NARHC Advocacy From A Clinic Manager's Perspective

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SPEAKERS
Nathan Baugh, Executive Director @NARHC
Sarah Hohman, Director of Government Affairs @ NARHC
Michael Tackitt, NARHC Fellow & RHC Clinic Director

Sarah Hohman 00:12
Hello, everyone, thanks for joining us today. I'm going to give it just a minute to let folks join and then we will kick off today's webinar. Thanks for being here. Okay, there will definitely be some more folks joining us, but I wanted to go ahead and get started. Thank you everyone for being here for today's webinar. This webinar is a federal policy update, intended to educate the RHC community about our current federal policy priorities. We have a special opportunity today to hear from narcs first Health Policy Fellow. So just a brief overview of the agenda. First of all, I'm Sarah Holman, I'm an IRA T's director of government affairs. And today you'll also hear from Nathan BOD narcs, Executive Director, and Michael Tackett, our Health Policy Fellow. Just a brief overview of our agenda, we're going to talk about the fellowship, Michael's going to share all about his experience, being here with us in the DC office for the month of June. He's then going to talk about the rural health clinic burden reduction act, which many of you have likely heard of, but we want to provide a really thorough overview of the bill, and talk about how you can be involved as well. And then we'll talk about Medicare Advantage and telehealth policy, two of our other big priorities in the federal space right now. Before we dive in, I do want to mention a few housekeeping things. We appreciate you being here today. And we will have lots of time for q&a at the end. For now the q&a feature is disabled until the end of the presentation. Just so if your question gets answered during the presentation, we're not using time during during q&a, because we usually run out of time to answer those questions. If you need clarification, of course you can, you can ask it again, if you have technical difficulties, we ask that you use the chat feature that will go directly to us as hosts. And we can help you out there. As with all webinars are at the mercy of good bandwidth for everyone. So if you lose connection or have challenges with your connection, just log off and hop back on and hopefully that resolves everything. This webinar is being recorded. And the link to the slides, the presentation are can be found in in the chat as well. And those will be on our website. In the slides are there now the webinar recording will be there in a couple of days. Next slide please. Okay, so I wanted to give a quick overview of the health policy fellowship that NMHC created last year to honor and recognize narcs co founder and longtime Executive Director, Bill Finnur. frock. Bill retired from the organization last year. And we wanted to find a way to honor the incredible legacy of the organization that that he had created. And so Bill was always throughout his career continues to be even in retirement. And educator, we always have interns in the office, and he just really values the opportunity to share his knowledge and experiences we get to have here with lots of other people. And so we thought what better way then to create a Health Policy Fellowship. The organization did that last year we had tons of very qualified applicants, RHC managers and others that work in rural health systems across the country apply. For this year's fellowship, we selected Michael takhat, Michael's clinic

director for a rural health clinic in brownfield Texas. Be intent of the fellowship was that the selected individual would come work, live in DC work out of our Washington, DC office for a month. Learn all about what we do in the federal advocacy space. And Michael's been with us for the month of June and has had quite the experience with our office. So I'll let him in just a minute talk a little bit more about that. But this experience has been really, really valuable. The intent of the fellowship is to be mutually beneficial for both the fellow to learn about this process and gain a deeper understanding of federal RHC policy, but also for us to learn about what it's like to provide medicine or to lead a clinic, those boots on the ground perspectives that we never want to lose, despite the fact that we don't live in rural America, as we work in, in DC. And so, this experience has been really valuable for everyone, I think, and we look forward to continuing the fellowship in the future. But with that, I'll turn it over to Michael, who will share a bit more about his experience and what he's done during his time in DC.

Michael Tackitt 06:12
Thank you very much for that intro, Sarah. First of all, like say it was a huge honor to be chosen for the Health Policy Fellowship. And the experience I've had here in DC and working with narc is just been amazing, I've learned so much. And I've been able to share my unique life experiences. You know, we, we really, when I came in, I wasn't sure what to expect. I knew that narc had been really pushing the burden reduction act and trying to get more CO sponsorships and Congress. And I think all of us as RHC directors and myself included, it's real easy to get our noses, you know, down into the weeds of running our clinics, and less focused on what's going on in DC and on the legislative side, even though that really does affect how we operate, how we run our business and if our businesses continue to exist. So I came into this fellowship with just kind of a brief touch of knowledge on the burden reduction act and everything the narc did and within a couple days of you know, shadowing Sara down the hill and listening to her advocate with various representatives, senators offices, I really kind of realize how important their work is and and how hard they are fighting to protect us. It's very, and I don't want to discourage people from working and reaching out to their their congressman. But when you're trying to be the voice that's heard among all the other voices, it can be difficult and challenging. So that's what I've said about fellowship, it's been great. But I want to move on to the burden reduction act. I've really been hitting this one hard and heavy as I've talked to various offices. It's it's changing, you know, we we've been around since 78 RHC space. And there hasn't been very many changes over the years to how we operate and the rules and regulations. And there's some barriers that have been created over the years not not through any faults of Congress or an arc. But just as time has changed, you know, what worked in the 70s isn't working now. So the burden reduction act as a first step kind of a foot in the door to get some of these issues aligned with modern practices. And I wanted to kind of touch base on what we're doing with that. So our first big change we're pushing the burden reduction act is we want to modernize the physician supervision to align with state level guidance. This is really important because that battles already been fought at the state level, whether you are a proponent for Nurse Practice having independent practices or for physician oversight, that's already been relegated to the states those decisions are made. Unfortunately, with the rural health clinics, as many of us know, we still have those requirements to have a physician supervising the Nurse Practice even if the states don't require it. So we're trying to kick that back down to the state level to kind of reduce that regulatory barrier and hopefully reduce some of the cost on those RH C's that are having to staff additional physicians for supervision. The next big change is the lab requirements. We all know we have our mandatory labs and my RHC we're directly connected to a hospital system. So we don't utilize all of those labs in the facility,

especially you know the hemoglobin. We have the machinery to do that I have to pay to get it inspected every year. But it just sits on a shelf and gathers dust and it's there to check a box when I get inspected. What we're wanting to do is change the regulatory guidance Are we don't have to directly provide but we have to have prompt access, the prompt access is going to end up being come down to guidance from CMS and what they define that as we, we don't really want that on the legislative side. So really pushing that down to where the clinics like mine and like a lot of us that don't have a reason for these these machines to take up space. In our clinics, we can, you know, prove that we have prompt access and don't need to have that. The next big change the nurse prac pa utilization requirements. So this is definitely not my area of expertise, but having them directly employed to meet our criteria as an RHC. We're wanting to change that to where we can have a contractual agreement where they're not actually a W two employee, so we can still satisfy that requirement wouldn't affect my clinic. But I do understand the concept after talking to Sarah, the importance and again, this is kind of we're trying to, you know, kick some of these issues down to where it's at the state level or the RHC level, to where what works for your practice is what's going to apply to your practice. We've had a lot of discussions over the last couple months about the location eligibility. And you know, with the changes the Census Bureau's definition, urbanized area or not or lack of definition, I should say, we're wanting to kind of realign that with what we've had the 50,000 person population guidelines, just that's more of a clarification, to where we're going to keep what we've had going, and that we want to have any major changes come down at the Census Bureau doesn't decide to update their definitions. The last one is a big one. And very, very important for the RH C's, you know, we all have to have that 51% primary care practice limits, and we're wanting to remove that limits for behavioral health services. If your RHC isn't a mental health hips up, this is a great change for many reasons. The first one is, is we feel like if your practice needs to offer behavioral health services, and you feel like your community needs it to the point that it might become more than 50% of your visits. We don't want to limit your visits to counts or staffing for what your community needs, just because of this rule from the 70s. The other issues, we really don't have great clarification on you know, what is a behavioral health service, you know, if a primary care physician diagnose someone with, you know, anxiety, bipolar disorder and treats them? And is that a behavioral health visit, will that push us past the 51% on accident, there's just not great clarity on that. So we just want to get rid of that statutory limit. Overall, I would say this bill has been, from the discussions I've had, we've had pretty warm receptions and many offices to very asked various aspects of it. I will say what has been interesting to me is is both sides of the party have different things that they kind of latch on to I met with Representative Crocketts office, and they're from Texas, they don't have a single RHC in their district. But the fact that we were wanting to reduce barriers to mental health services in the RHC, her staff had stated that that's a huge ticket item for her office, and they want to be an ally, and any lesson that's going to reduce barriers to mental health access. So finding what the different officers kind of keyed on was great. And also this bill is is budget neutral. That is a huge selling point, because we all know there's a battle going on on the Hill right now in regards to the budget and what we're cutting, what we're spending and trying to approach the hill right now with anything that would cost money is difficult. But when we approach with a bill that has you know, neutral cost, then that's that's much easier to digest and support. So the lessons I've really learned, and when we talk about, you know, our own advocation as managers, you need to kind of tailor that discussion to who you're talking to. I have found that Republican offices that I spoke with, are more interested in the cost saving aspects of this bill. So when you talk about having to remove regulatory barriers, remove these pieces of equipments that go on our cost report. We all know that's not going to be a huge

amount of money. But that's a great thing to kind of highlight when you're reaching out to your Democrat offices. What I've found generally is when you discuss reducing barriers to access, increasing mental health services, that's a huge seller for that side of the office. These are, you know broad generalizations, but you can kind of key in when you're having conversations and what they're looking forward to As the other big issue as we go into doing our own advocacy on this bill, the mid level oversight is definitely a hot topic. That's one that you want to be really careful with Sir Ken can tell you I kind of walked into bombshell my first week on accidents. But it's a very, very hot topic. And Republicans, Democrats all have varying opinions on what oversight should look like. So if you do have conversations, and you're trying to advocate for this bill, understand that you need to be able to kind of push that as a very neutral, we're not changing anything, we just want it to be at the state level, like it already is for everybody else. So I want to talk a little bit real quickly on how to be involved. So there are a lot of ways that we can be involved. And I feel like the narc community and RHC direction especially most of us are working managers, we're very busy in our day to day lives. And it's hard to to take yourself away from running the clinic and go into well, I needed to take some time to advocate it myself, I find it difficult if I'm having to cover shifts that for Collins, I don't have time to advocate. So we kind of have a variety of tools we can use that will fit your your workspace and your time availability. The first one is the voter voice tool, I'm going to exit the PowerPoint real quick. So we can kind of demonstrate this. Let me just go to this one n ar hc.org. So we go to NH dar n ar hc.org. You go over here to resources, policy and advocacy. And there we go. And then we're going to slide on over to the RHC burden reduction act. See it is 380. And on my clock, let's see how long this takes you type in your name. And we're going to put an email address and you're going to three address zip code, I'm not going to continue all this, it will auto populate a message for you that you can edit, once you hit this review message, it'll no pull up the email address of where the message needs to go, it will kind of list out what has been said in your message and you have the opportunity to edit and customize it. And then with one button, you can hit send it is a very, very easy tool to send your support to your congressman, on how you feel about the burden reduction act. So that is a great tool that I really would like as many RHC involved people to use. The next step is virtual meetings. So this is a very powerful tool. And I myself did not realize how easy it was to get into these offices. So if you go to your representative or your Senators office, there is always a contact link, where you can send an email to the Washington office, fill out that link asked for a virtual meeting. Tell them that you want to speak about the burden reduction act, and then the your concerns and what you feel needs to change with the rural health clinics, hit submit. And you'll be surprised at the number of answers you get as scheduled out 30 or 40 emails. And two thirds of those responded within a week wanting to set up meetings I met in person because I'm here but a virtual meeting is perfectly acceptable. And some people prefer that. So if you just take 15 minutes out of your day to have this virtual meeting and speak with your staff, that staffer has to take your concerns and that meeting what it was about in their weekly report to their congressman, and tell them was about. So if we sit here and there's we think 5300 ish RHC in the country. If we all do this once or twice a year, that's over 10,000 visits that we could have where we are being the squeaky wheel, we are really getting our voice heard. If you can get those meetings, that's going to be our most powerful tool to get legislation passed. The next one I would suggest is invite representatives to your clinic. And again, you can reach out through the website, or you can call their office. My congressman is Jody Arrington. He comes through the area all the time, invite their office tell their staff like hey, we would love for Congressman Larry represented Varianten to tour our clinic. The representatives they love that. So that's, you know, picture opportunity for them. They get to really press the palms of the people that are

voting for them. Let them see what our agencies do let let them see our value. So that next time you have a meeting or an issue comes up at the back of their mind. Like you know I was that RHC and brownfield and they're really doing a lot you know, they we've got to support them. The next Next one is just be active in your community. And this again, I know we're all busy, we have kids, we have lives. But we've got to build some social credits. Get involved in your local organization, your Lions Club, your rotary, your Elks, your VFW, if you qualify for that. If you get involved with these clubs, volunteer your time, get your name out there, good things will happen. I got heavily involved in Lions Club, and that somehow ended up with me being elected to City Council in my town, where I got to meet representative Arrington in a one on one meeting. And that led me to a great discussion about rural health clinics with him that I would have never had if I wasn't volunteering my time. And then the last one I want to talk about is applying for the fellowship. It's beyond valuable. The connections I've made, the people I've met, you know, you, you're going to get your voice heard, I got to meet with HERSA, the National Rural Health Association, they had so many questions about boots on the ground perspectives that they don't get, they want to listen to your voice, they want to hear your opinions. And you can affect the future of medicine in this country, if you apply for this fellowship. So if you're on the fence about it, and which I was because leave my clinic for this long is scary. But if you're on the fence about it, do it, this is a great program. So we're going to talk real quick, you must be an ark member, if you want to do this fellowship, it's going to open in October of this year, and we're looking to have a summer fellowship I know Sarah and Nathan are so kind of hammering out the dates and details. But please, you know, if you're on the fence, do it, this is a great opportunity. So Real, that's all I have, I'm going to hand it over to I believe Sara's up next,

Nathan Baugh 21:47
I'm actually going to step in real quick. And I believe Sara is going to put in the chat. The link to the page that Michael showed with the voter voice if you just want a direct link, I would I'm just going to plug this really hard. And I'm going to ask folks to do this right now. Please, please, if you you can review the message, you can see exactly what you're sending. So you know, if you don't like what we have pre written in there for you go ahead and change this change, change the message that will go to the right people in your congressman and your Senators office. And if you want to do more and request a Zoom meeting, that's awesome. We also can help you with that. But I'm, I'm I'm just I'm really asking the entire community everyone on this call. If you can, please use that voter voice tool. And I would ask you to you like do it. Now we're going to keep going, keep listening to the webinar. If you can, if you can multitask it and send the message, we would really appreciate it. I always kind of say, I, I grew up in San Diego, and I live in Washington DC. I'm not clinical at all. As Michael can attest, I've never filed a claim. It's not my story. It's not Sarah's story, even though she grew up in rural. But but it's not like we need the grassroots voice. We need you all in order to be effective with our advocacy. And we're going to talk about some other stuff that we're working on telehealth and Medicare Advantage. But but we need to build a grassroots advocacy network if we want to be successful for the RFC program. So again, I'll just plug it one last time, please go to voter voice. If you want to do it after I trust that you'll go after the webinar, because Sara is going to talk about some Medicare Advantage stuff next. But either right now or just after the webinar, we could really use the messages to our members of Congress to just show that we have support, not just from NRAC, but from our actual RFCs in our membership as well. So alright, I'm gonna stop there. That's my full pitch and plug and hand it over to Sarah.

Sarah Hohman 24:04

Thanks, Nathan. Michael, can you go to the next slide, please? Awesome. So I just wanted to Michael briefly showed you our landing page for the Archie burden reduction act and a variety of the resources that we have there. So the voter voice tool, like we've mentioned, is by far the easiest, you know, option for reaching out to your members of Congress, it will go directly to their health staff. That message is pre written for you. It should take you less than two minutes from start to finish to send that message. So we really encourage you to do that. But like Michael said, there's a ton of other opportunities to share your story with with your members of Congress, whether you send them a letter that more details, your experiences and advocates on a specific provision, or you invite them Meant to visit your clinic, which we really, really encourage you to do, especially as members of Congress are, are home in their states and districts a bit more over the next few months. But I, we have a variety of resources available to you to help you with this. We are resources to, to help you with this. There's a very sweet spot between the professional advocacy that we do here in Washington DC, and the perspectives and voices that you have working day to day in rural health clinics. And Michael had a really incredible opportunity to have 30 plus meetings during his time here in DC with his fellowship. He's having meetings right up until his last day on Friday afternoon. But it's really important that Michael and I have talked about this quite a bit, but that your members of Congress are not hearing for you hearing from you, for the first time on significant issues that will cost the federal government a lot of money, like perhaps some of the other things that we're going to talk about today in our policy priorities. And so the rural health clinic burden reduction act, Michael went over the various details of it. And we're happy to answer questions and q&a about it as well. But I just wanted to highlight that it may not be the flashiest bill, the burden reduction act does not talk about reimbursement, it does not perhaps create additional opportunities for rural health clinics. It's not a grant program. And so maybe you don't think that all the provisions will affect your clinic. And so you're not super interested in advocating on that. But advocating on something that's intended to be non controversial and cost neutral, and should be an easy sell to your members of Congress is, is really important in also developing a relationship with those folks. They're hearing from you, they're learning about the rural health clinics program, before we kind of start to tackle some of these bigger and perhaps slightly more controversial issues and things like that. So Michael gave his plug Maven gave his that's mine. But I just also wanted to highlight the variety of resources that we have. One of them is on your screen. These are the three primary priorities that we're working on in this Congress. The first you've heard of is the burden reduction act. The second we're going to talk about is Medicare Advantage. So if you want to go the next slide, Michael. Okay. So, as we all are quite familiar with Medicare Advantage. enrollment has increased significantly over the last decade. And you know, some areas of the country have had very small Medicare Advantage penetration others, their Medicare population. That was previously traditional Medicare is now almost entirely enrolled in Medicare Advantage, and it really varies. But overall in 2023, we've seen Medicare Advantage enrollment surpassed traditional Medicare enrollment in amongst those eligible beneficiaries. And for some Archie's that we talked to their traditional Medicare enrollment is so, so small, and based on the reimbursement that they're getting from Medicare Advantage, this is presenting some significant concerns for them. And so Medicare Advantage policy and reimbursement has been on our radar for a bit but increasing, as we hear for more and more RFCs about what their reimbursement challenges look like. Next slide. This is just an interesting graph that I found from the Kaiser Family Foundation. It shows that about half of all Medicare beneficiaries have more than 40 Medicare Advantage plans available where they live in 2023. And so not only does this highlight the wild amount of choice that perhaps some of your Medicare

beneficiaries may have, again, this isn't in all, all areas or all rural areas. But I think it's interesting to see the vast number of plans. This is not just kind of Medicare Advantage as a whole. But a lot of different plans out there. This also highlights as you know, the administrative burden challenges of you know, contracting with a lot of Medicare Advantage plans and what their reimbursements may look like and how they may all be different. And so we are going to talk about that a little bit more on the next slide. Okay, so, like, you know, providers across the country who are facing prior authorization concerns concerns and critiques of how Medicare Advantage plans are marketing to eligible beneficiaries and other administrative burdens concerns. We hear all of these concerns from the rural health clinics community. But right now, we are primarily focused on the reimbursement challenges. And so just as a little bit of background, federally qualified health centers have had a quarterly what we call a rap payment. They've had this since 2003. That ensures that FQHCs will not receive less reimbursement from Medicare Advantage plans than they would from traditional Medicare. And so this doesn't necessarily come from the Medicare Advantage plans themselves. But if their contract with a Medicare Advantage plan is paying them less than what their traditional Medicare reimbursement would be, they'll receive that difference from Medicare in the form of of quarterly payments to make up that difference. As we all know, in the rec space, Archie's do not have those rap payments for Medicare Advantage contracts. Every single one of your ma plans will be contracted with you like any other commercial contract. We hear varying experiences from Archie's across the country in terms of what their individual contracts look like. Some Archie's had been able to negotiate those contracts, in that they will receive something very comparable to what their Medicare all inclusive rate is. Others we hear are, you know, receiving a significantly less or lower reimbursement from their Medicare Advantage plans than they would from traditional Medicare. And there's no statutory protection for that reimbursement. I'm going to launch a poll really quickly, that I would love for everyone to fill out. So this is a very high level kind of question, but it asks, What best describes the reimbursement amount received for the majority of your Medicare Advantage encounters. So I know that this varies a lot. Some Medicare Advantage plans will pay you like fee for service. And so it's hard to know if that amount is perhaps comparable to what your AR is. But the options for you here are higher than your Archie's all inclusive rate payment from traditional Medicare about equal or comparable, and then significantly less than the Archie's AR payment is the third option. So I'm gonna give everyone just a minute to complete that. This is really, really valuable data for us. Okay, I'm going to leave it open for just a second because some responses are still coming in. But Michael, I think you can advance the next slide while the postal but okay. So on the advocacy front, and I'll share these results in just a minute when I close the poll. But on the advocacy front, our policy priority in this area is for a floor payment for rural health clinics relative to RHC plans. So to Medicare Advantage plans, excuse me. So our our biggest point around this is that we cannot let Medicare Advantage Plans diminish our rural safety net. And so when the rural health clinics program was created in 1977, it was traditional Medicare and Medicaid reimbursements were created to be higher for our safety net providers as rural health clinics in order to ensure that access was financially feasible in in rural areas and that it was advantageous for providers to operate there. If a significant amount of our what was traditional Medicare population is now enrolled in Medicare Advantage plans that are paying us significantly less than what traditional Medicare was paying to protect that rural state. v net, that becomes a significant problem. And we're concerned about RHC feasibility in cases where the reimbursement is, is significantly lower. And so on this friend we've started conversations with, with members of Congress and their staff around what a floor payment could look like. So there's lots of different options in terms of how this floor would be set what it would

be set at, and then also for financing the floor. So as I mentioned before, FQHCs wrap up payment requires that Medicare pays that difference. If Medicare Advantage contracts with them for a lower reimbursement. There also, perhaps is the option that Medicare Advantage plans themselves would be required to, to pay at that floor. So we mentioned before that the rural health clinic burden reduction act is non controversial, and cost neutral. There is this is certainly on the Medicare Advantage side, not non controversial, not without controversy, and also would certainly cost money, regardless of sort of who was responsible for, for paying that floor foot per financing that floor. So this is a significant fight. But it's one that that we know is important to our clinics across the country. And so it's one that we that we are working on. I'm gonna end the poll now, and just share the results with everyone. So this is this is interesting information, showing that about 5% of you said that your Medicare Advantage reimbursement is higher than your Archie's all inclusive rate. Very happy for you there. I'm also happy for the 46% of you that have about equal to your all inclusive rate payment. And then there are 49% of you that are receiving significantly less. So that is certainly tracking with what we're hearing. And we know that you may have several contracts with Medicare Advantage plans that may all pay you a varying amount. So this is something that we're continuing to focus on. But like I said, Your we will also rely on your advocacy and the support that you can provide in these campaigns for things like Medicare Advantage. When we have legislation introduced around what a floor, a floor could look like. And so now's the time to start developing those relationships with your members of Congress, invite them to your clinic, show them the value of the care that you provide in in their communities, and advocate for the Archie burden reduction act while you're at it. Next slide. Okay, I'm gonna turn it over to Nathan to talk about telehealth.

Nathan Baugh 37:58
Thank you, Sarah. Yeah, the Medicare Advantage, we really, this is going to be a tough lift, it will likely take several years before we get legislation. Maybe we move faster for lucky but we're going to need to work together as community if we want to create a benefit for our ACS visa vie Medicare Advantage, because right now, we're all clinics are just like any other outpatient office to a Medicare Advantage plan. Right. And that's something that we certainly would like to change. And I think the concern that I've been hearing is in some areas where they completely dominate the Medicare market. It's really forcing people into tough financial situations if all their Medicare patients have left and gotten to a Medicare Advantage plan that that don't play well. So great job, Sarah, going over that. And that's definitely going to be something that you're going to hear both of us talk about for probably years to come unless we can get a solution swiftly. But you know, just in this political environment, something like that, that will either cost the plans money or potentially Medicare itself money. We don't think it's smart to sort of aggressively push a solution soon. We're kind of doing what they call in DC the socialization it's it's a long term issue that we need to socialize and then when the political environment is such that Congress might want to take a look at this, where we've already done that groundwork. So that's the plan there. And the telehealth. The telehealth issues also have a bit of a timeline with them. But as many of you know, that timeline is the end of 2024. So this is is something that a lot of folks know is coming. And Congress has basically resigned itself to knowing that they're going to have to deal with this next year. They don't want to deal with it this year. Because basically, policy is set through the end of 24. They're going to probably deal with it close to November, December of 2024, likely after the next presidential election. But I want to get into exactly what we're advocating for for the post 2020 for telehealth, but before I do that, I need to make this disclaimer that telehealth, especially, you know,

before people knew a lot about it pre COVID It was an umbrella term that could be used in a variety of different ways. Like when someone says virtual check in or virtual care. You know, gig I think someone could pretty easily categorize a virtual check in as a telehealth service, right? chronic care management, digital e visits, these are all things that are using technology, which can get broadly categorized as telehealth. However, what I'm going to be talking about for the rest of my little section here, and then in the end, the thing that really is through the end of 2024 is what we call telehealth visits. And that is a one hour one to one substitution for just in person services. The only difference is that this is being done through a telecommunications device. And but it's a normal CPT code that you would do in in the office. This chart, I think is pretty helpful in explaining the differences the amounts and you know, when what how we bill for these, which is different than our fee for service peers bill and that QR code will also take you to our our chart and our resources on telehealth. Next slide please. So, just to recap on telehealth visits what the policy is today, until the end of 2024. We have g 2025. Policy, which pays that $98 and change for the over 200 codes that can be billed through telehealth. This is the policy that is a special payment rule that began a couple of months into COVID. Right. We do have permanent or at least until the policy would change. But we have permanent coverage of mental health, telehealth visits for Medicare patients and that telehealth service or visit is considered a normal telehealth or a normal encounter that you do receive the all inclusive rate payment for you count it normally on your cost report. And you bill normally for it with just a modifier to indicate that it was done via telehealth but it is by all intents and purposes an encounter just like you would receive in person. So this is the the current shape of our telehealth policy. Next slide please. Our objective for post 2024 is to have basically all of telehealth work like it does for mental health telehealth. That is normal coding normal cost reporting normal payment normal billing for telehealth. Essentially we want to pay our telehealth encounters through the all inclusive rate system. Right. And that would be another way to say this is payment parity between in person and telehealth, which is by the way, what our fee for service peers have received since the beginning of COVID. So they've all been getting parity absolutely no difference in coding or billing other than a modifier code for their telehealth and in person. If, of course we get the all inclusive rate, which is generally speaking better than fee for service payment, though, there will need to be some guardrails and Medpac recently released a report which I think I have some details on on the next slide. So Michael, can we get to the next slide? Okay, it's coming after this. Before I get to that Medpac report, I just want to make a couple of further things clear. The good news is, is that we do have several pieces of legislation already introduced in this Congress that will achieve the normal coding and normal reimbursement for telehealth. And it's definitely everyone's expectation, and everyone we talked to on Congress knows that they are going to pass something before the end of 2024. What that is unclear, but we're not going to go back to pre COVID telehealth. That's pretty much baked into the baseline at this point. Again, even though there are pieces of legislation introduced, we're not really lobbying or advocating on them this year because the activity for telehealth at One knows is in 2024. The bad news is that, again, we're not going to get that activity until the end of 24. When we get close to that telehealth cliff, and it is also very possible that Congress will maybe not commit to a permanent policy even by the end of 2024. And instead extend telehealth for a year or two. Because of a whole host of reasons, but the biggest one is that it's it was score cheaper by the Congressional Budget Office. If we're if Medicare is only extending telehealth for two years, so it'll be easier for Congress to pay for it. And Congress is probably not ready to commit long term to a policy. So if they do a short term, temporary extension, it gives them It forces Congress to come back and clean things up as we sort of learn more as a country about how telehealth coverage should work with Medicare. So it's likely that you'll probably

you'll hear us talk about telehealth until we get that permanent policy which which might come after several temporary extensions. So this is like a it could be a it could be a decade's long issue before we get to to permanent policy. Next slide, please. So the Medpac study, this is what I mentioned. We want normal coding normal reimbursement, right, which if we got that would be quote unquote, better than what fee for service providers receive? Right? And if we want that for telehealth, we have to have some appropriate guardrails. Medpac. And I know there's a ton of text on your screen. So I apologize for that. If you really want to read the full 500 page report that QR code will take you to the Medpac report. Medpac is this advisory committee that Congress takes very seriously they were created by Congress to advise on, you know, Medicare issues. So oftentimes, Congress will direct Medpac to study things. And they directed Medpac to study what Medicare should pay RFCs and FQHCs for telehealth, and I cut out the key part of that 500 page report. Medpac did not recommend that they that Medicare pay us normally instead, they recommended to Congress that Medicare pay us rates quote comparable with PFS rates for telehealth services. Basically, the special payment Rule g 2025 system that we have today. Now, they have a number of points that they make. They have four points and I kind of have my in read, I have my rebuttals to them. And I'm not going to read the whole thing, but I'll go through them one step at a time. The first is that they say that it will increase costs for Medicare and it will also increase beneficiary coinsurance because 98 is lower than most clinics, all inclusive rates. As you can see in red there, that is an inaccurate statement. As you all know, coinsurance for it is based on Patient Charges, not the all inclusive rate, despite the recent Mac issue, which is a whole tangent that I won't get into. But that's an inaccurate statement. So Medpac was just simply not informed there. And we will be pushing back to make sure that policymakers know that if they pay us the all inclusive rate, it actually won't impact beneficiary coinsurance. The next point is that they argue that currently, the providers do not need to be located in the rural are an underserved area. And that is true, they there isn't sort of a guardrail for that yet. That's implemented. We have plenty of ideas of how to address that. And I think what we what I want to get across is that we don't necessarily want providers and patients that don't live in rural underserved areas to be able to do a telehealth visit and just receive higher reimbursement because they're billing it through the RHC. And so we have plenty of ideas and about guardrails that could protect the better reimbursement the all inclusive rate reimbursement for RHC providers in our 80 patients. Third day, they say that by paying parity, it would be a disincentive to do in person care, since telehealth visits have less cost. I think that this is a very illogical and silly argument. Because what they're recommending is to create a huge financial incentive not to do telehealth by only paying 98 Or you know Around $100 for the telehealth visit, when all our all inclusive rates are significantly higher, so I have no idea why they wrote that when it's pretty clearly illogical. And, and then finally, obviously, I have some critiques of Medpac here. And finally, they talk about how this could be a program integrity concern, because, you know, like I said, folks might be able to route their telehealth visits through the RHC or FQHC, just to take advantage of our higher rates. And again, we have some ideas about guardrails that could be implemented with some either occasional in person requirements of service area rules. So we we have rebuttals to everything that they said and we will be making this known this year and next year. So that hopefully Congress will take our recommendation to do all telehealth through the all inclusive rate, post 2024 and not med packs recommendation to pay essentially rate, this special payment Rule g 2025. Study that picture there with the I guess those are those moose meat. What's the plural for moose? Multiple mooses fighting is what I what I what I got when I typed in conflict, right. So obviously we're conflicting with Medpac here a little bit, but I think we have a really strong argument. Next slide please.

Sarah Hohman 51:28
This is Nathan highlighting that he doesn't live in rural by most moose. But are they

Nathan Baugh 51:33
elk? Yeah, I don't know what they are. I just typed in conflict. That's what I got guys. So the last thing I want to point on telehealth is the big picture is that we I do not want real health clinics to ignore telehealth telehealth is great as a additional new way to care for your patients, it will provide conveniency it'll help those patients that have struggled to get to your RHC allow you to provide care for them. And you know, could potentially increase some efficiency. But notice on sort of the good things about telehealth, I don't view this as some sort of scheme to get a bunch of revenue through the RHC. If it becomes it will never become a scheme to generate a ton of revenue through the RH C's because Congress and Medpac are watching out like a hawk for that. They do not want to create that, quote unquote loophole for this just to be a way to increase revenue. That's not what we're trying to do with telehealth. But we do want to pay our ACS properly for truly RHC patients and RHC telehealth visits, right. Because if we do not invest in telehealth, our peers in the city will and telehealth could fundamentally alter what it means to have access to health care if you have an internet connection. If you have strong bandwidth. Will policymakers say hey you have access to health care? So why should we place a premium on physical proximity to a provider? I would strongly push back against that telehealth is great, but you can't do everything in person. Healthcare still matters physical proximity to our clinics and providers still matters but it's a threat. And finally, the question is will you find yourselves competing with city based entities offering telehealth services and siphoning off visit void? Michael was telling me that one of the insurance plans which I won't mention, has a a number for their telehealth service on the back of their insurance card that they are pushing all their enrollees to right so they are siphoning potential visit volume away from the RFCs to you know, the insurance companies telehealth provider, right. If we have competitive and strong telehealth offerings, hopefully our patients will pick the local entity and that some entity went off in the city. So but this is kind of a new scenario because we've never really had to truly compete with services offered in the city. But now potentially you have to view people in the city as competitors to your patient base. So the bottom line here is just do not ignore your telehealth offerings. We're going to work to improve the Medicare reimbursement. But you want your patients to pick you the local provider over a corporate telehealth company. So that's my pitch on telehealth and again, we're going to be pushing hard to get that Medicare payment working properly the way the way it does for mental health. Um, next slide I think That ends my telehealth pitch. I probably went a little long. Sorry, this is the right.

Sarah Hohman 55:06
This is yes. So Kate's going to open the q&a box. So if you have questions, please put those there. And we'll get to those in just a minute. I just wanted to highlight some, in addition to our fellowship, some additional opportunities that folks in the rec community have had to advocate recently on the on the federal level, which has been pretty exciting for us, and it's given more folks the opportunity to hear from clinic managers and others in the IoT space. And so the first one that I wanted to highlight was a recent Senate Finance hearing on rural health, which was the first one in over five years. And Senator Danes from Montana, asked Aaron Ani, to testify during that hearing. And so Aaron came to Washington, DC and testified, she represented her clinic and Glasgow, Montana, and she represented

an RHC, as well, and talked about our priorities and sort of the innovative ways that they're providing care in Montana. And so this was a really exciting opportunity for Archie's to be included in a Senate hearing. And then next slide, please. And then the last one, which happened just last week, was an air HCS fly in. So 10, NRDC members came to Washington, DC, and they took part in over 30 meetings with senators and representatives on the Hill last Thursday. And so this is really great. They were advocating on those priorities that we've talked about throughout today's presentation. And, you know, they met with senators and representatives and a few dogs that hang out in in offices on the hill as well. This was a really, really neat opportunity to showcase the merici perspectives on the hill. In addition, in addition to what Nathan and I do, and in the future, we hope to expand the fly in to welcome more of you to Washington, DC to participate in something like this. But we had great success with the with the 10 members that came last week. Next slide. We've talked about many resources throughout today's presentation in the policy and advocacy space and beyond. So I just wanted to direct you to our website where all of those are held. Our email list, which you probably got information about this webinar through all of our policy and advocacy priorities are on that page, that telehealth chart that Nathan showed is there as well. And we update that frequently with with any any new information as well. So just wanted to direct you there to make sure you had all those resources. And of course, we are have resources too, as well. And finally, on the next slide, we're gonna get to questions, and I see that a few have come in. So I want to, I want to start there. Okay, first one, from Christie, can you clarify if behavioral health visits and an RHC are currently required to be less than 51% of the visits? Or the time?

Nathan Baugh 58:19
It's great question, Christi. It's not 100% Clear. Some people do visits and some people do time. And this is part of the reason why we'd like to sort of change this rule so that you don't have to worry about it. What I generally tell folks is that you have to have a methodology if you're going to use, for example, the visit methodology to evaluate how much behavioral health you do versus, you know, other medical care, then put that in your policy and follow that. If you're going to do the time method, then you can put that in your policy and do that. It's not 100% clear, you can always reach out to your creditors or surveyors, if you want their opinion. This is been flagged for years now is something that CMS should clarify. And we really haven't gotten that clarity. I think I generally hear the visits is probably more commonly used than time. Sir, do you have anything to add on that?

Sarah Hohman 59:29
Nope. Nope. I think you mentioned this too. But probably the biggest thing that we hear is just to make sure that what you have in your policies and procedures is what you're following in terms of how you count how you count those visits or that day. Yeah.

Nathan Baugh 59:48
Can I address the Jeff Jeffrey Carter? question or comment and I appreciate that Jeffrey Jeffrey says so the Medpac has failed to interview any RHC patients or facilities and putting profit over health again. I Um, I appreciate that perspective. Jeffrey, I do want to be a little bit fair to Medpac. Obviously, I have some criticisms of what they're recommending for the RFCs. We did meet with Medpac. And, you know, made our case. So they didn't at least reach out to, or we, we probably reached out to them to be honest. But I will say that at least, I don't think they are trying to put profit over health. You know, they are they are concerned about the Medicare trust fund. And, you know, that is part of what they're

supposed to look at. So they are just trying to make sure that it's not abused. That the RHC FQHC reimbursement is not abused, to sort of, again, benefit people that are in suburban Alexandria, Virginia, and not in medically underserved rural areas. So I do have to give them you know, they're not horrible people. They're trying to protect taxpayer dollars, but I think they got, obviously, I think they got the mark the I think they got it wrong on this particular case. So.

Sarah Hohman 1:01:11
Okay, next question. Cassie asks, in regards to mA plans, are you advocating for us to get paid at 80% of the all inclusive rate plus 20% of billed charges? They find that many Medicare Advantage plans only want to pay the all inclusive rate, which is lower than the full Archie payment?

Nathan Baugh 1:01:33
Um, it's an interesting question, Cassie, we I don't think we have an answer yet. I think, as Sarah mentioned, we're trying, we're advocating for a floor. Okay. And anything you negotiate above that floor is still your prerogative. So I think we would advocate for either at least the Ayar or potentially, maybe even like the upper payment, the National upper payment limit, as a floor, but again, you can negotiate with the MA plans, anything above that amount. So I don't know if I can properly answer your question. If you want to still be able to bill the patient for 20% of your total of the total charges, that would probably be something that you would still need to negotiate in, you would just have this extra quiver in your tool kit, or your, your, you'd have this extra tool in your toolkit to to negotiate a better payment rate than you do currently. So I'll

Michael Tackitt 1:02:48
jump in Sure. On that bill in the 20%. I feel like whenever most of these patients already have a copay with their plan and then having to say well, yes, you paid your copay, but you need we're gonna bill you for 20% as well. I personally feel like that would kind of disincentivize utilization of our ACS by the Medicaid Medicare Advantage plans. Right. That's gonna be all of this is a difficult discussion. But that's kind of just the tip of the iceberg. We look at the complexity of trying to line this up. Yeah.

Nathan Baugh 1:03:21
And I guess another question that comes to my mind is do most MA or most ma plans structured like traditional Medicare with a 20%? Coinsurance feel like the reason people pick him a is so that they either don't have co pays and coinsurance or or they have co pays instead of coinsurance? Would you

Michael Tackitt 1:03:38
agree with that, Mike? Yeah, what I what I, in my experience, and this is just, you know, my little clinic in Texas, I see low co pays, as one of those recruiting tools that are using Medicare Advantage, they can have a five or $10 copay for primary care and a 15 or 24 specialists is pretty common that you see on these cards. So you know, trying to get them to pay the 20%. That's kind of I don't know how well that would go over. Yeah. Now that's good insight. Thanks, Michael.

Sarah Hohman 1:04:10
Next question, Bethany asks regarding telehealth, do you foresee the regulations specifying whether the visit must be audio and video, or if audio only would be acceptable? I'll start with this one. So as of right

now, that list of all codes that you're eligible to Bill, Sgt zero to five does specify which codes can be billed audio only. So that list is updated every year. Audio Only will be part will need to be sort of decided as part of the next temporary extension of telehealth policy broadly or, you know, if we get to permanent policy sooner rather than later. Those decisions would need to be made in that I know that audio only is a big priority. For many, that conversation is something that audio only is obviously important to rural. We hear that a lot. But audio only is also part of the broader Medicare telehealth conversation. And whether Congress when they make those next extensions, or like I said permanent policy, they'll, you know, have an opportunity to decide whether audio only is paid at the same amount as audio visual or perhaps less, or differently. So, those are still all kinds of pending pending conversations.

Nathan Baugh 1:05:42
Yeah, I think that covered it, sir.

Sarah Hohman 1:05:48
A couple of more kind of questions or anecdotes on Medpac. Jeffrey asks, Will there be a push shove RHC workers, patients or clinicians on the Medpac board to provide a more realistic look into the struggles faced by those service by rhps and the benefits are achieved can offer and as the Medpac know that vn API demographic information can be used as a barrier to non RHC medical centers impinging on Archie patients structures.

Nathan Baugh 1:06:26
Yeah, so Jeffrey, I, you know, there's we don't have a current plan to try to try to influence Medpac more, I'm not entirely sure with their I don't think they really lean on advocacy organizations like us to, to, you know, staff out their committees and, you know, get get their feedback, they they're kind of an independent, and that's the whole point is that they aren't really part of industry is supposed to be like non interested, or like, neutral experts that are just going to provide analysis for Congress. So, you know, potentially to the extent that we can make sure that they're considering rec viewpoints, I think we can do that, but can't necessarily completely answer your question.

Sarah Hohman 1:07:10
Yeah. And and while Congress, you know, looks at the Medpac report, it is not kind of the end all be all right. So, Congress, still, members of Congress introduced legislation, there's the opportunity to weigh on, weigh in on those and Congress's, ultimately, who passes or doesn't pass legislation around telehealth and everything else. And so I think that's sort of the avenue, we can, you know, give feedback to Medpac. And in a few different ways, but I think our opportunity is really through members of Congress themselves. Yeah. I'm Whitney asks any updates on substance abuse and behavioral health services being covered better by Medicare, also being able to perform more than one type of visit per day and still getting your wrap for each service?

Nathan Baugh 1:08:08
Behavioral Health Services, I think Medicare is probably slowly going to better cover more of them, certainly where you're getting marriage and family therapists and mental health counselors as covered provider types in 2024. You know, I, I believe that Medicare does pay for behavior, some behavioral

health service and substance abuse services already, but in terms of them being better covered, I think that's probably something that is reasonable to expect over time. I'm not entirely sure exactly what you think should be covered by Medicare today that isn't in terms of the more than one type of visit per day, Sara did, was there recent legislation. I feel like this issue just came up.

Sarah Hohman 1:09:00
Yeah, it did. And I'm not sure. I was trying to remember where that came from. Yeah. Now I'm blanking on it, but we might have to follow up with Yeah.

Nathan Baugh 1:09:18
We're gonna pass on that. But this issue was brought up and I think some people are looking at being able to you being able to be able to bill twice on the same day

Sarah Hohman 1:09:31
for four there heard about this recently. Yeah. Um, Jennifer asked, is there more appetite to reimburse specialist telehealth visits at the regular rate than for primary care? It's extremely difficult and expensive to attract specialists to an area. So telehealth has been an important avenue to have specialists consult on our rural patients.

Nathan Baugh 1:09:53
Yeah. So what we're advocating for you, you would be able to Bill your all inclusive rate for for specialist visits via telehealth and also your primary care visits. But that is as a distance service, or distance site provider and distance site means that you're providing the year on the doctor side or the clinician side of the screen. If you're talking about having the patients in your clinic, or connecting them to specialists in the city, that is kind of more like serving as the originating site and the distant site where the specialist is their reimbursement would depend on sort of how they're billing it. You know, it would probably be fee for service, if they're not an RHC, it could potentially be the G 2025 system if they are an RHC. So I don't know exactly what your question is, which one of those but certainly, we would like if you're billing as this insight for both primary care providers and specialists to be able to get the full all inclusive rate through telehealth as distance site as originating site. You know that there is a payment. If you provide a room and a screen and a camera and a setup for the patient to do a visit with a specialist. I believe that is a cue code. Sara Do you know, and it pays not the greatest

Sarah Hohman 1:11:43
$23 or something?

Nathan Baugh 1:11:44
Yeah, yeah. And so there is a payment for that, to provide that from the originating site standpoint. But so hopefully that answers your

Sarah Hohman 1:11:55
question. But yeah, in terms of like different providers receiving different telehealth, reimbursement under kind of the distance I umbrella, though, that's not a conversation that that we've heard anything about. It's basically broken down by distance site is the location of the provider or the facility that's

employs those providers and then originating site is is where the patient is. And some of those like originating site, geographic site, those have been sort of used differently and in, in many cases, less, less important during all the flexibilities of of COVID and post COVID. But no conversation that we're aware of in terms of like different reimbursements under that kind of umbrella based on the type of provider. Yeah,

Nathan Baugh 1:12:47
we want a full stop for all providers, behavioral health primary specialists for telehealth.

Sarah Hohman 1:13:03
Eric has a question I'm trying to just hit a couple of questions at once I'm trying to. We talked a little bit about audio only versus audio visual visits, and sort of how that all of that and what will be covered, longterm is is still up in the air. also mentions what if patients receiving mental health or behavioral health services, such as addiction treatment are also treated for chronic diseases receiving both behavioral health and primary care services, sometimes within the same visit, to reduce the burden of multiple visits? I think Eric's asking about how that relates to 49% Behavioral Health. This is another reason why we're advocating within the Archie burden reduction act to eliminate that 49% threshold is because there's confusion and complication as to how do you count those visits if it's a primary care visit, but within their scope of practice, that provider is still perhaps like Michael said, diagnosing their patient with anxiety or whatever it may be within that same visit, and how do you count that right as behavioral health or medical health? And so that's another reason why why we want to eliminate that just so you can, your providers can provide the care that your patients need, first and foremost, as opposed to worrying about the number of visits or the number of hours or whatever it may be.

Nathan Baugh 1:14:37
Yeah, it's unclear. So Eric, yeah, the bottom line is that it's unclear this scenario you laid out to kind of count that. I can't tell you, I wish I could. And I wish I did. It didn't matter. That's, that's where we're going with this. So So okay, go ahead.

Sarah Hohman 1:14:57
Good. Yeah, there's just two more so I'm gonna hit on them really quickly. But I know everyone's a lot of you have stayed a little bit late. So we'll wrap this up soon. But appreciate you all sticking with us. Vanessa, if you could follow up with me, I'm not sure I fully understand your question around pas and RCS. But I happy to chat further if you want to follow up with either Nathan, right. And then Eric says, not really a question here. But sometimes we're both originating site and distant site at the same time. We employ a pmhnp that lives in a different state and does all visits by telehealth some of these patients come into our clinic to do their?

Nathan Baugh 1:15:40
Yeah. That's interesting, Eric, I think that your ability to be both originating site and distance site long term may not be the the where the policy lands, I think there's been some question about whether whether you can do this or not. And there hasn't been a lot of regulation on this front. So I think that, you know, clearly you are able to do it now. But the it's really kind of an absence of rules. In my opinion, on this subject, I'm being both distant and originating site, I think a lot of people think that the

originating site is becoming irrelevant, because the originating site can essentially just be wherever the patient is, you know, pre COVID, the patient had to go into a qualifying originating site. Now, the originating site rules are basically gone. And so you can just as a patient, you can take a telehealth visit from wherever you have good enough bandwidth, and, and, you know, a device. So not, you know, clearly, I think still having the setup at an originating site might be something that some patients are still interested in. But this may not be something that is allowed long term. So, just, you know, I It's definitely an issue that I would continue to sort of watch the news for, and certainly, we'll be looking to have clarity on whether this is explicitly blessed, or not going forward.

Sarah Hohman 1:17:38
Yeah, I would just lastly, say there's, you know, there's being both the originating site and Justin site, and then there's billing for both the originating site and destined site. So there has also, you know, to our knowledge not been, you know, explicit language saying that you can't, Bill for both originating site and distant site, I would say you're not intended to bill for both just in how kind of telehealth is intended to work. But there's also not not explicit guidance there. So, you know, serving as that, that location and, you know, assisting your patients and getting set up, if that's you, perhaps your RHC is the only place that has that connectivity. That may be one case, but but billing for it could be a different story. So. But like Nathan said, not, not entirely clear. So with that, I'm going to close this out for today. Thank you so much to everyone that that joined. This was a little bit of a different style of of webinar than we oftentimes do. But I'm appreciative to everyone that joined and learned about how you can advocate, we really, really encourage you to do so I hope that when I log into voter voice, I see that a ton of messages from all of you on today's call have been sent to your members of Congress so that we can continue to track that and that they continue to feel the pressure, if you have questions about this legislation or any of our priorities. That's what Nathan and I are here for this is Michael's last week with our office, but he'll continue to be a resource as well. And finally, if you're interested in applying for our fellowship, look for that application later this fall. Otherwise, that's all from us. Thank you so much for being here. And we'll talk to you all soon. Thank you