

2023 Physician Fee Schedule Update – 12/14/22

Kristine Sande:

Good afternoon, everyone. I'm Kristine Sande and I'm the program director for the Rural Health Information Hub, and I'd like to welcome you to today's webinar. We'll be discussing the 2023 physician fee schedule update, and I'll quickly run through just a few housekeeping items before we begin. We have provided a PDF copy of the presentation on the RHihub website, and that's accessible through the URL that's on your screen. We'll also be sharing that link through the chat function, so you'll be able to find it there.

If you have any technical issues during the webinar today, we ask that you visit the Zoom Help Center at support.zoom.us. If you have questions for our presenters today, please submit those through the Q&A button that's on the bottom of your screen. Please do use the Q&A function rather than the chat for those questions, to ensure that we don't miss your questions. We do hope to have time for those questions at the end of the webinar. Now, it is my pleasure to introduce our speakers for today's webinar.

Tom Morris is associate administrator for Rural Health Policy at the Health Resources and Services Administration, where he directs the Federal Office of Rural Health Policy. We also have two speakers from CMS.

Lindsey Baldwin is an analyst in the Center for Medicare in the Hospital and Ambulatory Policy Group, Division of Ambulatory Services. Her work is focused on behavioral health topics, including Medicare payment policy for opioid treatment programs.

Kris Corwin is an analyst in CMS's Center for Medicare with the Hospital and Ambulatory Policy Group, Division of Practitioner Services. His work focuses on payment policy for telehealth remote monitoring and other topics related to annual updates to the Medicare Part B Physician Fee Schedule. With that, I'll turn it over to you, Tom.

Tom Morris:

All right. Thank you, Kristine. I appreciate it very much, and thank you so much for hosting this webinar. We were really pleased this year, to see some of the really nice changes and clarifications that CMS made across many of its rulemaking activities, but some really stood out. I think we were really pleased to see what they did on the Rural Emergency Hospital. We're also glad to see the clarification on the Critical Access Hospital mileage standards.

Then as we move towards the physician fee schedule, we really thought it was quite noteworthy the changes they made related to direct supervision, to general supervision for a broader range of behavioral health providers and some of the changes they made related to telehealth. I think what we wanted to do was make sure that rural stakeholders understood these changes and what it meant. As you know, the department has had a priority on really focusing on behavioral health issues.

The opportunity to expand the range of those mental health, behavioral health clinicians that can operate in rural communities and any community really, was quite important. We wanted to make sure folks understood that and had a chance to hear it straight from CMS. I greatly appreciate our colleagues from CMS being willing to do this. I also want to thank Courtney Turner of our office, for really doing all the work to work with RHihub and our CMS colleagues to make that happen.

The reality is, as I look at the range of providers who will now be able to operate under general supervision. These are the behavioral health clinicians that I think are more likely to be able to be recruited to rural communities, given that we see shortages around the country. It really will

have the potential to expand access to care and to get people regular behavioral health treatment that perhaps before was out of reach. We just really wanted to create a forum where CMS could talk about what they did and how they did it.

Make sure if people had any questions, they had a chance to do, similarly with the telehealth provisions. We know that that telehealth utilization has gone up considerably during the pandemic, thanks to the public health emergency flexibilities. Yet even as that's going, most of it under the flexibility of the PHE. The reality is CMS has done a nice job each year of using the full range of its regulatory authority to do what it can under current statute, to expand access to telehealth services.

With that, turn it over to the experts who really can go into more detail with this. I think Lindsey is the next speaker. Kris, thanks again for hosting and thank you again to our CMS colleagues for doing this.

Lindsey Baldwin:

Great. Thanks so much, Tom. Good afternoon, everyone. I'm happy to be here. As Tom mentioned, I'll start us off first with a focus on recent Medicare policy updates in the behavioral health space. First off, I just wanted to highlight CMS's Behavioral Health Strategy, which seeks to remove barriers to care and services, and to adopt a data-informed approach to evaluate our behavioral health programs and policies.

The CMS Behavioral Health Strategy strives to support a person's whole emotional and mental wellbeing, and promotes person-centered behavioral healthcare. As you'll see on the slide here, specifically, the goals of the strategy are to strengthen equity and quality in behavioral healthcare, improve access to substance use disorder, prevention, treatment and recovery services. Ensure effective pain treatment and management, improve access to and quality of mental healthcare and services.

Lastly, to utilize data to inform effective actions and measure impact on behavioral health. On this next slide, we just have links to the CMS website where you can access the CMS Behavioral Health Strategy fact sheet, CMS's strategic plan and other resources. Next, consistent with the goals in the CMS Behavioral Health Strategy in that I just mentioned, I wanted to highlight several policies in the calendar year 2023, Medicare Physician Fee Schedule Final Rule, that are aimed at expanding access to behavioral health services.

First under "incident to", in light of the current needs among Medicare beneficiaries for improved access to behavioral health services, we considered regulatory revisions that may help to reduce existing barriers. And make greater use of the services of a broader range of behavioral health professionals, which includes but is not limited to, licensed professional counselors and licensed marriage and family therapists.

We finalized our proposal to add an exception to the direct supervision requirement under our "incident to" regulation, that allows behavioral health services to be provided under the general supervision of a physician or non-physician practitioner. Rather than under direct supervision, when these services are provided by auxiliary personnel "incident to" the services of a physician or non-physician practitioner.

We also clarified that any service furnished primarily for the diagnosis or treatment of a mental health or substance use disorder, can be furnished by auxiliary personnel under general supervision of a physician or non-physician practitioner, who's authorized to furnish and bill for services, provided "incident to" their own professional services. We note that the regulatory definition of auxiliary personnel has not changed. They still must meet any applicable

requirements to provide “incident to” services, which includes licensure requirements imposed by the state in which the services are being furnished.

We do believe that this change will facilitate utilization and extend the reach of behavioral health services under Medicare. Next, we also made updates to the code set describing behavioral health integration. Behavioral health integration or BHI, is an evidence-based strategy in which behavioral healthcare is integrated typically into a primary care setting. And has been shown to improve outcomes for millions of Americans with behavioral health conditions.

CMS first began making payment for these services back in 2017 when we established coding describing the Psychiatric Collaborative Care Model, as well as what we call the general BHI code, which was meant to capture other models of integrated care. For this year, 2023, we finalized our proposal to create a new, general BHI code that describes a service personally performed by clinical psychologists or clinical social workers, in order to account for monthly care integration where the services furnished by these professionals are serving as the focal point of care integration.

We also finalized our proposal to allow a psychiatric diagnostic evaluation to serve as the initiating visit for this new, general BHI service. Lastly, we also indicated in the final rule, that we intend to address payment for new codes describing caregiver behavioral management training in CY 2024 rulemaking. With that, I will pass it off to my colleague, Kris, to talk about Medicare telehealth. Thanks so much.

Kris Corwin:

Thank you, Lindsey. Thank you to everyone attending. I'm excited to present to you today and we're going to do some level-setting upfront. Based on the amount of time that we have, I don't want to spend too long setting the stage because I want to allow adequate time for questions. But the purpose of this first slide is to give context, and a background and a basis of the history of the telehealth statute.

Beyond what's on the slide, I want the group to conceptualize or understand that under Medicare Part B, the separately payable practitioner services that may be furnished via telehealth, are aligned with three basic points. First, that there's a list of eligible telehealth practitioners, which are a subset of suppliers for Medicare purposes. Second, there's a list of eligible sites and locations for originating sites.

Third, a telehealth eligible beneficiary, which is essentially a beneficiary that has a fee-for-service Part B benefit. That's what this slide sets up. Just to underscore, the telehealth statute predates quite a lengthy period where we're at today, so I won't spend too much time setting up what happened and how the telehealth statute's structured. Because with public flexibilities and adjustments for the public health emergency, there were several actions that Congress took to amend the statute.

I think that's important for this group because many of those do relate to behavioral health, so we'll go over those today. Just as a final point before I move to the next slide, and then we may come back here during Q&A, but the statute also sets up a process for adding and removing services to the telehealth list. Next slide, please. Again, this slide just sets up the context of the pre and then early PHE. Very soon after the public health emergency, there were a number of changes made.

But again, as was framed up earlier in the intro to this presentation, we've seen a significant uptick in telehealth services, in part due to the necessity of needing to furnish more services virtually. In part, because of some of the flexibilities that we implemented. As I referenced

earlier, the Consolidated Appropriations Act of 2021 was a piece of legislation that Congress enacted that did a number of things.

But what's important for this group to understand, is that it allowed for less restrictions in three major ways, those groups that I set up earlier. First of all, there was a broader range of services that could be furnished. There were fewer restrictions on site of service, and also an ability for CMS to go a bit further with services that we're offering. To Lindsey's point earlier, she framed up some behavioral health considerations with virtual supervision.

We have a concept or a construct of virtual direct supervision. Again, as the slide clearly states, for the duration of the public health emergency to limit infection exposure, we revised the mission of direct supervision to include virtual availability of the supervising physician or practitioner. It still requires use of synchronous communication, that's audio, video, real-time communications technology, as it's defined in regulation.

But what I want the group to take home or takeaway, is that for purposes of calendar year 2023, this policy remains in place. There was a lot of learning that happened about what types of services both could be furnished via telehealth, but also what an appropriate level of supervision is spent for services. Another point is that direct supervision or virtual direct supervision, it's a floor in terms of safety, not a ceiling.

There may be certain circumstances where patient safety or other considerations would call for closer supervision. But really what this means in effect, is that the practitioner who's providing direct supervision may not be in the same room, may not be in the same location. Further, they merely need to be immediately available to give real-time assistance to the auxiliary staff providing resources. Consolidated Appropriations Act of 2022 was an extension of many of the flexibilities that the CAA 2021 implemented.

I think the key takeaway for the group without getting too far into the weeds here, is that Congress establishes an extension period. Because as I referenced, the telehealth statute requires and restricts eligible telehealth practitioners, eligible services and eligible sites who were originating sites, for provision of these services. In effect, what Congress did was allowed an extension for 151 days.

Specifically, that meant that there would be a period whereby providers and suppliers or services would have adequate notice of transitioning away from the public health emergency. Now, we're going to get into two parts in the summary of this year's rulemaking. I described that there's a process by which CMS considers adds and removals of certain services. We also had certain services on the list that were established on a Category III basis, which was a temporary category that was implemented in 2021.

So CMS could understand whether or not certain telehealth services that weren't initially on the list, but due to public health emergency for COVID-19, may have some clinical benefit. There's sometimes a lag in evidence available, because many of these services weren't offered because of the restrictions for telehealth prior to the public health emergency. In that learning, we had several rounds of public comment and we considered the feedback from the public on a variety of services.

In some regards, the telehealth flexibilities that are in place during the PHE, CMS only has certain flexibility to go so far. Where we could or where it made sense, based on public comment and within our regulatory authority, but we have Category III services that will be available through calendar year 2023. But however, back to the transition period that I shared earlier with the CAA 2022, certain flexibilities will no longer be available when the PHE ends.

Because of that, certain services will have to come off the telehealth list. But to that point, this also ties into where services are being delivered. We also finalized that for Medicare telehealth services, we're going to continue to make payment with the place of service code that had the service been furnished in person. That allows payments to continue to be made at the non-facility based rate for Medicare telehealth services through the latter of the calendar year 2023, or the end of the calendar year in which the PHE ends.

That's important to note, that payment will be as it sits right now for the PHE. Next slide, please. The next slide just gives a bit more context. We did add certain services to the Medicare telehealth list for the first time, and those include prolonged services and chronic pain management. I'll send some links out in the chat as we get into the Q&A, so folks may dive into the rule or find the list as well.

But we post and go through discussion and consideration of how we garnered input and public comment feedback about services. Additionally, I'll note that we also accept submissions on an annual basis for additions to the list. There are multiple ways that CMS considers what to add to the telehealth list. I spent some time earlier upfront describing the flexibilities related to direct supervision, which will remain in place for calendar year 2023.

As I framed up with the Consolidated Appropriations Act of 2022, certain flexibilities will end after the transition period. That means that certain geographic and site of service restrictions will again take effect. However, from a substance use disorder and mental health standpoint, those services will be available in certain sites that were originally excluded, and that includes the patient's home.

Another point that I want to emphasize here. For any service that's on the telehealth list, and when the service is being furnished to an eligible beneficiary for the ongoing treatment or management of a mental health or substance use disorder, that service may be furnished audio only. That comes into play because there may be circumstances where audio-only services are no longer available. That's tied into restrictions inherent with the telehealth statute and what may be a telehealth service.

The requirements are such that in order to add something to the telehealth list, CMS's threshold question is whether or not it's a substitute for in-person service. Again, we have some nuanced flexibilities that we can get into. But if the service itself is not a substitute for in-person service, the elements of the service that is, then it's not appropriate and it's not considered a telehealth service for the purpose of Medicare Part B. However, there are a variety of related services that leverage communication space technology.

That's not what we're talking about here. We're talking purely about formalistically, the Medicare telehealth services. I mentioned place of service codes most importantly, will still allow the place of service code had the service been furnished in person until the later of 2023 or the year in which the PHE ends. What that means again, is that payment stays the same. I think I've covered all the bullets on this slide, so we can go to the next slide, please.

All right. Just briefly for context, to just give the group a rundown of how for purposes of the physician fee schedule telehealth services are defined, but there's also some regulatory changes regarding the use of telecommunications in other contexts. We also finalized our proposal to revise regulatory language for Rural Health Centers or Federally Qualified Health Centers mental health visits to include visits furnished using interactive, real-time telehealth communications technology.

That change allows both RHCs and FQHCs to report and receive payment for mental health visits furnished via real-time telecommunication technology when the visit takes place in person, including the audio-only visits when the beneficiary's not capable of or does not consent to the use of video technology. Additionally, CMS also finalized that an in-person non-telehealth visit must be furnished at least every 12 months for these services.

However, there are exceptions, as long as the reason's documented in the patient's medical record, and more frequent visits are also allowed under the policy. Again, that's driven by clinical need on a case-by-case basis. I think we're at a point where we can move into Q&A, but next slide please just to make sure. Great. If you have questions of general policy, please send them to our divisionofpractitionerservices@cms.hhs.gov or similarly, I'll leave my email in the chat as well, so people can reach out directly.

Kristine Sande: Great. Let's move into the Q&A portion of the webinar. If you do have questions for the presenters, you can go ahead and click on that Q&A icon that shows up at the bottom of your screen, and that'll allow you to enter your questions.

It looks like we do have a few in here already. The first few look like they're for Lindsey, a couple related to licensed professional counselors. The questions are will BHI include LPCs? Does the LPC need to be enrolled with Medicare?

Lindsey Baldwin: Yeah. Thanks, Kristine. I can take those. For the question asking does an LPC need to be enrolled with Medicare? No, they do not. They, in fact, LPCs don't have that option right now because there is no separate statutory benefit category. The policy that we finalized that I described in the slides earlier. What it does is currently, LPCs can participate in furnishing care to Medicare beneficiaries under "incident to", where the service is billed by a supervising physician or non-physician practitioner.

LPCs can already do that now and under direct supervision. Starting January 1st, 2023, the changes that they can do that under general supervision. The other question that Kristine just read off asked, will BHI eventually include LPCs, as there's a shortage of behavioral health professionals in rural primary care practices? The answer on that one is actually that they already can. The way that the BHI codes are described and defined, is that those are billed "incident to" as well and depending on which BHI code we're talking about.

For example, in the Psychiatric Collaborative Care Model, there is a behavioral health consultant. That person could be a clinical social worker, a licensed professional counselor, because those codes are billed by the treating or billing practitioner. In most cases, the primary care physician or practitioner, so they can already participate in that care described by behavioral health integration. Both those codes that specifically describe the Psychiatric Collaborative Care Model and the general BHI codes as well.

I will just note for the new code that we established for 2023, LPCs could participate in that code as well when billed by a clinical psychologist, because in their statutory benefit category, they can also supervise others furnishing services "incident to" their professional service. But for clinical social workers, they would need to just personally perform the service because they don't have that ability in their benefit category. Okay. Kristine, do you want me to just move on to the next question?

Kristine Sande: I'll go ahead and read it for you.

Lindsey Baldwin: Okay.

- Kristine Sande:** How is general supervision defined, or where can we find the definition? Does the general supervision change pertain only to behavioral health providers, or is it for use in all "incident to" billing?
- Lindsey Baldwin:** Yeah. The change that I was describing for 2023, it is specific only to behavioral health services. We define that pretty broadly in the final rule to say that it's really any service furnished primarily for the treatment of a mental health diagnosis, including a substance use disorder diagnosis. As for the definitions of, I know we talked a lot about direct supervision versus general supervision, those are defined in our manuals. I believe there is some discussion of that in the comments and responses in the CY 2023 PFS final rule.
- But I can tell you now that for direct supervision, the definition there is that the supervising physician or practitioner needs to be located within the office suite at the time that the service is furnished. But with general, they do not have to be located there in the office suite. That's why we thought that this change really can be a meaningful one, in terms of expanding access. I think that covers that question.
- Kristine Sande:** All right. The next question says, "I'm looking for a little clarification on the incident-to consideration in terms of reimbursement for RHCs and FQHCs."
- Lindsey Baldwin:** Yeah. This is something that we did hear a lot about in the public comments to the proposed rule. In the final rule, we had a response stating that the proposal that was made, was specific to physician fee schedule billing.
- RHCs and FQHCs do not bill under the physician fee schedule. They have their own separate billing mechanisms. We said that we would definitely take this into consideration for future rulemaking, as it pertains specifically to RHCs and FQHCs.
- Kristine Sande:** All right. The next question is for Kris. Can tribal health providers perform telehealth care across state lines for established patients? If the clinic is located in Michigan and the patient is in Florida for the winter, for example.
- Kris Corwin:** I wanted to address this and forgive that it's a bit of an indirect way, but that's a bit fact specific in the general overview of policies that I provided, speaks specifically to the physician fee schedule.
- IHS may be different and there may be certain considerations, but I did want to take the opportunity to underscore that so long as scope of practice and state licensing laws are met, that's sometimes possible but I didn't want to go too far there. That question's best directed to somewhat at IHS, but can certainly forward it though.
- Kristine Sande:** Great. Thank you, so another question. In an RHC, can the in-person visit for mental health telemedicine, be performed by the primary care provider? Are mental health telemedicine costs RHC allowable on the cost report?
- Lindsey Baldwin:** For that one, I know we have some colleagues that are joining us on the line who are the experts in policy for Rural Health Clinics.
- I wondered if any of our colleagues wanted to chime in on that one? If we don't have the answer right now, we are happy to follow-up after the webinar.
- Michelle Franklin:** Hi, Lindsey. Yes. Can we get back to the inquirer on this question, and we can certainly follow up with them after the webinar?

They can feel free to also send the question into the RHC resource mailbox at RHC@cms.hhs.gov. I'll add that resource mailbox in the chat as well, in the Q&A, I'm sorry, as well.

Lindsey Baldwin: Great. Thanks so much, Michelle.

Michelle Franklin: Sure, thank you.

Kristine Sande: All right. Next question is, are there any provisions for pharmacists working under collaborative practice "incident to" a Medicare provider to provide the behavioral health services?

Lindsey Baldwin: I think we did not speak to that specifically in this final rule. I think in order to give you the most comprehensive answer, let us dig into that one a little bit and we can get you an answer over email.

That one can be sent to, we had a slide at the end of the presentation with a resource box. That is divisionofpractitionerservices@cms.hhs.gov.

Kristine Sande: All right. And just for clarification, can the "incident to" visit for an LPC, be with a primary care MD and not a behavioral health physician?

Lindsey Baldwin: Yes. The only requirement is that the service that's being furnished, is for the primary purpose of treating or diagnosing a mental health condition or a substance use disorder.

Yeah. We didn't make any specification about the specialty of that physician or non-physician practitioner who is on the claim form.

Kristine Sande: All right. If an LPC is in private practice, would they still be able to bill?

Lindsey Baldwin: That's an interesting question. I think going back to the point that an LPC cannot independently bill Medicare at this time, because they're not able to enroll as a Medicare provider.

But to the extent that an LPC is in private practice with a Medicare enrolled physician or non-physician practitioner, then they could participate in that care on an "incident to" basis.

Kristine Sande: All right. Another one for you, Lindsey. It says LPCs and LMFTs are not considered a core FQHC provider in the CY 2023.

Is there a provision to allow for these two healthcare professionals to be reimbursed similar to what you had previously described?

Lindsey Baldwin: Right. I think this question is similar to one that came up earlier, which was that the policy we finalized for 2023, was specific to just physician fee schedule billing. But we did respond public comments to say that we would definitely consider similar changes for future rulemaking.

Kristine Sande: Lindsey, do you know whether any state Medicaid plans or waivers have adopted these flexibilities regarding auxiliary personnel?

Lindsey Baldwin: I don't, unfortunately. I think the folks on the line today, we are just in the Center for Medicare and we don't have our colleagues from CMCS on the line as well. That's something that we could, I think, try to reach out on and loop in some other colleagues.

Kristine Sande: All right. For Kris, can we revisit the telephone only billing? Is it discontinued as of January 1st, 2023 or through the 151 days following the end of the PHE?

Kris Corwin: Yeah. Forgive me, I stumbled a little over myself there a little bit in the presentation, so let me clarify that. For any telehealth service that's on the telehealth list, for purposes of ongoing treatment, diagnosis of a mental health or substance use disorder, audio only is fine.

That continues past the PHE. The transition period that I referenced, is because there are some specific audio-only ENM codes that are temporarily on the list and those do go away. I think that clarifies, but if that doesn't go far enough to the question there, please send a follow-up. We can try.

Kristine Sande: All right. Another question for you, Kris. Are you the CMS contact for billing issues? If so, can we have your email address?

Kris Corwin: I'm happy to share my email address. I want to level set on expectations. We can answer general questions of policy, and if it's something that's fact specific, the best resource is the MAC.

If you're a supplier asking a specific question, your Medicare administrative contractor is the best resource. Because there are multiple considerations and those folks are able to assist with, again, going beyond general explanations of policy, or clarifications of policy, but I'm happy to get back to you.

Kristine Sande: All right. Next question is understanding the consideration for RHCs and FQHCs to be included in the changes for LPC is still pending. Do you have any insights on if it will be decided upon in 2023?

Lindsey Baldwin: I don't think we have answers to that yet. The physician fee schedule is on an annual rulemaking calendar, and so policies have been finalized for all of 2023.

Then for policies that would take effect January 1st, 2024, CMS will issue the physician fee schedule proposed rule sometime in the summer of 2023, so definitely keep an eye out for that. There's always a 60-day public comment period following that rule. It typically posts in early July.

Kristine Sande: Will the COCM focal point of care changes allow for behavioral health providers to drive the model instead of the model being primary care based?

Lindsey Baldwin: The new code that we finalize, which I don't think I mentioned, is G0323. That code is a general BHI code and we were able to define it this way, it being a new code. But the Psychiatric Collaborative Care Model is a very specific, evidence-based model that's really already established.

We did not make the changes there, but rather just we made this change in this new G code that can be more mental health focused rather than primary care focused. I hope that answers your question.

Kristine Sande: All right. For Kris, after the PHE, will telehealth services that are not behavioral health need to be provided in the original originating sites designated by CMS?

Kris Corwin: Brief answer, yes. Yeah.

Kristine Sande: All right. The question is, with the questions that needed more research or additional people to address, will that information be sent to the whole group or just to the people asking questions?

It'll definitely be sent to the people asking questions. If you, Lindsey and Kris, want to also provide that to us, we can see if we can include it in the transcript of the call.

Lindsey Baldwin: Okay, sure.

Kristine Sande: Just to clarify, if we have a family nurse practitioner in the office that is credentialed with Medicare, then the LPC could bill under "incident to"?

Lindsey Baldwin: Correct.

Kristine Sande: Will Medicare Advantage plans be required to follow these changes?

Lindsey Baldwin: I don't think we have the folks on the line today that work on policy under Medicare Advantage, so I think we'll have to loop in other colleagues on that one.

Kristine Sande: All right. Another clarification, the LPC updates are not applicable to FQHCs?

Lindsey Baldwin: Correct. The change in the required level of supervision for "incident to" services was only specific to the PFS, but we will consider for FQHCs and RHCs for future rulemaking.

Kristine Sande: All right. Then somebody asked, can all the questions in responses be sent as well? Those will be included in the transcript that we send out. Where can we get information on which degrees and certifications qualify as auxiliary providers for SUD?

Lindsey Baldwin: That we do have a definition of auxiliary personnel in the regulation text on "incident to", which is 42 CFR 410.26 but it varies by state.

I think that in that definition it says that you need to meet any applicable state law and requirements regarding licensure. I think you would need to check the state laws for the state in which you are providing services.

Kristine Sande: Thank you. The next question is, do we send the transcript to participants? Yes, we do. That'll also be on our website. I'm not seeing any other questions at this time so I think we can wrap up. On behalf of RHlhub, I'd like to thank our speakers for the great information and insights that you've shared today.

Also, thanks to all of our participants for joining us as well and asking some great questions. A survey will automatically open at the end of today's webinar. We encourage you to complete that survey to provide us with some feedback that we can use for hosting future webinars. The slides used in today's webinar are currently available at www.ruralhealthinfo.org/webinars.

In addition, a recording and a transcript of today's webinar will be made available on the RHlhub website, as well as sent to you by email in the near future, so you can listen again or you can share it with your colleagues. Thanks again for joining us and have a great day.

If we receive any copies of follow-up emails we will add them to the transcript at that time.