Welcome
The Council typically meets for an hour and a half, but considering the COVID-19 pandemic, this meeting was shortened to 60 minutes and focusing on COVID-19 rural relevant topics.

Understanding the Rapidly Changing Telehealth Environment in Rural
Jonathan Neufeld, gpTRAC (Great Plains Telehealth Resource & Assistance Center) program director, provided an overview of the rural implications of the telehealth regulations, payment, and privacy changes in the Appropriations Act passed on March 6 and the Coronavirus Aid, Relief, and Economic Security (CARES) Act passed on March 27. There are 12 regional and one national Telehealth Resource Centers, which are federally funded to provide support to all types of telehealth programs but focus on rural and underserved.

Context of telehealth:
- Always viewed as public good in rural, moving towards public good in all settings.
- Often unclear who benefits from telehealth, which makes it hard to apply (and figure out payment)
- Who is going to pay for it and how?
- General movement of telehealth support in this administration
- Chaos right now - setting up services, sustainability long term, paying for. Information coming out fast, but more guidance will be needed.

Near-term implications:
Billing and reimbursement will settle unevenly. Medicare's approach to telehealth was confined by statute, so CMS has tried to define new ways of practicing that do not use terminology of "telehealth" to help with billing. Other payers will vary (speed and pattern), state regulations will also have impact.

Medium-term implications:
Not going to return to the previous state. Enough providers have had to implement and are finding it works and that they like it. At least anecdotally, feedback has been better than expected (from both providers and patients), at least anecdotally. Requires being planful and ensuring that your own community's and organization's needs are met.

Provider implications:
More readily adopted than expected, and see some unforeseen benefits (including indirect benefits, such as willingness to try new things more generally - creativity or innovation). The equipment costs have been lower than expected, but there are high time/complexity costs and need. There are new billing opportunities available. Telehealth is shifting into a tool for providing care, not a program; and there are more options for purchasing versus building.

Payer implications:
Significant pressure to cover new methods. More direct to consumer contracting is emerging, and investment in spaces/models that allow for monetization of models. New models are trying to reimagine health care; some will fail, and some will succeed.

Open questions:
- What direction does value-based care go after this epidemic?
- What will be the level of damage to the rural health care system?
- What will be the political development impact on rural health care going forward?

Discussion:
- Telehealth in a fee-for-service environment is essential for rural, and revenue and income are essential to preserve rural access and services. Will there be support or stimulus funds available?
  - It is unclear whether there will be a rural health policy stimulus; but one theme to rely on is that where we are going will not look like it did 6 months ago. For example, the movement we saw already was towards a stratification of health care, such that not every hospital will be full service top to bottom, and using telehealth as a means to recruit rather than "losing" the population for a service line to another group (e.g., behavioral health).
- Current circumstances are a bit of a natural experiment to explore some of the barriers that have prevented telehealth expansion. Even when providers have had time on their hands to implement telehealth, they struggled. How to make sense of this?
  - If telehealth is not reimbursed well, can't use it. How does health care need to evolve? Chronic Care Model and Collaborative Care Model, for example. Pay a per member per month for services, and services are deliberately less defined.
- Is there a rural-specific example of a "sweet spot"?
  - Will be more state-specific. Sweet spots tend to be where state Medicaid will pay for certain things.

From the Field: COVID-19 Issues Forum
Council member Brock Slabach from the National Rural Health Association shared what he is hearing from NHRA members that are the other big issues for rural related to COVID-19 (other than telehealth), then (in limited time remaining) was some additional discussion. Framed as an opportunity for Council members to share with FORHP what is happening on the ground and in the field.

NRHA Issues:
1. **Workforce.** Expanding the fractures -- before COVID-19, there were rural health infrastructure fractures, and COVID-19 has made them wider, especially in communities hit badly with the outbreak.
2. **PPE.** In short supply everywhere, and the workarounds are troubling.
3. **Testing.** Lack of instrumentation and reagents, confusion between nasal and blood testing.
4. **1135 waivers.** Many waivers issued by CMS – length of stay, bed size, swing beds. Still need rural health clinic (RHC) productivity requirements to be waived.
5. **Telehealth.** Missing guidance on how to submit certain claims for telehealth. Authority for distant site status is only through end of public health emergency for federally qualified health centers (FQHCs) and RHCs. NRHA will be pushing for this to be permanent later.
6. **Reimbursement.** As result of CMS and CDC recommendations for cancellation of elective and nonemergent surgeries, seeing 50+% decline in volume, which is directly related to cash flow. Significant reductions in volumes for rural hospitals – average days cash on hand before the public health emergency was only 33 days. CARES act relief has been sporadic. County and government hospitals are not eligible for the Payroll Protection Program.
7. **Quality Reporting.** CMS has suspended mandatory quality reporting deadlines, will need to consider implications for monitoring and evaluating quality performance.
8. COVID-19 recovery planning. Pandemic phases are Planning → Response → Recovery. Need an active recovery plan for rural health. Use experiences now and feed that into an evidence-based system that recommends actions to Congress. Kevin Bennet from U of South Carolina will be leading up that effort for NRHA and welcomes input from others.

Discussion:
Additional issues which Council members added to the list, or reinforced their importance:

- Ability to resource out of the hospital things like environmental and pulmonary services, packaged food.
- Mental health of providers, staff, and the community -- when we come out of this, will the mental health arena be ready for the fall out?
- Decreased revenues (75% dip in volume experienced by some). How far is this going to go out? Will we be able to keep our doors open?
- Elimination of services due to illness and secondary exposure (e.g., one community lost an entire EMT unit secondary to exposure, lost nursing home staffing).
- Need to look at secondary phase, and how the wave is moving into rural, and what a likely Fall weather wave will look like. What will happen when support is not-- for example, limited staff in nursing home, loss of all hospice and home health aides, fire department all quarantined.

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