

Nathan Baugh:

Hello, good afternoon, or good morning. Depending if you're on the west coast, my name is Nathan Baugh. I'm the Director of Government Affairs with the National Association of Rural Health Clinics. I'm joined by Bill Finerfrock, the Executive Director of the National Association of Rural Health Clinics, and we are the moderators and presenters for today's call which is of course is Covid-19 Surviving Covid-19 as a Rural Health Clinic.

Can opportunities and policy changes that you need to be aware of. This webinar series is sponsored by the HRSA Federal Office of Rural Health Policy and it's done in conjunction with NARHC. We're supported through a cooperative agreement as you can see on your screen and that allows us to bring you these types of webinars free of charge and the purpose of the series is to provide RHC staff valuable technical assistance and RHC specific information. Today's webinar is the 92nd in the series which began in 2004 and we've had over 23,000 combined participants over the years. As you know, there's no charge to participate in the call series and we encourage you to refer others who might benefit from this information to sign up to receive announcements regarding dates, topics and speakers presentations at the RHI Hub website and also on our website narhc.org.

All right, so with that we are going to get into the content of today's topic which is of course surviving covid-19 as a rural health clinic and I'm going to do the first half which is going to be largely focused on all the policy changes regarding Telehealth visits what we can do, what we still cannot do, what we're still waiting for clarification on, etc things like that and then we're going to switch over to Bill and Bill's going to handle some of the financial relief programs that are just getting off the ground as a result of the Cares Act and other legislation that the federal government has done and so it will be a sort of first half telehealth, second half talking about financial relief, Paycheck Protection Program things like that.

And before I get into Telehealth, I just wanted to put out a quick couple of notes on different things that aren't necessarily Telehealth related. The first is pretty straightforward, which is that CMS is delaying the filing deadline for cost reports.

So, this is across all MACs, if you know need more time to get your cost reports in, the deadline is being extended. All right, I'm getting advice that I'm echoing bad. I'm not on speaker's, Bill am I echoing bad for you?

Bill Finerfrock:

Not for me.

Moderator:

Nope, you sound good to me.

Nathan Baugh:

Okay. Alright, so I'm just gonna power through again. I'm not on a speaker. So hopefully this is coming through for most folks. Second note that I wanted to just put out there before we get into Telehealth issue is as of Tuesday during the public health emergency for covid-19, any area that is serviced by an RHC or an FQHC is determined to have a shortage of Home Health agency or

Home Health area and so I just that was something that changed as of Tuesday traditionally the RHCs were only able to provide this service if the area that they are located in was designated as a home health agency shortage area. But as of Tuesday, every service area that an RHC serves is just for the Emergency period considered to have a shortage of Home Health agencies.

And there is a brief note here that if a patient is under a home health care plan of care the Home Health agency must provide optimal care to achieve the goals and outcomes identified in the patient's plan of care for each patient's medical and nursing and rehabilitative needs. So essentially you need to ensure that the patient is not already under a different home health plan of care.

All right let's dive into the Telehealth piece of this and there's been just a confusion regarding Telehealth because it's just moved at a very fast pace and Telehealth and telemedicine, virtual, electronic, Technology-based Communications. All these terms they all are there. All synonyms of each other and common English vernacular so it can be very confusing when someone says Telehealth phone visit. What do they mean? Right? And the first thing that I think we need to understand is that the terminology must be precise, especially when we're talking about billing and what Medicare covers and what Medicare does not cover, okay.

So, the first thing I want to do is just go over some very clear terms. Telehealth and telemedicine can be used by the government and obviously by the public as an umbrella term for a wide range of services. These include the virtual check-ins or virtual care communications, which is a specific style, a digital e-visit service that is its own category. And then there's Telehealth visits and that's a third category. There are also other categories that given the context of whatever whoever is talking they might also throw these services in this category. Care Management, some people would call technology, enabled remote patient monitoring I've seen included in the broad category of Telehealth, provider to provider consultations. So there is a broader category, but for the purposes of today's call we're really going to focus on these three different styles: virtual check-in, digital e-visit and then the Telehealth visit, okay.

So this is a visual that is still currently on CMS's website. It's in the Telehealth fact sheet. Some of you have probably already seen this. It was created on March 17th. It's out of date already, but I wanted to still include it because I do think it really shows you. Okay, there are three different categories of Telehealth. Telehealth visit again virtual check-ins and e-visits really have to think about these things separately. Okay. I also wanted to include it because this pandemic is obviously a very fluid situation and the policy is also very fluid and already at least three things on this, perhaps more are already out of date.

For example, the virtual check-ins and the E visits do not have to be for established patients anymore. You can do those for new patients and patients you haven't seen last 12 months. Also, the e-visits can be communication between the patient and the provider through the online patient portal but also through telephone so already from March 17th this is out of date.

So this is the nature of moving policies so fast, there's going to be mistakes and there's going to be a lot of changes. So, you just really have to look at the dates of when things were put out including this presentation.

All right. So just a little bit of background on the first service, which is that we're going to talk about which is the virtual check-in. Initially when Medicare started covering this service, they called it virtual care communications and in some contexts they still call it virtual care

communication services. They have short-handed as you can see from that last slide to Virtual check in as well. Okay. So those are similar terms. They mean the same thing. We could start billing virtual check-ins on January 1 of 2019, but we had to bill it a little bit differently than our fee-for-service peers could. Fee-for-service peers had two different codes: G2010 and G2012 and we could not bill either of those codes. RHCs had to bill and FQHCs had to bill G0071 when they whenever they performed either of these two codes and just for I think people are getting more familiar with what a virtual check-in actually is, but this was at least five minutes of time that the provider spent either analyzing a picture that the patient had sent them that would that would be a G2010 if you're in a fee-for-service setting or on the phone with the patient giving them some quick advice, right? The major caveat is that this contact with the patient cannot lead to an RHC or an FQHC visit within the 24 hours after it occurs or the next available appointment and it cannot be a follow-up for a condition related to an RHC visit, all right, that was performed within the previous seven days. Okay. So those rules all still apply if you're doing a virtual check in during a covid crisis and for whatever reason you advise the patient to come into the Rural Health Clinic, you cannot bill G0071 if the patient comes in within 24 hours or in the next available appointment so those rules still apply.

What doesn't apply what has been changed as I've said before is that during the emergency period we can bill this for new patients and patients that we have not ever seen. Okay. So, this is now available for all patients.

This FAQ at the bottom in these slides will be out and publicly available on various forms NARHC, RHI Hub Etc. So, these slides will be available. This FAQ this link at the bottom here is from before covid-19. This was a released when the service came on board in the early January 2019, so it's not totally up to date on everything but it's still is our guiding document on certain aspects of billing G0071 so it's still important and it's still relevant to have but it's just not completely up to date as a result of covid-19 emergency.

Okay, so digital e-visits it is the next category, right? So, you have two virtual check-in that's in for lack of a better way to describe it, that's the easiest or the least amount of interaction. The tier higher is the digital e-visit codes. Medicare began paying for these codes in this year January of 2020 but RHCs could not do any of these but as a result of the Public Health Emergency on Tuesday March 30th, or maybe that was Monday March 30th, CMS released an interim final rule that expanded our code that we use to build virtual check-ins are virtual care communications codes G0071 to include the digital e-visits okay.

And so essentially what that means is that now the G0071 code pays that the average of the five different codes instead of just the two and that has brought the payment for G0071 from I think in the \$14 range to \$24.76. Okay, these digital e-visits are mostly designed around using patient portals to go back and forth with a patient, the provider answers the question for the patient, and they have a back and forth conversation. On the fee-for-service world depending on how much time the provider spends on the patient portal responding to a patient asking a series of questions over the course of a week seven days, they can build the different codes.

Again, for Rural Health Clinics, as soon as we cross that 5-minute mark is if your provider is spends five minutes responding to a patient question through the patient portal for Medicare, then that is now a G0071 billable service. Okay, and you're going to get paid \$24 and 76 cents for it. Again. This can just for the Emergency period can be provided to new and established

patients. There also and that's the direct language from the interim final rule just in case folks wanted to cite it if people didn't believe it, go to that link and that is Verbatim what is in the interim final rule. A couple of things on other things that I want to mention on the fee for service side there are these three other codes G2061, 6-2 6-3 that the that those folks can bill. Those are for non RHC practitioners such as physical therapists and therefore that's why those codes were not included in the calculation of G0071 if you have a physical therapist or a non RHC practitioner providing these in your clinic, you will not be able to bill G0071 for that so just wanted to put that out there because if you're reading stuff that's designed for fee for service providers it will probably mention that as well.

So, the digital e-visits also have a lot of the same thinking that the virtual check-ins do which is that it can't be a follow-up for a service that you have provided in the last seven days. It has to be it could be if it's a new problem. Let's say the patient did come into your office for one condition. And then is now asking about a second condition through the patient portal that would within seven days. That would be billable as a G0071 code if it the services within seven days of the patient reaching out to the provider online, then that time still gets added in to that first G0071, so the doctor might think that they're done with the patient after one email but the patient follows up again and again and you've already built G0071 let's say on Monday, and the patient comes back say on Wednesday or Thursday and is asking additional questions about the same condition. That would not be another billable G0071 code because it's for the same condition. But if the patient came back on Wednesday or Thursday for a different condition and you again respond spend at least five minutes on the patient portal that would be billable as a G0071. This is all very new and very fresh as you can tell. So there are still things that we are hoping to get clarified one of which is exactly how this seven-day clockworks. It is clear in terms of if it's the same condition within seven days, that's not another G0071 that you can bill and it is clear that if it's a different condition within seven days that is a second G0071 service that you can bill for. What's not clear is if you are providing, let's say you're just in constant contact, maybe every three or four days with patient over the course of an entire month, does the clock ever reset or are you only able to bill that one time. That's a clarification that I'm working to find. I haven't seen it and might be out there but I'm working to find that. So, the question is does the seven days, you know start at the beginning the onset and then reset every time you send an email back to the patient through the patient portal or does it not reset and you know after seven days you can bill it again. Those are some of the questions that we don't have answered and I'm working to get that clarified.

Patient, I get a lot of questions about patient consent on this. Patient consent, you still do have to get patient consent for, before you can bill for these codes. However, it can be obtained at the point of care and it can be obtained by your staff that are working under the general supervision of the practitioner. So those are changes as of the public health emergency. So, they're making it easier to obtain patient consent.

And finally, I'm jumping ahead a bit, perhaps the easiest thing now you can do to obtain patient consent is you can waive coinsurance and cost sharing for your Medicare patients on this. You don't have to but you can waive it so that 20% of 24.75 is I don't know about five four or five dollars. That's an awkward bill to explain. You can waive that, my math is bad that's over five dollars five to six, you can waive that for the purposes of Telehealth now, you don't have to but you are allowed to waive that and I have the link for that later, that clarifies that.

Just some of the billing basics. You're, just to be clear you're billing for these digital e-visits and or virtual check-ins on the UB-04, you're using your normal Revenue code, so 0521. There's no modifier so you're definitely not putting the CG modifier on the claim and the payment is \$24 and 76 cents. Again, the average of those five different services.

So, here's what I alluded to just a second ago. Providers have the option to waive cost sharing for all Telehealth services. And so this is a document here from OIG talking about how they will not enforce statutes of providers choose to reduce or waive cost-sharing for Telehealth visits. Now, this is a perfect example of terminology needing to be precise, right? In the OIG document, they say Telehealth visits. Now from context, I presume that also included digital e-visits and virtual check-ins, but that's not explicitly what it said. So, I think someone was on their on their case for this a week after they made the first policy statement at the first link here, they came out with a defying statement to say that when they said Telehealth does its thing and everything and so that's what you see at the bottom of the screen here. It says 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, which is again, very specific thing, virtual check-in services, e-visits and they even included monthly remote Care Management and monthly remote patient monitoring. Now, so for some of you that are doing chronic Care Management during the public health emergency, I think they I read this as you being able to waive the cost sharing for those services.

Alright, so now we're moving on to the final category here, which is Telehealth visits. Okay. Now Telehealth visits are the highest tier here. They are true, they are supposed to be true substitutes for in-person visits. The coding is the same as an in-person visit you use 99213, 214, etc and the list of codes that Medicare will pay via Telehealth is maintained at that link but it is a I think maybe about a hundred codes that Medicare will pay through Telehealth and they expanded that as of the covid-19 pandemic significantly.

Now before the covid-19 pandemic, Telehealth in Medicare was very restricted. There was an originating site rule which describes where the patient is located. There was a distant site rule which describes where the provider was located and rural health clinics were allowed to be the originating site, but they couldn't be the distant site. Telehealth Services were only available for patients that live in rural areas and they couldn't do any service really from their homes the comfort of their home. They still had to get in their car go to a qualified originating site to receive a Telehealth service.

So in reality and our context of the most common way that this was used was patient maybe needs to see a specialist in the city they could go to the Rural Health Clinic the rural Health Clinic would have the equipment set up and they could see a doctor that was or a provider that was far away. That's sort of before the pandemic hit and all of this had to be done through a very secure, there was you couldn't just call up your doctor. It had to be done through a secure HIPAA video communications platform.

But because Telehealth is one of the most obvious ways in which we are obviously going to combat this crisis. This has been completely flipped on its head. Patients don't have to be at originating site. They can be at their home. They can be outside. They can be at work. There are no originating site requirements anymore essentially. The rural aspect has been completely removed. You can be in Manhattan, San Francisco or South Dakota. It doesn't matter. The rurality requirement has been completely removed and it can also be performed through a non-

HIPAA compliant video platform such as FaceTime. The full link or the full list of video platforms you can use is that that link at the bottom. There's only a few that are prohibited such as Twitch, Facebook live, Instagram a lot of things like that that are quote public-facing but everything else including Skype, Google Hangouts, things like that all can be used. It can be done on a smart phone. Right, one of the old sort of rules indicated that telecommunication Services cannot be done on a phone. But those regulations were written before we had smart phones with cameras and the like so CMS clarified that it absolutely can be performed on a smartphone, but the Telehealth visit is cannot be audio-only.

Now there is as of the 30th, the interim final rule CMS is now paying for audio only calls with the provider. There's a set of I think six codes. That is on the fee-for-service side. Rural health clinics, if we're audio only, it has to be a G0071, okay. It has to be a G0071. If you do have video, now we're talking about a Telehealth visit.

We will probably be going back to CMS and pointing out that hey you've now included these Audio Only Services as something that fee for service providers do, either you need to reevaluate G0071 and include those codes in the average or create a separate mechanism for us to do that as well, but that's neither here nor there right now. If you have a sort of a prolonged audio-only conversation with your patients, that is a G0071 in the rural Health Clinic context as of today.

And obviously the biggest change for RHCs in terms of Medicare Telehealth benefit now is that we can now be the distant site providers. As of March 27, which is last Friday when the Cares Act was enacted, okay, it is only for the emergency period but there is speculation that a lot of these Telehealth changes not only the Telehealth benefit here, but the E check-ins and all that stuff. There's speculation that it will be difficult to unwind that, but they probably will unwind some of it and keep some other things. Hopefully we will be, you know permanently added as a distant site but as of now we're for the emergency period allowed to be the distance site providers. The big problem that we still have is that billing and payment for a Telehealth visit for Rural Health Clinic is still unclear. We, what we know is that you if you had a video audio and video communications and you perform a 99213, a 99214, any code that is on this list at the link here, you will get paid as a Rural Health Clinic.

But what we don't know is how you get paid or how to bill for it as of yet. I know CMS is working overtime to figure this out

Bill Finerfrock:

Or how much.

Nathan Baugh:

Or how much, yeah, and you know, this is not a conversation for here, but this is not necessarily the way that we wanted to set it up. We wanted it to be the all-inclusive rate, but the language in the Cares Act made it very clear that the secretary had to develop you see it on your screen, develop and implement payment methods that apply under the subsection for FQHCs and RHCs and furthermore made it very clear in the Cares Act that whatever this payment method looks like, costs associated with Telehealth Services cannot be used to determine our all-inclusive rate calculation. So that's very explicit. Again, a lot of these details we are awaiting from CMS, maybe sometime next week, but I really don't know it could be earlier than next week, could be next week. It could get delayed. It's pretty complicated to implement this in the context of a rural

health clinic and FQHC payment policy. So CMS is working overtime and hopefully they can get some guidance out sooner rather than later.

For all of these Telehealth services including and I use Telehealth in this context and the broad sense right, virtual check-ins digital e-visits, anything we do related to G0071, anything you do as a Telehealth visit video audio video communications, all of that, all of those costs will not count as an allowable cost for your all-inclusive rate, okay? So I pulled out the little the lines on the cost reports, this section is as you can see and that's the top one is independent cost report and the bottom one is provider-based cost report. These are costs other than RHC, FQHC services and you can see Telehealth has its own specific line.

I would presume that when CMS does release the details, they're going to tell us specifically to put the costs associated with providing the distant site Telehealth services on this line. Okay. Now that has implications for your revenue, has implications for your productivity standards, your FTEs. It has a lot of product, implications but we don't want to go too far down that path until we know exactly what CMS is going to make us do all right, but I just wanted to alert people now you're not going to get well, it's unlikely that you'll get your all-inclusive rate exactly and it will be, it's unknown what the payment is going to be for the telehealth visits as of today. Bill am I missing anything?

Bill Finerfrock:

No, I don't think so.

Nathan Baugh:

Okay. Alright, so I know that there are going to be a ton of questions and I'm here to answer those. Hopefully, I was relatively clear. I'm going to pass it over to Bill now for the second half and at the end we'll we should have a good amount of time to take questions from folks.

All right. And it should be coming your way right now.

Bill Finerfrock:

Thank you Nathan for that coverage on the Telehealth and we'll have ample time. We do not have to stop this at three. We will continue hopefully, you know much longer and try and get to as many questions as we can when we've completed the presentations.

But the first thing I want to say before beginning is thank you. Thank you to all of you who are out there continuing to see patients, continuing to provide care, continuing to work in the back office, the front office, whatever your role in your rural health clinic is during this National Public Health Emergency. We recognize that you are taking some level of risk. We recognize that it is emotionally and financially challenging and we want you to know that we are working on your behalf to try and make things easier, to try and get revenues to you that will help you keep your doors open, but at heart we want to say thank you for everything you're doing to try and make health care accessible in your communities and it is appreciated.

I'm going to talk about a couple of the different program options that you have available to you to try and help keep some of the cash flowing. We recognize that revenues are down substantially in many rural health clinics, if not most, simply because patient visits are down patients aren't interested in coming out of their homes. They're under some cases mandatory

quarantines, you know governmental restrictions on travel and so forth. I'm sorry, non-essential visits are being discouraged certainly non-essential surgeries are being cancelled. And so revenue flow throughout the healthcare system is down not just directly related to covid-19, but for in communities where there is no evidence of covid-19, and as a consequence of that a number of programs have been created or expanded in order to help you address those.

There's the new Paycheck Protection Program which started starts today. There are some other SBA programs that are out there that you might want to take a look at, there are Medicare Advance payment options. And there's a provider lost Revenue program. So, the paycheck Protection Program, as I said is as is starting today, this is being overseen by the Small Business Administration, and it was created by the Cares Act so it was only literally created a week ago by the Congress it has been funded to the tune of about three hundred and forty-nine billion dollars. It is open to any entity that meets the requirement as a small business which for purposes of this program is any employer or health facility with up to 500 employees full-time or part-time.

For this program they're counting bodies not FTEs in terms of who, how you count employees. Most rural health clinics will be able to receive a loan which is forgivable. The government will lend you the money and if you do certain things that money will the government will forgive that loan and convert it to a grant. The amount of the loan that you will be eligible for is an amount equivalent to 2.5 times your qualified monthly payroll.

So most clinics will use their average monthly payroll for 2019 and out of in doing that calculation, you will exclude any payroll on a personal and individual basis over \$100,000 annualized salary.

If you are a new clinic one that opened after January 1 still use the average monthly payroll using the January 1 through February 29th time period and again exclude cost of over 100,000 on an individual basis. So if you have an individual in your clinic an employee or an owner who has an annualized salary or income above a hundred thousand, you only can claim a hundred thousand for that. Anybody below that you can claim their salary up to that hundred-thousand-dollar figure. So here I just a real simple math equation to show you so the monthly payroll amount where the clinic is determined to be 17,500. You multiply that by two point five and this particular clinic would be eligible for a loan of forty-three thousand seven hundred and fifty dollars.

Now this entire loan can be forgiven if your clinic meets certain requirements. If you fail to meet the requirements, then the amount forgiven will be reduced or you may have to pay the entire amount back. But as you'll see that's not necessarily a really bad thing. Obviously, everyone would want to get converted to a grant but even if some or all of it has to remain as a loan the terms on that are not particularly bad. In order for your loan to be forgiven your clinic must demonstrate that the loan monies were used to pay employees' salaries, health insurance premiums, rent on your clinic or the mortgage insurance if you own the clinic are in I'm sorry interest and your utilities. So if you use the loan for that purpose, you can get the loan forgiven. You must attest that you have the same number of employees full-time and part-time at the end of the loan period which is eight weeks as you did at the beginning. So I when you apply for the loan, you will tell them how many individuals you employ a full-time, part-time. If it's ten full-time, five part-time, it's 15. If it's three full-time, 2 part-time it's five. It doesn't matter as I said whether it's FTE, you're counting bodies. And if at the end if by June 30th, you have the

same number of employees as you had when you applied for the loan then and you used it all for paying salaries, paying health insurance premiums, rent or mortgage interest in utilities. You can have that whole amount forgiven. If you did, if you terminate an employee during the period and you do not rehire that individual or you reduce salaries or you use the money for some other purpose you can use it for another purpose, you don't have to use it for salaries, health insurance premiums then it simply becomes a loan and you would have two years to pay that back. You would payments would be deferred for six months at the conclusion of June. You would have six months deferral of payment and at that point your loan would be you would have to pay it back at 1% interest over the next two years. So, it's not a particularly onerous loan amount if you had to pay it as a loan and you were unable to get it converted to a grant. If you retain a majority of your employees and you use it for the purposes intended, you may be able to get a partial conversion from loan to Grant. So you need to look at this and talk to your bank. There are specific banks that are doing this. These are banks that already participate in the SBA loan program. There are other banks from credit institutions are participating, other banks. Some of the large national banks have indicated now that they're not participating but there will be many many banks that will be available in participating. So, as I said it starts today and the applications are available online. Here's a link. You can also go to the Small Business Administration sba.gov. And they have links there to Emergency Loans emergency disaster loans just follow their links and you can get instructions. You will participate I'm sorry, you will apply through a local participating bank. So again, you may want to reach out to the bank that you normally do your work with, find out if they are participating. If not, when you go onto the SBA gov website, you can find out what banks are participating in this program.

So you can as I said, you can apply to an existing SBA lender or through a federally insured depository institution, federally insured Credit Union, Farm Credit system institution that is participating at this point participation by the banks is voluntary. So it's possible that your bank isn't voluntarily participating even though they may be eligible.

There will be an expansion to other regulated lenders, we expect but those will have to go through an approval process. Those that I've mentioned are automatically approved to participate in this program. There is there are other SBA Disaster Relief Programs if that Ppaycheck Protection Program is not of interest to you. There are other programs. This one is interesting, but it is only eligible available to those who have an existing SBA loan.

It is called the SBA Enhanced Debt Relief Program, and it will provide a reprieve for businesses including rural health clinics with existing SBA Loans, as you come overcome the challenges for the covid-19. Under this program, if you have an existing SBA loan, they will pay off the principal and interest of your existing SBA Loans for a period of six months.

I was talking to a doctor just last evening who had an SBA loan on their practice and he contacted the bank or in the SBA and within 24 hours he got approval to waive their waving his payments for his mortgage and his interest on his practice for the next six months. It's worth several thousand dollars in savings to that practice.

So, if you have an SBA loan, I would encourage you to look into to this this program. There's another program and this is a pre-existing program. It's called the Small Business Economic Injury Disaster Loan or EIDL loan program. Under this loan program you can borrow up to two million dollars of which the first \$10,000 will be considered a grant.

So let's say you wanted to borrow 80,000 dollars you got approved for \$80,000 they would immediately say the first ten thousand of that is a grant you only have to pay back \$70,000 of that grant. This money can be used to pay existing debts. It can be used to pay your payroll. It can be used for accounts payable and other bills that can't be paid because of the impact and the you can't pay them because your revenue is down. On this program, there's an interest rate of 2.75 percent and it's payable over thirty years and you can defer the initial payment for up to a year. In this program you again apply directly to the SBA and you can apply online and here is the link to that online application or you can call the toll-free telephone number on your screen if you want to talk to someone and learn more about this program

Now, it's important to understand that you can either do these sequentially with for both the EIDL and the PPP loans. If you do it sequentially, you can use the loan for the same purpose. So for example, let's say you want to participate in the Paycheck Protection Program, which will give you eight weeks of revenue to cover your payroll and you apply and you get accepted and you do that but your some of your payroll may not be covered. So as I mentioned you have a hundred thousand dollar cap so you have some individuals in your practice some of your clinicians, perhaps who have an income above a hundred thousand, you could sequentially apply for and get an EIDL loan to cover that aspect of your payroll that is not covered by the PPP loan. There may be other costs that you're incurring that you have. There may be an existing loan on a building or an existing loan that's not a mortgage for equipment, something that is not going to be covered by the PPP Loan program. You can apply to get a loan to help pay for your obligations under this EIDL program and you could do it simultaneously. Or as I say you can do it sequentially where you take out the loan for one period of time that loan expires you were able to get that converted but you are still things haven't come back as quickly as you had hoped you're looking at into June and July you're looking at the prospects that your revenue is going down at that point. You may want to apply or even advance of that apply for an EIDL loan to help you help you continue to pay for those expenses. Again, it's not fully forgivable. But the first 10,000 of that would be converted to a grant.

So again, you want to talk to your SBA representative and work with them to determine the best combination mix or sequencing of these loan options. There's also the opportunity to get Advanced Medicare payments. Now. This is an existing program that has been used. Some of you may in fact have used it for natural disasters such as hurricanes or tornadoes that have hit communities where there are rural health clinics.

I know we've had many rural health clinics hit by tornadoes, for example through the Midwest, some with hurricanes in other parts of the country down along the coastal areas. Under this program, Medicare has relaxed the requirements for providers wishing to obtain an advance payment on their Medicare on your future Medicare claims. It used to be that you would only be able if you had claims disruption so that you could submit claims that or get an advance payment on claims that were expected to come in, here, you can just be concerned or you need revenue for purposes of the covid-19 pandemic because again, your revenues are down and so you can apply for an advance payment under the Medicare program. They are authorized to make these through the duration of the covid-19 national public emergency and the application will go through your Medicare administrative contractor. So, whoever is the MAC that you deal with as a rural Health Clinic is who you would deal with in order to get and securing Medicare Advance payments. You are eligible for this as long as you've billed Medicare within the past 180 days,

you are not in bankruptcy. You're not under active medical review or a permit program Integrity investigation, or you do not have any outstanding delinquent Medicare overpayments.

Rural health clinics is limited as are all providers in how much you can receive. You can receive the equivalent of up to three months of advance payments based on your monthly average Medicare billing for the previous six months. So, you would look at your Medicare billing for the previous six months, divide that by six to come up with your monthly average and then you multiply that by three and that's what you could obtain in the way of a Medicare Advance payment. So again, this clinic has average monthly Medicare billing of 10,000. They would be eligible for a total advance of \$30,000 that's 10,000 times 3. This money does have to be repaid. Repayment will begin automatically 120 days after the advance and must be fully repaid within 210 days of receiving the advance. So, if you got the advance on April 15th to cover April, May, June 15th, April 15th to May 15th, May 15th to June 15th, June 15th to I'm sorry, July 15th. You're covered. Thirty days after that so be a hundred and twenty days after the loans that the advanced started, Medicare would begin recouping that money based on claims that you submit. So, at that point when you submit a claim for Medicare, Medicare would say, okay this is your allowed. This is your RHC AIR, this is what we're going to pay.

And so instead of paying you, we are now going to apply this to the advance we gave you back in April. That amount must be satisfied within 210 days of the start of the loan or over the next 90 days. So, August 15th to September 15th, September 15th to October 15th, October 15 to November 15th, November 15th would be 210 days and you would have to have fulfill the obligation to repay the advance at that point. It's important to note that you can continue to submit claims to Medicare. This doesn't mean that you are doing it in lieu of patients they're seeing, visits that you're doing whether it's Telehealth or in person, so you can continue to submit claims throughout this period the three months and get Medicare payments for your visits during that period of time. This is an advance.

It will be paid off based on future claims. This does not affect or impede your ability to submit claims real time over the next over the three months where you would have this advance. So it is a way to get these advanced payments can be approved relatively quickly and they're saying they could do it within five to seven days of submitting an application. So, it's a way to get some quick cash into your practice. But again, it is a, think of it more as a no-interest loan that you're going to pay off over a 90-day period beginning a hundred and twenty days after you receive that money. So, you're going to get a cash infusion. But you're also going to have a cash shortfall when they start doing the recoupment. So, you have to consider the full ramifications of this program.

There's also a new program that has not yet started called the Provider Lost Revenue Program. Under this program due to the covid-19 pandemic many rural health clinics as we've talked to have seen a precipitous drop in your patient visits. The purpose of this new fund is to provide grants to practices that have experienced that kind of a reduction in revenue or have seen an unexpected increase in cost do the covid 19 pandemic. The money will be available during the period of the National Emergency. Now with respect to cost, you have to be able to demonstrate that there is no reasonable prospect for you to get those cost reimbursed at some point. So, for the rural health clinics on a who are paid already on a cost basis, this is going to be a little bit of a challenge because if you have unexpected costs, presumably there will be some means for cost settlement at the end of your fiscal year that might allow you to recoup that and then be reflected

in your future RHC rate so that you would ultimately get approved. I think where the more likely opportunity is to occur is on this lost revenue again due to reduction in patient volume or whatever the purpose of reason for that reduction may be so as I said, it's a brand new program is only sign into law a week ago. The Department of Health and Human Services is working aggressively to try and get this set up and get the money flowing out to the providers. A hundred billion dollars has been approved for this program that is being administered by the Department of Health and Human Services. It is not yet operational. As soon as the information on how you can apply for a Lost Revenue Grant. These will be grants. They won't be loans.

This is this is money and it's to cover not just your Medicare loss but your commercial your Medicaid whatever may be any revenue that you didn't get that you would have anticipated and they're looking to have a formula on how you might calculate that. So, in order to be eligible, you do have to be enrolled in the Medicare or Medicaid Program. It's also going to be what's called a rolling program or we believe from our conversations, it will be a rolling program because the revenue loss that you experience is not going to be consistent.

You may have seen a decent amount of revenue in March your collections but recognize that part of your collections in March were based on visits that may have occurred in February. So, if you did it exclusively on a calculation of lost revenue in March it might paint an inaccurate picture, so there will be an opportunity to do a recalibration based on a change in circumstances. So, your situation in April may be much worse than your situation and was in March but by May maybe it's a little bit better. And again, you would recalibrate to see what your revenue loss may be and this is going to vary from region to region in terms of the speed with which we recover from the national pandemic, what communities, there may be some areas that come back quicker than others. So, the program needs to be flexible to reflect that as well. So again, this is what it could look like.

And again, this is just illustrative, this is Bill Finerfrock. This is not based on anything, any insight I've gotten but just to give you an example. So, you have a Rural Health Clinic whose average monthly collections from all payers for March 1 of 2019 through this should be February not 12, but 2-28-2020 was \$60,000 a month. The providers collections in March of 2020 was \$20,000. So, the estimated lost revenue is \$40,000. It is potential that under this program that that Rural Health Clinic could get a check for \$40,000. So, it's very simplistic. This is again not how the program is going to be set up. It's just too kind of give you an indication of the thinking.

Now one of the things I want to point out is that you cannot double dip. You cannot obtain money from programs that are intended to cover the same expenses. So, if for example you apply for a Medicare Advance Payment and you also want to apply for this Lost Revenue Program again, this is my estimation, but that you would you would have to take out of your estimation those Medicare Advance Payment dollars that you have received.

Otherwise, you would be double dipping. There may be other ways in which you're going to have to demonstrate. If you got certain participation in a loan program for example, there may be some adjustments made there, again, if you're getting revenues to cover expenses that would have otherwise been covered. So, you do need to give some thought to what programs you may want to participate in, what you don't, and what the consequences are, you again you don't want to have someone come back after the fact and say oh it looks like you got money twice for the same thing. So, you do need to try and avoid that as much as possible. Now, we don't know when this is going to be stood up. We know that they're working. There's some talk that it could be

relatively soon, but we don't know you're just going to have to stay tuned. And as soon as we get information, we will share that with you.

I did want to say some of you I know are doing this session for your CRHCP certification. This is the code you should use to get credit for participating in this webinar WL 9 2 4 CV. So, at this point we'd like to open it up for questions for folks and Cate you can give everybody instructions on how to post a question in the chat box?

Moderator:

Yes, on the right-hand side of your screen is a box looks like a chat box with a question mark in it and you can post your question there and then Bill and Nathan can answer that for you.

Nathan Baugh:

Hey Bill, so I'm seeing a lot of the questions come in and thinking what makes the most sense will do a few that are on here now, but if you had a question from earlier, like my section of the program and it was not answered and you're still here and you want to ask it again. Please go ahead and ask it again because I'm not going to look at the questions from the early half just because we have too many.

Now we're going to go ahead and start right here 3 o'clock first question is from Mark Lynn and it's for Bill. It says what does Medicare billing mean for Accelerated payment program? The amount paid by Medicare or some other number? The reason I ask is RHCs received very little money in the first quarter of each year from Medicare due to negative reimbursement.

Bill Finerfrock:

Again, all I can tell you is what it says for the advance payments, which is your average monthly Medicare. I believe it is the billing that you do because as you point out there is that it's not what you're getting paid, but it is I believe it's what your billing but I would check with your Mac as to how they would do that calculation. There may be others who are more familiar with the details of that who have had experience with a prior disaster. They're not changing the way that they determine the amount as my understanding. So whatever, however that calculation may have been done before, although this one is a little bit different in terms of doing it on estimates, but we don't I don't have an answer to that question Mark

Nathan Baugh:

And I apologize to folks and we're not going to be able to get every question out. So I'm going to just try to select the ones that I think we can answer or that we haven't sort of addressed before next question we have is from James HallsBerg who wants to know how this will all work with the cost report. Will we still get to claim expenses on the cost report and any grants that are on top?

Bill Finerfrock:

Yeah, there's a couple different things in terms of Nathan touched on for the Telehealth visits. There are going to be cost report ramifications because of the way that they are talking about standing up this Telehealth benefit and how they are going to pay. So, there will be ramifications there. There is a mechanism on your cost report. It's already in terms of how to calculate and factor in grants. I'm not a cost reporting person. I would talk to some of the folks

who are experts in that, but my understanding is that you will calculate it as a grant as you would if you had gotten grants for other things.

Nathan Baugh:

Bill, can you go back to the code? So people are asking for that just go on your screen. Or did you read it? There it is. Hopefully is it still up? We can see it? All right. So, the next question that I see here is from Samantha who asked for Telehealth visits would we use G0071 or E&M codes? Again, this is where we need to have precise terminology. For Telehealth visits that are video audio based, you're going to be billing the E&M codes or one of the codes that are listed in that list that I gave you. Okay, these are substitutes for in-person office visits. So, you would build the E&M codes for the Telehealth visit. Now if you do an audio only thing or a patient portal thing, that would be G0071. Okay?

Bill Finerfrock:

Your coding is going to be just for the Telehealth visits you coded just as if the patient had been in the clinic face-to-face. So whatever code you would have used in that instance are the codes that would use for Telehealth. The difference is that you're not we don't know for sure. But we're anticipating you're not going to get your all-inclusive rate for that visit in totality. You will get probably some adjusted rate off of that. But you code it just as you would have if the patient had been in the office.

Nathan Baugh:

So I think we have some confusion Bill next question in terms of the lost revenue being able to be coupled up with the Paycheck Protection Program. So Lucy asks the way she puts it is if you receive payroll help, can you still apply the lost for the lost revenue?

Bill Finerfrock:

We don't know the answer to that question because they haven't issued any of the guidance or requirements with regard to the Lost Revenue program. What they have said and what it says in the statutory language that created the lost revenue is that the you know, they should they will not allow essentially double dipping. So we don't know whether or not it is like the Advance Payment and the Lost Revenue whether that would constitute double-dipping if you tried to do both. We don't know whether it will apply to the loan programs. You could make a case that the purpose of the Loan program is a little bit different than the Lost Revenue program. Although one could argue the revenue or you're using is what you would have used to pay salaries. We just don't know and we're going to have to wait for the guidance to come out on that, but we know that they were very clear that they are not going to allow double dipping

Nathan Baugh:

And I think that answers your question Tim. Tim has a different take on The Accelerated Payment Program. But as Bill said, we're not sure if they would count the accelerated payment program against your lost revenue so you could be right, but it also could be the other way that could one day clarify the Lost Revenue program. They could count against you, so you don't know yet. So next question. I have from Lisa. Lisa, I don't fully understand your question to Bill 99201 through 99215. Those are just the normal E&M codes. So, I'm not sure what the context of your question is. Perhaps you can come back to me on that. Denise is asking about modifier 95

and correct me if I'm wrong here, but modifier 95 indicates that the service was performed via Telehealth, right?

Bill Finerfrock:

Yeah, that's a great question and it should have been addressed. So previously when you performed a Telehealth visit you were instructed to use place of service code 02 and that would indicate that it was a Telehealth visit versus an in-person visit. Just this past week, CMS changed that instruction and you are now on Telehealth, you will use modifier code 95 and I've been told informally that that code will be used on your Rural Health Clinic claims as well when they issue the instructions. So, when you do a Telehealth visit, you will do that with the 95 modifier. And that will be the same and you know, this was one of the questions I think we've gotten previously

Nathan Baugh:

But that is a telehealth visit to be clear right Bill. The G0071 you do not need to modify. This is for the new forthcoming.

Bill Finerfrock:

Yeah and the clinician who's doing the Telehealth visit does not need to be in the rural health clinic at the time that they engage with a patient in with a Telehealth visit, individual can be home. So your physician, your PA, your nurse practitioner for whatever reason can be engaging in these Telehealth visits from their home location, that location does not need to be enrolled in the Medicare program by virtue of the way the Telehealth benefit is going to work during the public health emergency so you can just do those like I said from home for whatever reason the provider chooses to be home.

Nathan Baugh:

And now and again a lot of these questions are really good questions that we are seeking the answers for in the forthcoming guidance, specifically written in regard to the Telehealth visit. So, I'm seeing a lot of questions that we just can't answer yet because we don't have the explicit guidance to point to. All right. I'm reading these questions here does our revenue cycle team would like to provide Telehealth Services real time audio video and instead bill G0071 to Medicare and G 2010-2012 Etc to other payers. I believe this is fraudulent billing. What is your take on this?

I think maybe we need to have a sidebar. I wouldn't advise billing the Telehealth visits that use audio and video as G0071 because those are only going to be paid \$24 and 76 cents. If you're doing an audio video style Telehealth visit I wait for the guidance that's forthcoming from Medicare and bill that then because it I have a very high degree of confidence that it will pay a lot more than twenty four dollars and 76 cents because it's more of a replacement for in office visit. In terms of billing those other codes to other payers. The other payers are going to tell you what they will take and what they will not take so I don't think, it's not fraudulent to follow Medicare billing rules on G0071 and bill a 99243, if your State's Medicaid pays that that's not fraudulent. Those are payer specific rules. So hopefully that answers your question. Bill do you want to chime in while I find the next question?

Bill Finerfrock:

No not on that, but I did want to address something we didn't mention is there has been some concern expressed with regard to telehealth visits in terms of the productivity standards. We have raised this with CMS to ensure that if you are now going to be doing Telehealth visits and those would have normally been in-person visits that you are not adversely affected by that in terms of meeting your minimum productivity. We're asking CMS to issue a broad instruction and guidance to that effect, and they've not done so yet but they have mentioned that the carry the contractors are authorized to waive the productivity minimums in when there are extenuating circumstances and one could certainly argue that having this as an extenuating circumstance. If there ever was one this would apply so we are we have asked for that. The other question that we've gotten is many of the RHCs that are Provider-based that are under 50 beds. Some of you are at numbers relatively close to 50 beds and that it may become necessary for you to add beds in order to fulfill the demand for patients in the event you have a surge for covid-19. We've asked CMS for guidance and a waiver of that 50-bed limit for purposes of the exemption from the cap in the event that a hospital has to temporarily increase their bed numbers due to covid-19. We're waiting responses for both of those, but we have submitted those to CMS for consideration.

Nathan Baugh:

Alright, so the next couple of questions again, we're waiting on CMS to be able to really answer if you know, for example, do we need to use the CG modifier. What is the place of service code for a Telehealth visit, things like that? Yeah, I think we already answered the question about the provider being.

Bill Finerfrock:

Yeah. Yeah place of service is no longer the issue now, you'll just use modifier 95 and place of service is not an issue. So you would code it just although it as if it happened in your Rural Health Clinic using for Telehealth and using the 95 modifier.

Nathan Baugh:

Okay, and so Michelle you would use in your example for G0071, you would use place of service code 72. I would have to verify that with the experts on the place of service codes Michelle, but I believe it would be 72. Okay, next question just to be clear. We cannot bill for an audio-visual visit in RHC? No, you can do it, you will get paid for it. We don't know how to bill Medicare for it yet, that's the clarity. Do we know if the provider has to be in the office for a Telehealth? We just answered that. Sorry. I'm reading these. Anything on governmental agency RHCs. What options for financial support for the government owned RHCs? Bill?

Bill Finerfrock:

Well, of course you would still have the Advance Payment Option. Um, you would not have the ability to seek a loan, those are for businesses or certain nonprofit organizations. They there's nothing in there that I have seen that would extend that to a government owned facility. The it is potential that under the Lost Revenue program, I would think that you would be eligible to participate in that once that program is set up, but the loan programs would not be available to you because you are not a business, a entity that would qualify. So, it'd be the Medicare

Advanced Payments presumably the Lost Revenue Program would be your options to get revenue during this during the pandemic.

Nathan Baugh:

So we're at 3:20 Bill. Do you think we should do hard stop at 3:30? We're not going to get through all these questions. Sorry folks, but Bill and I are answering questions in our in our email that we can but what do you think go till 3:30, or do you want to go further?

Bill Finerfrock:

I mean we can go and I mean I'm fine we can go till 3:30 and see how it's going. But please understand we had nearly thousand people on this webinar today. So as you can imagine that has the potential to generate a lot of questions, but that many people I think many of you have had the same question and so but we will stay on for a while and try and answer some more until our voices died out or you get tired of hearing and we see that the numbers have dropped off and no one's listening.

Nathan Baugh:

Okay, would getting a PPP Loan in applying for the grant producing companies consider double-dipping? you already answered that sorry. I'm trying to find a good question here. Talked about supervision of RHC supervision. What does that mean Hannah? I don't understand your question. I apologize.

Bill Finerfrock:

Well, you've got you have supervision requirements of staff. So you would have a physician supervision for PAs or nurse practitioners you would have supervision of other staff who are ancillary staff. Supervision requirements are by and large dictated at the state level and CMS says as long as you're adhering to the requirements established by your state. Now, I know a number of states have relaxed supervision requirements in order to expand the workforce and facilitate the delivery of care, so based on CMS's policy of following state law, if your state has relaxed a supervision requirement then, so perhaps your state required you'd be under the direct supervision and now has moved it to the general supervision. That would be fine. So for example, let's say you have a situation where the clinician is doing Telehealth visits from home and staff is in the Rural Health Clinic doing work and there's no one there because the clinician is at home, that would presumably be permissible under this relaxed situation. So, we're looking at that. We're also looking, we've had some people inquire as to whether or not CMS could relax some of the staffing requirements, that based on volume and the requirement that you have a PA for example on site at least 50% of the time the clinic is open and can there be some relaxation of that requirement in order to allow more rational staffing based on patient volume? So, you know you might have the doctor is going to be there certain days the PA or the nurse practitioner is going to be there other days and over the course of time. You may not make that 50 percent requirement. We've asked CMS to look at that as well to provide some additional staffing flexibility. But that would also then tie in with the supervision issue because they may not be there in the building to provide direct supervision if that were to have been required, but now is relaxed.

Nathan Baugh:

Right and just and she is she asking the context of getting the consent. So, if again if you're not in the same building as your auxiliary support staff, let's say your calls are getting forwarded still to the to their homes, they could obtain the consent from their home and then pass along the patient to the provider and that would be appropriate.

Bill Finerfrock:

Yeah, let me just see if there are these kinds of issues and where you feel like there is a policy or a rule that is going to prohibit you from delivering care or doing staffing or putting people in places where they need to be in order to protect them or create a more safe environment and you're worried about this type of a thing. What I would ask, is that you send me or Nathan an email with as much specificity as you can provide as to what it is that you feel may be adversely impacting your ability to allow staff to work from locations that are safer because it would potentially violate some rule regulation or policy. We can then in turn take that to CMS to see if we can get an opportunity to get it waived. I think as a general proposition what you are seeing, both at the federal level and the state level is a relaxation and policies to facilitate the ability to utilize individuals in roles that they may not have originally contemplated. I was on a call earlier where they're talking about taking radiologic technologists who are not in high demand right now and giving them two weeks training to become respiratory therapists. We're seeing this kind of change in that the states are allowing that; the Federal government is allowing that. The problem is we don't know what all of the policies are that may be creating these barriers that could potentially be waived. So, we have to look to you to say, you know, this is what we want to do. This is the priority, our compliance people are saying we can do it. Why can't you do it and then we can investigate to see if that can be waived.

Nathan Baugh:

Great. Luis Lopez asked does this apply to Medicaid payments? No, everything that I talked about today from the Telehealth standpoint applies to Medicare. Medicaid in many states is out in front of Medicare on Telehealth. So, you're going to have to verify with your Medicaid Program in the state that you are in, what their payment policy is and how they expect you to bill Telehealth visits.

Bill Finerfrock:

I want to add to that Nathan, you know, one of the issues we've heard from many of you is the ability to use a an audio-only phone for a Telehealth visit. As Nathan mentioned right now, the policy has to be an audio video phone. The request is particularly poignant for many rural communities where you don't have particularly good internet access or good cell phone service and so CMS, there are a number of members of Congress, if CMS won't do it. And we do do a phase for bill in Congress that this is one of the issues that will be put on the table for consideration; to allow Telehealth visits to occur via a traditional audio only phone because of particularly in rural areas where you have those technical shortcomings. Did I get cut off?
Nathan, Cate?

Moderator:

I'm still here. I'm not sure what happened to Nathan.

Bill Finerfrock:

Can you ask the questions and until maybe he can get reconnected?

Nathan Baugh:

I'm reconnected now. Okay. Yeah, I just got muted here just accidentally hit the button. All right. So yeah, just a clarification on the place of service code if you're billing on the UB-04, there is no place of service code. So just that's why I was struggling with the O2 vs the Rural Health Clinic, the 72. Picking back up. We were just at the Medicaid. Christie asked does the virtual check in have to be patient initiated or can the physician initiate this contact? The answer is that it has to be patient initiated as of everything that I've seen. I have looked to see if CMS is waving that. Now the virtual check in again is just that first contact. Clearly the digital e-visit since it's over the course of seven days, there could be a back-and-forth in perhaps the provider could initiate, send two emails in a row, but the initial service for G0071, those have to be initiated as of today by the patient. And Bill, I think you were talking about Audio Only Telehealth visits or Audio Only visits. We don't have a proper name for it yet. I just want to be precise. These are six codes that as of this week on the fee schedule are now billable on the fee schedule side. We don't necessarily have an access as rural health clinics to build that set of services yet. The closest thing would be the G0071 that may be modified by CMS to include this this suite of services that are available in the fee schedule side. It's it may be a different code that CMS creates, or we might not really be able to bill that. So, I just wanted to add my that was what I was going to say before I accidentally hung up on myself. We're at 3:30, we're down Bill to 878 which is or 873 which is still a lot. But obviously not where we had at our peak. Do you want to keep going or it's your call? I can stay on.

Bill Finerfrock:

Yeah I can't see the questions so I don't know if you want to just take a quick look to see if there are unique questions that haven't been answered or anything that we need to address or we can just ask folks to send us an email if there was something we didn't get to. Again, some of them we can't answer because we just don't know that these new programs. But if you see anything there that looks like an interesting question. And if not, then we can go ahead and yeah close it out.

Nathan Baugh:

Just one that I'm seeing right in front of me that is easy, which is Is verbal consent ok? Yes, it is ok, but you should note in the patient's chart verbal consent is allowed. Those questions Bill were all from 3 to 3:04 submitted. That just shows you the volume of questions that we've gotten. Okay, so well again, I don't think I'm going to be able to synthesize all the questions, you know, I know there's stuff that we probably didn't get to or clarify specifically. So please if you feel like you need the extra clarification recapped email Bill or me. My email is Nathan, n-a-t-h-a-n dot Baugh b-a-u-g-h dot org, and I will try to do my best to answer questions there. Bill do you want to give your email?

Bill Finerfrock:

Yeah, it's in the slides. It was up on the first slide.

Nathan Baugh:

So BF@narhc.org, and we apologize that we couldn't get to everyone and we are going to have more content absolutely as details about loan forgiveness become available, as details about how to bill a Telehealth visit specifically for health clinic become available. We will be pushing out more information as soon as we get it and can understand it. Any last words Bill?

Bill Finerfrock:

We will probably schedule another webinar similar to this one when those issues get clarified. And again, I just want to close out by saying thank you again for everything that you're doing for the people in your communities whether you're seeing patients as a physician, a PA, nurse practitioner, Midwife, social workers, psychologists, whatever your clinical experience if you're someone who's in at the front desk or your someone who's sitting in the back office, you're all performing a particularly important role and it is much much appreciated from those of us who are the patients of the world and who rely on you to be able to be available to us in our times of need and we just thank you for doing what you're doing at this particularly challenging point in our nation's history.