Emily DeMent:
Hello everyone. Welcome to today's session: Your Questions...Answered!, which is part four of our new series Finance Office Hours: Strategies to Manage Operations During COVID-19.

Emily DeMent:
My name is Emily DeMent, Program Associate in the Training and Technical Assistance department here at NACHC. I'm pleased to bring you this webinar along with my colleagues, Ted Henson, Director of Health Center Performance and Innovation, and Gervean Williams, Director of Finance Trainings.

Gervean Williams:
Good morning everyone. This is Gervean Williams. Go ahead Ted.

Ted Henson:
Hi, this is Ted Henson from NACHC.

Gervean Williams:
Today we're going to have a little bit of a different format. On the last three webinars we had a lot of questions come through the chat so we're going to have this mostly just a Q&A of all the questions that you've submitted almost over the last month or so. We have some of our great partners with us, we have BKB, Jeff Allen and Catherine Gilpin, we have Feldesman Tucker Leifer Fiddell. We have Marty Bree, and Mike Glomb, and then we Ray Jorgensen from PMG.

Gervean Williams:
To help facilitate the Q&A we have Ann Loeffler on the line. That's going to be the roll call. But before we get started I want to give you guys some late breaking news, as of yesterday CMS has released that now FQHCs can now provide telehealth visits via audio only. This is just brand new out, here's a link so all FAQs, so this is something every health center should be utilizing because as we know a lot of the Medicare eligible patients might not have video capabilities at home.

Gervean Williams:
This just came out yesterday. We're going to put some more FAQs out and some more tips and tricks on that. Wanted to let you guys know that and then the next thing that I wanted to update you guys on is the uninsured program portal that's now open. This is a program that's administered by HRSA. If a patient comes to your health center and they don't have any insurance, you verify that they have no coverage from Medicaid to anyone else, you can actually bill HRSA directly for those claims. This just opened up and more information to come, so we'll post some more information. Feldesman Tucker are putting together a White Paper for us and that will be up on our website soon to give you more information about this program.

Gervean Williams:
I don't know if any of you guys online were with us on Tuesday but we had CMS on the line talking about the pre-yesterday telehealth information. There were some questions asked by CMS, and they responded to those questions and I'm going to go through those answers with you right now.
The question was, if the claim was billed without the modifier, will it be flagged for recoupment? As we talked through the webinar Tuesday until July 1st you're going to get your PPS rate but then they're going to adjust it down to the $92.03, and this is a suggestion from CMS. Yes, it should be resubmitted and sent through by this example here.

Gervean Williams:
Next question, if we already billed with the 95 modifier but not the G2025, do we need to correct the claim? Again, they said yes you'll need to correct the claim and make sure you have the G2025 on there.

Gervean Williams:
Okay, the next question is will you please ask the representation from CMS whether they're expecting claims to be submitted with the G2025 before July 1st? Again, there they answered that is correct, you need to put the G2025 on all your claims.

Gervean Williams:
I know they updated the MLM matters and Ray Jorgensen is going to go a little bit more detail about that document a little bit later on in the presentation. So that's the update for the NACHC folks, and now I'm going to turn it over to the BKD folks in order to give us some more grants management and finance information Q&A. Catherine and Jeff.

Jeff Allen:
Yeah, thank you, Gervean, I appreciate it. This is Jeff Allen and I'm going to address one of these first questions that popped in and then we're going to let Catherine really go some of the grant questions that we've received. One of the ones, and I think it's a real good question, it's really something that we need to be thinking about now even if your fiscal year end is still months and months away and filing the cost report is even several months after that.

Jeff Allen:
The question was how will telehealth services be reported on the Medicare and or state Medicaid cost reports? I'm glad that a lot of people are already thinking this way. How are we going to make sure that when we file those cost reports at the end of our fiscal period that they're accurate in accordance with the rules? You will need to do separate allocations for telehealth services, especially for Medicare, and that may not be for Medicaid, but we'll talk about that in just a couple of minutes. But for Medicare purposes you will.

Jeff Allen:
If you have an allocation, if you have provider that provides face-to-face services, and also spends time providing telehealth services, there will need to be an allocation of time between the two because salary and benefits from that particular provider will really go on two different lines of the Medicare cost report. We have to have some kind of allocation now, getting providers to provide time records, getting that time allocation down to the minute will be difficult if not impossible, but there needs to be some type of allocation made whether it be by visits, or however that's a reasonable and defendable in order to make sure that the cost is correctly allocated.
So the telehealth visits they are paid for and that's great, but they're not considered to be a FQHC, PPS visit that we're going to capture on the cost reports. Along the same line the visits as I just mentioned will have to be separately identified in the records too.

Jeff Allen:
It would be just like a dental visit. We're not going to put those telehealth visits on the cost report. We're not going to capture that information on the cost report, that will be left off. So in order to do the cost report correctly we'll have to have visits and a time to be able to allocated between the two separate areas.

Jeff Allen:
Now Medicaid may be a little different. A lot of the state Medicaid agencies came out and said that the telehealth visit will be billed and paid just like it was a face-to-face visit inside the clinic. It will be treated like a PPS visit like any other visit.

Jeff Allen:
In that case, in most cases there will not be a need to track that separately for Medicaid. Now you'll have to for Medicare, so you'll have to anyway, but when you file your Medicaid cost report in your state if there's one that required, not every state has a Medicaid cost report, but if there's on that's required those visits could be just captured along with everything else. The key is, is this visit a true FQHC that is paid for under that payment system that the cost report is trying to capture? If it is, you can and if it's not, then you need to allocate those visits separately to make sure those records are separate.

Jeff Allen:
That answers that question I'm going to turn the next question that's more grants related and let Catherine answer the next one. Catherine, you are muted. There you go.

Catherine Gilpin:
Yup, perfect. Thank you Jeff. We wanted to address also a couple of common questions we've been receiving in regards to grants management, the payroll protection program from an accounting perspective, and just other questions.

Catherine Gilpin:
Here are the most common, I probably had 10 conversations with clients this week in regards to what are the permissible uses for funds received through the CARES Act provider relief fund? Ultimately the funds that you received, those two payments you probably received I think they payments started going out on April the 10th, they were maid April the 10th to April the 17th, and I believe some additional deposits were made to some health centers on April the 27th.

Catherine Gilpin:
Weekly moving forward HHS will be sending out those payments based off of the information that they have. There's information on HHS's website that makes a statement that that funding will be used to support healthcare related expenses for lost revenue attributable to COVID-19, and to ensure uninsured Americans can get the testing and treatment they need for COVID-19.
Catherine Gilpin:
You ultimately, everybody received two payments or they should have thus far. You actually have to go into that website and make two different attestations, and attest to two different terms and conditions.

Catherine Gilpin:
That's one of the things we mentioned, but ultimately when we move onto the next question, we're receiving very frequently, when should my health center recognize revenue for this funding? There are some different strategies in regards to obligating these grant funds because ultimately you can use them for lost revenue or you can use them for expenses.

Catherine Gilpin:
Ultimately there hasn't been a lot of guidance issued related to this funding. Whether you use these funds for lost revenue or on expenses can potentially depend on the amount of money you received the size of you health center. Did you actually have lost revenue after you looked at additional support that you've received related to the COVID-19 pandemic? So that when you recognize revenue will depend on whether you're using this expense for lost revenue or expense.

Catherine Gilpin:
So there's different strategies involved. Last week during our office hours we actually talked about potential in order of spending, and depending upon your choice, whether it's lost revenue or expense, you might prioritize this funding differently in your order of spending.

Catherine Gilpin:
All right, so let's talk about our next question. Regarding the payroll protection program, does my health center need to re-budget the 330 grant because I'm allocating a different percent of an employee, or different employees to the 330 grant because of the payroll protection? Ultimately, no you don't. When you prepared your 330 grant budget, if you had salary expense listed in the federal column of your budget and let's say for an example, if you originally allocated 50% of an employee's salary to the 330 grant.

Catherine Gilpin:
If you need to change that allocation to 60% or 70%, you don't have to ask permission because you've been approved for salary and wage expense. If you have to remove an employee because that employee has left your organization and replace them with another employee that would be applicable to the 330 grant, you don't need to ask for permission.

Catherine Gilpin:
This is the exact same concept once you've been approved for salary and wage expense, you can go ahead and make changes to either the percent of that employee that gets allocated, or the actual employees, so long as you're thinking about grant management and not allocating salary expense to over the salary cap from employees that are working on out of scope activities or employees that are supported by another ward lets say the payroll protection program.

Catherine Gilpin:
We've been talking about this for a couple of weeks but ultimately we're commonly receiving this question about the re-budgeting process for the 330 grant and it is as simple as contacting your grants management specialist and asking them how to do that. I actually asked this question on behalf of a client today just to make sure that I was refreshed for this call, and the grants management specialist responded in about a half hour, sent a template that says take what you budgeted originally. Catherine Gilpin:

There's a modification column, proposed modifications to the budget, and show them the budget you'd ultimately like them to approve now. You're going to submit that through a task in the electronic handbook, and then HRSA will potentially issue an NOA that says your new budget has been approved, and that's how easy it is. In years past I think it might have taken a little bit longer, but I think HRSA is very focused right now on making sure they get those approved very quickly, so I don't think there would be a big delay.

Catherine Gilpin:

Well let's talk about the most common question we're receiving but the most common we're making with health center PPP funding. We're still seeing health centers that don't understand that if you budgeted for a certain staff member on the 300 grant, you can still allocate them to PPPs. If I budgeted, and Catherine was was on your 330 grant and I was originally at a 0.5 FTE for that eight week period of time that you receive the Payroll Protection loan, you can take 100% of any employee's salary up to the $100,000 cap and allocate it to PPP.

Catherine Gilpin:

You don't have to draw anything from your 330 grant from the eight weeks that your salary expense is being supported by the Payroll Protection Program. You don't actually have to call HRSA or your grants management specialist and help them to understand what you're doing.

Catherine Gilpin:

You could just not draw on your 330 grant or you can't actually look at the difference between what your allocation to the payroll protection program, and what the salary cap, because if you have an employee that earns up to the salary cap, anything over that weekly amount or the biweekly amount of the 100,000 anything in excess of that but lower than the HRSA salary cap can still be supported by your HRSA grants.

Catherine Gilpin:

So, don't automatically exclude anyone over $100,000 and just remember that you don't actually have to ask HRSA or ask them for permission, or help you understand you won't make a draw on your 330 grant, because in week nine, and week 10, when you begin to use your 330 grant more, you can make a draw at that time. It's not something you need to ask for permission for. Just remember, that you don't have to ask to re-budget because you're changing to allocation to your 330 grant.

Catherine Gilpin:

If you have an employee ... This was another question we recently received, if you have an employee that as of the end of March would have made $100,000, that doesn't prohibit you from charging the
$15,385 to the Payroll Protection Program for that eight week, because the 100,000 is an annual figure, and the Payroll Protection Program per employee for eight weeks' cap, that 15,385 per employee.

Catherine Gilpin:
One of the other things I'd like you to remember is that I feel that a lot of questions this week in regards to hazard pay, or premium pay, and HRSA has clarified on several of the conference calls that we've had that hazard pay, or premium pay that you're paying to your employees, because of the conditions in which they're working, and the potential exposure to themselves or their family, could potentially warrant hazard pay if your health center, or if it's the policy of your health center to provide hazard pay under those unusual circumstances, but to make sure that you have a policy when you're thinking about hazard pay.

Catherine Gilpin:
Sometimes hazard pay is a one time payment to employees. It could potentially be something that you add, you increase their wage for a specific period of time, but do remember that the eight week cap for the Payroll Protection Program is 15,385, and nothing that you pay during that period of time, in excess of the cap is going to be output to the Payroll Protection Program.

Catherine Gilpin:
If you're trying to think strategically through some of those questions that might be gray areas, please remember that the small business association has yet to release the forgiveness application, and especially if you're considering a one time payment. We've been advising clients to, if they can wait to make a payment, because they're trying to figure out their strategy to maximize forgiveness on the Payroll Protection loan. It might be beneficial to have the forgiveness application, prior to making some of those business decisions.

Catherine Gilpin:
The last question I was going to address is, how do I count for funding that congress is providing for COVID-19 testing on the budget due to HRSA on May the 8th? Ultimately, HRSA actually responded to this question in one of their Q&A sessions that they held related to the COVID-19 fund.

Catherine Gilpin:
One of the things that they mentioned is that health centers, when we're budgeting for the COVID-19 cares act funding, we don't actually need to budget for any non-federal considerations. You can if it's something that you feel strongly about. But ultimately HRSA doesn't expect anything in the non-federal column of the budget you submit on May the 8th.

Catherine Gilpin:
They're just expecting to receive a budget for your award related to the cares act COVID-19 grant, and then the expenses that are going to be specifically attributable to that award.

Catherine Gilpin:
Now I'm going to pass the presentation over to Marty. Hold on.
Thank you. We didn't get too many new questions regarding telehealth. But there are a couple of ideas I did want to get out and get across to you. Let's review some of the basic telehealth questions that we received over the past few weeks. Then I'll have a few concluding remarks.

Marty Bree:
Here we are. That's the usual slide. First question that we always get is, and I apologize for the typos. As it's my fault, and my typing. Does the FTCA coverage extend to telehealth visits for both established patients, and non-health center patients?

Marty Bree:
The clear answer to that is yes. HRSA is one of their frequently asked questions post on March 27th, they stated, that if you're providing services that raise scope of project via telehealth, to health center and non-health center patients, with all the other requirements of the program being met, then that encounter will be covered by the Federal Tort Claims Act program. That was HRSA's fairly clear statement on that subject.

Marty Bree:
The next question, another question is, can our providers provide telehealth services from home? We've gotten this question constantly, and the answer from HRSA was, yes, if you go to the particular rights determination that HRSA published, in an actually the frequently asked questions, you can see that clearly speaks to that issue.

Marty Bree:
A reminder is that working from home we're going to have this scope of employment of the individual. If the provider is at home in another state, which can be very common, you've got to understand the licensing laws in the state where you are located, and where the patient is located. Most likely things always have changed in many states recently in response to this pandemic.

Marty Bree:
Informed consent, you have to have a consent to the telehealth, or the mechanism, and to the actual treatment. We need to document it. That's the next point. Record keeping is critically important here. Non-health center patients might separately be registered, and a record created for them. These are all points that you must take into consideration with any telehealth, telemedicine encounter.

Marty Bree:
Can we see via telehealth a new patient for screening, for COVID-19, for the first from the patient's home? This is where the patient is calling the health center, and the patient is at home, and you've never seen this patient before. The answer is yes. Remember the comment that I just made about scope of employment, license, informed consent, and record-keeping.

Marty Bree:
Can we see via telehealth a new patient for healthcare services other than COVID-19 screening? For example, behavior health or chronic disease management. Again, we're talking about a new patient, not a patient who's previously been seen at one of your Form 5B sites.
Marty Bree:
The answer here is, yes. You can, provided that you provide a screening or triage service, and that you register the patient. When you're having this telehealth encounter with the new patient, for a non-COVID-19 screening, you've got to triage and screen these new patients before you provide treatment.

Marty Bree:
You must register the patients in your system at the health center. Remember the previous comment again on scope of employment, license, informed consent, and record-keeping.

Marty Bree:
can we provide services via telehealth to patients who are in a different state? That's very similar to the question about can I provide services from my home as a physician? Remember that licensing laws vary from state to state. In the past, states would require you to have a license in the state where the patient was.

Marty Bree:
The licensing was in many, many states, probably the vast majority have been eased over the past few weeks. You can go to the federation of state mental board website, and get a list of the individual states, and find out what their current licensing rules are regarding this.

Marty Bree:
This is an interesting question that came up, and it came up more than once believe it or not. Can I help health center practitioner provide services via telehealth when he or she is not in the United States and still expect FTCA coverage? The answer to that is probably not. You can imagine, a lot of different ways that department of justice can try to deny coverage in this sort of a situation.

Marty Bree:
Our best advice is that you would have to assume that you don't have FTCA coverage. You've got further issues than that in that the, what are the laws of the nation which the physician is in, regarding providing telehealth services from their country? [inaudible] probably not a good practice to engage in.

Marty Bree:
Before we go in, I want to summarize with a general comment about what we're seeing out in the department of justice is coverage of FTCA claims. It's not good. The department of justice has been aggressively denying claims in the last few years. Recently, they've been doing what we call, or what I would call deep dives into HRSA policy and pals in writings to find items that might be relevant to the particular claim, and trying to, using newer lack of absolute compliance with the HRSA policies to deny coverage.

Marty Bree:
My recommendation here in particular for these activities that we're engaging in right now is documentation. If you're providing any service to anybody outside of one of your Form 5B sites, document it on Form 5C. Make sure you can get it on Form 5C. If you're going out and doing screenings at a convention center, if you're providing care at a screening site, in another location. If you're
providing telehealth services to a population, or a rascal of folks that's provided to you by the health department, put it in Form 5C.

Marty Bree:
Over-documentation is better than under-documentation. Make sure your employment agreements, if you're allowing your physicians and other staff to provide telehealth services from other locations, make sure that their employment agreements, your policies, whatever, that there is some documentation that this is permitted.

Marty Bree:
I know I can't stress more the need to document what you're doing, and let HRSA know what you're doing. If you can't get into the EHB, if you can't get into Form 5C, email your project officer, you get a copy of that email. Documentation is critical. With that, I will pass the ball to Mike.

Mike Glomb:
I get the sense here as well, with the notion of, or with the disclaimers of right as Marty's back as far as legal advice. I'm responding here to a question that was answered after the very first webinar, which was April 3rd, which also happens to the first day that the PPP program was opened up. The question was, are there financial criteria that determines whether you can be approved for the loan? For example, do you have to show cash need such as low days cash on hand, et cetera? How does current financial position impact the amount that can be forgiven?

Mike Glomb:
The advice, the bottom line right, for the purpose of replication, you do not have to show a financial statement. You do not have to show low cash need, you do not have to show that you were turned down for a loan by someone else. Ultimately, although as Catherine pointed out, we don't have the guidance on forgiveness yet.

Mike Glomb:
We do what the statute says, and it doesn't seem like your cash position when you applied, or when you seek forgiveness will be relevant to how you spent the money. To implement the PPP program, the language in the statute says, basically the only thing other than that you weren't convicted of a crime, and then you were in business, and the likes, but you had the certify regarding financial circumstances, is that the uncertainty of current economic conditions makes necessary the loan request to support the ongoing operations of the eligible recipient.

Mike Glomb:
That's a pretty vague standard obviously. But it was also intentional. Remember, congress' notion was to gap money to organizations to be able to make payroll for eight weeks in a situation where businesses were closing down, businesses were being shut down by stay at home orders, and the like. That is still the law.

Mike Glomb:
However, on April 23rd, and it's been reiterated a couple of times since then, the small business administration administration in its FAQ, it's frequently asked questions, which by the way everybody
should look at it from yesterday site to that, at the end in the resources, because these things come out almost daily.

Mike Glomb:
What they said was, well, when you're making the certification, remember, this is three weeks after a lot of the loans were applied for. The highlights there are my highlights. In good faith, taking into account current business activity. Presumably the current business activity existed when you made the application to support your ongoing applications in a way that would not significantly be detrimental to your business.

Mike Glomb:
Then they went on to say. Based on these criteria, we don't think that any publicly traded company, meaning, one whose stock is traded on one of the public stock exchange would be eligible. That's not true. We understand that. Why was this change in tone? Why did this come out?

Mike Glomb:
Well, I think the first obvious reason is that people ran out of money on April 16th. If there was still money in the pot, either from the first transfer now, I don't think we would be having these issues. Secondly, there were a lot of congressional inquiries.

Mike Glomb:
Joe's diner in my district did not get a loan. How come? This is supposed for small businesses and the like. Then there was really bad press, which I'm sure all of you have seen one way or the other, in the newspaper, or on TV, and the like. Shake Shack, Ruth's Chris Steakhouse. The LA Lakers. Just a few that got bad press.

Mike Glomb:
The Washington Post this morning had a story that said that something like 300 publicly traded companies had a total of one billion dollars worth of loans in the paycheck program. Now, one billion is like 1/300 of the amount that was appropriated at the beginning. Those of us who are not used to looking at numbers in federal appropriations that have so many zeroes behind them ... In some sense it's really not terribly shocking, but obviously there's been a response in the government.

Mike Glomb:
The first obvious one, or the first publicized one is that the Secretary Mnuchin and the SBA had announced that they were going to audit any PPP loans over $2,000,000 and over. In the first round, there was something like 20,000 of those loans as reported by the government. There is a lot of business there.

Mike Glomb:
Recently, in another FAQ that came out two days ago, they said that loans over $2,000,000 would be reviewed by the SBA, after you submit your application for forgiveness to the bank. Review is a different thing than an audit. Audit in our world means something under very stringent standards and the like. The point is that these are going to be looked at.
Mike Glomb:

Also, in the course of various pronouncements, the government has made threats about potential legal action. The most obvious ones from a perspective of potential liability on the federal false claims act, where you've made up claims to the government. You're going to do something, or you got money based on pretense, it was false, or with records disregard for the truth, or false statements, same principles.

Mike Glomb:

False statements are the kinds of things that got almost everyone who went to jail in the MERLO investigation in trouble, not what they did underlying it, but making false statements to the government in the course of investigation.

Mike Glomb:

What do you do now? Well, I think this is a risk analysis situation. Probably, if you've got a loan under $2,000,000 you probably can feel very secured. I'd say probably that's not going to be tracked on the advice I'm about to give you. If it's over $2,000,000 folks are going to look at it. Remember, you're not the Lakers, or Shake Shack.

Mike Glomb:

By the way, in my view, the Los Angeles Lakers are a small employer. They have fewer than 500 employees. When they applied for the loan their business was shut down. The NBA is still shut down. Nobody knows when it's going to open.

Mike Glomb:

In terms of the certification, it seems to me like it squarely fits that. Moreover, at the end of the day, with regard to my sports junkie friends, it really doesn't matter if the Lakers come back, or if the NBA goes back in business. It matters a whole lot, whether you guys are in business, can stay in business, and are able to emerge at the end of the day in some reasonable ways to continue the good works that you've been doing.

Mike Glomb:

Right off the bat you have a lot of equities on your side. That being said. Especially if you think that if you're above $2,000,000, if you haven't don't this already, this is the document word that you'll hear, and have heard from everybody throughout this process, and the CPAs, and just from Marty on the FTCA issues. Document or memorialize the conditions that existed when you applied for loan funds.

Mike Glomb:

Again, this is a prospective statement that you make, that the government may come back and say, "Well, now looking at it now, it wasn't really accurate." You only had the advantage of looking forward. Memorialize what happened. And we all know, how devastated the health center world has been by the decline in patients, and decline in other factors that have affected revenues and the like.

Mike Glomb:

It's important, write that down. Write a memo to the file. When the government comes knocking beyond passing time for repayment in a couple of years from now, everybody tends to forget how bad...
things were when this stuff happens. Hopefully, two, or three years from now, we're back to normal, and it's like, "Oh, it wasn't so bad. We made it through."

Mike Glomb:
But back then it was really bad, and people who were there then even some of you may not be now, gone on to different jobs, retired, whatever. Have something in your file that documents the exact financial position that you had, and that you expect to have when you applied for the loan.

Mike Glomb:
Secondly, it's really important to through all the use of the proceeds, to document how you spent the money on the allowable and forgivable expenses. That would also help if you ever questioned after the forgiveness application goes in or you're audited later. This can get a little tricky because remember ... I had a few clients, or a client, who said, "Back in the early days I have, we're losing $8,000,000 a month on dental and other things. But happily we have $20,000,000 in reserves. And so we're not really concerned about this for a while."

Mike Glomb:
I don't know what they're thinking now. To the extent that you were forcing them not to have a substantial reserve sitting somewhere, or you got a lot of money from HRSA or other sources to help make this up, I think after the fact the government grant thing is a different situation, but if you had reserves of a significant amount, you should pay attention to the fact that someone might say, "Well, why didn't you spend that?"

Mike Glomb:
Obviously, we know we don't want to spend all our reserves down, and the like, but that's really an individual question. That's where you're going to have to work with your CPAs, and help you sort through this if you think you have a problem.

Mike Glomb:
Even if you don't think you have a problem, I strongly recommend that you document what was in existing when you applied for the loan. Because remember, all you had to give the bank was past payroll in terms of numbers, not what's your cashflow, what's getting down, not how many people you laid of, not the like.

Mike Glomb:
Again, you among maybe more importantly than a lot of other businesses that are affected by this, I mean, it's bad for Joe's Diner if it doesn't come back. It's bad for Joe and his employees. It's really bad for the community if you guys don't get back. That's something to keep in mind when you write this up.

Mike Glomb:
Finally, and I'm saying this only because I would be remiss in not mention it, and that is the government has announced that if for some reason or other ... This is definitely targeted towards the publicly traded companies. If you give the money back by May 7th, they won't penalize you from making a "false statement."
Mike Glomb:
There is a lot of legal issues of whether they can do that anyway. But yet after a lot of thought, and prayer I would say, and whatever, you feel like you are really at risk you might consider giving the money back, but you only have a couple of days to think about that. With that, and I’m sure we’ll we able to answer other specific questions on this. I’m going to turn it over to Ray.

Ray Jorgensen:
All right, a couple of quick items here. When I tell you my had has been spinning with what feels like an almost daily update from Medicare about how health centers are going to deal with this whole program, I can only imagine, you guys are feeling the same out in the field.

Ray Jorgensen:
What I wanted to just go over real quick was this Medicare learning network revision, SE20016, literally just came out yesterday. I had just finished rewriting another revision, based on something we had just read when this came out. It's great news. It's really good news. But I want to make sure we're clear about the fact that this is evolving.

Ray Jorgensen:
Just because this is what we're telling you today, this does not mean that we might not be telling you something different literally early next week, since it's Friday. What they're allowing us to do, or as Gervean said at the very beginning, is use audio only for telehealth. This is gigantic. It's a really, really big deal. For you guys familiar with the evaluation and management text 99441 to 99443, those are phone only.

Ray Jorgensen:
The practitioners, and PPA, midwives, those type of folks. They're retroactive to March 1st, so not all the way back to the 27th of January. But we're really going to strongly urge you to check you with your Medicare administrative contractor. And for you folks dealing with more than one MAC, check with all of them.

Ray Jorgensen:
Here is the challenge, 99441, the 99443, it’s not a qualifying visit for PPS. And even if you check the latest updates of the telehealth list, they do not list these codes in that telehealth. This is a very unique item they're putting out there for us in this MLN that says, "You can do this." This is the exact quote that I have here.

Ray Jorgensen:
When furnishing services via telehealth that are not FQHC qualifying visits, and these are not ... They are saying, "Hold these claims until July 1st." Gervean and I were ... Actually, I was feeding some information to Gervean, and she was trying to check with CMS, and whatnot, and they initially said, "Oh no, you can bill the G2025 as a standalone item."

Ray Jorgensen:
Meaning no other HCPCs goes on the claim form, and we'll pay you. Then when we asked for one other level of clarification they said, "Check with your local MAC." I'm not trying to put CMS under the bus.
Understand that, as powerful an organization as they are, they're struggling with the daily crazy rate of change as things continue to evolve.

Ray Jorgensen:
We're encouraging you to check with your MAC, and look for stuff in writing. They typically, all of them have had really pretty wonderful COVID-19 updates, and you need to read them. You need to go and look at them. If you're not comfortable with them, hire an outside person, find an outside consultant. Call or email me, and I'll give you my best update on what we believe to be true. We're doing revenue cycle, management work with health centers in more than, I think we have 22, 23 states, we're dealing with a lot of MACs. Not all of them by any stretch.

Ray Jorgensen:
Then working with a lot of PCAs, and doing some program content. So certainly glad to health. It's not a charge for surplus, it's not about making money. It's about making sure we all understand what we're doing. Here is the gigantically wonderful thing about this, by allowing that telephone only piece, and by them expanding the services, and I want to talk incident two billing as well, they're essentially allowing us to get paid for a telephone call, even for a 99211.

Ray Jorgensen:
I'll say that again, they're allowing us to get paid for a telephone call, even for a 99211, once the G2025 is in place, because under telehealth, 99211 is a qualifying visit. It is not a qualifying visit for PPS at an FQHC. I'm going to say that again, 99211 at nurse visit, that MA visit.

Ray Jorgensen:
I joke about the fact because you guys have heard me speak before, you could hire me, and have me go in and do a blood pressure, or do a quick visit check, and I could be a 99211, but right now I wouldn't qualify for a PPS rate. I could bill manage Medicaid, I could bill manage Medicare, I could bill it commercial 99211 for me, but they're telling us under telehealth, we're allowed to get that 99211. These services, 99441, the 99443, require MDDO, and PPA, what I typically call, "core providers."

Ray Jorgensen:
The last thought on this page says, check with all your payers, because a lot of them follow Medicare. And if they're following Medicare, this is what Medicare is allowing us to do, but you really want to get this stuff on writing. You don't want to take any chances on putting something in play that could be problematic for you down the road.

Ray Jorgensen:
This is a claim format. This isn't news. This is right out of that MLN article that says for data service, the 27th of January, through the 30th of June, they want us to see the PPS, the G0467 is here as the example, but it could be G0468, G0469, all the way up to G0470, any one of those, then the corresponding HCPCS code, in this case the 99214, an EM code we're pretty familiar with. It definitely gets a 95 modifier, you can see over on the right.
Then the G2025, you want to make sure you're capturing that as well. So that you're adding that 95 modifier. That's the thought here. And we're not sure how we're going to do this, or what we're going to see, is that you're going to get paid your PPS rate for all these dates of service through the 30th of June. Then there will be some sort of recovery, so here is the big question.

Ray Jorgensen:
Let's say there is $92.03 you're getting for the G2025, let's say you did a thousand of them. So I'm going to just say 92 even, that should be $92,000 that you get paid. Let's say your PPS rate was 150, so they're going to pay you 150,000, when really they wanted to only pay 92,000 for these "telehealth services."

Ray Jorgensen:
If that's actually the case, and that's what we're doing here for these telehealth services, then are they going to take back the full 150, and then cut your jet for 92 grand, or are they going to just take back the difference?

Ray Jorgensen:
There is nothing we've seen that's given us that answer. It's not a good or bad thing, it's just, understand that we don't know how recovery is going to take place. Nor, do we fully understand how the accounting is going to take place.

Ray Jorgensen:
As an organization, as a revenue cycle management firm, we're discussing with our clients about possibly holding these Medicare claims. By UDS data, it's only about nine and a half percent on average of every health center's volume. And then billing later in June just to not have this massive financial accounting we have to manage.

Ray Jorgensen:
Food for thought. For date of service after July 1st, they're saying, use the G2025 with the 95 modifier, and I should say that 95 modifier is optional, but it is something that we want to make sure that you think about using a check with your MAC, whether or not they want it. To me, the 95 is redundant, because the G2025 is telehealth, and the 95 modifier saying the service was delivered telehealth. That again seems redundant, but it is what it is.

Ray Jorgensen:
For any telehealth after July 1st, you want to use that number claim format. For any audio only telehealth, starting March 1st, you want to do G2025. We're conservatively thinking we want to hold those claims until July 1st. CMS told us in writing, "Oh no, you could do it now." Then when pushed it a little further they said, "Check with your MAC." That's why want to make sure that you check with your one ore more Medicare Administrative Contractors, and see what they want you to do, and get it from them in writing obviously.

Ray Jorgensen:
This is a subset of a virtual coding summary, a virtual health coding summary I should say, that we put together at PMG. This just gives you a quick breakdown on the left hand column, the type of service, the CPT code in column two. A brief description in column three, and then the coding that you're going to
want to look for, admittedly no modifiers are listed here, but you do need them as we just talked about. And then some payment expectations that you can see.

Ray Jorgensen:
As we mentioned below, that 99211 is a telehealth COVID-PHE approved code. We gave you the link down below that shows that it is linked. Therefore, that's why I'm saying that 99211 is eligible for compensation. So $92 for a nurse, or an MA, doing a follow up visit, or doing any sort of connectivity.

Ray Jorgensen:
Other interesting note, and I'm going to paste this quick link real quickly, is that as incident two billing is discussed. They tell us that incidents billing, under the PHE COVID-19 pandemic, or public health emergency, that we're actually able to use the incident two in a virtual way.

Ray Jorgensen:
I'm going to just type this out, and I'm going to try and get this to go out to the whole group. Hopefully, that went to everybody. Everyone, I'm going to throw it in your chat too, so you can send it out to everybody if you can. This is the link, and the quote that came from CMS that says, we're allowed to use incident two virtually during this crisis.

Ray Jorgensen:
What does that mean? Well, typically incident two requires direct supervision, which means the provider, under whose name you're billing is physically in the office suite, Medicare has gone as far to define it as "within shouting distance." In this world, they're saying, we're going to obviously let up on that. There is going to be some leniency, because people are operating from home. People are operating on disparate locations. We need to do what we need to do to take care of our patients. That's a wonderful flexibility.

Ray Jorgensen:
Last two bullets here real quick, I know we're short on time. We want to be patiently persistent with the MACS, again, we look at whether it's United, it could be UGS or whatever, these big machines that should know how to do this stuff.

Ray Jorgensen:
From my initial life working at Blue Cross, and United, they're just like you guys. They're people trying to do the best they can, trying to learn, trying to put the best information out there, but it's going to take time that's going to to pass all to get this down.

Ray Jorgensen:
It constantly evolves, and I love the statement that Feldesman Tucker folks were talking about, what did you know at that moment in time it is so critical? What did you know at that moment in time? Because we're billing claims based on what we know to be true today, right now.

Ray Jorgensen:
It's one of the reasons I encourage folks to keep CPT and ICD books going back seven years, because when someone says, "Why did you bill it that way five years ago?" I mean, how the hell do you
remember that? You have to go back and figure out what you knew then. Same thing around all these elements.

Ray Jorgensen:
Memorializing documenting is difficult. Check with Medicaid and commercial, and see if they're going to follow this Medicare TeleMed, the CMS TeleMed policy. That would be awesome. If they say they follow Medicare, if you're in a state where your state Medicaid is doing PPS, then theoretically they're going to follow up. Medicare does, I mean, these nurses theoretically are certainly eligible. Get it in writing, make sure it's there.

Ray Jorgensen:
Last point about documentation that's not on the slide, but you guys I've heard this before, and I just want to make sure I say this, it's really critical that you document the time spent on the day of the E&M service, understanding that they're following really the proposed evaluation and management documentation guidelines that are supposed to take effect January 1st, 2021, which is time and medical decision making.

Ray Jorgensen:
History and exam, they're important, but we're no longer going to be using the 95, 97 guidelines to get history and exam leveling, as much as looking at time and medical decision making to make actual evaluation and management code level selection.

Ray Jorgensen:
I'll stop there. I know we're a little short on time. Thank you to NACHC for putting this together. I'll be glad to answer any questions. Probably not now, but later on. Feel free to shoot an email or whatnot out to our PMG website. My email is rayj@gopmg.com. I'll be glad to help. Thanks very much, and Emily I'll pass this back to you, or Gervean, I'm sorry, I'll give this to you.

Gervean Williams:
We're probably going to run a little bit over, but just one thing about the relaxation of the telehealth rules and regulations. This is something in my opinion that it might not be rolled back completely, but it might be changed once we're post-COVID-19. I highly suggest you guys do an inventory of your patients, and their audio visual capabilities, so that we can go ahead and support audio, visual telehealth in the figure.

Gervean Williams:
With that, I'm going to turn it over to Ann to get in at least at three or four questions before we sign off today, Ann.

Ann Loeffler:
Thanks Gervean, jump back in and let me know when to stop. I'll just keep going. Our first question, for those of you who maybe didn't catch everything in the last piece, or dialed in later yesterday, CMS waived a video component for telehealth. Does it apply to FQHCs also, and do we submit claims with 99212 with modify or 95, and G2025, to get Medicare PPS rate for now until July.
Ray Jorgensen:
Gervean, I'll jump in, we did answer that I think pretty quickly there. Do you want to have the PPS G code? Because 99212 would qualify for that. It can be telephone only. That was a big amendment. So you want to have the PPS go code. For instance G0467. An example they gave was that 99212, or 99213, whatever is appropriate from an E&M level. And that we want to add the G2025.

Ray Jorgensen:
It's essential that you have the G2025, because it's going to be a re-adjudication starting July 1st, and if the G2025 is not in there, you do run the risk of them recovering money without affording you additional dollars, because the service was rendered via telehealth.

Ann Loeffler:
Great. Thanks for that summary again. Will telephonic non-video visits be covered by FTCA? Maybe ask Mike this one, or Marty, do you want to weigh in?

Marty Bree:
Sure, whether the visit is just via telephone, or just audio, or audio and video, doesn't enter it to the calculation about coverage. As long as the service is in scope of project, and all the other requirements of the FTCA program are met, there's going to be FTCA coverage.

Ray Jorgensen:
Great. Thank you. Next question is for just, and this is preferential grant, is re-budgeting required if the amount in question exceeds 25% of your funding award?

Jeff Allen:
Catherine, go ahead...

Catherine Gilpin:
There is a difference when you're talking about the two COVID awards, versus the 330 grant. The two COVID awards have a 25% re-budgeting threshold, whereby the 330 grant actually has a 25%, it's the lesser of 25% or $250,000. There is a different re-budgeting threshold between the two awards.

Ann Loeffler:
Thanks Catherine. Next question back to you Catherine, what's an appropriate way to determine lost revenue for purposes of the provider relief fund?

Catherine Gilpin:
What we're telling people right now, and this is based off of some of the information on the HHS website, is think about your budget. Think about your budgeted revenues, and then your actual revenues, taking into account the 40 to 60% decline in your performance right now. Also, thinking about the additional revenues that have been infused into your health center.
Think about your budget, and then think about all revenues, total revenues, not just net patient service revenue. From what we're seeing it looks like a budget to actual lost revenue calculations. I'd like to add that there is no official guidance from HHS. That's something that hopefully they'll release more guidance, but we haven't received yet.

Ann Loeffler:
All right. Thank you.

Ann Loeffler:
Is there any reasonable amount of cash reserves, line of credit availability, or investments that you could have, and still legitimately accept the PPP loan and forgiveness? For example, if you took a $2,000,000 loan, but you had $10,000,000 in cash and investments. This can be for you Mike or someone else.

Mike Glomb:
I'll touch that. This is a very fact specific situation. You could envision a situation where that would be totally unreasonable to try to get a loan. You can envision a situation where, even with that kind of money, you could be out of business in two months.

Mike Glomb:
I don't think you can use a rule of thumb at all here. I think you need to look at your particular situation. Again, this is a statement that you either made when you applied for the loan, or if you're considering trying to apply again, because a lot of people have asked that question, should we put it in application?

Mike Glomb:
I think there is somewhat a third of the money I believe, as of Wednesday, secondary source, don't hold me to that. But if there is further appropriation for this, applying for [inaudible] For that digression, I mean, I think, what my point is, document your best judgment for those issues. Even in crisis I would say, where it's a slam dunk, that no one would question it, or you think that no one would question it. Documented it, because it's like a seven year old coding block.

Mike Glomb:
You don't know when these things are going to be looked at, and you need to be able to point out what existed at that time, not what exists when somebody comes to look at you.

Mike Glomb:
Not to mention there is legal arguments to be made about whether this is even supportable. The short answer is, there is not a rule of thumb. You have to make, and I encourage you to make the best case possible for your particular organization.

Ann Loeffler:
Great. Thank you. Gervean, do we have time for one more?

Gervean Williams:
Yes, one more.
Ann Loeffler:
How should we determine the fee for G2025?

Ray Jorgensen:
Gervean, could I jump on that? Because I meant to cover that?

Gervean Williams:
Yes, go ahead.

Ray Jorgensen:
All right. A couple of key things, like all of your other services, you should be theoretically looking at local prevailing rate. You should be able to look at something and say that you could demonstrate your cost on average if it was above a certain level, all important stuff.

Ray Jorgensen:
I just like your PPS rate, and I know for some health centers this was new, but this is how the whole rest of the fee for service world gets paid. You get your charge or the payer's fee, whichever is less. The key is, the charge has to be more than $92 to get $92. That's why it's $92.03.

Ray Jorgensen:
What you're theoretically doing is figuring out what it cost you to deliver care? Certainly the biggest expense is going to be typically your salaries. Then also what other elements of care? Especially now adding TeleMed. All the different resources in terms of maybe additional computers, additional hardware, additional software, secure files or whatever it is you're having to manage, if you have to get tablets.

Ray Jorgensen:
All those different elements, you're simply adding those up, and creating an average expense for delivery of that service. There is no one way to do it just like with setting rates for PPS G codes. The CMS does not give us a requisite methodology. You just need to be able to explain it to somebody. It's not any different than setting your other rates within the organization.

Ray Jorgensen:
I'd be hard pressed to think most of you wouldn't be able to maximize that expense just because it's as much money in my opinion as rendering care on site, just because of all the different locations, and putting them together very rapidly, versus being able to go out and price the best deal for everything. You have to deploy this stuff very quickly right now.

Ray Jorgensen:
Again, prevailing rates locally, but also making sure you can justify it from a cost perspective.

Gervean Williams:
Thanks so much Ray and-
Ann Loeffler:
Thank you Gervean.

Gervean Williams:
Thanks so much, Ann, Ray, and all, and Marty, and Mike, and Jeff and Catherine for this great webinar.

Gervean Williams:
Thanks for all of you out there on the front line. We really appreciate everything you do. We here at NACHC are here to support you. Anything you guys need, please just reach out to you us, and let us know.

Gervean Williams:
We will have another financial office hours in two weeks on Friday. Until then, everyone stay safe, and have a great weekend, bye-bye. (silence).