Welcome to the

Rural Health Clinic Technical Assistance Webinar

This webinar is brought to you by the National Association of Rural Health Clinics and is supported by cooperative agreement UG6RH28684 from the Federal Office of Rural Health Policy, Health Resources and Services Administration (HRSA). It is intended to serve as a technical assistance resource based on the experience and expertise of independent consultants and guest speakers.

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Surviving COVID-19 as a Rural Health Clinic

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NARHC NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

Overview

- Telehealth
  - Virtual Check In
  - Digital E-Visit
  - Telehealth visit
- Financial Relief
  - Paycheck Protection Program
  - Provider "lost revenue" program

Quick Note on Cost Reporting Deadlines

CMS is delaying the filing deadline of certain cost report due dates due to the COVID-19 outbreak. We are currently authorizing delay for the following fiscal year end (FYE) dates. CMS will delay the filing deadline of FYE 10/31/2019 cost reports due by March 31, 2020 and FYE 11/30/2019 cost reports due by April 30, 2020. The extended cost report due dates for these October and November FYEs will be June 30, 2020. CMS will also delay the filing deadline of the FYE 12/31/2019 cost reports due by May 31, 2020. The extended cost report due date for FYE 12/31/2019 will be July 31, 2020.

Quick Note 2: Home Health Shortage Areas

- Therefore, for the duration of the PHE for the COVID-19 pandemic, we are determining that any area typically served by the RHC, and any area that is included in the FQHCs service area plan, is determined to have a shortage of HHAs, and no request for this determination is required.

- However, RHCs and FQHCs should check the HIPAA Eligibility Transaction System (HETS) before providing visiting nurse services to ensure that the patient is not already under a home health plan of care. If a patient is under a home health plan of care, the HHA must provide optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs (§ 484.105)

Telehealth ~ Terms

- Terminology must be precise

- "Telehealth" and "Telemedicine" can be the umbrella term for all of the following services:
  - Virtual Check-In or Virtual Care Communications
  - Digital E-visit services
  - Telehealth visits

- Some may also include other technology enabled services in the broad category of telehealth such as:
  - Chronic Care Management or "Care Management"
  - Remote Patient Monitoring
  - Provider to provider consultations

CMS Visual from 3/17: Already out of date

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425–G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	**✳** For established patients.
E-VISITS	**✳** A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	**✳** For established patients.

✳ Already out of date

Virtual Care Communications or Virtual Check-In

- Medicare began covering Virtual Care Communications services in 2019
- In the 2019 Physician Fee Schedule (PFS) Final Rule, CMS finalized a policy that, effective January 1, 2019, RHCs and FQHCs can receive payment for virtual communication services when at least 5 minutes of communication technology-based or remote evaluation services are furnished by an RHC or FQHC practitioner to a patient who has had an RHC or FQHC billable visit within the previous year, and both of the following requirements are met:
    - The medical discussion or remote evaluation is for a condition not related to an RHC or FQHC service provided within the previous 7 days, and
    - The medical discussion or remote evaluation does not lead to an RHC or FQHC visit within the next 24 hours or at the soonest available appointment.
- G2010 = evaluation of an image through store and forward technology
- G2012 = brief conversation with patient (can be audio only)
- RHCs could only bill G0071 whenever they performed either of these two codes
- During the emergency period may be billed for new patients
- FAQ from before COVID-19 on Virtual Care Communications:
    - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf

Digital E-Visits

- Medicare began paying for this in 2020 but RHCs were excluded

- On March 30th CMS released an interim final rule that expanded G0071 to include digital e-visits for RHCs (for the emergency period)

- https://www.cms.gov/files/document/covid-final-ifc.pdf
  - 99421 (5-10 minutes)
  - 99422 (11-20 minutes)
  - 99423 (21 or more minutes)

- These "E-visits" are described as "online digital evaluation and management services" where the practitioner spends over the course of 7 days 5+ minutes of time providing those online E/M services

- As of March 1, G0071 will pay at the average of G2010, G2012, 99421, 99422, 99423 which is $24.76

- During emergency period may be provided to established AND new patients.
  - G2061, G2062, G2063 not included

Digital E-Visits

If the patient had an E/M service within the last seven days, these codes may not be used for that problem.

If the inquiry is about a new problem (from the problem addressed at the E/M service in the past 7 days), these codes may be billed.

If within seven days of the initiation of the online service a face-to-face E/M service occurs, then the time of the online service or decision-making complexity may be used to select the E/M service, but this service may not be billed.

https://codingintel.com/cpt-codes-online-digital-evaluation-and-management-services/

Digital E-visit ~ 7 day clock

- G0071 service provided on Monday
  - Patient comes back with additional questions/calls on the same condition on Friday
    - Only 1 G0071 billed
  - Patient comes back with additional questions/calls on a different condition on Friday
    - Now 2 G0071 codes may be billed

- Seven days must elapse before you are able to bill G0071 again for a patient who has the same condition
- Does the clock start on the date where there first was communication with patient or does it reset every time there was additional communication?
  - I am currently working to clarify this

G0071 ~ Patient Consent

- From CMS Interim Final Rule:
  - Also, in situations where obtaining prior beneficiary consent would interfere with the timely provision of these services, or the timely provision of the monthly care management services, during the PHE for the COVID-19 pandemic consent can obtained when the services are furnished instead of prior to the service being furnished, but must be obtained before the services are billed. We will also allow patient consent to be acquired by staff under the general supervision of the RHC or FQHC practitioner for the virtual communication and monthly care management codes during the PHE for the COVID-19 pandemic.

Billing for G0071

- Bill on the UB-04
- 0521 Revenue Code
- No modifier necessary
- Payment is $24.76

Waiving Cost Sharing for Telehealth

- Providers have the option to waive cost sharing for telehealth services.
- https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/factsheet-telehealth-2020.pdf
- The policy statement notifies providers that OIG will not enforce these statutes if providers choose to reduce or waive cost-sharing for *telehealth visits** during the COVID-19 public health emergency, which the HHS Secretary determined exists and has existed since January 27, 2020.
  - *OIG's Policy Statement is not limited to the services governed by 42 C.F.R. § 410.78 and referred to by CMS as "telehealth visits." OIG intends for the Policy Statement to apply to a broad category of non-face-to-face services furnished through various modalities, including telehealth visits, virtual check-in services, e-visits, monthly remote care management, and monthly remote patient monitoring.
  - https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/telehealth-waiver-faq-2020.pdf

Telehealth Visits in a RHC

- Telehealth visits are considered true substitutes for in-person visits, with the distinction that they are furnished through an interactive audio/video communications system.

- The list of CPT codes Medicare will pay via telehealth is maintained here: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Medicare Telehealth Benefit Before COVID-19

- Originating site = patient location
- Distant site = provider location
- RHCs were not allowed to be the distant site
- Telehealth services were only available for rural Medicare beneficiaries
- Medicare patients still had to travel to a qualified originating site
- Electronic communication had to be done through a HIPPA secure videocommunications platform

Medicare Telehealth Benefit Now

- Patients do not have to be at an originating site
- Rural beneficiary requirement removed
- Can be performed through non-HIPPA compliant video platform
- May be done on a smart-phone but CANNOT be audio-only
- RHCs can now be distant site providers (as of March 27th when the CARES Act was enacted)
  - For emergency period only (as of now)
- https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

Billing and Payment for Telehealth Visits Still Unclear

- CARES Act text:
- "(B) SPECIAL PAYMENT RULE.—
  - "(i) IN GENERAL.—The Secretary shall develop and implement payment methods that apply under this subsection to a Federally qualified health center or rural health clinic that serves as a distant site that furnishes a telehealth service to an eligible telehealth individual during such emergency period. Such payment methods shall be based on payment rates that are similar to the national average payment rates for comparable telehealth services under the physician fee schedule under section 1848. Notwithstanding any other provision of law, the Secretary may implement such payment methods through program instruction or otherwise.
  - "(ii) EXCLUSION FROM FQHC PPS CALCULATION AND RHC AIR CALCULATION.—Costs associated with telehealth services shall not be used to determine the amount of payment for Federally qualified health center services under the prospective payment system under section 1834(o) or for rural health clinic services under the methodology for all-inclusive rates (established by the Secretary) under section 1833(a)(3).".

Reporting Costs in the Non-Allowable Section of the Cost Report

49		Subtotal-Administrative Cost (Lines 38-48)	
50		Total Overhead (Lines 37 *a* nd 49)	
		COST OTHER THAN RHC/FQHC SERVICES	
51	5100	Pharmacy	
52	5200	Dental	
53	5300	Optometry	
53.50	5350	Non-allowable GME Pass Through Costs	
54	5400	Other (Specify)	
55			
55.50	5550	*Chronic Care Management*	
55.60	5560	*Telehealth*	
56			

	(sum of lines 10, 14, and 21)	
	COSTS OTHER THAN RHC/FQHC SERVICES	
23	Pharmacy	
24	Dental	
25	Optometry	
25.01	Telehealth	
25.02	Chronic Care Management	
26	All other nonreimbursable costs	
27	Nonallowable GME costs	
28	Total Nonreimbursable Costs (sum of lines 23-27)	

- 20. Can virtual communication services costs such as software or management oversight be included on the cost report?
  - Answer: Yes. Any cost incurred as a result of the provision of RHC and FQHC services, including virtual communication services, is a reportable cost and must be included in the Medicare cost report. Direct costs for virtual communication services are reported in the **"Other than RHC/FQHC Services" section of the cost report and are not used in determining the RHC AIR or the FQHC PPS rate.**

- Already in place for G0071

- Anticipated that costs for telehealth visits will also go in this section of the cost report ~ likely on the telehealth line that had been previously used for costs associated with being the originating site.

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Thank You!

What we will cover

New Paycheck Protection Program

Other SBA Options

Medicare Advanced Payment Options (clients only)

Provider Lost Revenue Program (clients only)

Paycheck Protection Program

Paycheck Protection Program

What is it?

- The Paycheck Protection Program is a newly created loan/grant program.

- Most rural health clinics will be able to receive a forgivable loan in an amount equal to 2.5 times the clinic's qualified monthly payroll.

- For purposes of this program, an eligible health facility is one with up to 500 employees (full-time or part-time). If you are an RHC owned by a large health system, this may affect your ability to receive a PPM Loan.

Calculating your eligible monthly Payroll Amount

- Most eligible clinics will use their <u>average monthly payroll</u> for 2019, excluding costs over $100,000 on an annualized basis for each employee.

- If you are a NEW RHC (one that opened after January 1, 2020), average monthly payroll should be calculated using the time period from January 1, 2020 to February 29, 2020, excluding costs over $100,000 on an annualized basis for each employee.

How much can you borrow?

- To calculate the total amount you can borrow, multiply your eligible monthly payroll amount by 2.5 and this is the amount you can borrow under this program.

- Example: Monthly Payroll Amount: $17,500   X   2.5 = $43,750 loan amount

How much can be forgiven?

- The entire loan can be forgiven if the your clinic meets certain requirements.

- If you the business fails to meet the requirements then the amount forgiven will be reduced or you may have to pay the entire amount back.

What must a business do in order for the loan to be forgiven?

- In order for the loan to be forgiven, the RHC must demonstrate that the loan monies were used to pay employee salaries, health insurance premiums, rent or mortgage interest and utilities.

- The clinic owner(s) must attest that you have the same number of employees (full-time and part-time) at the end of the loan period (8 weeks) as you did at the beginning.

- If you terminated employees during this period OR you reduced their salaries by more than 25%, then the you may to pay the entire loan back – 2 years @ 1%*.

Paycheck Protection Program

The program starts TODAY! Here is a link for the application.

https://home.treasury.gov/system/files/136/Paycheck-Protection-Program-Application-3-30-2020-v3.pdf

- You must apply through a local bank that is participating in this program.

Participating Banks?

- You can apply through any existing SBA 7(a) lender or through any federally insured depository institution, federally insured credit union, Farm Credit System institution that is participating.

- Other regulated lenders will be available to make these loans once they are approved and enrolled in the program. You should consult with your local lender as to whether it is participating in the program.

Other SBA Disaster Relief Programs

SBA Debt Relief

- The SBA Enhanced Debt Relief program will provide a reprieve to small businesses with **existing** SBA loans as they overcome the challenges created by the COVID-19 crisis.

- The SBA will pay the principal and interest on existing **SBA 7(a) loans** for a period of six months.

- Contact your local SBA loan office for details.

Small Business Economic Injury Disaster Loan (EIDL)

Small Business Administration (SBA) loan for up to $2 million, including a $10,000 grant up front. May be used to pay fixed debts, payroll, accounts payable and other bills that can't be paid because of the disaster's impact.

Interest rate of 2.75%, payable over up to 30 years. Can defer initial payments for up to a year.

Apply directly at the SBA. Applicants may apply online https://disasterloan.sba.gov/ela/ or call 1-800-659-2955.

- NOTICE – You can have sequential or overlapping EIDL and PPP loans.

- If sequential, you an use the loans for the same purpose.

- You can have simultaneous (overlapping) SBA loans the funds must be used for different purposes.

- Your SBA representative- should work with you to determine the best combination/mix or sequencing of these loan options.

Medicare Advanced Payments

Medicare Advanced Payment Option

- CMS has relaxed the requirements for providers wishing to obtain an advance payment on future Medicare claims.

- CMS is authorized to make advanced payment through the duration of the COVID-19 national public health emergency.

- Application is through the provider's Medicare Administrative Contractor (MAC).

Who is eligible for Advanced Payments?

- Any provider –

- 1. Who has billed Medicare within the past 180 days.
- 2. Who is not in bankruptcy
- 3. Not under active medical review or program integrity investigation
- 4. Does not have any outstanding delinquent Medicare overpayments.

Amount of Advanced Payment

- The Rural Health Clinic is limited in how much you can receive. You can receive the equivalent of up three months of advanced payments based on your monthly average Medicare billing for the previous 6 months.

- Average monthly Medicare billing $10,000

  Total Advance available $30,000

- Repayment will begin – automatically - 120 days after the advance and must be fully repaid within 210 days of receiving the advance.

Can the Rural Health Clinic continue to submit claims during the 3 month advance?

Yes, Rural Health Clinics are not precluded from submitting claims during the 3-month period covered by the advance. Recoupment will still not occur until 120 after receipt of the advance.

Provider Lost Revenue Program

Provider Lost Revenue Program (clients only)

Due to the COVID-19 pandemic, many Rural Health Clinics have seen a precipitous drop in patient visits.

The purpose of this fund is to provide grants to practices that have experienced a reduction in revenue **or** an unexpected increase in costs due to the COVID-19 pandemic. The money will be available during the period of the national emergency.

What is the Lost Revenue program?

- This is a brand new program, authorized by Congress and signed into law by the President as part of the CARES – legislation signed into law last Friday.

- Congress authorized $100 Billion for this program to be administered by the Department of Health and Human Services (HHS)

- This program is not yet operational. HHS is working on the details – specifically, how- providers will report/calculate their lost revenue or unexpected costs.

Who is eligible?

Any provider who is enrolled in the Medicare or Medicaid program.

- This will be a rolling program meaning that the calculation could be redone each month.

What MIGHT this look like? Illustrative purposes ONLY

Provider's average monthly collections (all payers) for 3/1 2019 – 12/28 2020 was $60,000.

Provider's collections in March 2020 was $20,000

Providers estimated lost revenue $40,000.

HHS sends provider a check for $40,000

When?

Unknown but hopefully soon – stay tuned!

CRHCP Code

WL924CV

*Please note, this code is only for those that are CRHCP certified and need to maintain their certification.

Questions?