Rachel A. Gonzales-Hanson (00:00):
Good morning or good afternoon as the case may be. I am Rachel Gonzales-Hanson, senior vice
president of Western Operations for the National Association of Community Health Centers. Thank you
for joining us today. Before we begin this session, we are going to hear from a very special guest, Mr. Jim
Macrae. Jim is the associate administrator for the Bureau of Primary Health Care at HRSA. Jim, thanks
for joining us. We're really glad you're here. We'll turn it over to you.

James Macrae (00:30):
Great. Thank you, Rachel. And as you said, good afternoon and of course good morning to those out
actually now in the Midwest and the West Coast. So glad you could join us today and so happy to come
back to this session that you all are doing. Really appreciate all the work that NACHC and its various
partners are doing to support health centers really as we're moving forward with COVID-19. As you've
heard me talk quite a bit, this has been just an enormous impact on the health center family, both in
terms of personal impacts as well as professional impacts. And again, just really want to thank you all for
everything that you've been doing really to support your patients, your staff, your communities, and
really making a huge difference.

James Macrae (01:14):
I have the opportunity quite often to share information with the administrator here at HRSA, but also
the secretary as well as the coronavirus task force. And they deeply, deeply appreciate the work that
health centers have been doing. We're really excited of course it's health center week next week and
we'll be able to even highlight some of the great accomplishments that health centers have done. In
terms of today, I know we're going to spend a lot of time talking about, for lack of a better word, how to
best manage all of the different resources that you all have and to make sure that you're doing
everything correctly and crossing all those P's and dotting all those I's and most importantly doing what
needs to be done.

James Macrae (01:55):
But it really is important to be able to document that for a variety of different reasons. Number one, of
course, you don't want to get into any kind of trouble or issues. But it also again proves that health
centers are a wise investment and use the money to the best of their ability. And so anytime that we can
show that and demonstrate that is really important. From the HRSA standpoint, I think you all are well
aware, but we've put out a little over $2 billion in total to our FQHC health center family. We put out
$100 million in late March. We then added another $1.32 billion through the CARES Act in early April.
We then put out additional money in May to support testing in health centers. And then of course, we
were really excited to be able to provide about $17 million for lookalikes to support testing.

James Macrae (02:49):
You have translated that into really miraculous impacts. We just have the most recent data and we've
actually tallied it up. But we've now reached over 2.6 million tests that health centers have done. So that
includes both the viral detection as well as antibody tests. And you continue to test the individuals that
are most at risk. And so really appreciate all of your efforts in that space. Also, we're happy with this
week's report that will be coming out soon shortly that the turnaround time for the test is starting to
come down. We definitely experienced what many folks across the country have experienced in the
health centers, but that's starting to turn around a little bit. So that's a positive sign.
James Macrae (03:31):
In addition, we've seen movement around the number of visits that health centers have been able to get back up to. And it's been fairly consistent for the last three weeks. We're at about 78% of where we were pre-COVID. It's pretty much staying there, however, and so we do hope at some point that will begin to rise even further as more and more folks are encouraged to come and get their preventive and primary health care services met in addition, of course, to dealing with COVID.

James Macrae (04:04):
One of the areas that you're going to hear a lot from us in the next couple of weeks really is around childhood immunizations. That is a key area for us. There's going to be a whole effort throughout the department. And one of the key groups that they've asked us to work with are our community health centers. And even to consider from August 17th to the 31st to potentially even expand ours, if that's possible, you can use your CARES Act dollars of course to support that, but to make sure that there are time and space available to get kids immunized. Of course, there's going to be a big push a little bit later when the flu vaccine becomes available and of course knocking on wood when we get to that COVID-19 place with vaccine. So that absolutely is absolutely essential in terms of our work.

James Macrae (04:50):
The other item that continues to really stand out is the whole push around virtual healthcare. So right now, we still are at about 33% of health centers are conducting their visits virtually. And again, that has stayed fairly consistent for the last three weeks. As you know, we were close to 60% early on in the pandemic and right now we're hovering right around 33%. You've heard me talk that as we move forward some of the critical pieces really are going to be how do we maintain some of the positive changes that have happened as a result of COVID and how do we of course get back to more routine operations when it makes sense.

James Macrae (05:34):
And so several of the things that we've asked you all to do and really appreciate it is to report on the progress of all of your different funding opportunities that you've received from us. We know it's not easy, but we have tried to make it as simple as possible in terms of those progress reports. But it is critically important that you get those in. We're at about 95% and this is the last day before we have to unfortunately take some action against folks in terms of making sure that they report their progress in terms of how they're spending their money. So we're at 95%, which is great, but we just need to get those last 5% in today.

James Macrae (06:14):
And then the last thing I would just say in terms of what we're seeing, health centers have definitely risen up to make sure that their patients and their staff are as safe as they can be and are using their resources to help support that. They of course are using it to support testing, they of course have been using it to help support their operations, to either get close to back to where they were before, or to at least keep staff in place to be able to deal with any kind of surges or any kind of needs that are existing in their community. They have absolutely made the pivot towards telehealth and are using resources to support that. And of course, many of you are using some of your resources to help support Capitol.

James Macrae (06:55):
In terms of the future, so we are like you watching what's happening on Capitol Hill. We are hopeful that something will happen. The good news from the House and the Senate side is they both have agreed to include $7.6 billion for health centers at this point in time. But they do differ in terms of their focus. So on the House side of the bill, it includes resources for both health centers that are funded as well as FQHC lookalikes, as well as our native Hawaiian program. On the Senate side, it only includes those that are funded. On the Senate side, it also includes a more expansive use of the funds to include Capitol. And so all of that of course will have to be reconciled, including if and to what extent we are included in that bill. So we like you are very much looking at that and we will of course get those resources out as soon as possible if and when that happens.

James Macrae (07:52):
The last thing that I will just say and then turn it back to you, Rachel, is just to say that we are continuing to look at how we can best support you all with this transition to virtual healthcare. The real desire from where I sit is that we do not go back to the way that we've delivered care. I think we've seen such a benefit of virtual healthcare in terms of access, especially for some of our most vulnerable populations to be able to come in and get care virtually without having to come in physically into a health center space and take time off of work or deal with transportation issues or other things. We've also seen the quality improve and a lot of cases heard anecdotally that, for example, the no-show rates have dropped significantly for virtual visits as compared to in-person visits.

James Macrae (08:38):
And then we do think from a financial standpoint, we can make it work. And so we want to over the next year or so really work with you to figure out what is that right balance for health centers around virtual and in-person care. And then of course with all of the issues related to institutional racism, social determinants of health, we really want to help support health centers as you all are dealing with many of these issues within your communities and help support you with your work in that area to really deal with some of the more upstream impacts in terms of health because we definitely have seen that in terms of COVID, we've seen it with respect to chronic disease, and we absolutely have seen it in terms of the impacts on our patients, our staff, and our community.

James Macrae (09:21):
So just again look forward to the partnership. Please if you haven't, get in those progress reports. And I think the folks that you're going to hear from today will provide you some good support with some of the other resources that you all are getting. And thanks for everything that you're doing. So all yours, Rachel.

Rachel A. Gonzales-Hanson (09:40):
Thanks for your support, Jim. And please know how much we appreciate the Bureau's partnership with health centers as we work to ensure access to quality healthcare for everybody. Unfortunately, next president and CEO, Tom Van Coverden, will not be joining us today due to an urgent matter at the office. So we're going to get right into it and let's take care of some housekeeping items. If you are having technical difficulties, you can click on the "Request Support" button at the bottom of the screen.

Rachel A. Gonzales-Hanson (10:07):
For those joining via internet, today's speakers will have content slides and a link to the slides can be found in the resource box on the bottom left of your screen. For those who are calling in, the recording
transcript and slides will be posted on next website after the webinar. If you have a question either during the panelist presentations or during the formal Q&A time at the end, please enter that in the Q&A with speakers area and include to whom you are directing your question. Questions that are not addressed on air will be added to the NACHC website on the COVID-19 page. Feel free to chat with our other participants or communicate with the next staff during the webinar using the chat feature.

Rachel A. Gonzales-Hanson (10:52):
Lastly, we would like to remind you about our exciting CHI at home coming up August 31st and September the 1st. And of course, we will be offering the Board Member Boot Camp as well that will be on August the 30th. So please remember to register today and let's not miss that. So let's get to it. As you know, NACHC's reimagining webinar series is focused on supporting health centers as they continue appropriately responding to the COVID pandemic, all the while taking that flexibility, those brilliant innovations and transformations that health centers are using to paddle COVID-19 as it guides us in reimagining healthcare delivery. This is how we will shape the future of healthcare and continue to uphold America's health centers as leaders in primary healthcare. This is the last of our five webinars for our series. And it will be moderated by Gervean Williams. Gervean is the director of health center financial training in the Training and Technical Assistance Department at NACHC. Gervean, it's yours.

Gervean Williams (11:58):
Thanks so much, Rachel. And good afternoon, everyone. Well, before we get into our content, I just want to highlight a couple of things. NACHC has just launched a new community health center finance toolkit. This toolkit gives guidance on proactive communication internally and externally, cash flow planning, understanding the relief options available in cybersecurity, just to name a couple of things that it covers. Another tool I would like to highlight is our telehealth implementation quick guide. This is a live document that we're continually to update as we're getting information from the field and getting more information about this whole transformation at telehealth.

Gervean Williams (12:34):
All these resources are in the resource tab on the bottom left hand of your screen. So you can click on that and see these resources. And speaking of telehealth, we are in the process of trying to collect more lessons learned, more data on the effectiveness of telehealth. So if you have any lessons learned or any great best practices you have, or if you need assistance in telehealth, please reach out to me and I'll put my email address in the chat so we can have that conversation, so we can gather this data, so we can spread more communication and education to everyone across the field. Okay, with that, I'll go ahead and turn it over to our session today. We're going to hear voices from the field and then an update on provided relief fund and Paycheck Protection. And our first speaker today is Mike Holmes, CEO of Scenic River Health Center. I'll turn it over to you, Mike.

Michael Holmes (13:23):
Thanks, Gervean. Good morning and good afternoon, everyone. It sure has been a long five months. And in many respects, it seems like a lifetime. I know a number of you have already gone through the first wave of COVID-19. Some of you are in the middle of that first wave, but there still are a number of us that are aware that wave is still coming. Just because you are in a rural area where there aren't a lot of people and you may be far away from the most serious outbreaks, it doesn't mean that you have protection from the virus because that viruses is spreading everywhere. Our clinic sites are in Northern Minnesota. They're considered to be frontier and remote. For us, social distancing is a fact of life.
Michael Holmes (14:10):
We've already tested about 6% of our patients for COVID. We're seeing about two to two and a half percent of those tests coming back as positive, but those test results, positive test cases are starting to tick up. And I'm just going to give you a couple of examples of what we're starting to see. We had a family travel to our area on vacation from a state that opened early. When they left home, everybody was asymptomatic. 400 miles later, the family had symptoms, the entire family tested positive. We had a summer camp counselor who was asymptomatic test positive. We had a local father and son go to a youth hockey tournament. They came back, became symptomatic, and they've tested positive.

Michael Holmes (15:01):
And a few weeks ago, we had the rodeo, small town had their 65th annual rodeo. Because of state restrictions, COVID restrictions, the organizer announced that spectators wouldn't be allowed. However, if people would like to come and protest against this ridiculous government overreach, they would be free to do so and they would not stand in the way of the people's right to assemble. So we had thousands of people show up at this event and sure enough that very next Monday morning we had a positive case from that event. Now, attendees at this event came from seven states and over half the counties in Minnesota. But this was just a small event.

Michael Holmes (15:47):
Tomorrow starts the 80th motorcycle rally in Sturgis. This rally has drawn upwards of 500,000 people. Even with COVID, they're expecting hundreds of thousands of people to be gathering. And people are coming from all over the United States and Canada to attend this event. And with that being said, we still have schools that are starting to reopen within the next month. And so we have to deal with what's going on with COVID and how we live in this environment because we're in a mobile and free society, but the virus is here and the virus is going to continue on for years.

Michael Holmes (16:35):
Gervean, if you go to the first slide, a couple of months ago I talked about... I had a slide on the impact of the potential effects of COVID on the organization. It was showing the fiscal effects of COVID, the fall off of revenues and how long it would take to climb back from those drop offs in revenue. The next three slides I've got are representative or show what actually happened to our patient volumes. The immediate effect on our medical patients you can see was a sharp fall off in visit counts. We thought those medical visits would drop to about 50% of our average visit counts. They actually fell to 40%, but they climbed back faster than we had originally anticipated. And that was the result of implementation of telemedicine visits.

Michael Holmes (17:39):
And as we changed our visit protocols of moving patients through our clinics in a safe fashion for both the patient and our staff, you can see that we've actually returned more to the 80% to 85% of pre-COVID visit levels. Right now, about 15% of these visits are telemedicine visits. Now, if you could move to the next slide, this is what happened to dental. Now, we weren't under a two-month mandatory shutdown for dental. We could only see emergency dental cases. We thought it might be about 25% of our prior visit totals that actually dropped to about 15%. We spent the last part of the dental shutdown preparing to come back online with our dental clinics, with new visit protocols and procedures. Right now, we're running approximately 60% to 65% of pre-visit levels.
Michael Holmes (18:45):
And if we could go into the next slide, and this will be what's happened in our behavioral health area. Behavioral health has been the area that has been most adaptable to telemedicine or telebehavioral health. And so it was quicker because we initially had started a telebehavioral health project. It was quicker to bringing those patient visits to an entire telemedicine format. And so right now, most of these visits are conducted virtually and you can see that those visits have continued to rise as the weeks have progressed. And we expect to see continued increases in behavioral health visits given the current environment.

Michael Holmes (19:38):
These levels now for patient visits and medical dental and behavioral health, there are new normals, there also are new fiscal normals. Providing changes to increase these levels to pre-COVID right now are going to take time and they're going to take work. And we've got some obstacles. We're seeing delays in getting test results back. Right now, the commercial reference labs are getting results back to us in 15 to 18 days. There's a severe shortage of test kits for the two Abbott rapid test machines that are in the critical access hospitals that are adjacent to two of our clinics. So those tests are restricted to congregate housing, long-term care patients, ER patients, and ambulance transports.

Michael Holmes (20:31):
And so what we're doing right now is we're finalizing arrangements with Mayo to try and move some of our testing to the Mayo Clinic. And that should reduce the result times to three to four days. We're looking at changing air filtration and making air handling modifications in our dental clinics to try and speed up our traffic and dental. Right now, we're leaving dental chairs vacant for an hour between patients to allow the aerosols to settle before cleaning. We've made it up to this point with all of the additional resources that we've had from PPP, the Provider Relief Fund and HRSA grants. And we've got to continue to make changes in this world of COVID, it's our new environment.

Michael Holmes (21:19):
Just want to say in closing thank you for all the patient care you're providing and all of the hard work that you're doing. And last and finally, if you've missed any of the webinars on reimagining care, they're archived on the NACHC website. It is under COVID-19 on the COVID-19 webpage. And at this point, I'll turn it back to Gervean.

Gervean Williams (21:44):
Mike, thank you so much for sharing your story and your leadership. So next, I'll turn over to our next presenter, David Fields and Justin Kensinger from BKD.

Justin Kensinger (21:55):
Hi, this is Justin. I'll start off by talking about the Provider Relief Funds, and then I'm going to turn it over to David to go through some of the reporting requirements and seeing a lot of impacts as well as the accounting for the Provider Relief Funds. So if you can go forward to the next slide please. So in summary, from a general perspective, most of our health centers have gotten general distributions from those that participated in Medicare, as well as coming up those that participated in Medicaid. If you can go to the next slide please. From a Medicare perspective, most of you have seen this back in April, on April 10th and April 17th most of our health center clients have gotten some sort of reimbursement.
from a Medicare perspective. That was the initial $30 billion that was allocated out. A week later on April the 24th, this essentially got trued up to about 2% of net patient service revenue.

Justin Kensinger (23:04):
So collectively, this is the general distributions that really came out of the Provider Relief Fund. In addition to that, there's been some targeted distributions that I'll show you here in a second, but I really wanted to point out to you the Provider Relief Fund website. So this website has some great information on it. If you are unsure of what provider relief funding you've received, you can go to this website and you can actually even see what you've received and what you've attested to right from the public information that's out there. A lot of the information that's on David and I slides are from the FAQs that are also listed on the website. It's about a 56-page document at this point that continually gets updated based on new information that's made available.

Justin Kensinger (23:52):
If you can go to the next slide please. So the general distributions, these were the ones from April that I mentioned. The Medicaid distribution, which is phase two that is ongoing right now. So those providers that did not receive the initial phase one distributions, which is primarily going to be those health centers that may not have any Medicare population or didn't build Medicare back in 2019 could be eligible to now be participating in phase two. You can go to the next slide. From a targeted distribution perspective, the most significant population here has probably been our rural health centers. So that's the second target there.

Justin Kensinger (24:41):
A lot of these targeted distributions have been more for high impact areas, which I think a lot of hospital and rural health centers out there have gotten. The majority of this targeted distribution at least so far has been for our rural providers, although some of our urban health centers received at least a small portion of that targeted distribution. Time's going to tell on the allocations of the remaining Provider Relief Funds and its additional Provider Relief Fund are added to the population to be either distributed targetedly or from an overall general perspective. You can go to the next slide please.

Justin Kensinger (25:26):
There's been a little bit of confusion in recent announcements. So I was very happy to see the first thing listed on the slide, which is really a second chance option. So we've fielded a lot of calls from clients saying, "Hey, maybe I didn't get my fair share, or I didn't get up to my 2% net patient service revenue based on the general allocation." So that would have been the initial 50 billion. So you have another option now. So starting I think next week you'll have through the end of August to really get in and apply for your share of the net patient service revenue from the target or from the general distribution.

Justin Kensinger (26:06):
So I would recommend those that that may not have gotten that initially, or maybe you just didn't get a chance to get your information in in the initial phase, please go in there and make sure you submit that information so you can be considered as part of this phase two. The Medicaid side of things, a lot of our health centers aren't eligible for. I think there's been some confusion out there. So I really wanted to point that out. So the only entities that are eligible for phase two are those that did not participate in phase one. So if you did get a Medicare distribution as part of the original allocations back in April, you are not eligible for the Medicaid side. So I wanted to make that clear for everybody.
Justin Kensinger (26:57):
Next slide please. So let's get into the details in this. So we've been fielding a lot of questions around this, and honestly, there are still some unknowns out there. The FAQs that are on the website go into a little bit of detail, some of that's listed on this slide here. But the question we field mostly right now is, "Hey, what expenses or what lost revenues are eligible for reimbursement in the Provider Relief Fund?" So if you think through that, they've been really pretty general with some of the information that's out there. The healthcare-related expenses attributable to the coronavirus it's a pretty broad term. And this is really meant to be really anything that a health center is doing to really prepare for or respond to coronavirus. So I think this gives you a lot of flexibility to really make sure you document things and can allocate those expenditures or lost revenue to this funding.

Justin Kensinger (28:02):
One thing that I wouldn't recommend you guys do is continue to track your expenditures that you're charging to this funding. And if you are calculating lost revenue, that is great as well. But I would recommend you continue to track the expenses on top of that because at the end of the day... And David's going to get into this a little bit more in the accounting and auditing side of things. But we don't know yet what the audit procedures are going to look like. So tracking the loss revenue, but then on top of that accounting for the expenses is very important.

Justin Kensinger (28:39):
Keep in mind that the Provider Relief Funds do have similar to like your 330 grant federal salary limitation of the 197,300. And the timing of this funding has really been open question until this most recent FAQ that was announced. The HHS expects... And David will get into this a little bit with the reporting requirements. But they had said in the FAQs that they expect the payments for Provider Relief Fund to be extended before your final reporting of July 31st of 2021. The next couple of slides here, you can go to the next one, really pull in some examples of what eligible expenditures might look like from the FAQs. So I'm not going to go through each one of these for time's sake, but I really wanted to show them on the screen for you. From an FAQ perspective, this is right from there.

Justin Kensinger (29:38):
So if you read these, applies for possible or actual COVID patients. You can read through the rest of the list. These are examples out of the actual FAQ of things that you can charge to these Provider Relief Funds. So I think as you read this, my interpretation is you've got a lot of flexibility. So make sure you document things and make sure you are allocating that within your general ledger, that way you have that support for an auditor that would come at a later point.

Justin Kensinger (30:09):
I think there's one more slide that has some examples on it. So in this slide, it lists additional examples, which number one, employee payroll. So payroll represents 60% to 70% of our overall expenses. So if you're not charging this to another grant, then you can charge that to your Provider Relief Fund along with other things listed on this slide. So I'm going to turn it over to David next, and he's going to get into the accounting for the Provider Relief Funds as well as some other things. David?

David Fields (30:44):
Thanks, Justin. If we go to the next slide, I'll cover... Inevitably when we start talking about how we're going to handle special grants, contributions, supplementary funding, I think those of us who are on the call that are from the accounting persuasion realized that that our portion of this oftentimes is an afterthought or something that comes later. The key thing is cash is king right now and we want to make sure that we've got funding to meet our obligations and sustain the organization so that we can be that tremendous resource for the communities that we serve. But now that we're five months into this, a lot of those accounting questions are coming to the forefront.

David Fields (31:24):
One of the things that we've been asked is, okay, we know there has been a lot of discussion about new accounting standards and one of them that has been implemented for most organizations over the course of the last year, most community health centers across the country is a contribution clarification standard. And really what that means is that our grants and contributions now fall under some of the same accounting methodology. So whether that's the 330 grant or Provider Relief Funds. And some of the new language that may exist for some of you out there is, "Okay, so how do we define this for Provider Relief Fund and some of the payments?"

David Fields (32:06):
The executive summary is that it really is considered a conditional contribution, which means that we've got some terms and conditions that we need to follow, kind of like their terms and conditions associated with your 330 grant. And how we show these as revenue for the organization is when we have met those conditions. And typically, what we're going to think of is when we have met those qualifying expenses, when we have incurred some of those lost revenues. I will point out that there is a tremendous amount of discussion in the accounting world on this. It involves the AICPA, which is the American Institute of Certified Public Accountants, lots of things from HFMA. And I know BKD is involved in those conversations with NACHC when were brought to the table to try and just urge clarity on how some of the reporting and the testing is going to go in regard to these provider relief payments.

David Fields (33:12):
So the key item here is that for those of you who may had a 331 April 30, May 31, June 30, year end, we recognize that there's some pressure to make some of these decisions in a short-term timeframe. We're trying to provide some of that clarification and guidance and I encourage communication with your auditors as health centers are required to have financial statement audits to make sure that there's some clarity on an agreement on what revenue's being recognized and the precise timing of that. If we can go to the next slide.

David Fields (33:51):
So the revenue for most of the Provider Relief Funds is going to be an operating revenue. That means that it'll count for operating income. But what we're really trying to measure that against is what are we really charging as the expenditures to this grant? Again, if we're considering it more as a replacement for lost revenues, I would say that would keep it as an operating income as well. If we use it for any property, plant, equipment, maybe big renovations or something, Mike had mentioned using this for HPAC sorts of stuff that might be capitalized and that would be something that would be after operating income. We'll go to the next slide.

David Fields (34:38):
The key thing that I wanted to highlight and make sure that I saved some time to talk about is the Provider Relief Funds are going to be things that show up on your Schedule of Expenditures of Federal Awards. And we've listed here the CFTA numbers associated with this. We expect that there will be a number of community health centers that require this to be tested as a major federal program. But regardless, we are still waiting for the testing rules and expectations that will exist for this program. Right now, the release date for those are talked about being this fall. And it's not much more specific than that.

David Fields (35:17):
There is something called the compliance supplement that is released each summer. That'll get released shortly. But we expect that there is a second supplement coming to that. And why is that significant for you as a recipient of Provider Relief Funds? Because it's going to give you sort of HRSA's playbook, their expectations for what it is that your financial statement auditor would look at, or if they're not, I would say it's a reflective of the guidance that the OIG might expect. So it could influence even how we recognize some of this revenue as the terms and conditions are made clearer through what will be tested as part of these programs. So it's something that we will be working with NACHC to communicate as additional guidance comes out.

David Fields (36:05):
Going to the next slide, Justin had highlighted that there is revised reporting requirements associated with this. Some highlights are that the instructions will be coming out here in a little bit less than two weeks. The reporting will be available October 1st. The idea is if you fully have expended these funds, then you'll be able to complete essentially a final report anytime between then and the initial report due date of February 15th. I would caution some health centers to not necessarily rush to file that because we're going to want to know what the auditing expectations are for those funds, because you may change or shape or reaccount for how you've spent those funds based on some of those clarifications of the rules. And then the final report if it's not completed by February 15th through the December 31st year end date would be July 31st.

David Fields (37:01):
Looking at the last slide, Jim Macrae talked about some of the additional funding that was out there and why is that key. It's key because we need to recognize that as we're obligating some of these funds, that there's going to be future funding that is likely to be available. And so it may influence the timing in some of the expenses that we use to charge to some of these grants and then taking advantage of max resource on the telehealth side of things. So with that, I'll turn it over to Mike.

Gervean Williams (37:41):
And Mike, you might be muted.

Michael Glomb (37:50):
I thought that the two are going to introduce me, but that's okay. All right. So next slide please. While we're setting that up, I do have to include the typical disclaimer that this is not legal advice. This is training, this is information purposes only. And if you do need specific legal advice or other advice on these matters, please consult a competent professional. There are a number of slides that you will see. I'm going to do basically an overview and a highlight, and there's a lot of additional material in the slides...
that I’m not going to talk about that illustrate the key points that I will address here. Hopefully, that'll be a useful resource for you participants when this is posted. Next slide please.

Michael Glomb (38:41):
So the key features of my presentation have to do with the changes to the Paycheck Protection Program that happened since June. The major one being in the 5th of June Congress enacted the Paycheck Protection Program Flexibility Act, which as the names implies provided some additional flexibility in how the funds that were available to you could be expanded in terms of the times that they could be expended and the purposes for what they expended on. Basically, it allowed the so-called loan covered period which was eight weeks to be extended to 24 weeks from the time that you received the loan. And if you received the loan before June 5th, you could also use the 24-week covered period. Excuse me. This is essentially the period of time in which you are allowed to use the funds that are provided to you for allowable payroll costs and non-payroll costs and still obtain forgiveness for those expenditures.

Michael Glomb (39:54):
The bottom line of this is you can only extend it to December 31st. But for most people, unless you got a loan very late in July, the December 31 is not that relevant because that will be further out in 24 weeks when you got your loan. This is important because the Flexibility Act gives you flexibility that’s a plus, but it also gives you some challenges. And this has been addressed in prior sessions as well. But when you’re dealing with a variety of funding streams from the federal government, starting with 330 and other types of grants and all this supplemental funding we have, all of which have specific requirements or specific uses for those funds, there can be a challenge in how you use those funds and the timing of those expenditures so that you at least for Paycheck Protection purposes maximize the loan forgiveness amount, which again is the payroll expenses and the non-payroll expenses, which are limited than defined by law in terms of what are allowable against your other funding sources because you cannot double bill, if you will, charge one program for something another program is paying for it.

Michael Glomb (41:19):
But at the same time, you want to make sure that you are maximizing your utilization of these resources that you have. And that’s going to require consultation. Certainly, your CFOs needs to be on top of that and your financial advisors. Your auditors probably need to be involved in that because as you also hopefully know that if you have a loan of Paycheck Protection on under $2 million, probably the government isn’t going to look at it for audit, but loans above that are likely to be... We’ll audit. We don’t know what those process audits are going to look like. But you’re probably be some exhibit level of review, not to mention an OIG or rather auditor coming in a couple of years and looking at it again.

Michael Glomb (42:10):
So the basic point is that now that the main provision here was you were allowed to now spend your funds over a 24-week period instead of only an eight-week period. The other key change was to change the amount that had to be spent on allowable payroll costs from 75% of your overall loan allowable expenditures to 60%. And I thought it was interesting that Justin pointed out that in their experience payroll is 60% to 70%. So under the original rule, they'd be hitting 75% of your loan for payroll cost was more of a challenge. Now, it can't be as down to 60%. Next slide please.

Michael Glomb (43:06):
So the other key thing is that... In these other key things, I should say, in the statute, the original statute you and exist now, you are penalized as a borrower. If you reduce your full-time equivalent employee count from a period of time, you have an option to pick which period of time it is. That's detailed in later slides to during the period of between February of this year and April 26th if you made that reduction. These dates seem at this point pretty random. But remember, this statute has evolved over time and a lot of features in the initial statute in terms of the dates haven't been changed. So you have now until December 31st, 2020 to make corrections to that FTE count, meaning bring the count back up to what it was and the so-called reference period.

Michael Glomb (44:06):
And you also have under the statute 10 months from the time that you expended... the last expended the funds to actually apply for your loan forgiveness. So there are planning options here and there's opportunities to maximize this that you have the opportunity to take care of, but it's going to require some advanced planning and some coordination with your other funding sources to maximize the benefits. I also should note that if you haven't applied for a loan, you have under the current law two more days till August dates to apply. There is some talk that the next ground of relief that's in Congress will include something on Paycheck Protection. I had heard that it would focus on smaller employees only smaller than 500. I think with everything else that come out of Congress on the COVID matter, we just have to wait to see what comes out and what the president signs.

Michael Glomb (45:21):
So under the original statute, if you had a loan that was FTE people, the FTE counts, and remember this FTE count non-employees reduced during that period from the reference period, you could avoid a penalty if you could document that they quit, or that they were fired for cause, or that they had their hours reduced upon request. What the new amendment give you is an opportunity to avoid a reduction, not just by hiring people back to get this FTE count, but documenting that you can't find the right people to fill that position. To put it bluntly, you don't have to hire two local people now to make up for say a provider who you can replace just to get your FTE count up. If you can document that you can hire equally qualified person, you are able to avoid a reduction in your penalty based on FTE count.

Michael Glomb (46:43):
There's also a penalty if you reduce the compensation of any employee who earns less than 100,000 a year annualized by more than 25% during your loan covered period, either the 8 week or the 24 week period. That is still in effect. But in some cases, people's income was reduced because their hours were reduced. So you had someone who went from a full-time employee to a halftime employee and had a commensurate cut in pay, which would be a 50% cut in pay. That could, if you look at those reductions, penalize you for reducing the FTE count from full-time to halftime and also penalize you for reducing the pay to 50%.

Michael Glomb (47:35):
What the SBA said is that, "No, as long as you keep the same rate of pay in effect when someone had their hours reduced, you will not be penalized for the payroll reduction, just for the FTE reduction per se." Also, and guidance that was actually issued before the June 5th amendment, the SBA clarified the statute which says that, "Payroll and non-payroll costs have to be incurred and paid during whatever covered periods you pick." They actually clarified that the end really means or. So with appropriate
documentation, you can show that your allowable costs will either incur in allowable covered period or paid after the covered period when they were incurred.

Michael Glomb (48:35):
I encourage everyone if you haven't applied for forgiveness yet to look at the updated revised forgive this application, which was issued shortly in the middle of June or so because it tells you very explicitly what you're going to have to present to the SBA and your bank to get forgiveness in terms of documentation and how to calculate things. And that is a really useful planning tool if you figure out what you need to do to coordinate those expenditures and how you're going to time those expenditures with your other grant funds that you may be spending so again to make sure that you are maximizing the available resources for both. But at the same time, at least for the loan purposes, not foregoing any forgiveness that you could otherwise get.

Michael Glomb (49:23):
And the other key thing, I should mention these loans can now go out to as much as five years. Even if you got a shorter loan under the initial statute, you can have the opportunity to going back to your bank and renegotiating for five years. I think that's about it for the summary. There's much more detail in the later slides that talk about how these things are implemented. But at this point, I think I'll turn it back to Gervean for the Q&A period.

Gervean Williams (49:52):
Thank you so much, Mike. And I'm sorry, I should've mentioned Mike Glomb is a partner at Feldesman Tucker Leifer Fidell and one of the trusted partners here at NACHC. And with that, I will turn it over to Julie and Philip to go through the questions and answers... Questions.

Phillip Stringfield (50:07):
Absolutely. Thank you so much, Gervean, and all of our speakers today. So we got a wealth of questions. So I'm to get a rapid fire, try and get in as many as possible. So I'm going to first start off with a questions for David Fields. So the question goes, "Using Provider Relief Funds for your last example, acquiring additional resources, do those needs to be related to COVID or can they be general? We are expanding capacity for dental, can we use it for that?"

David Fields (50:40):
So that's a great question. The broadest definition regard to Provider Relief Funds or several of the CARES Act supplementary funding, not the testing one, which would not be permissible for that would be to prepare or prevent, respond to the coronavirus. The stronger the correlation that you can tie to that dental expansion, is it supportable because of additional demands in the community, because as a health center we're able to provide maybe safer access, because of our funding? Really filling in some of those gaps I think that that would would encourage that happening.

David Fields (51:28):
Specifically, the guidance though is really trying to bridge that gap of some of that lost revenue. And the further you get outside of filling that gap on the lost revenue and outside of maybe direct additional expenses pertaining to COVID probably a little bit riskier. So the long answer on that is it is not as clear and straightforward that that would be permissible unless you can tie it to those community factors that
we talked about. But I'm still waiting to see clearer guidance on the periphery of some of this stuff as we maybe get outside the box and something like expanding dental services.

Phillip Stringfield (52:20):
Awesome. Thank you. And I believe I may have another question for you. It says, "It has been stated that the Provider Relief Funds were based on 2% of our annual patient revenues. Can you please tell me where the revenue amount was taken from to determine that 2% amount would be?"

David Fields (52:36):
So the expectation for FQHC is that they're using the 2019 cost report data if that had been submitted or maybe prior to that if your 2019 cost report had not been submitted. There is a net patient service revenue information that is gathered in the Medicare cost report. So that has been the understanding of where that information came from. So sometimes if there's been significant changes since that last cost report was filed or it wasn't filed timely, then that can create some risk for inaccuracies on some of those things. And that's where we've seen the biggest discrepancies on those. But I would encourage somebody if you disagree with what has happened or that there is some differences Justin really touched on the ability to reapply or to ask for additional clarification on that. And hopefully, the organization in the earlier window in June submitted some of the documentation, the requests in the portal that would allow for that revenue that they believe would be accurate to be considered.

Phillip Stringfield (53:55):
Thank you again for answering that question for us. So next, I'm going to go to Mike Glomb for a couple of questions around Paycheck Protection. So it says, "For those of us who elect the 24-week covered period and who brought back furloughed employees, must we wait until December 31st to take advantage of the ability to count recalled employees in our FTE count?"

Michael Glomb (54:23):
The answer to that question is you do not have to wait. The SBA guidance indicates that you can apply for loan forgiveness whenever you have extended the amount of the loans or before for that matter, but then you won't be forgiven for the part you haven't spent. But you don't have to wait to the end of the 24-week period to apply for loan forgiveness. And there sometimes can be reasons not to do that or not to wait the full 24 weeks particularly if your FTE count might go down again.

Michael Glomb (54:57):
I see a couple other ones on here if I could just quickly answer because they're easy. Whereas the loan forgiveness application, you can find it on the SBA website. Those references are at the back of my presentation, but you can go to the SBA website or the treasury department website that has COVID-related information to download it there. And the other question was, "What if we spend all of our Paycheck Protection loan on payroll? Can you do that?" Absolutely. The fact that if you could do that, that's easy. Just remember that individuals that you can't count the prorated compensation more than... You only can use it for the prorated amount of compensation under $100,000 for employee. So keep that in mind that might affect how much you have the ability to get forgiven, but there's no reason why you can't use it all on allowable payroll expenses. I think that's it that I've seen.

Phillip Stringfield (56:08):
Awesome. So I'll go back to David for one more. So it says, "Could using the Provider Relief Funds for lost revenue and COVID-related expenses we consider double-dipping?"

David Fields (56:23):
So this is a question that comes up a lot. Is it utilizing Provider Relief Funds for lost revenue or expenses, or is it the expenses that we're covering due to the lost revenue? I've had a lot of very, very high level in the accounting industry questions and clarifications on that. And that's why I say we're looking for what that single audit testing is going to be. What I am advising my clients is that you want to be able to demonstrate the lost revenues to show that you needed that due to decrease in patient service revenue. But I am encouraging and I know most of us here with the community health center team at BKD are encouraging our clients that your priority is to try and find all the expenses associated with it.

David Fields (57:20):
We feel like that's going to provide a better trail to show that we did not double-dip, that this is what we charge the 330 grant to the CARES Act grant, to the SBA, PPP, and the Provider Relief, and that it is more in keeping with what the uniform grant guidance expectations are and absent something that maybe provides a little bit more clarity on that, that in a national setting is what I'm comfortable with. If you feel like as an individual organization that you need to really get maybe outside of the clearest elements of that and get into more of the precise or the nuanced elements of that, then we encourage you to visit with a trusted advisor to really try and parse out how you might utilize those and minimize the risk to your community health center.

Phillip Stringfield (58:17):
Thank you. I think that's all the time we have for Q&A. So thanks again.

Rachel A. Gonzales-Hanson (58:22):
Thank you, Philip. Very much appreciated. We do have questions that went unanswered. But if you will just give us a couple of days, we will get those answered for you. They will be posted on the NACHC's website, the COVID-19 page, along with the recording transcription and the PowerPoint and all the resources for today's webinar. So please make sure to check there in a couple of days. Thank you all for joining us. We really appreciate you being with us. Our special thanks to the speakers and of course to our NACHC team to help bring this program to fruition.

Rachel A. Gonzales-Hanson (58:56):
While this is the last of the webinar series, we assure you that NACHC will continue to present trainings on what health centers need. So let us hear from you on the potential future topics. You can enter those in the chat box and we'll take those into account, or you can contact NACHC staff directly. Don't forget, register today for the CHI at home. NACHC's counting on you to be part of that. Remembered to stay safe. You are important, and this ends our webinar today. Thank you.