further and ask some more questions.

And as we ask questions, we actually find out that their FTE is more geared towards like a 0.7, maybe they have some time with administrative duties, they’re actually going to the hospital and doing outpatient surgeries, or again, ER coverage.
They also provided distance site telehealth services that were paid under the fee schedule amount, and they have medical director time. As we whittle that down, really what we're counting then is that 0.7 FTE. All that other time we carve out.

Katie Jo Raebel 46:11
Now that also means that if we have expenses related to that time, we need to carve that out as well. So if the salary for that particular provider is all inclusive of their administrative duties and their hospital time and everything else, we also have to carve out out of our cost the appropriate costs related to that time as well.

Katie Jo Raebel 46:36
But our FTEs also have to be whittled down. So what are productivity standards really for our providers that are subject to those standards? 4,200 visits annually for one physician FTE and for non-physician practitioners or NPSPA certified nurse midwives, theirs are half of that.

Katie Jo Raebel 46:58
All right, so again, this is only a mechanism for calculating our cost per visit. If we're not meeting these standards, it doesn't mean that we're kicked out of the program. So keep that in mind, but it's really still important for our providers to know about these productivity standards, how if we're not meeting productivity standards, how it could affect our own inclusive encounter rate.

Katie Jo Raebel 47:21
I'm gonna give you an example of typically, this is what we may see in a cost report. Maybe that is correct, but maybe it's incorrect and we might dive into it a little further. This is a worksheet of the cost report where we input FTEs by provider type.

Katie Jo Raebel 47:45
And you'll notice our productivity standards are hard coded here. So we have 4.5 physician FTEs in this case, multiply that times our productivity standards of 4,200 visits annually, and we get almost 20,000 productivity standards or minimum visits for our physicians.

Katie Jo Raebel 48:06
For our physician assistants, we have 0.51 FTEs, multiplied by column three. Notice that's half productivity standards, right? That gets us to expected or minimum visits of 1,071. We keep going through this for each provider.

Katie Jo Raebel 48:24
And you'll notice in our total amount, we had productivity standard visits in column four in total of 26,817. That is less than our actual visits of 35,000. So what's our risk here? Productivity standards are less than our total visits.

Katie Jo Raebel 48:44
Therefore, what we want to really look at is our total visits, correct? If this is causing us to go below our cap, either our grandfather cap or freestanding cap or a Medicaid rate is gonna be affected by this, could it be possible that our actual visits are overstated?

Katie Jo Raebel 49:03
We're about 9,000 over productivity standard visits. This would kind of cause me to go, are we double counting visits? Are we including nurse only visits? Are we including multiple services on the same day? Maybe we wanna dig a little further into this.

Katie Jo Raebel 49:18
Maybe it's correct, it definitely could be. This is oftentimes what we see, especially in rural areas, well, you'll notice our total visits are less than our productivity standard visits. So where we want to dig into this, our risk is that our FTEs are overstated because that's really driving our productivity standard visits.

Katie Jo Raebel 49:41
So could we have providers that are listed as 1.0 FTEs, but they actually have time in the hospital that's not parked out? So just to give you an idea of how this affects your reimbursement at the end of the day, in this case, let's say we had $4 million of costs in our numerator.

Katie Jo Raebel 50:00
And if we look at example one, where our product, where I think we had actual visits, used, we have a cost per visit of $112. Well, right now the cap is 126, right? So we're losing out on $14 per visit.

Katie Jo Raebel 50:20
In example two, we've got 26,000 that's being used in our denominator of 149. Where are we losing out on that? Depending on what year it is, if we're a grandfather cap, let's say we have a grandfather cap of 175 and this causes us to go below that, we're gonna owe some money back if we were paid on a 175 rate.

Katie Jo Raebel 50:46
So again, just to give you a visual of how this affects your rate, so important FTEs and visits both really honing in and having a good understanding of where we're getting those numbers and how it affects your rate.

Katie Jo Raebel 51:00
Now we do have the ability to request a productivity standard exception. That's always been in effect, although really rarely granted. So always rural health clinics have been have the ability to request these rarely given.

Katie Jo Raebel 51:18
CMS has actually told the Medicare administrative contractors, Hey Max, you guys have the ability to grant these, but we're gonna leave it strictly up to you. We're not gonna give you any guidance as to when you should be granting these or not, but it's totally up to you.

Katie Jo Raebel 51:34
Well, what does that do? Essentially what that does is in this calculation here, it gets rid of the productivity standards or maybe it reduces them. So in this case, rather than using the 26,000 of visits in our denominator, we'd use our 21,000 if we had a full productivity standard exception.

Katie Jo Raebel 51:54
And we saw those almost automatically being granted during the public health emergency. What we're seeing now is the, you know, max that are not granting them just for the, I don't wanna say excuse, but for the reason of COVID and there being a little less lenient on just granting those automatically.

Katie Jo Raebel 52:16
And I think we're gonna see those less and less. Maybe you do have a good reason. Maybe you have a new provider that doesn't have a full panel. You wanna be thinking of other reasons outside of COVID for a request for a productivity standard exception.

Katie Jo Raebel 52:31
Maybe you're in a very, very rural area. You have to keep a provider on staff full-time in order to keep them. But, you know, by doing so, your productivity standards are, you know, 4,200 when you don't even have the population, you know, all year round to provide those many visits.

Katie Jo Raebel 52:52
So just be thinking of other reasons besides COVID if you have a productivity standard issue that you wanna request an exemption for. Now, if you are a grandfather at RHC and let's say your 2020 cost report is gonna be used to set your cap rate, you definitely wanna make sure if you had a productivity standard problem that you requested an exception and if you didn't go back and request one and see if you can get that wiped out.

Katie Jo Raebel 53:20
That's gonna be an important part of your grandfather cap that's gonna be set really forever. That'll never be updated as the rules are stated right now. It's only gonna be increased by that Medicare Economic Index every year. So go back and look at that on your cost report and see if you had a productivity standard issue and if you requested an exception.

Katie Jo Raebel 53:43
Alright, so we've come up with our all inclusive encounter rate. That's kind of the first step of our cost report. Now we also get reimbursed for Medicare vaccines for direct Medicare patients for Medicare flu and pneumonia. These are paid based on cost.

Katie Jo Raebel 54:03
Basically, we get a cost per injection, which includes a cost of the vaccine. We get a portion of staff costs allocated to the vaccine. As well as overhead costs. So we want to make sure we are never billing for a direct Medicare injections for flu and pneumonia. That we're keeping track of these during the year with the name of our patient data service, Medicare number and basically we get paid at the end of the year on the Medicare cost report for these.

Katie Jo Raebel 54:31
So there's a timing difference. But it's much better than fee for service reimbursement. We can't build these to part B. We keep them and again get paid on the Medicare cost report. We get paid also for COVID vaccines.

Katie Jo Raebel 54:45
I get a lot of questions about all other injections. All other injections are either. Part of a visit or we're not able to bill for them. So let's say a patient came in and had an injection only like a B12 injection. It's a nurse only visit.

Katie Jo Raebel 55:02
We didn't have an R. H. C. Eligible visit. We're going to have to write those off. Yes, the costs are included in our denominator. But I think a lot of times people get confused that once we're over a certain cost, we're not going to get paid anymore for those.

Katie Jo Raebel 55:19
Those injections. So it goes back to that. What's our cost per visit? Limit what's our cap either freestanding or grandfathered and how much are we above that? Are we really getting paid for those injections?

Katie Jo Raebel 55:34
So these are flu pneumonia COVID vaccines for direct Medicare patients only. We want to make sure really important that we have a listing of those Medicare patients with their Medicare number data service. How can we automate these? So we're getting rid of manual reports.

Katie Jo Raebel 55:55
We have a lot of clinics that are still doing these manually and then they're being lost at the end of the year. What can you do within your system to spit out a report at the end of the year? Where are the vaccine costs? This is a really helpful thing for your cost report preparer. Where are they at on your general ledger? Do you have copies of invoices? That's going to have to be included with your cost report.

Katie Jo Raebel 56:18
And how much time does it typically take to perform these injections? That's an important thing as well. Have you done a time study? Is it 15 minutes? Is it 20 minutes? And being able to back that up if you were ever audited by Medicare? Medicare by debt is our really third component of reimbursement on the cost report.

Katie Jo Raebel 56:39
And Medicare by debt is often overlooked by rural health clinics. Some clinics don't even know about it. We are eligible to get paid 65 cents on the dollar for allowable bad debt in the year that the amount was written off. So this is really related to deductibles and coinsurance for part A claims. So these are rural health clinic services only. These are not our lab services that are billed to part B or technical component of diagnostics. These have to be related to our RHC services.

Katie Jo Raebel 57:12
And certain requirements must be met. Basically, there's three types of bad debt. There's the direct Medicare patients that we've made a reasonable collection effort to collect from them. And we follow all of our billing policies.

Katie Jo Raebel 57:29
And Medicare has said reasonable is 120 days from the date of the initial bill that we billed the patient. We need to make sure we're billing for 20, 120 days. If the patient makes any sort of payment within that 120 day period, the clock starts back over again. When it's written off is when we get to claim it on the cost report.

Katie Jo Raebel 57:52
So that's the first type. The second type is if we had Medicaid as a secondary payer. We get in a denial from Medicaid. We can write those off immediately and they can be claimed immediately. We don't have to follow that 120 day rule.
And thirdly, if we have a documented charity care policy, which rural health clinics are not required to have, but if you do, and your Medicare patient meets those charity care policy guidelines, we can also write those off.

Katie Jo Raebel 58:18
If it's documented in the patients record that they meet that guideline, we can write those deductibles and coinsurance. Claim them on the cost report and get paid 65 cents on the dollar for that claimed amount. CMS has provided clarification that if we have any amounts with the collection agency, we are not able to view those as un-reflectable and they cannot be reimbursed until their return from the collection agency is un-reflectable.

Katie Jo Raebel 58:49
So oftentimes what we have is clinics that look at the amounts that are in collections and maybe we want to say, well, the majority of our write-offs that are with collections during the certain point of time are high Medicare.

Katie Jo Raebel 59:03
We're going to take everything back. We can't just take Medicare. Take everything back within this time. Seize collection efforts on all payer types for the certain period, knowing that we're going to be able to claim our Medicare patients on the Medicare bad debt line on our cost report and get paid at least 65 cents on the dollar for those.

Katie Jo Raebel 59:24
So that is kind of a strategy that some clinics implement. We have certain information that has to be reported as part of claiming these. This includes the beneficiary name, Medicare number. There's a certain exhibit that has to be submitted.

Katie Jo Raebel 59:41
Write-off date is really important and an important component of this is again making sure if these are not Medicare secondary patients, they're not indigent. They don't meet our charity care policy guidelines that we have billed them for at least 120 days and Medicare is going to check that date and timeline on your form that's submitted.

Katie Jo Raebel 01:00:03
So that's the third part of our reimbursement. As a review, we're looking at our all-inclusive encounter rate. What did we get paid during the year? What should we have gotten paid? Number two, reimbursement for flu pneumonia, vaccinations and COVID vaccinations for direct Medicare patients and component three, Medicare bad debt.

Katie Jo Raebel 01:00:28
So I want to leave you with, before we get to questions here, cost report flow. There's some important data that you can get from your cost report based off of what type of rural health clinic you are. I separated the two. So for independent rural health clinics, here's the cost report worksheet that you can go to to find different information.

Katie Jo Raebel 01:00:47
So expenses will be on worksheet A. We have to move expenses around on worksheet A6 to different departments and maybe we've even added some expenses or subtracted them. Those are on A8. Our visit calculation, so that FTE, visit data, productivity standard issues, if we had an issue that would be on worksheet B.

Katie Jo Raebel 01:01:12
Our calculation of Medicare flu pneumonia, COVID vaccinations, monoclonal antibody reimbursement, that's on B-1. And really our bottom line calculation of settlement and our all-inclusive encounter rate is there on worksheet C. I also separated this for you for provider-based RHCs.

Katie Jo Raebel 01:01:33
Many of the worksheets are the same, but we also have an M section for provider-based RHCs. So I've listed them here as well. So you can go and check out your cost report, look at where some information is. Again, one of the most important components would be if you had a productivity standard issue and then again looking at what your all-inclusive encounter rate is calculating to be at that calculation of settlement on M-3, if you're provider-based RHC, or on worksheet C, if you're an independent RHC.

Katie Jo Raebel 01:02:07
So lots of information. This is meant to give you an overview of the cost report and information that you provide to your cost report preparer and how it affects your rate. I would love to answer some questions for you. I'm sure, again, that your head may be spinning and know that I'm here to answer questions either now or in the future if you have any.
Katie Jo Raebel 01:02:32
So Sarah, I'll let you open it up.

Sarah Hohman 01:02:35
Awesome. It is open now. I'll let a few come in. I'm going to turn to the chat for a few that came in during the presentation. So someone asks, they said that they started, they opened their RHC in 2021.

Sarah Hohman 01:02:51
How will they know if they were grandfathered?

Katie Jo Raebel 01:02:54
Good question. So you had to have an 855A submitted by the end of 2020 and grandfathered only applies to provider-based hospitals with less than 50 beds. So you may have not been certified until 2021, but when was your 855A submitted?

Katie Jo Raebel 01:03:14
That's the important thing. And I've had several Rural Health Clinics that were not recognized as grandfathered until we asked for it. So this is a really important thing to know.

Sarah Hohman 01:03:27
And I see a couple of questions about the slide deck.

Sarah Hohman 01:03:29
That's available on our website. And the recording will be there in just about 48 hours as well. Kamala asks, how long do you have to make adjustments to last year's cost report?

Katie Jo Raebel 01:03:44
It depends on if it's not finalized.

Katie Jo Raebel 01:03:49
So finalized, oh gosh, I'm trying to remember off the top of my head, it was three years from the data finalization. If it's not yet finalized and gone through what's called the NPR process, which is basically your finalization notice, you can go back and resubmit the cost report.

Katie Jo Raebel 01:04:09
But there are reopening guidelines and there are certain threshold amounts regarding reimbursement that may have to be met as well. But I can get that information for you if you want to contact me directly, I can give you some information regarding reopening guidelines and finalization.

Sarah Hohman 01:04:31
Folks, there's a handful of billing questions throughout this Q&A. Billing and cost reporting certainly go hand in hand in a lot of ways. I'm gonna focus on the cost reporting questions. We have a lot of billing resources out there as well.

Sarah Hohman 01:04:49
But if your questions are super specific, please don't hesitate to reach out to me. I'll put my email address in the chat as well. And then I can kind of direct you as to the best person or resource to follow up with.

Sarah Hohman 01:05:04
Certainly they go hand in hand, but we do want to focus on cost reporting. Robin asks, is a chiropractor considered a physician in the RHC, so they're subject to those productivity standards as well?

Katie Jo Raebel 01:05:17
Yeah, yeah, good question.

Katie Jo Raebel 01:05:19
So yes, we see specialists and chiropractors are considered physicians in rural health clinics. Therefore they would also be included on that physician line and they would also be subject to productivity standards.

Sarah Hohman 01:05:32
Awesome, thank you.

Sarah Hohman 01:05:34
Michelle asks, so to be clear, a provider can exclusively complete visits at a SNF and not need to see patients in the RHC assuming the provider is set up as an RHC provider and the visits billed through the RHC.

Sarah Hohman 01:05:49
Katie, if you want to take this first and then I have a few thoughts to share as well.

Katie Jo Raebel 01:05:54
Yep, yep, so yes, they can. And they can provide services in the nursing home. They can provide swing bed visits. And they're still RHC providers because that's an RHC quote unquote, I don't want to say place of service because we're not billing with place of service codes, but that is a place where you can provide services and get paid under all inclusive encounter rate.

Katie Jo Raebel 01:06:20
Again, we've got to make sure that we are meeting the conditions of participation. We have non-physician practitioners that are over, that are available to see patients at least 50% of the time that the clinic is open.

Katie Jo Raebel 01:06:34
So we still meet those requirements and but we can have our providers outside the walls of the RHC. They don't have to be necessarily providing services in the RHC walls itself. Those are still considered RHC services and build out under the RHC all inclusive rate.

Katie Jo Raebel 01:06:54
Again, costs, visits, FDEs have to be attributed to the Royal Health Clinic.

Sarah Hohman 01:06:59
Awesome, thank you. The only thing I'll add on this is there are some concerned about this policy specifically in the instance of urban providers seeing urban patients and urban SNFs and billing those all through the Royal Health Clinic.

Sarah Hohman 01:07:19
As of right now, there's minimal limitations on this, but there are some concerned about perhaps potential ties between patient provider in a rural location based on intent of billing through the RHC. So just wanted to flag that for folks.

Sarah Hohman 01:07:41
As well, Jodi asks, can you discuss the specific requirements related to time studies for flu, pneumocovid vaccines, lab and x-ray services a little bit more?

Katie Jo Raebel 01:07:54
Yeah, good question.

Katie Jo Raebel 01:07:55
I haven't seen any intermediary that has given any specific requirement related to this. Other time studies that are maybe required, let's say ER time studies that we see in hospitals, it's two to two week time studies, alternating weeks of the month.

Katie Jo Raebel 01:08:15
That would be something that some intermediaries have implemented. I have never seen any intermediary say, you have to follow this particular time study. I haven't actually seen an intermediary say, we want to see copies of your time studies for time.

Katie Jo Raebel 01:08:31
I've simply seen rural health clinics give average time to perform those services. But if you did do a time study, that would be kind of extra insurance if they were to ever say, your time looks excessive, you could point back to it.

Sarah Hohman 01:08:47
Next question is from Daphne. She says, if my cost per visit is below the cap and my expenses are correct, then the amount per visit is not as important since my costs are covered, correct? Cost per visit is a big problem when the cost per visit
exceeds the cap, then it could be counted visits or expenses that are too great and need to be reviewed.

Katie Jo Raebel 01:09:11
So basically, yeah, if we're falling below the cap, that doesn't mean that there's an issue, but we certainly wanna go, ooh, if, you know, what is causing us to fall below the cap? Are costs correct? Are visits correct? And yes, that means that we're getting paid based on cost, but we just wanna make sure that we're actually filing the cost report correctly.

Katie Jo Raebel 01:09:37
And again, what we have to be prepared for is, do we have a payable at the end of the year because we got paid based off of a 126 rate and our actual cost per visit is 114? We've got a lot of rural health clinics that I don't want to say a lot, but we do have rural health clinics that are seeing this.

Katie Jo Raebel 01:09:55
They owe money back at the end of the year and it's sheer panic. Well, you're still getting paid costs, you've been efficient during the year. And yes, you do owe money back, keep in mind, you're getting that, you got that money interest free and you're getting paid at a much higher rate than what you got paid previously.

Katie Jo Raebel 01:10:15
And you weren't getting paid based off of an increased cap before you were getting paid based off that $87 cap. And now you're getting paid more than that. So just because you have a payback does not mean that you're doing things incorrectly.

Sarah Hohman 01:10:29
That's really helpful, thanks. Katie, there's a handful of questions about Medicare Advantage plans in the Q &A. Can you just talk a little bit about sort of how what you're talking about pertains to traditional MA or traditional Medicare and sort of where that overlap lies?

Katie Jo Raebel 01:10:48
Yeah, so Medicare Advantage plans really for all intents and purposes are commercial plans. And as it stands right now, which I know there's some push towards making them pay based off of an all-inclusive encounter rate, they, you have the ability to contract with them just like any other commercial plan.

Katie Jo Raebel 01:11:08
And if you can get a rural health clinic all-inclusive encounter rate, which is better than like a fee for service rate from them, then go for it, but that doesn't mean that they will. We're seeing some that are, some that aren't.

Katie Jo Raebel 01:11:20
And in addition to how you bill for those services is different according to plan. I have only seen one Medicare Advantage plan that ever thought about implementing a cost report. So you wanna think about, okay, if they are contracting with us at all-inclusive encounter rates, our flu pneumonia cost is taken out of that rate, are they gonna let us then bill separately for flu pneumonia vaccinations?

Katie Jo Raebel 01:11:49
That's something to think about with Medicare Advantage. Maybe you're not billing them on a UB, you're billing them on a 1500 and getting paid based on fee schedule. Have you even tried to contract with them at our HC rates? So it really varies from plan to plan.

Katie Jo Raebel 01:12:08
And finding out how you're contracted first is gonna be really important. Thank you. Charlie says, you mentioned a cruel-based accounting for costs at one point. Do they need to be a cruel-based or can they be cash-based if you only keep cash-based financials?

Sarah Hohman 01:12:25
Medicare states that the requirements are a cruel basis. How is CAP on rates handled year to year? Year one at CAP, year two was under CAP and then year three over CAP does the CAP continue at the original amount with annual increases?

Katie Jo Raebel 01:12:45
Yes, so I'm assuming this is more geared towards grandfather CAPs, we can address both. But yes, so let's say you're a grandfather at our HC and your finalized rate is $250, that rate is gonna be slowly increasing by the Medicare Economic
Index, right?

Katie Jo Raebel 01:13:04
And every year your cost report is still gonna be important because let's say in year two, you fall below that at 225, your settlement on your cost report is gonna be based off of a rate of 225. If you got paid based off of a rate of 250 during the year, you're gonna owe some money back.

Katie Jo Raebel 01:13:24
In the following year, you're at 275, you're going to look back at that rate of 250 again increased by MEI. So you'll always be compared to that 250 plus MEI as your base rate. Always compare back to that. It doesn't go just because a year before that you were at 225.

Katie Jo Raebel 01:13:46
That doesn't set your cap all over again. I think that's what we're likely referring to with that question.

Sarah Hohman 01:13:53
Super helpful. We're going to have this be the last question. We always have so many questions and never quite the time to get to them.

Sarah Hohman 01:14:02
But as always, I'll look at all the Q &A and create a resource that will be available on our webinars page as well. So give me a little bit of time a week or so to prepare all those and then those will be available on our website. Certainly you can reach out to myself or Katie Jo as well.

Sarah Hohman 01:14:24
But just know that that resource is coming and if you're not sure which direction to go, don't hesitate to reach out to me and I'll help point you in the right direction. But we have time for one more question. So is there a limit or cap on how much administrative time a provider should have?

Katie Jo Raebel 01:14:42
No, I've never seen it be limited. I have not seen that. I don't see anything within the regulations at state that either.

Sarah Hohman 01:14:52
Super helpful. Thank you. Okay, so with that, I just want to thank everyone for attending today's webinar and especially to our speaker for her presentation as well as the Federal Office of Rural Health Policy for sponsoring today's call and all of our RHC Technical Assistance webinar series.

Sarah Hohman 01:15:13
Again, please spread the word about these resources and the availability of these technical assistance resources as well. If you have ideas for future webinar topics, don't hesitate to share those with us as well. As a reminder, you can always reach out to Nathan or I with ideas for these with general technical assistance questions or just for a point in the right direction.

Sarah Hohman 01:15:37
For our CRHCP folks, the CU code can be found when you leave today's webinar and you take the survey. It'll be found right at the end in the thank you of that survey. When we schedule our next webinar, we'll send that out as always and we will, like I said, post some of these follow-up resources on our website in the next week or so.

Sarah Hohman 01:16:00
So that concludes today's presentation. Thank you again, Katie, for being here with us and sharing your expertise as always.

Katie Jo Raebel 01:16:07
Thank you, Sarah.

Sarah Hohman 01:16:08
Have a good rest of your day, everyone.