Updated Information on Provider Relief Funds for RHCs
Healthcare Business Specialists
Sponsored by Azalea Health and ChartSpan
July 31, 2020

HBS
Healthcare Business Specialists

Contact Information

Mark Lynn, CPA (Inactive), CRHCP
RHC Consultant
Healthcare Business Specialists
Suite 214, 502 Shadow Parkway
Chattanooga, Tennessee 37421
Phone: (423) 243-6185
marklynnrhc@gmail.com
www.ruralhealthclinic.com

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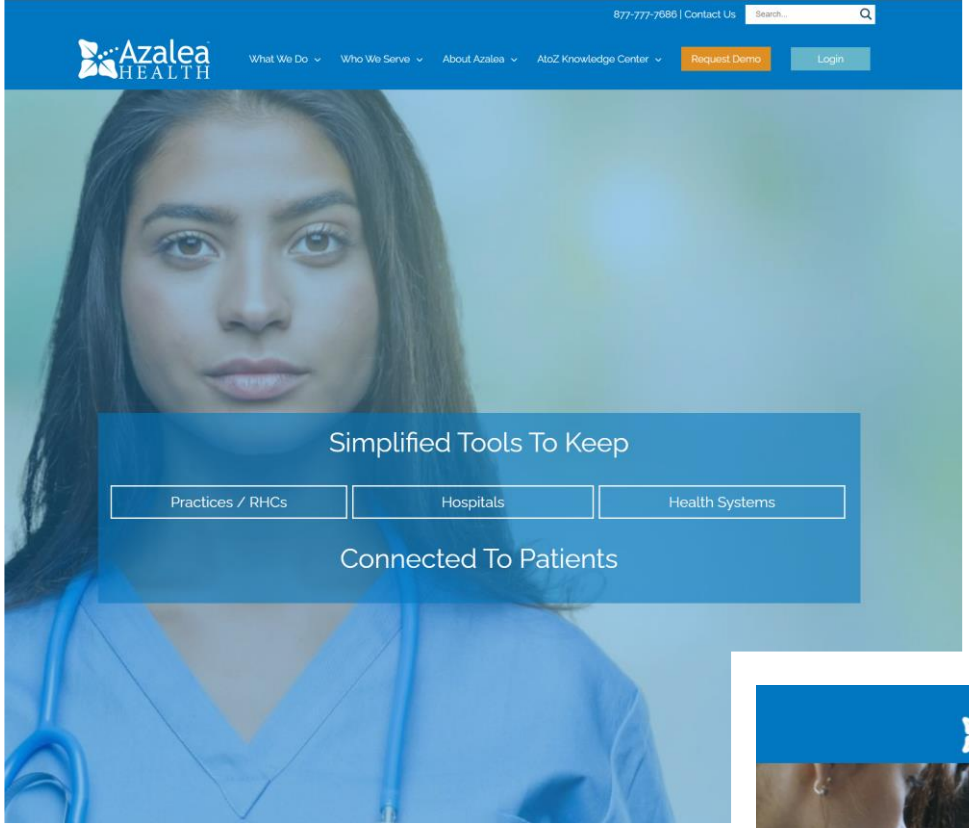
Healthcare Business Specialists

Dani Gilbert, CPA, CRHCP
RHC Consultant
Healthcare Business Specialists
Suite 214, 502 Shadow Parkway
Chattanooga, Tennessee 37421
Phone: (833) 787-2542
dani.gilbert@outlook.com
www.ruralhealthclinic.com

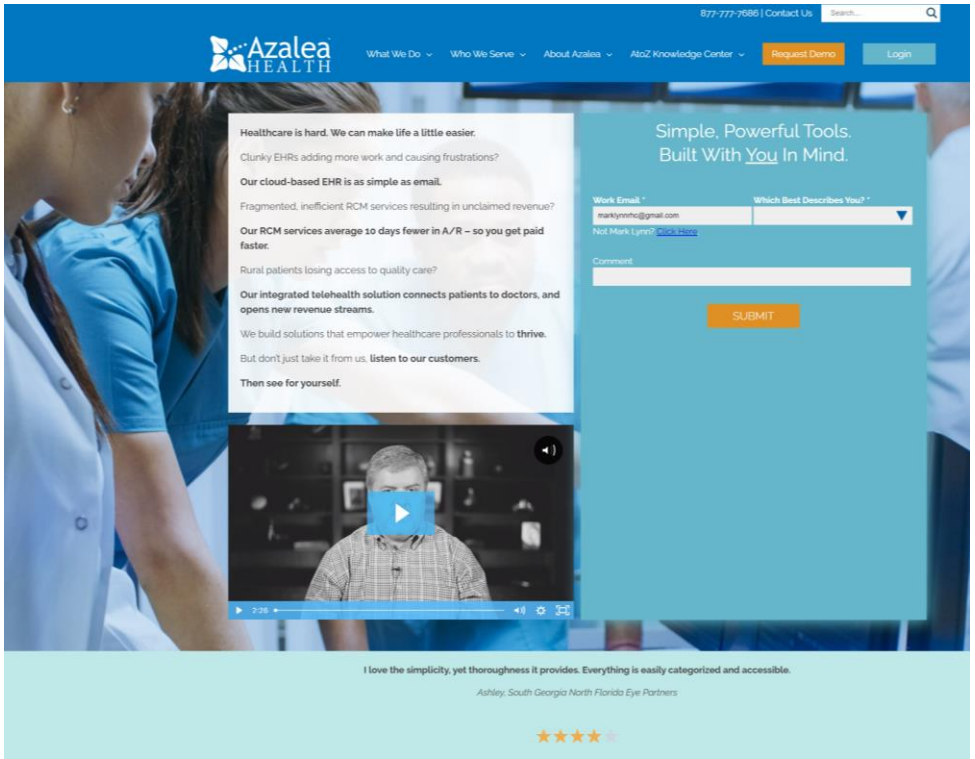
RHC Information Exchange Group on Facebook

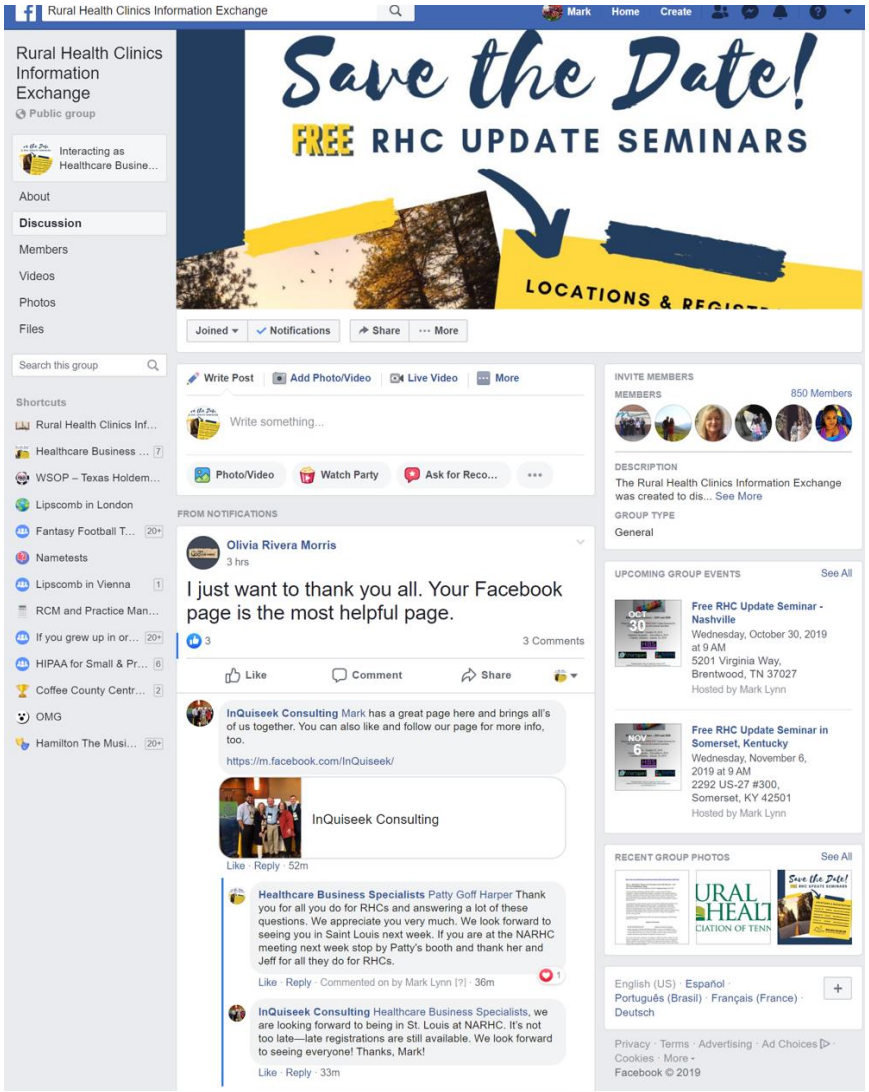
- *"A place to share and find information on RHCs."*



Azalea HEALTH

https://www.azaleahealth.com/





RHC Information Exchange Group on Facebook

Join this group to post or ask questions regarding RHCs. Anyone is welcome to post about meetings, seminars, or things of interest to RHCs

https://www.facebook.com/groups/1503414633296362/

HBS

Healthcare Business Specialists

- What does Healthcare Business Specialists do?
- Listing of Services

https://tinyurl.com/w63xbp9

- We prepare Medicare and Medicaid Cost Reports for Rural Health Clinics.
- We prepare Program evaluations of RHCs.
- We help clinics startup as RHCs.
- Emergency Preparedness for RHCs.
- We prepare Tenncare Quarterly Reports
- Our Cost Reporting Brochure can be found at the following link:
- RHC Cost Report Brochure

For Updates, a recording of this webinar, slide presentations, and lots of information on RHCs and COVID-19 go to our COVID-19 Website

http://www.ruralhealthclinic.com/covid19

MEET OUR SPEAKERS 

Charles James, Jr.-Charles took the position of President & CEO in 2004 after the loss of the company founder, Charles James, Sr. North American celebrates its 25th year in business in 2017. Charles began his career with James Clinic running the IT department. As part of North American, Charles has overseen & helped develop all aspects of the company. Today, North American is a proud gold-certified, Aprima EHR/PRM. In addition, he provides Revenue Cycle Management, RHC certification/cost reporting/Annual Evaluations, Provider Enrollment, and Financial Consulting to all types of healthcare entities.

Have Questions?
Toll Free: 888-968-0076
Local: 314-968-0076

Meet the Speakers

- Douglas Swords is Azalea Health's Co-Founder and Vice President of Revenue Cycle Management. I established the Azalea Health's back-office Revenue Cycle Management (RCM) service division, while providing financial planning and leadership to Azalea Health. I have seventeen years of experience in the healthcare industry, specializing in management and scaling of RCM operations for medical providers and facilities of all sizes. I graduated from Valdosta State University with a BBA majoring in Finance. I am a member of the Healthcare Billing and Management Association (HBMA), the American Association of Professional Coders (AAPC), and the South Georgia chapter of MGMA.

Patty Harper, RHIA, CHTS-PW, CHTS-IM, CHC®

InQuiseek Consulting

Pharper@inquiseek.com

318-243-2687

Patty Harper is CEO of InQuiseek, LLC, a business and healthcare consulting company based in Louisiana. She has over 21 years of healthcare experience in the areas of healthcare finance & reimbursement, health information management, compliance, and practice management. She began her healthcare career as a hospital controller and reimbursement analyst. Patty holds a B.S. in Health Information Administration (cum laude) from Louisiana Tech University. She is credentialed through AHIMA as a RHIA, CHTS-IM, and CHTS-PW. Patty successfully completed AHIMA's ICD-10 Academy and has been recognized as an ICD-10 Trainer. She is also Certified in Healthcare Compliance (CHC®) thorough the Compliance Certification Board. Patty is a frequent speaker and contributor for national, state and regional and rural healthcare associations on these and other reimbursement-related topics. She has held memberships regional, state and national organizations throughout her healthcare career including NARHC, NRHA, AHIMA, MGMA, and HFMA. Patty currently serves on the Board of NARHC and LRHA.

Disclaimer

- Due to COVID-19 Healthcare Policy is changing rapidly, waivers are being issued, guidance is being backdated, issued and retracted, official documents are out of date almost as soon as they are issued, so proceed with caution. Some of our resources will contain outdated information, but most of the information is still relevant. The trick and frustrating part is knowing what changed and when. This presentation was prepared on July 31, 2020 and we believe it to be current as of that date, but we could have missed something. If you know of an omission or change, please let us know and we correct it.

Please do not type your questions in until all the presenters have finished. We will have time at the end of the session for questions

Slides and Recording of this session will be posted to the Facebook Group and on the HBS COVID-19 Website.

Agenda

We have prepared this update for RHCs related to the following five items as it relates to RHCs.

1. HHS renews the Public Health Emergency (PHE) for 90 more days
2. Provider Relief Fund Reporting Requirements
3. Provider Relief Funds are Taxable
4. Exceptions to Productivity Screens for RHCs
5. Cost Reporting implications of the Payroll Protection Program

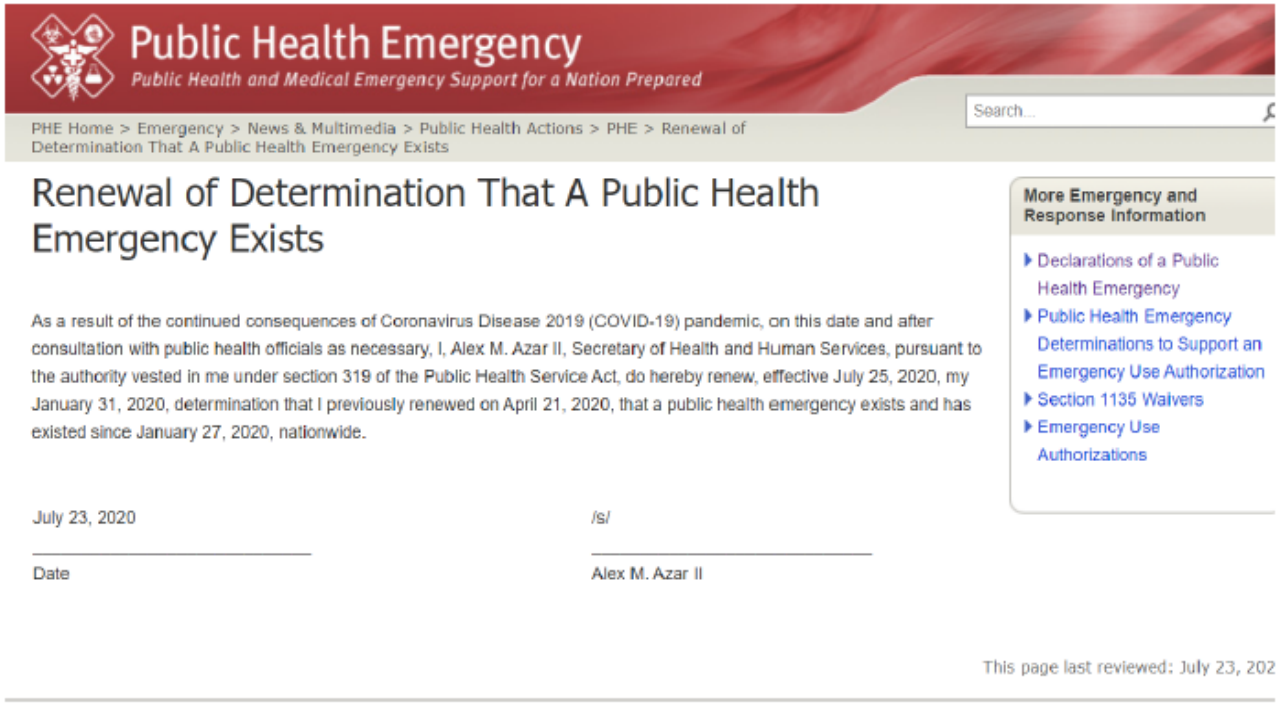
Extension of the Public Health Emergency

HHS renews public health emergency

The Department of Health and Human Services (HHS) on July 23 formally renewed the COVID-19 public health emergency declaration. The 90-day extension will help RHCs, hospitals, and other providers continue to combat COVID-19 in their communities. **RHCs will especially benefit from the continuation of the Telehealth reimbursement rules that allow RHCs to act as distant site providers and patient's homes to be originating sites.** The previous declaration was set to expire on July 25.

To read the announcement go to the following address or view the image below:

https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-23June2020.aspx



Public Health Emergency

Public Health and Medical Emergency Support for a Nation Prepared

Search...

PHE Home > Emergency > News & Multimedia > Public Health Actions > PHE > Renewal of Determination That A Public Health Emergency Exists

Renewal of Determination That A Public Health Emergency Exists

As a result of the continued consequences of Coronavirus Disease 2019 (COVID-19) pandemic, on this date and after consultation with public health officials as necessary, I, Alex M. Azar II, Secretary of Health and Human Services, pursuant to the authority vested in me under section 319 of the Public Health Service Act, do hereby renew, effective July 25, 2020, my January 31, 2020, determination that I previously renewed on April 21, 2020, that a public health emergency exists and has existed since January 27, 2020, nationwide.

July 23, 2020 — Date

/s/ — Alex M. Azar II

More Emergency and Response Information

- Declarations of a Public Health Emergency
- Public Health Emergency Determinations to Support an Emergency Use Authorization
- Section 1135 Waivers
- Emergency Use Authorizations

This page last reviewed: July 23, 202

https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-23June2020.aspx

What does Extending the PHE to October 23, 2020 mean for RHCs

The Extension of the PHE allows RHCs to:
1. RHCs may continue to bill Telehealth until the end of the PHE
2. The Waivers that CMS has granted RHCs will continue to be available
A. Telemedicine
B. RHCs are not required to have a NP/PA/CNM onsite at least 50% of the time.
C. RHCs can Establish Facilities without Walls (Temporary Expansion Sites)
D. RHCs can be paid for Home Visits by Nurses
E. Bed Count for Provider-Based RHCs and RHC Payment Limit:

RHC COVID-19 Waivers Memo from CMS

https://www.cms.gov/files/document/covid-rural-health-clinics.pdf

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS Flexibilities to Fight COVID-19

*** Indicates items added or revised in the most recent update*

Since the beginning of the COVID-19 Public Health Emergency, the Trump Administration has issued an unprecedented array of temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. These temporary changes will apply immediately across the entire U.S. healthcare system for the duration of the emergency declaration. The goals of these actions are to 1) expand the healthcare system workforce by removing barriers for physicians, nurses, and other clinicians to be readily hired from the community or from other states; 2) ensure that local hospitals and health systems have the capacity to handle a potential surge of COVID-19 patients through temporary expansion sites (also known as CMS Hospital Without Walls); 3) increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home; 4) expand in-place testing to allow for more testing at home or in community based settings; and 5) put Patients Over Paperwork to give temporary relief from many paperwork, reporting and audit requirements so providers, health care facilities, Medicare Advantage and Part D plans, and States can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

Medicare Telehealth

- *Payment for Medicare Telehealth Services:* Section 3704 of the CARES Act authorizes RHCs and FQHCs to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE. Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. (During the PHE, some telehealth services can be furnished using audio-only technology.) RHCs and FQHCs with this capability can provide and be paid for telehealth services furnished to Medicare patients located at any site, including the patient's home, for the duration of the COVID-19 PHE. Telehealth services can be furnished by any health care practitioner working for the RHC or the FQHC within their scope of practice. Practitioners can furnish telehealth services from any distant site location, including their home, during the time that they are working for the RHC or FQHC, and can furnish any telehealth service that is included on the list of Medicare telehealth services under the Physician Fee Schedule (PFS), including those that are added on an interim basis during the PHE. A list of these services, including which can be furnished via audio-only technology, is available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

Workforce

- *Home Nursing Visits:* RHCs and FQHCs can provide visiting nursing services to a beneficiary's home with fewer requirements, making it easier for beneficiaries to get care from their home.
  - Any area typically served by the RHC, and any area that is included in the FQHC's service area plan, is determined to have a shortage of home health agencies, and no request for this determination is required;
  - Any RHC/FQHC visiting nurse service solely to obtain a nasal or throat culture would not be considered a nursing service because it would not require the skills of a nurse to obtain the culture as the specimen could be obtained by an appropriately-trained medical assistant or laboratory technician; and
  - The revised definition of "homebound" will apply to patients receiving visiting nursing services from RHCs and FQHCs.

- *Certain staffing requirements:* CMS is waiving the requirement in the second sentence of 42 CFR §491.8(a)(6) that a nurse practitioner, physician assistant, or certified nurse-midwife be available to furnish patient care services at least 50 percent of the time the RHC and FQHC operates. CMS is not waiving the first sentence of §491.8(a)(6) that requires a physician, nurse practitioner, physician assistant, certified nurse-midwife, clinical social worker, or clinical psychologist to be available to furnish patient care services at all times the clinic or center operates. This will assist in addressing potential staffing shortages by increasing flexibility regarding staffing mixes during the PHE.

- *Physician supervision of Nurse Practitioners in RHCs and FQHCs:* We are modifying the requirement at 42 C.F.R. 491.8(b)(1) that physicians must provide medical direction for the clinic's or center's health care activities and consultation for, and medical supervision of, the health care staff, only with respect to medical supervision of nurse practitioners, and only to the extent permitted by state law. The physician, either in person or through telehealth and other remote communications, continues to be responsible for providing medical direction for the clinic or center's health care activities and consultation for the health care staff, and medical supervision of the remaining health care staff. This allows RHCs and FQHCs to use nurse practitioners to the fullest extent possible and allows physicians to direct their time to more critical tasks.

CMS Facility without Walls (Temporary Expansion Sites)

- *Temporary Expansion Locations*: CMS is waiving the requirements at 42 CFR §491.5(a)(3)(iii) which require RHCs and FQHCs be independently considered for Medicare approval if services are furnished in more than one permanent location. Due to the current PHE, CMS is temporarily waiving this requirement removing the location

Now is the time to Lobby for RHCs and Telehealth per Nathan Baugh

Dear RHC Community:

NOW is the time to advocate.

The GOP phase 4 (HEALS Act) draft allows RHCs to be distant site providers for 5 years after the public health emergency (good news) but it also locks us into the $92.03 payment (very bad).

If we want normal coding, billing, and reimbursement for telehealth we have to act now.

Tell your Senators that telehealth will not succeed in underserved communities if they lock us into our current reimbursement policy in the phase 4 legislation.

We need Congress to hear from RHCs. Use this link to find your Senators and their staff:
https://docs.google.com/spreadsheets/d/1nVTIuYf2pi4L64ceEKQCMWCU2dFBoSveV81X7NZ3JbU/edit?fbclid=IwAR2qJA1ZZdNQ-WrNy8KEqfIN1wS4MnE3aPY_uGDSJI9VAcy8eaPG5wuXMyE#gid=653341771

"Where do we stand?"

Fourth COVID-19 Relief Package

- Timeline: We expect Congress to act before breaking for August Recess. Congress is slated to break for Recess next Friday, August 7.
- On Monday, July 27, Majority Leader McConnell introduced the Health, Economic Assistance, Liability protection and Schools (HEALS) Act. This will serve as the marker for negotiations in the Senate. Of note, this bill included:
  - Delay of the date in which providers must begin repaying Medicare Accelerated and Advance Payment loans.
  - Extension of all CARES Act telehealth flexibilities in Medicare through December 31, 2021.
  - Extension of FQHC/RHCs telehealth flexibilities for an additional five years after the public health emergency.
  - $25 billion for the Provider Relief Fund, $16 billion for testing, $20 billion for vaccine, therapeutic and diagnostic development at BARDA, $7.6 billion for Community Health Centers and $225 million for Rural Health Clinics;
  - Additional dollars put in the PPP program (deadline to apply is *still* Aug. 8th)
- ***Now*** is the time to advocate to make this bill 'better'...

NRHA
NATIONAL RURAL HEALTH ASSOCIATION

https://www.narhc.org/News/28492/Changes-to-Telehealth-Will-Require-YOUR-Advocacy

Provider Relief Funds For RHCs

HHS issues new details on provider relief fund reporting requirements

The Department of Health and Human Services (HHS) last week shared additional information on reporting requirements for recipients of provider relief funds authorized under the Coronavirus Aid, Relief, and Economic Security Act and Paycheck Protection Program and Health Care Enhancement Act. In its notice, HHS said recipients that received one or more payments exceeding $10,000 in the aggregate from the Provider Relief Fund will be required to submit reports to the agency on how the funds have been expended using a portal that will open on Oct. 1, 2020. Detailed instructions regarding the reports will be released by Aug. 17, 2020. To read the notice, go to: **https://tinyurl.com/y6jktsxa**

https://www.hhs.gov/sites/default/files/provider-post-payment-notice-of-reporting-requirements.pdf?language=en

General and Targeted Distribution
Post-Payment Notice of Reporting Requirements

July 20, 2020

Purpose

The purpose of this notice is to inform Provider Relief Fund (PRF) recipients that received one or more payments exceeding $10,000 in the aggregate from the PRF of the timing of future reporting requirements. Detailed instructions regarding these reports will be released by August 17, 2020.

Overview

Congress appropriated funding to reimburse eligible health care providers for health care related expenses or lost revenues attributable to coronavirus. The Health Resources and Services Administration (HRSA) is administering the distribution of payments under the PRF program, funded through appropriations in the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136) and the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139). Each recipient of a payment from the PRF that used any part of that payment agreed to a set of Terms and Conditions (T&Cs) which, among other obligations, require each recipient to submit reports to the Department of Health and Human Services (HHS). The reports shall be in such form, with such content, as specified by the Secretary of HHS in future program instructions directed to all recipients. HHS will be releasing detailed reporting instructions by August 17, 2020.

These reporting instructions will provide directions on reporting obligations applicable to any provider that received a payment from the following CARES Act/PRF distributions:

General Distributions:
- Initial Medicare Distribution
- Additional Medicare Distribution
- Medicaid, Dental & CHIP Distribution

Targeted Distributions:
- High Impact Area Distribution
- Rural Distribution
- Skilled Nursing Facilities Distribution
- Indian Health Service Distribution
- Safety Net Hospital Distribution

The reports will allow providers to demonstrate compliance with the T&Cs, including use of funds for allowable purposes, for each PRF payment. HRSA plans to provide recipients with Question and Answer (Q&A) Sessions via Webinar in advance of the submission deadline. Additional details will follow regarding the Q&A Sessions.

Notice on Timing of Reports

The reporting system will become available to recipients for reporting on **October 1, 2020.**

- All recipients must report within 45 days of the end of calendar year 2020 on their expenditures through the period ending December 31, 2020.
- Recipients who have expended funds in full prior to December 31, 2020 may submit a single final report at any time during the window that begins October 1, 2020, but no later than February 15, 2021.
- Recipients with funds unexpended after December 31, 2020, must submit a second and final report no later than July 31, 2021.
- Detailed PRF reporting instructions and a data collection template with the necessary data elements will be available through the HRSA website by August 17, 2020.

Provider Relief Funds Reporting -Summary of July 20 Memo from HHS

Question	Answer
When will reporting instructions and Forms for reporting uses of Provider Relief Funds be available?	August 17, 2020
When the portal to submit reports be available	October 1, 2020
If we have spent all the funds prior to December 31, 2020 when do we prepare the report for HHS?	Anytime between October 1, 2020 and February 15, 2021.
What if we still have funds available after December 31, 2020? When do we report the funds spent in 2020?	Submit a report of how you used the funds through December 31, 2020 by February 15, 2021
When to we report funds spent in 2021?	RHCs must submit a second and final report no later than July 31, 2021.

Where to get help completing the Forms

The key pieces of information related to Provider Relief Funding are as follows:

1. Quarterly reports are **not** required as previously thought.
2. More instructions and forms are going to be released on August 17, 2020
3. If you clinic has expended all of their provider relief funds they can report this using a portal that will open October 1st and they must report by February 15, 2021.
4. If clinics have expended all their funds by December 31, 2020, they must submit a second report by July 31, 2021.

Like many of the RHC consulting and accounting firms, we are adding this reporting to our cost reporting services and agreements that will be coming out in October and November for 12/31/2020 cost reports. We will know the pricing of the add-on service once we determine what the requirement are when the August 17, 2020 information is released.

https://www.narhc.org/narhc/Consultants__Vendors1.asp

Provider Relief Funds are Taxable

Provider Relief Funds are Taxable

Yes, Provider Relief Funds are includable as gross income for healthcare providers. See

https://www.irs.gov/newsroom/frequently-asked-questions-about-taxation-of-provider-relief-payments

Q1: May a health care provider that receives a payment from the Provider Relief Fund exclude this payment from gross income as a qualified disaster relief payment under section 139 of the Internal Revenue Code (Code)?

A: No. A payment to a business, even if the business is a sole proprietorship, does not qualify as a qualified disaster relief payment under section 139. The payment from the Provider Relief Fund is includible in gross income under section 61 of the Code.

Pediatric RHCs have until August 3rd to apply for additional funds if they qualify

- **Apply Now:**
Provider Relief Fund
- **Application Deadline Extended: August 3, 2020**
- 📷
- The Provider Relief Fund Payment Portal is open to eligible Medicaid, CHIP, and dental providers. The portal allows providers to apply for payments made for healthcare-related expenses or lost revenue attributable to COVID-19. Eligible providers may receive a reimbursement up to 2% of their annual reported patient revenue. Attend next week's final Technical Assistance Webinar on July 27, 2020 at 3:00pm ET. Register Here.
- Resources and Application Link
- Before applying, read the Portal Instructions and Frequently Asked Questions
- Register or log in to watch a previous Technical Assistance webcast
- Read the Medicaid and CHIP Provider Distribution Fact Sheet
- Contact the Provider Support Line at (866) 569-3522
- 📷

HRSA
Health Resources & Services Administration

Provider Relief Fund: Medicaid, CHIP and Dental Provider Distribution

Fact Sheet

Applications due Aug. 3, 2020

On June 9, 2020, the U.S. Department of Health and Human Services (HHS) announced the distribution of approximately $15 billion from the Provider Relief Fund to eligible Medicaid, CHIP and Dental providers that have not received a payment from the Provider Relief Fund General Distribution.

The payment to each provider will be approximately 2 percent of reported revenue from patient care; the final amount each provider receives will be determined after the data is submitted.

How to Apply For Funding

1. Visit **hhs.gov/providerrelief** and choose "For Providers
2. Click on the **Enhanced Provider Relief Fund Paymen** within the Provider Relief Fund Payment Forms and Guic to get started.

Who Can Apply

Any provider that meets the eligibility requirements and can attest to the **Terms and Conditions** associated with the distributic for funding. Applications must be submitted by Aug. 3, 2020.

Eligibility Requirements

To be eligible, providers must have:

- Received no payment from the **$50 billion** General Distribution to Medicare providers
- For eligible Medicaid/CHIP providers: Billed Medicaid/CHIP programs or Medicaid managed care plans for health care-related services between Jan. 1, 2018 – Dec. 31, 2019
- Filed a federal income tax return for fiscal years 2017, 2018 or 2019; or be exempt from filing a return
- Provided patient care after Jan. 31, 2020
- Not permanently ceased providing patient care directly, or indirectly
- If the applicant is an individual, must have gross receipts providing patient or dental care reported on Form 1040
- Must not be declared ineligible by local, state or federal g
- Have not have already received the maximum eligible pay from this distribution
- For Dental providers applying after July 10: Must not have payment from the Medicaid/CHIP distribution

Repayment

Retention and use of these funds are subject to certain **Terms and Conditions**. If these Terms and Conditions are met, payments do not need to be repaid at a later date.

Uses of Funds

Provider Relief Funds may be used to cover lost revenue attributable to COVID-19 or health related expenses purchased to prevent, prepa for, and respond to coronavirus, including, but not limited to:

- Supplies used to provide health care services for possible or actual COVID-19 patients
- Equipment used to provide health care services for possible or actual COVID-19 patients
- Workforce training
- Reporting COVID-19 test results to federal, state, or local governments
- Building or constructing temporary structures to expand capac for COVID-19 patient care or to provide health care services to non-COVID-19 patients in a separate area from where COVID- patients are being treated
- Acquiring additional resources, including facilities, equipment, supplies, health care practices, staffing, and technology to expand or preserve care delivery
- Developing and staffing emergency operation centers

Attestation Requirements

Payment recipients must attest to the following within 90 days of receiving payment:

- Recipient provided, on or after Jan. 31, 2020, diagnosis, testing or care for actual or possible COVID-19 patients; is not terminated, revoked, or precluded from participating in Medicare, Medicaid or other Federal health care programs. HHS broadly views every patient as a possible case of COVID-19.
- Payment must be used to prevent, prepare for, and respond to coronavirus, and reimburse health care related expenses or lost revenues attributable to coronavirus
- Payment does not reimburse for expenses or losses that have been reimbursed from other sources, or that other sources are obligated to reimburse
- Recipient shall comply with all reporting and information requirements
- Recipients consent to public disclosure of payment

Terms and Conditions are located on **hhs.gov/providerrelief.**

How to Apply

Download the **Provider Distribution Instructions** and **Provider Distribution Application Form** from **hhs.gov/providerrelief.** Applications must be submitted by Aug. 3, 2020.

Where can I find more information?

Please visit **hhs.gov/providerrelief** for eligibility requrements, Terms and Conditions, Frequently Asked Questions (FAQs) and a recordin of past webinars on the application process. For additional information, please call the provider support line at (866) 569-3522; for TTY di 711. Hours of operation are 7 a.m. to 10 p.m. Central Time, Monday through Friday. Service staff members are available to provide real-time technical assistance, as well as service and payment support.

HRSA
Health Resources & Services Administrat

Program eligibility and allocation of funds is determined by HHS, subject to adjustment (as may be necessary) and available funding; see details at **hhs.gov/coronavirus/cares-act-provider-relief-fund.** Terms and conditions will apply.

Waiver of Productivity Screens

Health Care Provider FTEs

- Cost report requires separation of provider visits, time, (and cost):
- Physician
- Physician Assistant
- Nurse Practitioner
- Visiting Nurse
- Clinical Psychologist
- Clinical Social Worker

The Provider FTE calculation is important For Productivity Calculations (based up a 2,080 Hour work year)

Provider Type	Minimum Annual Productivity based upon 40-hour work week	Daily Productivity based upon 250 work days	Monthly Productivity
Physician	4,200	16.8	350
Nurse Practitioner/ Physician Assistant	2,100	8.5	175

If you have a short cost report year remember to reduce your FTE reported on the cost report

Waiver of Productivity Screens in RHCs due to COVID-19

On July 6, 2020, CMS released a revised SE20016 Medlearn Matters titled New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE). We have included a picture of the section related to Productivity screens in the document below.

Exception to the Productivity Standards for RHCs

Productivity standards are used to help determine the average cost per patient for Medicare reimbursement in RHCs. Physicians, nurse practitioners, physician assistants, and certified nurse midwives are held to a minimum number of visits per full time employee (FTE) that they are expected to furnish in the RHC. Failure to meet this minimum may indicate that they are operating at an excessive staffing level, thus, generating excessive cost.

Many RHCs have had to change the way they staff their clinics and bill for RHC services during the COVID-19 public health emergency (PHE). As a result, these RHCs may have difficulty in meeting the productivity standards. To minimize the burden on RHCs, exceptions to the productivity standard may be granted by your MAC during the COVID-19 PHE. Further direction will be forthcoming from your MAC.

ADDITIONAL INFORMATION

View the complete list of coronavirus waivers.

Review information on the current emergencies webpage at https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

Section 80.4 from Chapter 13 of the Medicare Benefit Policy Manual – Rural Health Clinic addresses productivity screens. This section reads as follows:

80.4 – RHC Productivity Standards (Rev.239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18) Productivity standards are used to help determine the average cost per patient for Medicare reimbursement in RHCs. The current productivity standards require 4,200 visits per full-time equivalent physician and 2,100 visits per full-time equivalent nonphysician practitioner (NP, PA, or CNM). Physician and non-physician practitioner productivity may be combined. The FTE on the cost report for providers is the time spent seeing patients or scheduled to see patients and does not include administrative time.

At the end of the cost reporting year, the A/B MAC re-calculates the AIR by dividing the total allowable costs across all patient types (i.e., the numerator) by the number of visits (as defined in section 40) for all patient types (i.e., the denominator). If fewer than expected visits based on the productivity standards have been furnished, the A/B MAC substitutes the expected number of visits for the denominator and uses that instead of the actual number of visits. The total allowable costs (numerator) would be divided by the higher, expected number of visits (denominator). In this example, this would have the effect of lowering the AIR.

The Provider FTE calculation is important For Productivity Calculations (based up a 2,080 Hour work year)

Provider Type	Minimum Productivity
Physician	4,200
Nurse Practitioner/ Physician Assistant	2,100

RHC cost reports are submitted to Medicare Administrative Contractors (MAC) who process the cost reports, establish rates, settle payment data, and approve RHC requests for waivers. Each of the MACs have separate rules for approval of the exception to Productivity Standards. We have included the guidance from Palmetto, CGS, and Novitas. You should reach out to your MAC for their specific guidance and any form they may have.

RHC Productivity Standard Exceptions

Per CMS Publication 100-02, Chapter 13 (PDF, 400 KB), Section 80.4, productivity standards require 4,200 visits per physician and 2,100 visits per practitioner.

If you are having difficulty meeting productivity standards as a result of COVID-19 PHE, you may request an exception to the productivity standards. The following information is required.

- Visit count that you are requesting as an exception to the standard of 4,200 for physicians and 2,100 for mid-level practitioners
- Documentation to justify an exception to the standard

A separate request is required for each facility/clinic, and we may ask for additional information after receipt of the request.

Last Updated: 07/21/2020

CGS Exception to Productivity Standards

CMS wants to minimize the burden on RHCs who have experienced disruptions in staffing and services and have had difficulty in meeting productivity standards as a result of COVID-19 public health emergency. If you would like to request an exception to the productivity standards, please send your request to RHCException@cgsadmin.com. Please include your provider name, provider number, cost reporting period and an explanation for your request.

JoElla Draper| J15 Manager, Provider Audit |CGS

Regular Mail
CGS Audit & Reimbursement
PO Box 20020, Nashville, TN 37202.

Courier Service (FedEx/UPS)
CGS Audit & Reimbursement
26 Century Blvd ST610, Nashville, TN 37214

email: joella.draper@cgsadmin.com | **voice:** 217-726-6240 (ext. 205)

Novitas Productivity Standard Exemptions for COVID-19

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00228302

Medicare JH
Providers in AR, CO, LA, MS, NM, OK, TX, Indian Health & Veteran Affairs

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Rural Health Clinic productivity standard exemptions for COVID-19

Many RHCs have had to change the way they staff their clinics and bill for RHC services as a result of the COVID-19 public health emergency (PHE). As a result, some RHCs may have difficulty in meeting the productivity standards.

Novitas Solutions will provide an exception to any RHC that has had difficulty in meeting the productivity standards as a result of the COVID-19 PHE. Novitas will grant productivity exceptions to RHCs who have experienced disruptions in staffing and services as a result of the COVID-19 pandemic and made a written request to the Novitas Provider Audit and Reimbursement Department.

Please submit the completed request form to:

Novitas Solutions
Provider Audit & Reimbursement
2020 Technology Parkway, Suite 100
Mechanicsburg, PA 17050

Request form (Form will download to your computer device)

The forms can be sent to following attention as well as any questions pertaining to this form:

JL: Jesse Yu: Jesse.Yu@novitas-solutions.com

JH: Theresa Bigsby: NovitasReimbursement@Novitas-Solutions.com

Novitas Excel Form for Productivity Exception Requests

RHC Productivity Standard Exception Requests

Background: Providers are held to a minimum number of visits per FTE that their Physicians and/or mid-level practitioners are expected to be able to perform in the Rural Health Clinics. These standards are 4,200 visits per Physician FTE and 2,100 visits per mid-level practitioner FTE.

Failure to meet this minimum number of visits may indicate that the facility is operating at an excessive staffing level compared with the patient level they are currently operating at, thus incurring excessive cost. This excessive cost would not be considered reasonable, and thus would not be allowable for reimbursement on the cost report.

When the minimum number of visits is not met, the minimum number is used in lieu of actual visits on worksheet M-2, Column 5, Lines 1-7 and subscripts. This increased number of visits in turn decreases the cost per visit, thus reducing the Medicare reimbursement.

CMS Policy at CMS Pub. 100-02, Chapter 13, §80.4 allows for providers to request an exception to these minimum standards, **subject to the MACs discretion.** This checklist has been developed as a guide to address some of the more common situations that, taken in combination, may potentially be considered adequate for an exception to these standards. **This checklist should not be construed as a guarantee that any individual criterion, or combination of criteria, will result in approval.**

Note that the manual does not include a specific time frame on when these RHC Productivity Standard Requests should be submitted by the provider, nor does it include a required timeframe for review and approval by the MAC. If the RHC Productivity Standard Request is submitted after the start of the desk review, the results may not necessarily be incorporated into that final settlement. In such a case, the additional documentation can be submitted as part of a request for consideration of a reopening. Ultimately, the decision as to whether or not to reopen will be left up to the MAC.

Source:	CMS Pub. 100-02, Chapter 13, §80.4 47 FR 54163 (12/1/1982)
Main Hospital Name:	
Main Hospital Provider Number (CCN):	
RHC Provider Number (a separate tab should be completed for each clinic):	
Impacted FYE:	
RHC City:	
RHC County:	
Date of Submission of Request:	

1.) What is the current number of FTEs and visits for the RHC for this cost reporting period for each category of staff?

	Col. 1 FTEs	***Col. 2 Total Visits***
W/S M-2 Line 1 - Physician =		
W/S M-2 Line 2 - Physician Assistants =		
W/S M-2 Line 3 - Nurse Practitioner =		
Add additional lines as needed		

2.) What was the number of clinic visits for the RHC in the prior year, and did the RHC request and receive approval for an RHC standard in that prior year?

	Col. 1 FTEs	***Col. 2 Total Visits***
W/S M-2 Line 1 - Physician =		
W/S M-2 Line 2 - Physician Assistants =		
W/S M-2 Line 3 - Nurse Practitioner =		
Add additional lines as needed		

3.) What visit count are you requesting as an exception to the standards of 4,200 (Physicians) and 2,100 (Mid-Level Practitioners)?

For questions 4 through 8, you only need to complete the ones that relate to your request, and that you believe may help justify the request for an exception to the RHC Productivity Standards.

4.) Explain and demonstrate whether the clinic employs no more than the minimum number of staff (physician and mid-level practitioners) necessary to meet applicable certification requirements. Include details on what the current staffing level is for each type and what the minimum certification requirements are.

5.) Is the clinic listed in a Primary Care Health Professional Shortage Area (HPSA)? If so, provide documentation from the below link or another similar resource.
https://data.hrsa.gov/tools/shortage-area/hpsa-find

6.) Document how the population base of the service area is significantly lower than would be needed to generate sufficient visits meet the minimum number of visits required of the RHC Productivity Standards. This generally requires evidence for #4 as well.

7.) Document whether any new physicians or mid-level practitioners were added during the cost reporting period in question and when they started. Explain why you believe this may require a temporary reduction to the RHC Productivity Standards.

8.) Explain and document any other justification for an exception to the RHC Productivity Standards.

Name of Submitter:	
Title of Submitter:	
Date Submitted:	

What should RHCs do now regarding Productivity Standard Exceptions

First, there is no need to panic. There Is no immediate deadline to complete these forms requesting an exception to the productivity standards. These exception request may be filed with the cost report, so for example you are a 12/31/2 020 year-end, the cost report will be due 5/31/2021 and as long as the Productivity Standard Exception Request is submitted by the time the cost report is reviewed by the MAC, the MAC will consider the Exception.

If you think your clinic is going to have a difficult time meeting the RHC productivity standards due to COVID-19, you should submit your Visit and FTE information in early to your cost report preparer. That way they can have extra time to review this information and complete the request for a waiver along with the cost report filing. Additionally, I would go ahead a review the form that your MAC uses to determine if you are eligible for the Exception or not. If you think you may be eligible for the Exception, you may want to start accumulating the information requested in the form your MAC uses.

RHC Productivity Standards During COVID

Do I need an exception? What about Telehealth?

We know many Rural Health Clinics have experienced lower than normal volumes in 2020 due to COVID-19. Many have turned to telehealth to see patients during this period. These two combined will have an effect on next year's cost report calculations and productivity standards.

CMS has acknowledged this challenge in the July 6 MLN Matters: " Many RHCs have had to change the way they staff their clinics and bill for RHC services during the COVID19 public health emergency (PHE). As a result, these RHCs may have difficulty in meeting the productivity standards. To minimize the burden on RHCs, exceptions to the productivity standard may be granted by your MAC during the COVID-19 PHE. Further direction will be forthcoming from your MAC." (Link to full publication: https://www.cms.gov/files/document/se20016.pdf)

What does this mean for me?

There is nothing to do right now! Your cost report preparer will need to review your clinic's volumes and whether or not you need to request exceptions to the productivity standard when it is time to complete your 2020 cost report. Several MACs have published guidance on how to request an exception to the clinic's productivity standard. Palmetto, Novitas and First Coast Service Options will accept requests WITH the cost reports, if an exception to the productivity standard is necessary. We expect other MACs to follow the same protocol.

How do Telehealth visits and time factor in?

- Telehealth time does not go into the FTE calculations for minimum productivity standard calculations.
- Telehealth visits are not included in total RHC visits.
- You will carve out telehealth just like you do Lab/X-ray/EKG

Link to Novitas Productivity Standard Exception Requests:
https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00228302&fbclid=IwAR2QwK1_mNiSx1mxFTLlQHnCtwyqKtdxvCt4JHpB4nYa7J6EfNfYuXGxbTM

Link to FCSO Productivity Standard Exception Requests:
https://medicare.fcso.com/PARD_provider_reimbursement/0462066.asp

Link to Palmetto guidance on Productivity Standard Exception Requests:
https://www.palmettogba.com/palmetto/providers.nsf/DocsR/Providers~JJ%20Part%20A~Browse%20by%20Topic~Emergency%20and%20Disaster%20Instructions~BR9RM57524?open

Additional information for Palmetto requests -

- For JJ providers, send the request to JJCostReport@palmettogba.com.
- For JM providers, send the request to JMCostReport@palmettogba.com.
- If you came over from Cahaba you will most likely be a JJ provider.
- If your request is due to COVID productivity/volume issues, a free form letter may be submitted. Please include the visit count that you are requesting as an exception, as well as the justification for the exception. Please indicate COVID as the reason for your request. The request can be submitted at any time.

I hope this helps!

Julie Quinn, MBA, CPA
Health Services Associates
jquinn@hsagroup.net

https://files.constantcontact.com/d9ff9a02301/9d9a5c39-5e1a-4987-9d76-2a645364e463.pdf

What to Do about the Productivity Standards Waiver

1. Keep good records including time studies from now until the end of the PHE. See Next Slides.

2. Get your Cost Report Information on visits and FTEs in early to your Cost Report Preparer, so we can determine if you need a waiver.

3. Complete the waiver application at that time. Remember most have separate reporting emails and processes, so do not submit it in the cost reporting workpapers as the MAC may not see it.

4. The MACs have indicated that the deadline to request the waiver is before the cost report is desk reviewed, so you should file this waiver request before the cost report is filed to be safe.

Productivity Standards Documentation – FTE Calculations

- Record provider FTE for clinic time only (this includes charting time):
  - –Time spent in the clinic
  - –Time with SNF patients
  - –Time with swing bed patients
- Do not include non-clinic time in provider productivity:
  - –Hospital time (inpatient or outpatient)
  - –Administrative time
  - –Committee time
  - **- Telehealth or Telemedicine time**
- Provider time for visits by physicians under agreement who do not furnish services to patients on a regular ongoing basis in the RHC are not subject to productivity standards.

Time Studies for Provider FTEs

Rural Health Clinic Physician Time Study

Physician Name: _____ Date: _____

Physician Signature: _____

To complete, place an "X" in the appropriate box for each 15-minute increment to identify the activities performed.

		Part A - Provider Component					RHC Component	
		Supervision	Committee Work	Administration of Department	Quality Control	Emergency Room Availability	Patient Services	Documentation
0:00	0:15							
0:15	0:30							
0:30	0:45							
0:45	1:00							
1:00	1:15							
1:15	1:30							
1:30	1:45							
1:45	2:00							
2:00	2:15							

Important: Time doing Telemedicine does not Count in your FTE Count

U.S. Small Business Administration

PAYCHECK PROTECTION PROGRAM

Cost Reporting implications of the Payroll Protection Program

Just as we said "Don't Panic" above, this one may require a little bit of panic. **CMS has indicated that expenditures paid with proceeds from the SBA Payroll Protection Program (PPP) can not be included in the allowable expense claimed on the Medicare Cost Report. This could potentially lower the reimbursable cost per visit and result in lower payment from Medicare when the cost report is settled.** If there is any good news, many independent RHCs (but certainly not all) are paid so far below their actual cost due to the Medicare cap of $86.31 they may not lose any reimbursement. Provider-based RHCs not subject to the cap would all lose reimbursement under this scenario. Both the NARHC and NRHA are looking closely at this situation and need some lobbying help to rectify this interpretation before it does irreparable harm to our RHCs and hospitals. I have added a picture of the letter that the NRHA sent to Administrator Seema Verma on July 22, 2020. You are encouraged to reach out to your legislators while the next round of stimulus funding is being debated.

Headquarters
4501 College Blvd. #225
Leewood, KS 66211-1921
816-756-3140
Fax: 816-756-3144

NATIONAL RURAL HEALTH ASSOCIATION

Government Affairs Office
50 F Street NW
Suite 520
Washington, D.C. 20001
202-639-0550
Fax: 202-639-0559

July 22nd, 2020

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

Dear Administrator Verma,

The National Rural Health Association (NRHA) writes today with urgent concerns regarding the Small Business Administration's (SBA) Paycheck Protection Program's (PPP) treatment within the Centers for Medicare and Medicaid Services (CMS) Medicare cost reporting. Recent interpretations of this program by CMS will undermine the program's intent, financially devastate rural providers, and significantly exacerbate the rural hospital and rural health clinic closure crises.

As you know, the PPP, created within the Coronavirus Aid, Relief, and Economic Security (CARES) Act, has been a much-needed lifeline for rural providers who are operating at the narrowest of financial margins. Pre-pandemic, hundreds of rural hospitals were vulnerable to closure; a record number of closures occurred last year. When healthcare providers nationwide ceased elective and non-emergency care in March 2020, in response to the COVID-19 pandemic Public Health Emergency (PHE), rural providers lost on average 50-80 percent of their revenue. Four rural hospitals were forced to close. Many others were forced to lay off 30-50 percent of their staff. According to a study last year by the National Bureau of Economic Research, rural hospital closures cause mortality rates in rural communities to increase by nearly six percent. In comparison, the study also found that urban hospital closures had no measurable impact on mortality rates. Additionally, when a rural hospital closes, extreme economic decline of a community ensues.

The PPP program was a critical part of the relief provided by Congress. It has literally enabled thousands of rural health care providers keep access to necessary health care services in their communities during this pandemic, which has proven especially critical as COVID-19 hotspots have recently begun to flare up across rural America. NRHA worked closely with the SBA to provide a series of webinars to educate rural providers on the importance of this program and how it could help them continue to provide necessary health care services to their communities during this pandemic. It was our understanding that if a recipient utilized the program properly, such using

funds to keep health care providers employed, they would not be penalized for the funds that did not have to be repaid.

However, recent notifications from CMS directing PPP funds to be offset on labor expenses of Critical Access Hospital (CAH) and Rural Health Clinic's (RHC) cost reports are deeply troubling. We were extremely disturbed when one of our members received the following notice:

> *"To prevent the duplication of benefits from the federal government - i.e., once via the SBA's PPP loan forgiveness and a second time in reimbursement for Medicare's share of providers' reasonable costs, funded by the loan forgiveness – providers must offset the amount of the SBA's PPP loan forgiveness from the operating expenses they report on their Medicare cost report."*

We are not aware of any other recipients of the PPP who are penalized for proper use of the program and are unclear why CMS would require this of rural health providers during the pandemic. As you know, the result of this cost-offset could result in a reduction in reimbursement for Critical Access Hospitals (CAH) and Rural Health Clinics (RHC) for Medicare and Medicaid in most states. This could amount to a loss of 70-80 percent of their PPP loan forgiveness amount.

Such a requirement will prove disastrous for the necessary rural health care providers and will likely accelerate the rural hospital and rural health clinic closure crises. We do not believe that the intent of Congress, nor the President, was for the SBAs PPP to fund the Medicare trust fund. We believe this program was created to help keep employees working and we strongly urge you to reconsider.

Thank you for working to improve the health of rural Americas. We look forward to collaborating with you to resolve this troubling issue. If you would like additional information, please contact Josh Jorgensen at jjorgensen@nrharural.org, or 202-639-0550.

Sincerely,

Alan Morgan
Chief Executive Officer
National Rural Health Association

CC: Alex Azar, Secretary of the Department of Health and Human Services; Eric Hargan, Deputy Secretary of the Department of Health and Human Services

NRHA members,

We have *more* good news from Capitol Hill today; **Sens. Collins, Rubio, and Shaheen have sent this letter (linked and attached via Connect) to CMS Administrator Seema Verma to address concerns regarding offsetting PPP funds on provider cost reports.** They write:

As the authors of the PPP, we assure you that such an offset would be directly contrary to Congressional intent and, if these reports are accurate, we respectfully request that you reconsider and reverse CMS' interpretation as soon as possible.

Congressional leaders *are* actively engaged on this issue, and we are optimistic that our concerns will be address, either by guidance from CMS or a legislative solution (under development). We want to thank each of you for your advocacy on behalf of this priority, and we will update you as we learn more.

Sincerely,

Mason Zeagler
Government Affairs Communications Coordinator
National Rural Health Association
50 F Street NW Suite 520
Washington, DC

Reimbursement for Counseling Patients to Self-Isolate

NEWS ALERT
July 30, 2020

CMS and CDC announce provider reimbursement available for counseling patients to self-isolate at time of COVID-19 testing

Today, the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) are announcing that payment is available to physicians and health care providers to counsel patients, at the time of coronavirus disease 2019 (COVID-19) testing, about the importance of self-isolation after they are tested and prior to the onset of symptoms.

The transmission of COVID-19 occurs from both symptomatic, pre-symptomatic and asymptomatic individuals emphasizing the importance of education on self-isolation as the spread of the virus can be reduced significantly by having patients isolated earlier, while waiting for test results or symptom onset. The CDC models show that when individuals who are tested for the virus are separated from others and placed in quarantine, there can be up to an 86 percent reduction in the transmission of the virus compared to a 40 percent decrease in viral transmission if the person isolates after symptoms arise.

Provider counseling to patients, at the time of their COVID-19 testing, will include the discussion of immediate need for isolation, even before results are available, the importance to inform their immediate household that they too should be tested for COVID-19, and the review of signs and symptoms and services available to them to aid in isolating at home. In addition, they will be counseled that if they test positive, to wear a mask at all times and they will be contacted by public health authorities and asked to provide information for contact tracing and to tell their immediate household and recent contacts in case it is appropriate for these individuals to be tested for the virus and to self-isolate as well.

CMS will use existing evaluation and management (E/M) payment codes to reimburse providers who are eligible to bill CMS for counseling services no matter where a test is administered, including doctor's offices, urgent care clinics, hospitals and community drive-thru or pharmacy testing sites.

Further information and resource links are available in the Counseling Check List PDF here:
https://www.cms.gov/files/document/counseling-checklist.pdf

Counseling Check List

☐	Discuss the need for immediate isolation, even before results of the test are available.
☐	Advise patients to inform their immediate household/contacts that they may wish to be tested and quarantine as well. Review locations and people they have been in contact with in the past two weeks.
☐	Review the signs and symptoms of COVID-19.
☐	Inform patients that if positive, they will likely be contacted by a public health worker and asked to provide a list of the people they've been with for contact tracing, encourage them to 'answer the call'.
☐	Discuss services that might help the patient successfully isolate and quarantine at home.

Further information is available through the links below:

Overall:
https://www.cdc.gov/coronavirus/2019-nCoV/index.html

Testing:
https://www.cdc.gov/coronavirus/2019-ncov/testing/index.html

3 Steps to Take While Waiting for Your COVID-19 Test Results

Symptoms:
https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

Self Care:
https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/index.html

Care at Home:
https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/care-for-someone.html

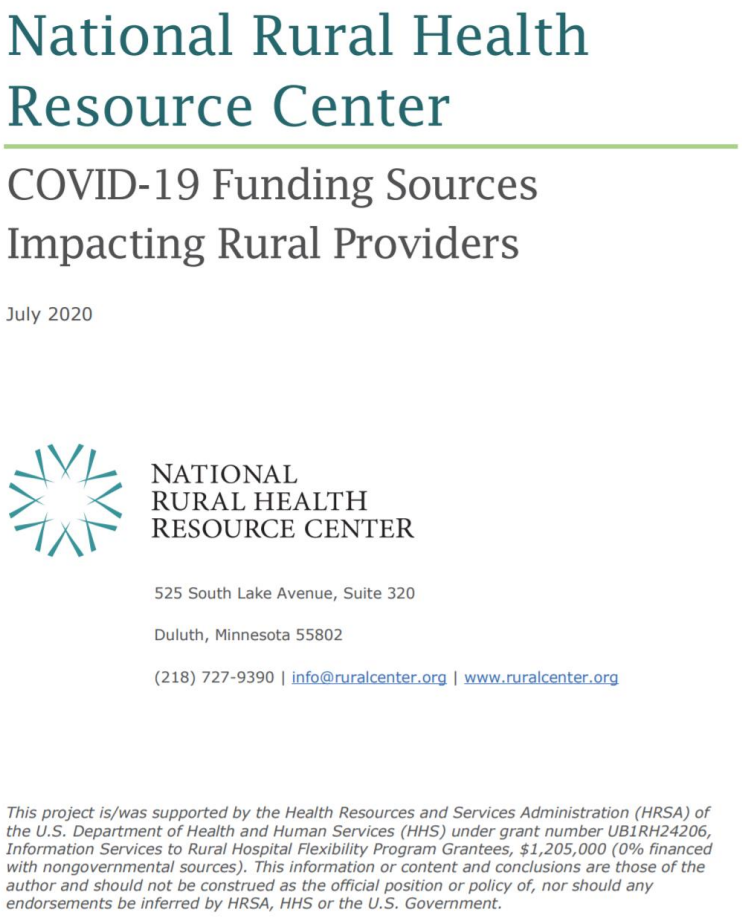
Contact Tracing:

https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/contact-tracing.html

https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/overview.html

- Communication Toolkit:
  https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing-comms.html
- Consumer Page:
  https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/contact-tracing.html
- FAQs:
  https://www.cdc.gov/coronavirus/2019-ncov/faq.html#Contact-Tracing

The Technical Assistance and Services Center in coordination with the Federal Office of Rural Health Policy has released a guide for COVID-19 funding sources impacting rural providers: https://bit.ly/308jlp6



National Rural Health Resource Center

COVID-19 Funding Sources Impacting Rural Providers

July 2020

NATIONAL RURAL HEALTH RESOURCE CENTER

525 South Lake Avenue, Suite 320

Duluth, Minnesota 55802

(218) 727-9390 | info@ruralcenter.org | www.ruralcenter.org

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Table 3: Use of Funds Matrix, Rural Health Clinics (RHC)

Note: Programs in the program column are linked to their description within the document.

PROGRAMS	USE OF FUNDS									
	Payroll	Rent	Mortgage Interest	Utilities	Lost Revenue	Prevents, Prepares for, or Responds to COVID-19	Patient Account Balances	Connected Devices for Telehealth Services	Advance to be Repaid	Grant or Program Specific
Paycheck Protection Program (PPP)	X	X	X	X						
Paycheck Protection Program (PPP)	X	X	X	X						
Employee Retention Credit	X									
$50 Billion General Allocation					X	X				
$10 Billion Rural Allocation					X	X				
Uninsured Allocation							X			
Accelerated/Advance Payments									X	
FEMA Disaster Relief										X
COVID-19 Telehealth Program								X		

Questions?

Thank You!!!

HBS
Healthcare Business Specialists

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