



# CROSSROADS

AUGUST 2020 ISSUE

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**CROSSROADS** is published quarterly by the Mississippi Rural Health Association

### What is **CROSSROADS**?

Crossroads is a publication of the Mississippi Rural Health Association and aims to communicate up-to-date health care news and events through relevant and timely articles.

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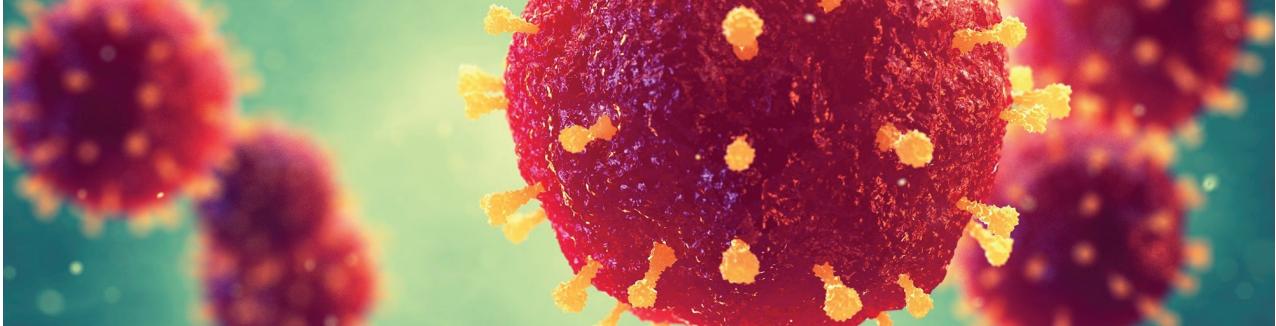
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The Mississippi Rural Health Association is proud to be a state affiliate of both the National Rural Health Association and the National Association of Rural Health Clinics.

# CORONA VIRUS

## ALL KNOWN POLICY UPDATES

The Mississippi Rural Health Association created a page on its website, [msrha.org](http://msrha.org), to house COVID-19 related policies for both Mississippi and the US. This page is being updated as policies are changed, so please reference this page for questions about current policies. If you notice a policy missing, please contact Ryan Kelly at [ryan.kelly@mississippirural.org](mailto:ryan.kelly@mississippirural.org). This section also includes daily updates from the Mississippi State Department of Health.



## PROTECT YOURSELVES AND OTHERS DURING THIS TIME

By: Ryan Kelly

As I am sure that you have noticed and seen, the COVID-19 positive rates in Mississippi have continued to increase over the past several weeks. Although this was largely predicted and the percentage death rate is continuing to fall, the fact remains that our hospitals are seeing increased rates of utilization and many are reporting at or near capacity.

We must continue to practice and encourage public health practices shown to reduce the spread and exposure to COVID-19. This involves washing hands,

wearing masks when appropriate, staying away from crowds, and limiting contact with non-family members when needed. Vaccines are being fast-tracked for approval and distribution, and providers are exploring new methods of treating the illness using current medications. I am optimistic that we are nearing a place of sufficient treatment and stabilization of our healthcare system.

For now, though, let's stay the course and ensure that both our communities and our healthcare facilities are strong through this pandemic.



Connecting with the Mississippi Rural Health Association on Facebook is a great way to keep in touch with like-minded people! Help support Mississippi's rural health while also staying connected all year round through the latest national and local news in the field of rural health.



# 25<sup>TH</sup> ANNUAL MISSISSIPPI RURAL HEALTH CONFERENCE

The Mississippi Rural Health Annual Conference is the state's largest rural health conference. Each session of the year's conference is custom-designed with our members in mind, focusing on the hottest topics of rural health.

Not only will we have the best education that you can find and a large number of CEUs offered, but we will also have awards presented for hospital quality and leadership, and opportunities to network and learn from other fellow rural health professionals and stakeholders.

The draft agenda and conference details will be made available soon. Mark your calendars and stay tuned for details!



Virtual Conference



November 19-20, 2020

# Mississippi Telehealth User Group Meeting

August 26, 2020 | 1 – 2 p.m.

The Mississippi Telehealth User Group is a collective group of telehealth stakeholders from across the state that gather to learn and discuss telehealth opportunities and advancements. A partnership between the Mississippi Telehealth Association and the Mississippi Rural Health Association, this group meets once per quarter with a primary topic of discussion and then open group discussion and Q/A.

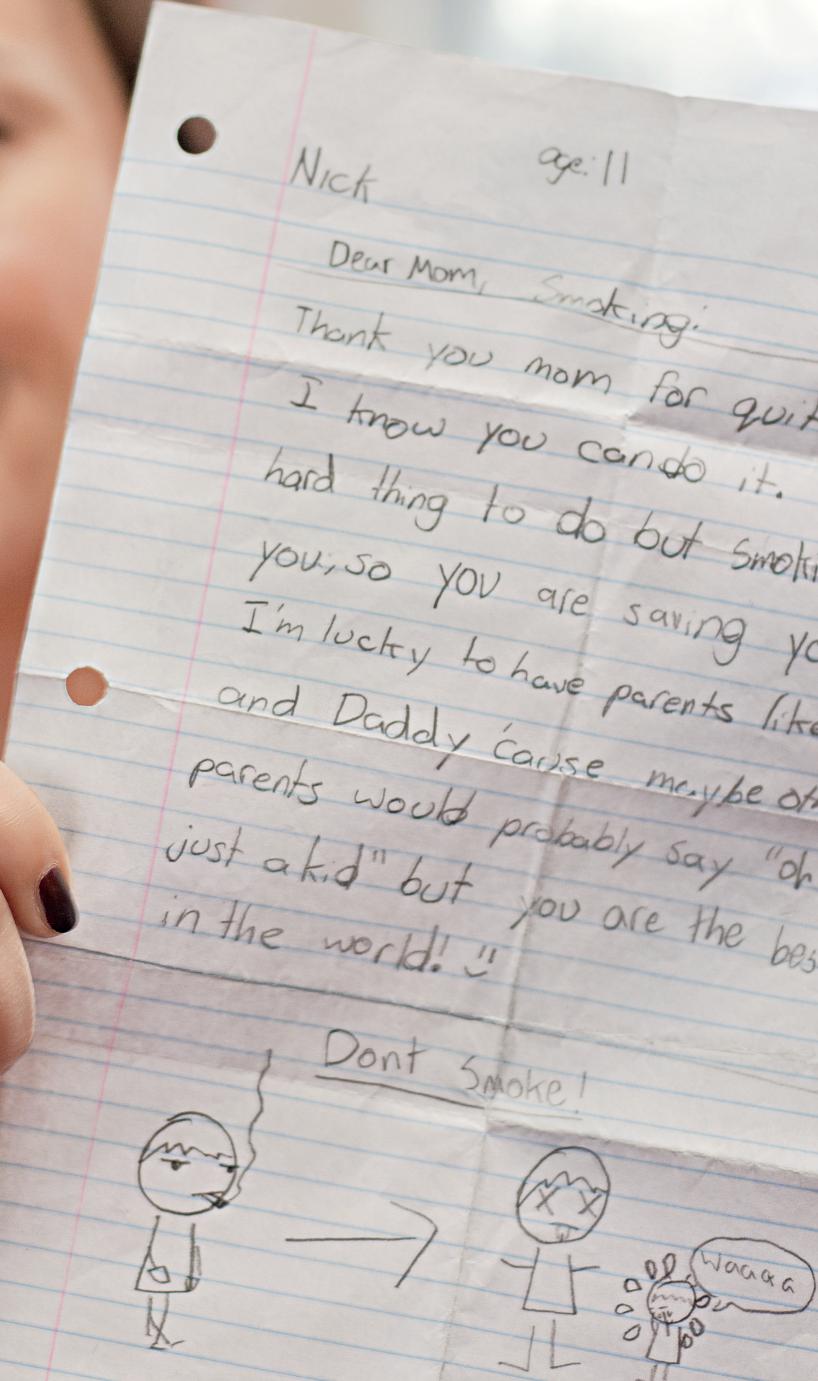
This upcoming August meeting will feature a legislative update from Mississippi Representative Sam Mims, chair of the House Public Health and Human Services Committee. There is no cost to participate.

Visit [msrha.org/events](http://msrha.org/events) to receive login details.



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## WHO IS THE MISSISSIPPI OFFICE OF RURAL HEALTH AND PRIMARY CARE?

By: Madison Moore

The MS Office of Rural Health & Primary Care (MORHPC) seeks to support the Mississippi State Department of Health's mission to "promote and protect the health of citizens" through various public health efforts, both for the public and the professional, and particularly the underserved.

MORHPC assists our rural state by administering five grants: Medicare Rural Hospital Flexibility Program (FLEX) Grant, Mississippi Qualified Health Center (MQHC) Grant, State Office of Rural Health (SORH) Grant, and the State Primary Care Office (PCO) Grant.

These grants vary in assistance from strengthening state, local, and federal partnerships to collecting and disseminating health-related information to addressing health disparities and access to primary health care.

Recently awarded the Small Rural Hospital Improvement Program (SHIP) Grant, MORHPC will administer this grant to SHIP eligible hospitals affected by COVID-19, which includes hospitals with forty-nine beds or less and located in a rural area. Eligible hospitals will receive \$83,293.

### **MORHPC Special Highlights:**

- MORHPC is pleased to announce that a Consortium formed in FY18 with the Mississippi Hospital Associations Affordable Care Organization (ACO)

has made great progress. This activity started with only 6 participating SHIP hospitals and now there are 20 eligible SHIP hospitals.

- The SHIP grant funds have enabled MORHPC to keep the ACO cost low for many facilities so that the small rural hospitals can continue to participate in this Organization. The ACO has developed a state-wide Clinically Integrated Network (C.I.N), and they have also reported an increase in revenue for participating hospitals and their clinics. MORHPC has been able to address population health issues such as annual wellness visits, chronic care management and advanced care planning, the hospitals have reported an increase in these visits within this last cycle. They are optimistic that this ACO will continue to improve the health and community of rural Mississippi.
- MORHPC has awarded a number of rural health hospitals through the MQHC grant based on the Hospital Strength INDEX.

MORHPC seeks to partner and connect with organizations statewide to provide better access to healthcare services for rural communities. The Mississippi Rural Health Association thanks MORHPC for their partnership and looks forward to watching their efforts help advance the state of rural health in our state.

*A friendly reminder from:*



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# The 3 Pillars of Successful Telehealth



The COVID-19 pandemic has put unprecedented demand on America's healthcare providers. Further complicating the situation, COVID-19 has simultaneously increased the risk of infection for patients and providers alike. This combination of factors makes telehealth services essential to the delivery of safe, high-quality patient care.

To fulfill this need, the offices of Health and Human Services, the Office for Civil Rights, and the Centers for Medicare and Medicaid Services have changed their privacy and payment policies to promote telehealth services. To support these organizations' efforts and to expand access to telehealth services to those who most need it, the Federal Communications Commission (FCC) has also established the COVID-19 Telehealth Program. This \$200 million fund will help healthcare providers fund the costs of the technology required to deliver telehealth services effectively and safely. Nonprofit and public healthcare providers alike are eligible to apply for these FCC funds.

In order to help providers make the transition to telehealth as smoothly as possible, we have put together this guide to simplify the process. By selecting the correct three solutions for broadband, video conferencing, and network security, providers can maintain HIPAA compliance, connect with patients, and deliver the same level of care they offer in the office.



## Fast, robust connectivity is your patients' lifeline.

To offer quality care, providers need a fast and robust connection to the Internet. While each healthcare organization's precise connectivity requirements will vary based on its particular circumstances, here's why it's important to choose an Internet service provider powered by expert engineering, such as ENA.

As Internet usage has increased and evolved, so have the attacks on Internet service. 2019 saw the evolution of new forms of DDoS attacks and botnets successfully used to disrupt the Internet service for large companies and state governments. An effective ISP will actively scan its network to contain attacks before they disrupt service to keep patients—and their data—safe. An effective ISP will actively monitor and scan its network to detect and contain attacks before they disrupt the service across an entire provider network—thus protecting ongoing services and patient data.

Furthermore, because telehealth services involve patients at their most sensitive moments, it is essential that the connectivity be as robust as possible. An effective ISP will design its network with as much redundancy as possible to ensure connectivity disruption is minimized even in the event of trouble. That means providers can count on their connectivity when patients count on them. And when telehealth services are a patient's only means of accessing life-saving healthcare, the quality of the provider's connectivity is a matter of life and death.



## 2 Your video-conferencing platform must be as responsive to patients as you are AND comply with their privacy needs.

When patient healthcare and security are on the line, risks are unacceptable. Providers can ensure optimal care by deploying unified communications and video conferencing solutions that are easy to use, cost-effective, and secure. Selecting a platform with a wide selection of security and privacy settings, as well as capabilities for multi-person conferences, makes it easy to coordinate care among multiple providers.

Zoom Video collaboration maintains HIPAA-compliance without sacrificing ease of use. It does so through a host of safety features, including firewall compatibility, medical device integration, 128-bit AES video encryption, and password-protected meetings. With Zoom, gain security without sacrificing accessibility.



## 3 Hackers are always probing your network for weakness. Always.

Healthcare providers need to assume that hackers are trying to break into their networks at all times. Worse, they need to assume that if hackers do find a way into a network, they will try to steal patient data.

Indeed, according to one report, more than 41 million American patients had their data compromised in 2019 alone, making an increase of nearly 50% from the previous year. With more patient care now delivered online, providers can expect hackers to intensify their efforts.

To foil hackers and protect patient data, healthcare providers must take a holistic approach to security. A key security layer for protecting data is the deployment of a unified threat management system that offers deep visibility into a network. Because ENA's NetShield UTM is designed to do just that, it allows providers to manage applications, ports, protocols, and more in order to meet their specific needs. With such visibility and control, healthcare providers can identify—and address—security weaknesses before hackers do. That keeps patients and their data safe.

**Let's work together to bring innovative healthcare solutions to your community**

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## CMS TO RESUME HEALTHCARE PROVIDER AUDITS AUGUST THIRD

By: Tara Bannow | July 19, 2020

CMS will resume auditing healthcare providers' Medicare claims in two weeks, months after suspending such work due to COVID-19. The agency performs a variety of fee-for-service claims reviews, many through private contractors, to ensure hospitals, physician clinics and other healthcare providers weren't overpaid for services. It temporarily put most audits on hold in March when providers were forced to suspend non-urgent procedures, and some began laying off and furloughing employees. CMS on August 3<sup>rd</sup> plans to resume its enforcement actions "regardless of the status of the public health emergency," the agency announced in a recent notice.

That could present a challenge for providers, some of whom are still seeing a steady influx of coronavirus patients. Hospitals in Houston and parts of Florida are experiencing dramatic surges.

"I think the administration has decided it has to act as if COVID is over," said David Glaser, a shareholder with Fredrikson & Byron in Minneapolis, who helps providers comply with audits. "That will come as a shock to much of the healthcare industry, which is in the throes of a nightmare."

For some providers, it's possible the employees who normally would respond to an audit are still furloughed. Many providers sent their workers home without pay during the pandemic to preserve cash as staffing and supply costs ballooned and procedure revenue tanked. While providers like Mayo Clinic in Rochester, Minn. and Chattanooga, Tenn.-based Erlanger Health System have brought those workers back, most health systems that announced furloughs have been silent on that front.

The biggest challenge for providers will be reacting to audit requests in a timely manner, especially given up to 20% of the administrative workforce that normally responds to them is currently furloughed, said Rick Kes, a partner and healthcare senior analyst with RSM. "Right now, they don't think they can handle it, more or less," he said.

In normal times, responding to a CMS audit would be a typical part of business operations, Kes said. But some hospital volumes are only at 80% or less of pre-pandemic levels, and many hospitals still can't afford to staff like they normally would, he said.

In some cases, responding to an audit entails having a physician, nurse or other medical provider supplement the information in their records. That could be difficult in areas where front-line caregivers are busy treating coronavirus patients.

The federal government eased a number of regulatory compliance rules during the pandemic to help providers, such as those guiding telehealth visits and not requiring signatures on durable medical equipment orders, said Knicole Emanuel, a partner in Potomac Law Group's North Carolina office. A big concern among providers is whether CMS' auditors will remember all of those exceptions.

Providers appreciated having those burdens relaxed during a difficult time, but Kes agrees the big question now is whether auditors will be up to speed on all the exemptions that were made. He said providers would

prefer CMS hold off on audits for a few months so they can bring all their staff back and auditors can be fully trained on the rule changes that were made.

A CMS spokesperson said in a statement on Monday that the agency announced it would resume the audits on July 7, giving providers almost four weeks' notice.

"CMS is committed to ensuring that medical review continues while minimizing provider burden as much as possible," the statement said. "Providers who need additional time to respond to record requests and have other hardships because of COVID-19 should contact their Medicare Administrative Contractor for assistance."

To prepare for an audit, Emanuel recommends providers ensure their documentation is thorough and kept in a consistent location that's not affected by attrition among executives.

Another key task is designating someone in the office to capture the daily guidance CMS issues and keeping

those documents in a file, Glaser said. This is important because it's not always clear when guidance changes, he said. Once the old versions disappear from the agency's website, they're no longer easily accessible.

"If you're trying to find out what the state of instructions was on July 1, it would be very, very difficult a year from now," Glaser said.

In that vein, Glaser also recommends obtaining transcriptions of the CMS' office hour calls. With so many people, especially back-office employees, working from home, it's easy to forget to check the mail that's delivered to the office, Glaser said. Organizations have gotten used to corresponding solely via email, but audit requests will likely arrive via snail mail.

"Even pre-COVID, making sure the audit letters get to the right person in a timely fashion is often a challenge," Glaser said.

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# TRUMP ADMINISTRATION ANNOUNCES \$5B COVID-19 RELIEF FUNDS, FUTURE TESTING REQUIREMENTS FOR NURSING HOMES

By: Tina Reed | July 22, 2020

The Trump administration is allocating an additional \$5 billion in COVID-19 relief funds to Medicare-certified long-term care facilities and state veteran nursing homes in hot spots where the virus is has begun spiking again. President Donald Trump announced the funding, part of the Provider Relief Fund authorized by the Coronavirus Aid, Relief, and Economic Security Act, during an evening briefing Wednesday amid a fierce resurgence of COVID-19 cases, hospitalizations and deaths in several areas around the country.

At least 57,000 nursing home residents and workers in the U.S. have died from the novel coronavirus, representing more than 40% of the deaths from the virus since it began to spread, The New York Times reported in late June. Last week, national nursing home organizations warned state governors that new outbreaks of COVID-19 in nursing homes and assisted living facilities are “imminent” in light of the spikes in several states around the country, including Florida, Texas, Arizona and California.

Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma said more details would be coming on how the funds would be distributed. But she did say they would be targeted to nursing homes in “hot spots” that are experiencing “significant case loads.” The funding will be used for meeting critical needs in nursing homes such as hiring additional staff, implementing infection control “mentorship” programs with subject matter experts, increased testing and services such as technology that connects residents with their families.

Wednesday, officials announced CMS will issue a proposed rule to require, rather than recommend, all nursing homes in states with a 5% positivity rate or greater to test all nursing home staff each week. Funds from the Provider Relief Fund will be able to be used for that testing, as well as for additional testing of visitors, officials said.

Since April, nursing homes have been required to report if they have positive COVID-19 cases to residents and their families. But CMS will begin requiring expanded reporting to ensure that information makes it back to state officials.

“Based on our nationwide data reporting system, we will be distributing to governors on a weekly basis a list of nursing homes with increased cases,” Verma said. “This will give state officials an opportunity to intervene in those facilities with three or more cases as soon as possible to minimize the risk to residents. There’s also a requirement for states to inspect those nursing homes when there are three or more cases.”

CMS and the Centers for Disease Control and Prevention are rolling out an online, on-demand Nursing Home COVID-19 Training focused on infection control and best practices. Nursing homes must participate in the training to qualify for a piece of the \$5 billion of the relief funding.

CMS recently deployed federal task force/strike teams to provide on-site technical assistance and education to 18 nursing homes experiencing outbreaks across Ohio, Pennsylvania and Texas.

“This is a war, and we are constantly evolving our strategy to address the situation on the ground,” Verma said during a call with reporters in response to a question asking why more steps, such as requiring testing of staff and visitors, weren’t taken earlier. “From the very beginning, we immediately said, ‘No visitors.’ After that, we issued a series of regulations and guidance to nursing homes to help them prepare. We talked about the priorities for testing in nursing homes, we urged governors to do testing across the board, we’ve provided resources to nursing homes in terms of supplies. We are constantly always assessing what we need to do.”

# TRUMP ADMINISTRATION ANNOUNCES DETAILS OF NEW RURAL HEALTH MODEL

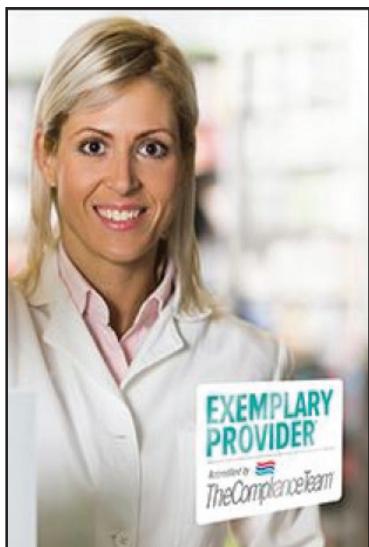
The Centers for Medicare and Medicaid Services (CMS) recently unveiled the details of the Trump Administration's long-awaited, new rural health payment model, the Community Health and Rural Transformation (CHART) Model. The CHART Model aims to, “[Unleash] innovation through new funding opportunities that will increase access and improve quality,” by allowing a limited number of rural health providers to participate in one of two tracks, the Community Transformation Track and the Accountable Care Organization (ACO) Transformation Track. According to CMS, this new model comes as a response to President Trump's Executive Order on Improving Rural Health and Telehealth Access that was made on August 3rd, as well as the President's Medicare Executive Order and CMS's Rethinking Rural Initiative.

The Community Transformation Track will include up to 15 lead organizations. These lead organizations are entities representing a rural communities comprised of either a single county or a set of contiguous or non-contiguous counties. This track will create a \$75 million grant program for the 15 organizations to share. This experimental track aims to give these up-front dollars to providers and allow them greater flexibility to create their own health care programs with a patient focus.

The ACO Transformation Track builds on the successes the very popular and successful ACO Investment Model (AIM) program. In this model, CMS will select 20 rural-focused ACOs to receive advanced payments to engage in value-based payment efforts aimed at improving

outcomes and quality of care for rural beneficiaries. We are supportive of this new and exciting opportunity, but we also want to acknowledge that how CMS currently sets spending benchmarks disadvantages certain rural providers. Currently, CMS compares the per-patient costs of a region's ACO with the operating expenses of its non-ACO competitors, but rural ACOs are often the only significant provider in their region. Thus, rural ACOs often face a much lower spending benchmark, because urban and suburban regions often have more non-ACO providers. We are calling upon CMS to fix this ‘rural glitch’ within the MSSP. This is a critical and common-sense step towards establishing greater payment for rural providers that are providing high quality care to their communities while decreasing health care spending. Unlike the earlier AIM program, participants in the ACO Transformation Track will enter into two-sided risk arrangements as part of the Medicare Shared Savings Program (MSSP), which could be a barrier to entry for many rural hospitals unwilling to bear risk without being able to define that risk completely. Additionally, a CHART ACO is limited to 10,000 covered lives which could increase actuarial volatility in participating in a dual-sided risk program.

The timeline indicates that a Notice of Funding Opportunity (NOFO) for the Community Transformation Track will be available in September on the Model Website and the Request for Application (RFA) for the ACO Transformation Track will be available in early 2021.



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# FDA ORDERS RETAILERS TO STOP SELLING 13 TOBACCO PRODUCTS

July 17, 2020

The products had been provisionally permitted to be sold on the market since 2011. The U.S. Food and Drug Administration (FDA) has issued Not Substantially Equivalent (NSE) orders for 13 tobacco products that had been provisionally permitted to be sold on the market since 2011. These tobacco products are now misbranded and adulterated and can no longer be distributed, imported, sold, marketed or promoted in the United States, the agency said.

Retailers with remaining inventory of the combustible cigarette and smokeless tobacco products listed above should work with the product manufacturer or supplier to discuss options for disposing of these products, the agency said. Failure to comply with the Federal Food, Drug and Cosmetic (FD&C) Act may result in FDA taking regulatory action without further notice. These actions may include but are not limited to civil money penalties, seizure, and/or injunction.

Upon scientific review of the Substantial Equivalence (SE) Reports submitted by R.J. Reynolds Tobacco Company and U.S. Smokeless Tobacco Company for their smokeless tobacco products, FDA said it determined that the new tobacco products were not substantially equivalent to the predicate tobacco products.

Regarding the Heritage Tobacco LLC cigarette products, the FDA determined the information submitted failed to sufficiently demonstrate that the predicate tobacco products listed in the SE Reports were commercially marketed in the United States as of Feb. 15, 2007; therefore, they were not eligible predicate tobacco products.

Before the issuance of the NSE orders, these provisional SE tobacco products were allowed to be marketed because new tobacco products first commercially marketed after Feb. 15, 2007, but before March 22, 2011—with an SE Report submitted to the FDA by March 22, 2011—could remain on the market unless the FDA issued an order that the new products were not substantially equivalent.

# GRASSROOTS ADVOCACY FORUM: HHS REPORTING

July 26, 2020

HHS issued an update on the reporting of CARES Act/Provider Relief Fund distributions. The following is an excerpt from the guidance:

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

To learn more, visit the National Rural Health Association website at [www.ruralhealthweb.org](http://www.ruralhealthweb.org).

# MISS. DELEGATION SEEKS DEFINITE RURAL HEALTHCARE RELIEF AS COVID-19 CASES INCREASE

July 6, 2020

Hyde-Smith Leads Letter for Rural Providers Set-Aside, With Support from Wicker, Kelly & Guest U.S. Senator Cindy Hyde-Smith (R-Miss.) late Friday led a letter to the U.S. Department of Health and Human Services strongly encouraging the agency to quickly provide relief to rural healthcare providers increasingly affected by the COVID-19 pandemic. The letter, signed by 49 members of Congress, including U.S. Senator Roger Wicker (R-Miss.) and Representatives Trent Kelly (R-Miss.) and Michael Guest (R-Miss.), seeks a dedicated 20 percent Provider Relief Fund set aside for rural America. “Rural healthcare was already in crisis prior to the COVID-19 pandemic, and the situation is only getting worse. Last year rural hospitals closures hit a record high, and 2020 is on pace to be even higher. So far this year twelve rural hospitals have closed, with hundreds more on the brink. Given both the cancellation of elective procedures because of the pandemic and the recent spread of COVID-19 in rural America, rural providers have a desperate and immediate need for more funding. Therefore, we request you make this funding available quickly to provide relief to struggling rural health care providers,” the lawmakers wrote to HHS officials. (A copy of the letter is available [here](#).)

COVID-19 cases are growing 13 percent faster across rural America compared to the 9 percent national rate of growth. For two weeks running, rural counties have accounted for the highest number of new COVID-19 cases in a seven-day period since the pandemic began. From June 17-24, rural counties had 23,366 new COVID-19 cases. The previous rural cases record was 19,022 new cases from the week of June 9-16.

The rise in cases across rural America represents a

growing concern considering that the 60 million Americans living in rural areas generally have more health conditions that make them more vulnerable to COVID-19.

In all, 49 Senators and Members of the House signed the letter calling on future allocations from the Provider Relief Fund to meet the following metrics:

- A 20 percent Rural Benchmark in the Provider Relief Fund
- Priority should be granted to facilities that have been significantly affected by COVID-19 preparation
- Priority should be granted for facilities that provide care for a disproportionately high percentage of Medicare and Medicaid patients
- Priority should be granted for facilities that provide care for populations with above average senior populations or co-morbidities that are particularly vulnerable to complications from COVID-19 and for populations in areas:
  - With limited access to health infrastructure;
  - With high levels of uninsured patients.

The metrics recommended in the letter match those included in the Save Our Rural Health Providers Act (S.3823/HR.7004), which would create a new formula to ensure the Provider Relief Fund has a dedicated set-aside amount of funding directed toward rural areas of United States. Hyde-Smith, Senator Joe Manchin (D-W.Va.), Representatives Xochitl Torres Small (D-N.M.) and Jim Hagedorn (R-Minn.) introduced the legislation in May. March 22, 2011—could remain on the market unless the FDA issued an order that the new products were not substantially equivalent.

**MEDICAL PRACTICES:**

# Act now.

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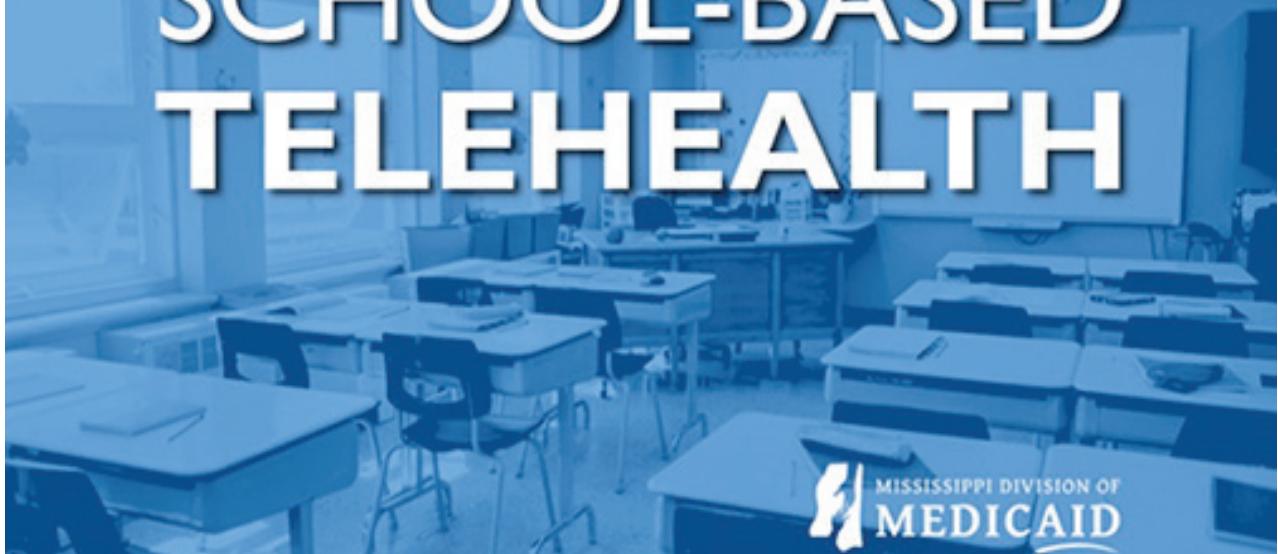
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# SCHOOL-BASED TELEHEALTH



## MEDICAID EXTENDS SCHOOL-BASED EMERGENCY TELEHEALTH COVERAGE

By: August 17, 2020

With the start of a new school year in the midst of the COVID-19 pandemic, the Mississippi Division of Medicaid (DOM) has extended its emergency telehealth coverage to include schools as temporary originating site providers. The move makes it possible for schools without school nurses or school-based clinics to access telehealth services.

Effective Aug. 1, 2020, schools are approved as temporary telehealth originating site providers on the condition that services are facilitated by a telepresenter acting within their scope of practice and license and/ or certification.

Traditionally, telehealth services are delivered by an enrolled Mississippi Medicaid provider located at a distant site to a beneficiary located at an originating site, such as a clinic. DOM's telehealth policy already allowed school-based clinics – staffed by a physician, nurse practitioner or a physician assistant providing well and sick care – to serve as an originating site for a beneficiary in need of services beyond the clinic's abilities.

The amended Emergency Telehealth Policy allows any school to serve as the originating site as long as the distant site provider uses a telepresenter who meets the definition of Miss. Admin. Code Part 225, Rule 1.1.D. Telepresenters can include registered nurses employed by a school/school district or staff employed by a Rural Health Clinic, a Federally Qualified Health Clinic, or private provider.

Ryan Kelly, executive director of the Mississippi Rural Health Association and the Mississippi Telehealth Association, says many parents work long distances away from the schools their children attend, and leaving work to take them to a clinic visit is often a burden on both the parents and the school itself.

"We are very pleased that the Mississippi Division of Medicaid has worked to expand its policy. This will allow students to stay in school longer, parents to be able to stay at work longer, and for care to be provided in a more timely and efficient manner," Kelly said. "Not only is this a direct cost savings to the State of Mississippi, but it will provide significantly better and more timely care for our treasured youth in Mississippi."

DOM Executive Director Drew Snyder said this was the latest step in supporting the state's response to COVID-19.

"Extending telehealth coverage has been a key part of ensuring access to care during this public health emergency," Snyder said. "As children return to the classroom, increasing access in school settings is more important now than ever."

To learn more, read the Emergency Telehealth Policy at: [https://medicaid.ms.gov/wp-content/uploads/2020/08/DOM-Emergency-Telehealth-policy-V8\\_7.31.2020.pdf](https://medicaid.ms.gov/wp-content/uploads/2020/08/DOM-Emergency-Telehealth-policy-V8_7.31.2020.pdf).

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