NARHC Webinar
Monday September 21, 2020
Moderator: Nathan Baugh
Speakers: Julie Quinn & Jeff Bramschreiber

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RHC Cost Reporting During Covid

Nathan Baugh:

0:05
Good afternoon, or good morning, Rural Health Clinic Community.

0:11
I want to welcome all of you to our technical assistance webinar series. My name is Nathan Bond, the Director of Government Affairs for the National Association of Rural Health Clinics. And I will be the moderator for today's call.

0:27
Today's topic is Cost Reporting During Covid.

0:31
And we have some really good speakers, which I'll introduce in a second. But first, I want to tell you that this webinar series is sponsored by HRSA Federal Office of Rural Health Policy and it's done in conjunction with an RHC or supported by a co-operative 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.

0:56
The purpose of the series is to provide rural health clinic staff with valuable a technical assistance, nicely specific information.

1:03
Please help us spread the word about these free webinars by encouraging anyone who might benefit from this information to sign up to receive announcements, to engage topics and speakers that are either the RHI Hub website or the RHC website.

1:20
When we get to the Q&A portion of today's presentation, which we should plan to have a good 15, 20, maybe even more time for that, we will open up a question box to allow participants to type in their questions.

1:40
I will note that as with all webinars, we are at the mercy of good bandwidth for all parties and we all know that connectivity can go up and down sort of randomly.

1:53
So if you have any audio or visual freezes, we suggest refreshing the page and usually, that fixes the issue.

2:02
If you continue to have issues, don't worry.

2:05

This will be recorded, and we will be posting it to both the RHI Hub website, as well as the NARHC website, with links to the slide and transcript.

2:16
So with that, I'm going to introduce our two speakers, get their pictures up for you.

2:29
We have two cost reporting experts with us today. And so really pleased to have Julie Quinn with health services associates. She's the VP of Compliance and Cost Reporting.

2:45
And Julie and Jeff.

2:50
Who I go to and I have really in the weeds questions about cost reporting. So, there are some great speakers. Also in, with Julie, we have Jeff Bramschreiber, who is with .... And ... has been a great partner for an RHC.

3:07
Both these organizations have been great partners for an RHC and we really thank Jeff and Julie for lending their significant expertise on cost reporting two to the artsy community for free, especially in a really challenging year. with ... and all the extra things that we're going to have to worry about on our cost report.

3:32
So with that, I'm going to turn it over to Julie, first.

3:38
Who will handle the first half, and then I think Jeff will handle the second half, and then we'll have a Q&A at the end. Julie?

Julie Quinn:

3:47
Thanks, Nathan.

3:50
What a year it's been, 2020, can you believe? We are now at the end of September.

3:58
Now we get to figure out, what do we do with all these changes with everything that's happened to us this year? We're gonna go through a few, a few things we're going to go through telehealth for productivity standards. Jeff is going to talk a bit about some of the funds that you received and what we need to work on with that.

4:19
First, before we talk about what we're going to do with the individual in the weeds, as Nathan mentioned, issues, let's just back up for just a second and talk about what this cost report does for you, what it means, because we don't understand how the costs are for works. It's difficult to talk about where to put individual calls within disclosure report. If you have ever heard me speak, one of the things you'll hear all through an enclosure for sessions, is this equation right here.

4:49
It all boils down to the RHC world, It is RHC cost divided by RHC visits equals RHC rate, cost, divided by visits, equals the rate.

5:02
Grab ahold of that concept.

5:04
And let's talk about telehealth, where the cost located.

5:09
When you look at a cost report, ABC 1 2 3: on an independent, your cost is only your visits or OMB. You will reach your settlement is on C, N 1, 2, and three.

5:23
Remember, if you're a provider based location, the M series is a chapter within your hospital cost report, but it mirrors what an independent looks like. So, then we can use those terms interchangeably, post visit rate, ABC 1 2 3.

5:45
A is where we put cost. Again, Cost divided by visits, equals R rate. Remember that RHC cost divided by four H C visits, equals R rate.

5:57
When we're developing our rate on Worksheet, A costs are put into 1 of 3 categories. Yeah, or H C healthcare cost.

6:08
At the top, you have overhead in the middle. You have known or AHCA at the bottom.

6:17
Overhead is allocated that middle section of the triangle is allocated on the ratio of health care cost, ... So, the middle, the overhead gets allocated. That's going to become very important.

6:34
That you understand that you don't have to direct allocate overhead and only get to some of these programs.

6:42
if you will allocate the direct cost the overhead allocates itself.

6:52
OK, so then, what do we do?

6:54
I understand.

6:55
Post is on a But where do I put it, you gave me this triangle.

6:59
Julie said, Health care costs is at the top, overhead is in the middle. Node RHC is at the bottom.

7:07
Here's how it works. Telehealth only carve it out, it goes in a non RHC Cost Airlines, 79 3 independent 125 for provider based.

7:19
Excellent.

7:23
They clarified this, there is no ambiguity here.

7:26
Calls for furnishing distant site help telehealth services will not be used to determine the RHC, OK, Great.

7:37
Or the FQHC PPS rate, it must be reported in the appropriate culture for non reimbursable call centers one in seventy nine on a provider based to settle.

7:51
OK, so you've got the cost.

7:55
Do I pull the cost of telehealth down to the bottom of the trending ... call center?

8:02
Or do I excluded, do I just pull it off?

8:06
This is a decision that we make with any nor it she cost.

8:11
When you're looking do our reclassify or do I exclude?

8:15
You always have to ask yourself, doesn't deserve an overhead allocation, should remember, overhead will allocate itself based upon the amount that you leave in health care call centers and the SQL centers.

8:31
Next slide.

8:33
So for telehealth, if you're using as most telehealth activities or you're using the clinic's EMR, you're using Bill or as you're using front desk referral co-ordinators, you're probably going to need to reclassify the direct cost.

8:52
If telehealth visit, if you're one of those small providers where, Hey, we just shut down our clinic and these providers like home and they did the telehealth from home. We didn't even have nurses setting it up for them. We just gave them their schedule and they handed it from there.

9:09

Then, in limited, in limited situations, you might find it more appropriate to do an exclusion. You're really going to have to discuss that with the culture for expert.

9:20
It really comes down to, does it need overhead? Did you use the water? Did you use the lights? Did you use the front desk?

9:29
Again, limited overhead, we might be able to do an exclusion, but for most telehealth activities, we're going to request by direct cost.

9:38
OK, so what does that look like?

9:41
Again, only allocate the direct cost.

9:45
The practitioner, obtain the clinical support staff wages because overhead will allocate to your cost report.

9:57
Couple ways you can do that. Again, we're calculating the direct expense to allocate to the telehealth call center to that non reimbursable costs there, to pick up overhead.

10:10
one way you can do it is you kept time studies.

10:13
Actual time spent the practitioners kept time studies.

10:17
You know, how much time it your clinical staff, if they were the set for your practitioner, some Linux had the nurses do the initial part of the pulse and did not, Then you're going to allocate percent of those people's salaries down to the Telcos there.

10:41
The next slide is an example of one such tool.

10:45
This is one that we have our providers using, or telemedicine.

10:50
Tell me how much time you spent doing it, then we can do the program on the ocean.

10:59
If you didn't keep term studies, you just were too busy, just keeping it, just get into, OK, they didn't get their stand, it. Nobody really knew what to do for quite a bit of time, when this first came out, then, we're going to do the best we can. We're going to get close. We're going to use a method, possibly, where you run CPT codes.

11:23

And, you know that in the definition of CPT codes to injury approximates 15 minutes to ensure approximates 25 minutes, you go through that exercise.

11:35
You can also use that to approximate your telehealth chai.

11:42
To calculate the practitioner and other clinical staff wages that you want to raise that you want to move down into a non reimbursable call center.

11:56
OK, so, we classified the cost, they will cost divided by visits, equals our rate.

12:06
We hit the cost where it needs to go, we put the direct costs down in the reimbursable cost center, the overhead allocates itself.

12:15
Then we have to call divided by visits.

12:19
We just took the telehealth cost out of our RHC cost.

12:25
So we'd have to take the telehealth visit out of our RHC visits.

12:31
Because, in this equation, in the end of it, we want alright, she calls divided by RHC visits, and CMS has told us telehealth is something else we're not.

12:40
It is not going to be paid within the all inclusive rate.

12:45
Cost, Now, we're going to pull out visits. Remember, visits or a face-to-face encounter.

12:50
Qualified provider during the RHC services are performed because telehealth is paid outside of the rate telehealth visit or no reported as a visit.

13:02
Oh, Worksheet B or into.

13:08
If you make a stop at Worksheet B, it's important to mention that post divided by visits, That visit is subject to a minimum.

13:19
And Jeff's gonna get into that and talk a little bit more about that, but let me tell you how that minimum is calculated.

13:24

It's based upon FTEs, FTEs are not warm bodies, their full-time equivalents. If you have two people that each work 20 hours a week, that's one FTE.

13:37
If you have two people, one is in the office 20 hours a week in Linda's telehealth, 20 hours a week. That's zero point five because till it is paid outside of the rate.

13:47
Therefore, the hours doing telehealth do not count toward the FTE calculations.

13:54
Exclude telehealth time from your RHC, FTE calculations.

14:05
If, after carving out the telehealth hours, you still have coded related FTE productivity standard issues, contact each, one of the max has indicated their intent to waive the Productivity Standards for 2020, when requested. Make sure you tell them that the reason that you are requesting it is due to coded due to telehealth due, to not being able to see, to do to lower volume, due to coding.

14:32
But it's not necessarily not necessary that we just all know do that right now.

14:38
I'm not sure without getting into each clinic as the founder of art.

14:45
Our company used to say Run Nelson. The RHC, if you've seen one RHC, you've seen one or H C. Each rural health clinic is different. You know, which way you look at it. It's gonna have different productivity. It's going to have different issues.

14:59
So I cannot just blindly say, hey, everybody's going to have productivity standard issues today. I don't think that's true.

15:07
I think once you pull out the visits, and you also pull out the FT E time, I'm just not sure that you're still going to have it.

15:17
But if you do, if we come to the end and you do your Do your calculations, and you still are not making a productivity standard, go to your bank, Give them a request to waive the productivity standards. You can do that with your cost report, and they have all indicated their intent to weight the productivity standard, CMS's district and then also to consider that when looking at these cost reports.

15:48
OK, we then visit region cost remember we pulled out the Telehealth.

15:54
Put it down in a non reimbursable call center, let the overhead do its thing. Went to worksheet B into Visits we make sure our telehealth visits were not in there because we have to go to visits out.

16:09
We did our FTE calculations on, in this time, or in nursing buntine only, made sure telehealth time was that in there.

16:18
And, again, if we had a productivity standard issue, we're gonna, we're gonna ask for an exception to because we did visits.

16:26
Now we're looking at Worksheet C, which is where the rate is.

16:29
What's the rates calculated, that when you pull up here sooner, which is a provider statistical assembly report.

16:37
It's Medicare's claims summary report.

16:41
You put those inputs into the pulse reportage. It's similar to the concept of a tax return pillows.

16:50
one of the things you can do is use your peer center as a check to be sure this year they included the telehealth visit somebody.

17:00
Speaking to my colleagues before this call, we, we are working with CMS right now. We suspect that some of the earlier telehealth visit that will build with E CG, 95 modifier had gotten onto the PS and ours that we are going to work.

17:20
Your work is going to work with CMS and with the max to ensure that we get these piercings cleaned up.

17:28
Um, also, in the last bullet, stay tuned.

17:32
Because right now, the current RHC caution for weight is currently the way it currently works. It cannot handle fiscally claims where the co-insurance has been waived. So, we expect some changes to worksheets, see worksheet in three of the cost report. There. There has to be some changes made or because right now, the way it currently sits, the RHC Cost Report can't handle co-insurance. We're kinda claims.

18:03
And that's all that I have.

18:04
I'm gonna pass it over to my colleague, Jeff, to take productivity wavers, and take us all the way into all of the nice funding issues.

18:17

Jeff Bramschreiber:

Wonderful. Thanks, Julie.

18:20
What I'd like to start off with is, just a discussion, a further discussion, on the productivity, and the productivity waiver process.

18:29
In terms of, you know, as Julie mentioned, previously, the Rural Health Clinic Productivity Standards are used by CMS to limit rural health clinic reimbursement for clinics, who have relatively low volume of patient visits in relation to their staff.

18:46
Since the rural health clinic reimbursement is calculated based on the formula of cost divided by visits, a low volume of visits in that formula would result in a higher cost per visit, and therefore a higher Medicare reimbursement.

19:05
If, however, if actual visits are less than the productivity standard, the amount that CMS has determined practitioners should be seeing, CMS will substitute the higher productivity standard visits in that calculation of cost divided by visits.

19:22
So if your actual volume was lower than the standard, you substitute the standard in the calculation of cost divided by visits.

19:31
You'll end up with a lower cost per visit, determination, and essence a lower rural health clinic reimbursement, then your actual cost per visit is.

19:47
This has always been an important concept for rural health clinics, but it's even more important this year, since in during the public health emergency, in many clinics, the product, the volumes drop dramatically. So therefore, that difference between the productivity standard as and the actual visits might be much greater this year than any other year. You can, as a rural health clinic, request an exception of the productivity standard. This reset exception is granted by your Medicare contractor, and that's at their discretion. It's important to know that each Medicare contractor has their own requirements around submitting a request for an exception to the productivity standards. So just recognize that it's your Medicare contractor that sets the requirements and it's your Medicare contractor That makes the decision whether or not your clinic is able to take advantage of a waiver.

20:47
We look for an example National Government Services MGS has on their website, some criteria for their request for a waiver.

21:02

In their information, there are example requests at least four different items of information including hours of operations, your provider FTAs, which again, Julie mentioned should exclude that telehealth time number of actual visits.

21:21
Then finally, the productivity adjustment that's being requested.

21:28
Your individual contractor might request some additional information. We've seen some requests regarding an explanation of provider staffing.

21:37
Whether or not staffing levels were adjusted during the year, if the Rural Health clinic has added new practitioners since the previous year. So there may be some additional information if you're a Mac as some someone other than MGS.

21:49
Our suggestions are plan to submit that request after the cost reporting period. So you have the information available to determine whether or not you even need or want a waiver.

22:00
And if you're going to submit that request, we suggest that you submit it at least 60 days prior to the due date of the cost report.

22:07
So for those of you who use December 31st as your year end for cost reporting purposes, you should submit that request for the waiver, if you're going to ask for one by March 31st.

22:21
As you're accumulating your information, it's important to understand whether or not you actually need a waiver. So if you're comparing your FTEs, your productivity standard in your actual visits, if you don't need a waiver based on your lower FTEs, for example, then there would be no need to actually request one.

22:41
You also could request an adjustment to the productivity standards, and not necessarily a blanket waiver, as well. So, you may suggest that the, that the productivity standard be reduced by a certain percentage based on your experience.

22:55
Just recently, we had a client submit a waiver request for their year end, which happened to be March 31st. They submitted that request on August 31st, and their approval was granted by WPS on September third. So very quick turnaround time. Surprising to us, I would suspect that turnaround is, is going to be longer, as more and more organizations start to submit request for waivers. But, at least in this instance, the Mac was very timely and responding to the request of the providers.

23:33
I'd like to talk a little bit about the HHS Provider Relief Funds and the PPP Loan Forgiveness Program.

23:45
The key question that has been uncertain for quite some time was how the Provider Relief Fund Payments, or the Paycheck Protection Program loan repayments received by rural health clinics would be treated on the cost report.

24:03
The key question was whether or not costs would have to be offset by, Those funds received us, provide a relief funds, or by the PPP loan forgiveness.

24:15
And, and really the question is, could we use the same payroll cost in obtaining the PPP lawn.

24:22
Loan, forgiveness, as allowable costs on the Rural Health Clinic Cost Report. Because, essentially, if we're able to do both, there's almost a double benefit for those costs.

24:32
So we could, on one hand, use payroll costs to obtain PPP, loan forgiveness, and the benefit of that loan forgiveness. And then, also, could we use those same costs on our Medicare cost reports and receive reimbursement for those costs?

24:51
Well, as recently as next slide, August 26th, we received clarification on both of those issues.

25:02
The, in the Frequently Asked Questions, there are actually two questions regarding the Provider Relief Funds and the PPP. First question was regarding the Provider Relief Funds and the answer, whether or not we needed to submit or offset expenses on the Medicare Cost Report. The response was No, which was really a great response to what we're looking for. That, Even though you, as a rural health clinic may have received, provide a relief fund payments, you did not have to use that revenue to offset your allowable costs on your cost report.

25:42
Similarly, the Small Business Administration, which manage the Paycheck Protection Program. Also, a response was that, no, we do not have to offset those costs associated with the PPP loan Forgiveness on the Medicare Cost Report. Again, very good news, on the part of the provider community, since we can now include those expenses, essentially, for two purposes, one for the PPP loan forgiveness and the other as a reimbursable costs on the Medicare Cost Report.

26:22
So while we got great news, in terms of the cost reporting treatment of those costs, there are still some unanswered questions, or at least some ambiguity, The first is, how well individual state, Medicaid programs treat both, the Provider Relief Fund payments and the PPP loan Forgiveness early on. We had some indication, from some state Medicaid agencies that they were going to require an offset of those expenses, But we don't know what the final treatment is in every state. However, it is important to just recognize that.

26:56

Your State Medicaid program might treat things a little bit differently than the Medicare Program, and we'd recommend that you stay tuned to information from your state Medicaid programs on how those payments will be treated as you prepare any state Medicaid cost reports.

27:16
The other question is, Can the same costs be reported as allowable uses for provider relief fund payments, as well as allowable costs subject to Medicare reimbursement on the cost report?

27:30
No, since Medicare has stated that the costs associated with the PPP loan forgiveness can essentially be used for both purposes, the PPP, and the Medicare Cost Reporting.

27:40
one would think that the same concept would apply to the Provider Relief on Payments, so that you could use costs associated with the use of the Provider Relief Fund payments as allowable costs and New Medicare Cost Report. And report those same cost as your allowable uses of those Provider Relief Fund payments.

28:04
However, when we look at some of the documentation as it currently exists, in particular, this HRSA website has documentation on the rural health clinic testing, Targeted Relief Fund payments.

28:17
There's some ambiguity, and we're really hopeful, hopeful that we're going to get a little bit greater clarity around treating costs bulk from our reimbursable costs on the cost report, as well as a allowable use of those funds for any reporting that might be required to HRSA or HHS.

28:39
If we look more closely at some of the information on the HRSA website regarding the rural health clinic testing Program, it seems to indicate that there's a restriction on reporting costs in multiple locations. Either on the cost report as a reimbursable costs, as well as I use in under the terms and conditions.

29:01
While we don't believe that that's a current than 10, based on some of the recent guidance provided for cost reporting, we'll certainly welcome better clarification in the not too distant future.

29:15
Nathan, do you have anything to add to that?

Nathan Baugh:

29:19
Sure.

29:19
And, and this, as Jeff's is alluding to, this is a bit of a gray area. We have alerted the government that we believe that this is a gray area and therefore, that we could use additional clarification.

29:37
But I am comfortable saying this is Nathan Baughs opinion, so take it as you will. I am comfortable saying that if you use your particularly or testing fund money on things like doing specimen collection and or purchasing test kits or reagents or things like that that that is going to absolutely be allowable. And if the government comes out and somehow says, oh, well we we wanted you to use this money for testing, but actually you guys are gonna get in trouble for using it for testing, we will fight that.

30:24
So if they, if they somehow ruled that you're spending the testing fund on testing is not allowed, then we would escalate the issue and to get it resolved.

30:38
So I feel pretty confident that you can, you know, take the testing fund and spend it on testing without fear, that, because it might be also considered an allowable cost that that was actually an inappropriate use of, of that fund, I hope, I hope that's clear, But happy to take questions in the Q and A when we get to that.

31:03
Jeff?

Jeff Bramschreiber:

31:04
Yeah, Thanks, Nathan, and I appreciate your insight on that. You know, we're, we certainly are hopeful that there's going to be additional clarification around how to report those funds and in particular, switch to the next slide. The additional reporting requirements around the use of the provider relief funds was just released over the weekend.

31:30
So on September 19, think that was Saturday, the Provider Relief Fund Data Reporting requirements was released. Now we have been waiting since August.

31:43
We were told initially that the data reporting requirements would be released on August 17th. As we approach that date, HHS came out and said, No, we're not going to be able to release them on the 17th. They will be coming soon.

31:59
We've been waiting certainly anxiously to be able to get an understanding of what the reporting requirements will be, and then, like I said, over the weekend on Saturday, September 19th, that information was released in the, in the slide itself as a link to the particulars around the provider. Relief fund reporting requirements.

32:20
A couple of things to note, Number one, instead of the reporting portal opening up on October first as was initially intended, other reporting requirements will be available or the reporting mechanisms will be available in early 2021. So, sometime early next year, you'll have the ability to begin to report information related to the use of provider relief fund payments. Any provider

who receded who received in excess of $10000 in aggregate of all of the provider really fun payments is required to report into HHS on the use of their provider relief funds.

33:05
So most all organizations that receive funds through HHS will likely need to report that information.

33:14
Again, beginning in 2021, the document that's referenced here has a fair amount of detail, in terms of the required reporting components, the elements that are being asked to be reported.

33:28
But it's important to recognize, also, that this reporting, these reporting requirements, do not apply, do not apply, to the rural health clinic testing distribution. So, most rural health clinics, however, did receive disbursements through the Provider Relief Funds back in May. I believe many organ to many rural health clinics got at least $100,000 of initial funding, and, and it may have been even more than that initially in addition to the Rural Health clinic testing distribution. So, most RHCS will have received an excess of that $10000 And we'll still have to report even now, this doesn't include the testing component. That'll be a separate reporting requirement.

34:14
The, just, you know, just keep, keep in tune with what the reporting requirements are. I'm sure we're gonna learn more information and more details about that in the coming days and weeks and months. And maybe even some changes along the way, but just be aware of the fact that there are at least some reporting requirements coming down the pike.

34:36
Last thing I wanted to touch on is on the Medicare cost reporting deadlines. And as most of you are aware, all well aware, the due dates for cost report had been extended. So beginning with the October 31st, the cost reporting year ends, those due dates were pushed back several months so that we had much later deadlines than what we typically would have in the past.

35:03
As of right now, no cost reporting years beyond, February 29th of 2020, have been extended for with the deadline. So, we're back to, as far as we can tell for the foreseeable future, we're back to the original reporting deadlines for cost report. So, if you're a calendar year N, anticipate your reporting deadline to be May 31st of 2021 as it normally would have been.

35:31
But just a couple of words of advice in terms of preparing for that cost reporting, as Julie mentioned.

35:36
There's gonna be a little bit more work involved with not only calculating your full-time equivalents, confirming your visit statistics, making sure that you're not including those telehealth visit, Senior Total encounters, reconciling and verifying your Medicare claims information off of your SNR and doing some of that cost allocations for your telehealth visits. That's all going to take more time. So, I think now more than ever, we encourage all rural

health clinics to get a head start on your cost reporting. So that you have adequate time to make sure that the data you're putting down in your cost report is accurate. And also make sure that the information you're getting from Medicare on your SNR is appropriate as well. So, we encourage people to get a head start on the cost reporting. We also encourage people to file their cost report in advance of their due date. Ideally, you'd want to file your cost report 30 days in advance to give the mac a chance to review your submission, and if there happens to be something missing, or they need additional information, you've got adequate time and you're not going to miss the deadline for filing your Medicare cost report.

36:46
So that concludes my comments. Nathan, I'm turn it back over to you.

Nathan Baugh:

36:52
Thank you very much, Jeff and Julie.

36:55
I know cost reporting is very wide and deep topic. So, I asked Jeff and Julie to leave a lot of time for Q&A. And right now, we should be, Cate, if you can help me, there should. Yes.

37:16
There should be the ability to type in your questions into goto Webinar and we will try to verbally get through as many of those as we possibly can.

37:30
I've included Jeff and Julie's contact information on your screen. And for those of you who are looking for the CEU code, the CEU code is 942TW.

37:45
The first question that I have is actually a question that I got e-mailed to me earlier today, which I haven't responded to yet. But I would like to turn this over to the cost reporting experts.

37:55
And it was a clinic who mentioned that they receive a significant amount of money every year, and at donations.

38:07
And noted that. And that makes up a good chunk of their revenue, noted that because of ... donations were down significantly that year, or this year, they were wondering if that would, if they would be able to claim that as lost revenue.

38:25
Jeff and Julie, to either of you, have thoughts on that one?

Julie Quinn:

38:28
I would say they kinda lost revenue, is going to be things.

38:35
And honestly, it really never went into the calculation to begin with, so it really shouldn't change.

38:42
The way, again, cost divided by visits equals your rate.

38:45
It shouldn't change already, because it never went into the rate calculation, right bucket,

Nathan Baugh:

but can they use the Provider Relief Fund money for that lost revenue?

Julie Quinn:

38:59
I will let Jeff take it.

Jeff Bramschreiber:

39:00
Yeah, I can take that one. So, the provider really fun money there. There are permissible uses for the treatment of, of Coronavirus patients, or prevention of, for antivirus or, or help, you know, Health care Services. Some of those costs associated with that. And then there's also a category of lost revenue.

39:21
And everything I've seen, the loss revenue calculation, has been based on net patient service revenue, which would not include those types of donations from the community.

39:32
So, I do not believe that that reduction in, in donations would. We would count as a reduction in that patient service revenue. However, when I look at the new reporting requirements, there may be a little bit wider view of some of those changes in financial position that might go into that. So I would generally, I would have said before looking at those reporting requirements today, I would have said. no, absolutely not.

40:04
Now, as I read some of the reporting requirements, it may be possible that organizations might be given credit for reductions in donations like that because of the pandemic. So I'd say, I'd point to the reporting requirements and looking at whether or not there's an opportunity to, to address that in those new reporting requirements that came out this weekend.

Nathan Baugh:

40:28
And I'll just add one thing to that on lost revenue.

40:33
I've been told that the government is going to come out with him more specific formula and rules around what constitutes lost revenue. So, like a lot of these things, more clarification is likely coming and likely needed.

40:51

So, with that, can I start getting into the questions that are being typed in right now?

40:58
The first question is from ...

41:00
Owen, who asks, Can you review the timing for the RHC waiver on Productivity? Is it 60 days before cost report filing? So, when, when do you file the waiver on productivity?

Jeff Bramschreiber:

41:18
This is Jeff. I'll just address it, and I know Julie is gonna offer some comments, too, but it really depends on your Mac.

41:25
Some Macs have said they requested that information 60 days prior to the due date of your cost report.

41:33
Other mack's do not have a deadline, such that you could request the waiver with the submission of your cost report.

41:42
Personally, I think, even if your mac. doesn't require that 60 days prior, I would try to get a waiver request in before submitting your final cost report, and so, with the idea that you could get your waiver request acknowledged prior to submission of the cost report and prepare your cost report in that way.

42:06
Julie, comments?

Julie Quinn:

I agree. I agree with Jim. You're gonna have to look and see what your mac requirements are.

42:11
I have seen some Macs actually, say, You can submit it with your cost report. So, there are some, that just, are taking a very liberal approach. And I do think that, in this year of ..., we will get a lot more latitude, then we will, in the future, or then we have in the past.

Nathan Baugh:

42:34
Great, thank you guys, Next question is from Coleen Nolin, Oh, who asks?

42:46
Can we use ...

42:47
funds for self insurance patients That were seen and tested on covert.

42:55

I'm gonna say Coleen here, when you ask these questions. The term, RHC Fun is not specific enough.

43:06
You need to really refer to which allocation you're talking about asked for us to give the most accurate answers. But let's just say, for the sake of argument, she's talking about the RHC Testing Fund.

43:26
Can can they use that fund on self insured or are basically self pay patients?

43:36
Jeff or Julie?

Julie Quinn:

43:39
I believe that you can use it on all payer types. But Jeff may be able to weigh in a little more on that.

Jeff Bramschreiber:

43:47
No, I believe you can, as well, I was just looking to see, I believe, that there is an FAQ on that particular question on the HRSA site. I don't have that here in front of me, but I believe that there is a question that answers that affirmatively, that you couldn't use those funds for uninsured patients as well.

Nathan Baugh:

44:13
Millimeter. Hmm, I would agree.

44:16
The only nuance that I would throw out there is that if you're signed up for the program, that pays for covert tests for uninsured patients and you're getting reimbursed through that program.

44:31
That's when the funding falls into the gray area, because you are technically being reimbursed.

44:41
So if you're not signed up for that program, you're not being reimbursed, buy a pair for the service, then absolutely. You can use the testing fund for that. All right, moving on.

44:56
Next question is from Tom, for Thibeault, who asks, if you do receive an exception to the productivity standard from your mac, how would that be reflected in the C R cost report, Will that will there be an update to the cost reporting software?

Julie Quinn:

45:15

Right now, this is Julie, just. It's already set up to do that. There is already a mechanism to do that within the cost report.

45:25
You can actually edit the productivity standard fields.

Nathan Baugh:

45:35
So you think that most software already has that functionality.

Julie Quinn:

45:40
I'm opening up one right now, just to issue. Yes. So I have one open just right here in front of me right now, Sue.

45:47
In looking at an independent worksheet B column three, productivity standard is an open input code. So if you needed to get an exception, if you have an approved exception, if you were applying for an exception, you can actually change the 4200 to a different number.

Nathan Baugh:

46:10
OK, perfect.

46:12
Next question is from. Go ahead. Jeff. Do you want to add?

Jeff Bramschreiber:

Yeah, I was just going to comment on, This is not a new concept, though, entirely, the waiver of the Productivity Standards. It's always been an option to request a waiver. Certainly, there's going to be greater accommodations for those requests this year, but, we've had clients over the years, whether they are located on islands, for example, or because of changes in their organization, where they've requested waivers or adjustments to the productivity standards, and we're able to accommodate that with their caught in the cost report software.

Nathan Baugh:

46:46
Perfect.

46:48
All right.

46:48
Next question is from Sam Nyima who asked a new loss or states. The new lost revenue for Cares guidance on Saturday said that they can only use it for NPSR. I'm not sure what NPSR stands for patient service revenue, OK? Perfect.

47:10
Do you agree with Sam's assertion here?

Jeff Bramschreiber:

47:14
Yes, I do.

47:17
So, the loss revenue calculation, at least in my view, has always been based on a net revenue calculation, not gros. So gross being charges.

47:28
Net being charges minus adjustments equals net revenue.

47:33
And, when we look at the reporting requirements to date. It's been the lost revenue calculation has been based on that. Net patient service revenue, so yes. I believe that's the way it has been treated in the past than that.

47:48
Here's how it would be treated and the reporting going forward.

Nathan Baugh:

47:52
Perfect. Julie, anything to add?

Julie Quinn:

47:57
No. I think both of these gentlemen are right on point.

Nathan Baugh:

48:03
Perfect.

48:05
Christie Stahl asks, Can you clarify again on the PPP loan funds?

48:11
If we use this for payroll, we can or cannot claim that cost on the Medicare cost Report.

Julie Quinn:

48:21
I would say, yes, you can, and need clarification that has come out recently saying there's no offset required. It was an allowable cost before it's an allowable cost now.

Nathan Baugh:

48:34

Yep.

48:35
Receive twice straightforward. And that's, and that was the good news. We were fearful that it wouldn't work out like that.

48:44
But that was the, the good news and the the recent guidance that, that we are allowed to still claim that payroll.

48:56
All right.

48:56
Next question is from John Kabbani, who said, Is the due date for the productivity standard exception of 60 days prior to the cost report deadline a set ruling by CMS?

49:09
I was told that the exception could be claimed when filing the cost report and will be reviewed by the mac during the cost report desk review process. I want to be sure that I requested exception in time, so that it is ultimately approved, needed. I think we already answered this, but, which is basically, you gotta check with your Mac. Right?

49:26
All right, OK. So, you gotta check with your Mac, we can't say, exactly. It's not set by CMS set by our Mac, So, that's that's the answer, John.

Julie Quinn:

Just as a side comment, it's none of these slides.

49:41
But, um, hopefully, you guys are all signed up for the dark ... newsletters. And in the summer newsletter, I was able to put several of the mix, their contact information and how they're handling the Productivity standard waivers.

50:00
The e-mail box it goes to, so if you want to go out to any RHC onto their website and get ahold of that summer newsletter, it has several of the max and how they're handling it in what mailbox it goes to and who to ask these questions to.

Nathan Baugh:

50:20
Yes. Perfect. Thank you. Thank you for.

50:23
Thank you for that, Julie.

50:25
Christie, I don't want to skip over you, but I'm not sure what you mean by what this also apply for any HHS funding we receive for cost reimbursement.

50:36
Perhaps you can e-mail me or Jeff or Julie.

50:41
If you if you have a more specific take on that unless Jeff or Julie, do you want to jump and I'm I'm not sure what exactly what she means.

50:53
OK, moving on, Some clarification.

50:56
Yeah. Next question is from Kay Ludwig.

51:01
What if we did telemeter visits from the clinic as in the doctor was in the clinic or in the clinic?

51:09
staffer in the clinic, and the patient was at home? Does that change how you treat it on the cost report?

Julie Quinn:

51:17
I think if you're in that situation, remember, we were talking about the decision tree we had.

51:23
We had to make a decision whether we wanted to reclassify cost because overhead needed to be captured. This is a situation where there is no ambiguity. You are going to have to reclassify direct cost down into that ... center and let it pick up a bit of the water in the lights, the great green electricity, these kinds of things.

Nathan Baugh:

51:46
Perfect.

51:47
I think that's pretty clear. Next question is from Michelle Kane.

51:52
The states that we're, we're paying extra for our software in order to provide video visits. Are we able to report those expenses on the cost report?

Julie Quinn:

52:03
Yes.

52:08
You're when, you're one of my people, so you can reach out directly to me, and it will work with you on what we need to do to get that done. There.

52:16

Short version of that is that IT costs are gonna go in the middle section. If you're thinking back on that triangle, it's gonna go in the overhead section.

52:26
In my opinion, we have to just really dig down into, boom, into what you bought it for, a fish. We really feel like it's a direct cost over to overhead crossing, probably going to tweak it as an overhead cost and allocate.

Nathan Baugh:

52:43
Perfect.

Jeff Bramschreiber:

I agree with that.

52:44
And that's a good distinction, Julie, in terms of when you get into trying to account for things that are not considered RHC, cos you really have to focus on the directs and not so much on the indirect or the allocations because that allocation would be done generally inside, done automatically through the cost report.

53:04
So what you're really trying to track is all of those direct costs, and I agree, the IT element.

53:11
It's generally considered unallocated.

53:15
Indirect cost, and therefore doesn't have to be accounted for separately.

Nathan Baugh:

53:21
Excellent.

53:23
Glenda states that one webinar because it, they thought replacing carpet with Tile would be a covered covered expense. What are your thoughts? I'll chime in first here. This, this absolutely word count. It's under one of the categories of the Testing Fund, which is retrofitting your facility. Now the the gray area here, though.

53:52
It would be let's say you're 25% Medicare.

53:59
Retrofitting your facility from to change it from carpet to Tile. Would that be considered an allowable cost? Jeff? Julie?

Julie Quinn:

54:09
Sure, Yeah, Yeah, What we're doing here is that to this concept, ABC went to theory.

54:17
You're talking about A, When you're talking about, can I allow it?

54:22
Is an allowable cost. You basically are asking yourself, is this related to patient care. If it is part of you doing business as a patient care facility, then it goes in a one, right? And then, you get over to see, that's when the split between Medicare and non medicare happens, but when you're talking about Can it be a cost. Just Think of that first That top, that first part of the equation. Can it go in the cost piece of that equation? Yes?

Nathan Baugh:

54:55
Right. But, OK. So, here's the gray area, though. Because it can go in that cost area, Medicare will essentially partially reimburse.

55:05
The clinic for that if you're, let's say, 25%, Medicare, you meet the productivity standard and your uncapped then, Medicare covers 25% of your allowable costs.

55:18
And so, the gray area is because Medicare is reimbursing you for that cost, can you use the RHC testing fund for that given that all the FAQs on the RHC Testing Fund say that you cannot use it for something that would otherwise be reimbursed by a payer?

55:43
Right.

55:44
This is the gray area.

55:46
Because also, in our FAQ, it says that if the expense or the service is not billable, it's not an RHC. It doesn't generate an RHC claim.

56:03
Then you can use the funds to cover those costs. So, the guidance is a bit conflicting on it.

56:13
And so, this is the area that we're trying to get.

56:17
Clarity on by the easiest and easy way to think of it is that if, let's say, you are 25% Medicare, and you're 75% other payer, then certainly 75% of the cost of swapping out your carpet for tile would be covered under or you could use the RHC testing fund on that.

56:42
So again, nuance caveat added.

56:46

Potentially needs more guidance.

56:48
I think you're OK to do it, and if the government ever said that you wouldn't, we would fight it.

56:59
All right, so with that, hopefully that's clear Glinda, feel free to contact me if you want to discuss that more.

57:09
Next question is, again, from Kayla, do we exclude costs and visits from the cost report.

57:13
If the telematic visits were performed in the clinic? I think Julie already answered that. But do you want to just clarify real quick idea, because maybe I wasn't, I don't think a ticket for exactly that, I am sorry.

Julie Quinn:

57:29
Um, yes, because we're going to exclude it from both. So we're going to take cost out an, A, on a worksheet in one. We're going to take the visits and B into so that it doesn't go into the end result. It goes out of both places. We wanted our cost and we're going to pull data visits. You remember to pull it out of your FTE calculation as well.

Nathan Baugh:

57:56
OK, perfect, thank you.

57:59
Next question is from Jodi Ricklefs.

58:02
He says, Can you use the testing or the funds for costs associated with enhancements made within the electronic health record?

58:09
These enhancements would be related to screening questions, and an office visit templates associated with covid patients.

58:17
If the RHC clinic directed patients required requiring testing outside the RHC, um, I don't know Jeff or Julie, I don't know if you guys want to weigh in, But I know what my answer is.

Jeff Bramschreiber:

58:34
I would love to hear your answer, Nathan.

Nathan Baugh:

58:39

I'm gonna go ahead and say, yes, that this is appropriate, if you, for example, Aren't doing testing directly yourself. You're not doing even specimen collection.

58:52
But you are advising patients on whether or not they should go to another entity and get tested.

59:03
And you are doing screening, when you talk to patients, et cetera, that would be considered an appropriate use of the funds and any sort of EHR enhancements that are related to helping you do that screening, I would consider allowable.

59:26
Now, what this, I think this doesn't mean is that you can just go, get all these other enhancements on your EHR, that aren't really related to screening or covert testing.

59:44
Those probably wouldn't, You couldn't use the testing fund for, but if you can with a straight face, say that, no, this is helping us do covert testing or do covert screening, Then I would say, I think you're OK.

Jeff Bramschreiber:

1:00:01
So, I think, I agree with you, Nathan, and clearly the obligation on the provider is to be able to, yeah, you know, substantiate that and provide your rationale.

1:00:13
And if you've, to me, I would think if you've got a reasonable approach and can justify that, that enhancement is compliant with guidance from the CDC, for example, or other appropriate measures, I would certainly think that that would be an allowable use.

Nathan Baugh:

1:00:36
Perfect. All right, the next question is from Jill Mcclung. She says, she asks, Do we know if any periods ending after 2-29-2020, will have cost report? due dates extended?

Julie Quinn:

1:00:52
I don't think they will.

1:00:54
Leave recently, just kinda tested the waters on affordability cost report. And did not get an automatic extension. They wanted to know why, when you're just forms out, said that they have to take it to CMS for approval, even quoted the fire flood necessity for an act of God.

1:01:15
So I don't think so.

Nathan Baugh:

1:01:20
OK, Perfect.

1:01:24
Then data Asks, If we can clarify the lost revenue calculation again did we

1:01:31
Clarify that a first time.

1:01:32
Is there as calculation out there specifically for lost revenue or could you calculate it different ways?

Jeff Bramschreiber:

1:01:41
So yeah initially you could calculate a different way.

1:01:45
So when the initial guidance came out for determining of the extent of provider relief fund payments and the lost revenue calculation was described, providers were given a number of options. It could be a year Prior, you know, current year prior year comparison. That was one option. It could be a current year to current year budget comparison. That's another option. And then the door was open for any other reasonable approach.

1:02:19
In reviewing the Lost Revenue reporting requirements, though, that came out over the weekend, really, it, the loss revenue references are made too.

1:02:33
Calendar year comparison current to prior year.

1:02:37
And at least in my initial review, I do not see the level of, of flexibility in reporting other measures of lost revenue, such as current to budget or other reasonable methods.

1:02:55
So, again, I would, I apologize a bit. I mean, this information just came out over the weekend. We really haven't had a lot of time to vet the requirements. And I suspect there will be some additional clarification, but it would seem that the lost revenue calculation is actually a little bit different in the latest information that came out over the weekend than what information had been communicated earlier in this whole process.

1:03:27
More restrictive. Yup.

Nathan Baugh:

1:03:29
And just, I know that we're at 3:04 here. We usually go, I should have said this earlier.

1:03:34

We usually go maybe to about 315, or until questions ran out, we only have three questions left. So if you do have a question, get that in now, and we'll try to get to it before 315.

1:03:50
The next question is more of a statement from Ralph, and it's right on on this topic. So Jeff, I want, I just want to hear your thoughts, he says Nathan just turned out that the definition of lost revenue has changed over the weekend. 9 19 reporting requirements now considers the lost revenue as a negative charge, and year over year operating income.

1:04:13
So once that patient revenue is identified, the healthcare expenses are identified to determine the net operating income, very confusing and complicated. Expect this to reduce the amount of funds to be documented to be used on lost revenue. Also, lost revenues cannot be claimed in first reporting per the updated guidance. Jeff, do you agree, does that make sense?

Jeff Bramschreiber:

1:04:40
Sorry, I don't disagree. I agree, question is, does that make sense?

1:04:47
Might be different in terms of whether it made sense that they changed the definition of lost revenue. Personally, I don't think that makes any sense, that that definition would change from previous guidance that was issued to these reporting requirements.

1:05:02
Um, I don't think this is the last, we're going to hear from the reporting requirements, any, throughout this entire process.

1:05:13
Things have changed considerably from the beginning to the end, and so I would expect that there would be some changes made in that particular area in terms of reporting lost revenue. Simply because it is different now than what it was explained to what it was intended previously.

Nathan Baugh:

1:05:38
Perfect. Thanks, Jeff.

1:05:39
Next question I think is, for me, from tracy paz who said, What does that also apply to changing cloth cover chairs to vinyl?

1:05:50
Basically, everything I just explained on changing your carpet to tile. Yes. Yes.

1:05:57
It's definitely related to covid, because it's something that you can now claim, which is better for your patients. Reduces transmission.

1:06:09

it would be considered an allowable expense, uh, so you do have to consider that the gray area is that the Medicare would pick up its share of that allowable expense, but private payers don't pick up that share.

1:06:26
So certainly that err of the costs of upgrading your chairs would be you could allocate the testing fund to two that share with confidence.

1:06:40
Next question.

1:06:42
Then DTI, I think, you, might need to provide, or e-mail us for us to help you here, but, she says, how to, how do you exclude telehealth time?

1:06:54
Telehealth and in person visits are done, side-by-side, depending on patient need.

1:07:02
Julie or Jeff, and I don't know if you've ever heard or seen telehealth be done side by side?

Julie Quinn:

1:07:12
And I just really think it's, it's when you're talking about telehealth versus in person, just document, if the provider was in the same room, physically as the patient in the in person column.

1:07:30
If the provider was not in the same room, and only saw the patient over some audio visual mechanism, then that's telehealth.

Nathan Baugh:

1:07:43
OK, and you would exclude it if it was telehealth, but not if it was for in person.

1:07:53
Hopefully that helps you in Nandeeta. Next question is from Dustin Hamlin. Who asks, What if your practice was not a RHC last year, therefore, not comparing apples to apples? new RHCS without the previous year? Comparison of lost revenue? What do you think?

Julie Quinn:

1:08:12
I would think that would be financial statement based, when you're talking about the funds.

1:08:19
Because these, yeah, that, Jeff, you can weigh in on that.

Jeff Bramschreiber:

1:08:25

Now, that's an interesting comment.

1:08:31
So, your net patient service revenue is going to be quite likely, dramatically different as a rural health clinic this year than last year, Not as a rural health clinic.

1:08:42
That's going to throw off your numbers quite a bit.

1:08:46
So I'm hopeful that there will be some accommodations made in that calculation over lost revenue.

1:08:54
And we'll go back to something similar to the definitions that were used originally, so that you would have the flexibility to report either current to prior year or current year to current year budget.

1:09:12
And using budget numbers would allow you to isolate or remove the impact of that conversion to rural health clinics, because you should not be penalized in that loss revenue calculation simply because your net revenue changed under a different reimbursement structure in 2020.

Nathan Baugh:

1:09:34
Yeah, that's a great question, Dustin and, I mean, I think Jeff nailed it on the head, hopefully, they will be sophisticated enough to understand that one definition of lost revenue might not work for facilities that change their facility type.

1:09:55
But, I haven't seen that clarification, it doesn't sound like that clarification has out yet, I have.

1:10:01
Correct.

1:10:02
Yeah. So, that one is a wait, and see, unfortunately.

1:10:08
Next question,

Jeff Bramschreiber:

I would just, just, Nathan just, It's sorry to interrupt, but I think all of this, in terms of reporting now, is a wait and see.

1:10:16
Now, the way this is kind of worked as we went along is as information comes out, people start to question and ask more questions and dig more into the details. And then we get further clarification. We get additional FAQs. We get some changes, as people are able to kind of digest

what what the new information that's published, so I think, again, we're at the beginning on the reporting requirements.

1:10:41
I think there's going to be some natural changes and further clarification as we go along. So, it's important to understand what the requirements are right now, but that also important to realize that this is probably not the final final, and we've got until the reporting requirement, or the reporting, opens up in early 2021, to have additional clarification, and perhaps some changes to be made.

Nathan Baugh:

1:11:08
All right. We got, let's just do these last three questions, and then, we'll call it, next question is from Connie Tanguy.

1:11:19
Who asks, can you deduct cost of new vehicles needed for transport due to covid, needing utility truck to move laundry around instead of going through facility as it was done prior to covid?

1:11:31
Uh, again, I have my answer, but Jeff. Julie, do you want to weigh in first?

Julie Quinn:

1:11:39
Vehicles can be a little tricky.

1:11:41
So, some of it has to do with is that it's only use, OK.

1:11:48
I'm not sure if the size of your facility, but if that is, all you use it for, is patience, care necessary, reasonable patient care activities, then yes, it would be an allowable cost. That's my initial reaction there and wanting to dig further into the specifics of your purchase before I could make a phone call.

Nathan Baugh:

1:12:12
Yeah, I would agree.

1:12:13
It's, it's, it's definitely not the clearest cut relation to covid.

1:12:20
Now, I can absolutely see that needing a via call to either transport laundry in your case, or even specimen samples to the lab could be something that you would want to use the funds for.

1:12:35

one of the issues is that is potentially, you know, if you purchased a new truck or car and then cove it ended and then you sold the truck and car no, I already know is the clinic just profiting off that sale of the car? You know, what?

1:12:56
What percent of the cars cost is most appropriately allocated to covid?

1:13:04
If you used it for one year, are covid, do you have to, sort of only only calculate that one year's worth of cost? So those are the types of questions. I don't think that there's any guidance that explicitly talks about vehicles.

1:13:23
But I would suggest if you had other clear-cut ways to use testing find, I would use it. I would use it there instead of on automobiles. Although I don't want to categorically say that it's not allowable.

1:13:38
Because, I think if you do the accounting work to appropriately demonstrate how much of it was truly associated with providing covid tests and, you know, doing things like that, I think it could be theoretically done.

1:13:55
So, hopefully, that helps.

1:13:59
two more questions or I actually got two more questions.

1:14:03
Josh Tucker says any hints or tricks for handling a hospital based RHC Code Fund separately for our hospital CAH covid funds? Best ways to keep the reporting separate.

1:14:20
Um.

1:14:22
Did the CAH get covid testing funds? Or does that make sense or should those?

1:14:30
Or is the premise off And that they're one and the same.

1:14:39
Jeff, Julie?.

Jeff Bramschreiber:

1:14:40
Yeah, my understanding is the car did not get specific are specific corvid testing funds, similar to the RHC testing so they're right.

1:14:50

I don't believe that there were designated funds for covid testing for the cost of their payments were generally or the general provider relief fund payments.

1:15:05
I'm struggling with the way I understood the question was whether there would be a difference in treatment, if it's a Part of the critical access hospital, a right, an operating department of the Critical Access Hospital versus the provider based rural Health Clinic.

1:15:22
And I don't believe that that treatment would be different for the general Provider Relief Funds.

1:15:30
But there, again, wouldn't be a testing component on the CAH side of the organization. Right.

Nathan Baugh:

1:15:37
Yeah, Josh, I think you're going to have to be a little more specific.

1:15:41
But, in general, if you have a hospital based RHC, the hospital that owns that RHC is the actually the entity that got all the funds now. And, for example, the RHC Testing Fund, you are allowed to use all of that funding and allocate it entirely at the hospital.

1:16:03
You do not have to spend at the RHC. So I guess we're taking issue with that, that the word separately and your question.

1:16:13
So feel free to contact, either Jeff and myself, Julie, if you want to dive into them, are. All right, We're going to have time for one last question.

1:16:23
Who's at, which is from Stacie Holland, actually, on the vehicles. Can we claim mileage for transporting specimens to the health department?

1:16:35
Again, I, I would, I would argue that that potentially is a cost that is attributable to covert testing. Let's say you're not purchasing a vehicle but you're reimbursing an employee for using gas and whatnot, and using their cars to transport the specimens to the health department or lab.

1:16:56
I would argue that, that is certainly an allowable cost for the funds. Jeff Julie do you disagree?

Julie Quinn:

1:17:08
I don't disagree.

1:17:09
I think that it gets to maybe even so deeper cost principles of choosing mileage versus actual expense vehicle.

Nathan Baugh:

1:17:23
Hmm, hmm. Hmm.

1:17:25
Yeah.

1:17:28
All right, Well, with that Jeff, you want to weigh in? Any last thoughts, Jeff or Julie, before we close this out?

1:17:37
Good. Thank you.

1:17:42
Yeah, I'd like to just thank everyone for attending today's webinar again, especially our speakers for their presentations. And I'd like to, again, thank the FORHP for sponsoring the RHC Technical Assistance Webinar series. Again, we encourage everyone to encourage others who may be interested to register for the webinar series at narhc.org or the RHI Hub website.

1:18:06
You can e-mail me.

1:18:09
Thoughts and suggestions for future call topics at natha.baugh@narhc.org and you can just be sure to put an RHC webinar topic in the e-mail subject line and I will I'll listen to those.

1:18:27
Again, for our Certified Rural Health Clinics Professionals, the CEU code for today's presentation is 942TW again, that's on your screen. I believe, 942TW when we schedule the next webinar.

1:18:44
Notice will be sent by e-mail to those who have registered for the webinar series with details, and you should be expecting something pretty soon in the beginning very beginning of October on the RHC testing reporting requirements. So, just be on the lookout for another webinar coming soon. With that, thank you all for your participation. That concludes today's call.