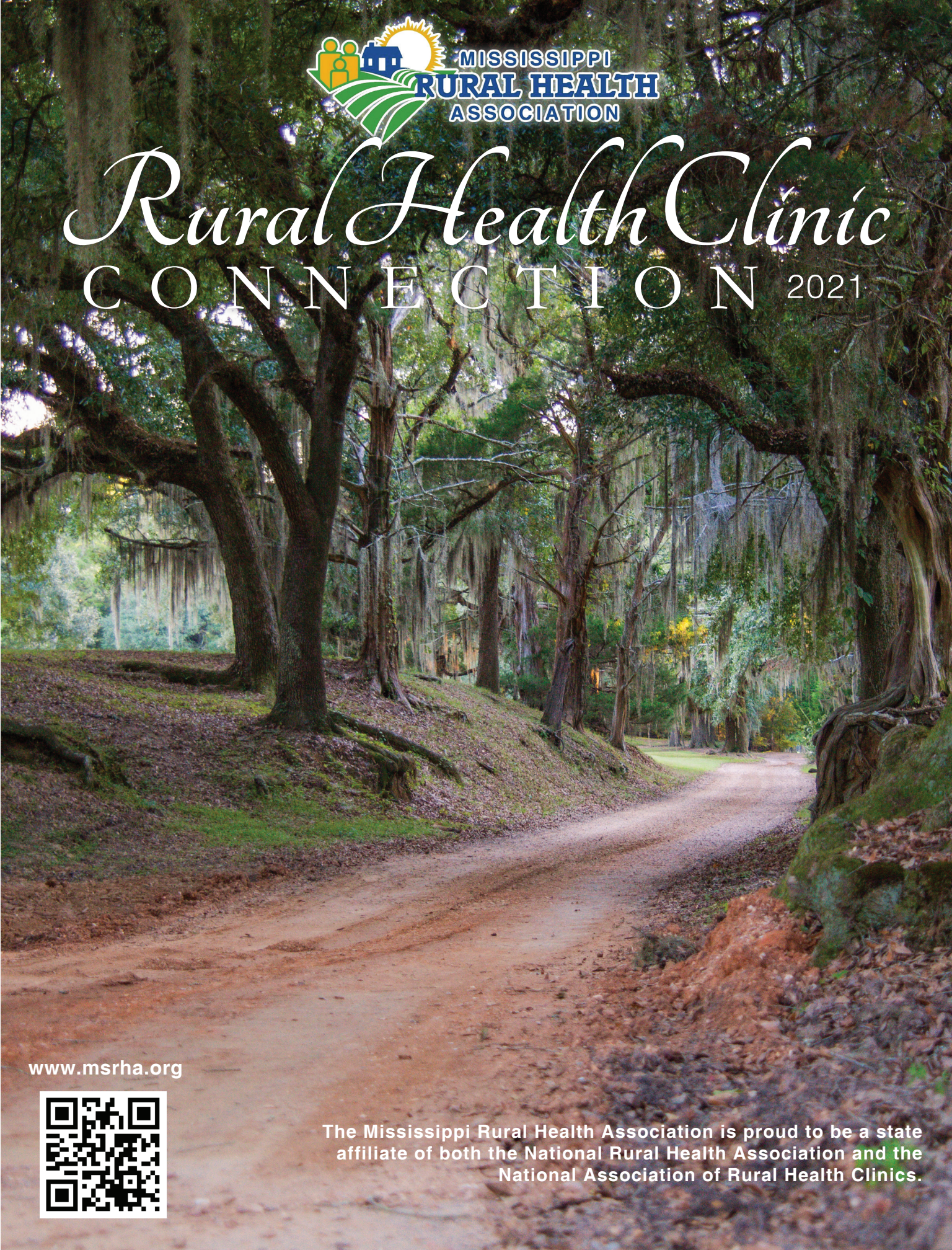
MISSISSIPPI
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The Mississippi Rural Health Association is proud to be a state affiliate of both the National Rural Health Association and the National Association of Rural Health Clinics.

CONGRESS PASSES MAJOR CHANGES TO RURAL HEALTH CLINIC REIMBURSEMENT

Beginning on April 1, 2021, the Rural Health Clinic (RHC) per visit upper payment limit increased from $87.52 to $100. The increased upper payment limit is a direct result of the payment changes included in Section 130 of the Consolidated Appropriations Act of 2021, passed in late December of 2020.

This bill was a huge benefit to independent rural health clinics in Mississippi and around the nation, but it came at a steep cost to provider-based clinics, capping their rate and limiting increases only for the annual Medicare Economic Index.

The legislation also contained a technical error, grandfathering existing clinics formed before December 31, 2019. The date should have been December 31, 2020. Congress put a correction into motion as part of a larger bill, H.R. 1868.

On April 14, 2021, President Biden signed H.R. 1868 into law. In addition to extending Medicare sequestration through December 31, 2021, H.R. 1868 makes the following changes to the Rural Health Clinic (RHC) program:

Corrects the error in the 2021 Consolidated Appropriations Act (CAA) that incorrectly listed a date of December 31, 2019, as the grandfathering cutoff date. The date was corrected to December 31, 2020, in the new law. This allows all uncapped provider-based RHCs that enrolled in Medicare through December 31, 2020, to obtain grandfathered status and not be subject to the new cost-per-visit caps.

Permits RHCs owned by hospitals with fewer than 50 beds and that submitted either form CMS-855A or a PECOS application to establish themselves as an RHC prior to December 31, 2020, to obtain grandfathered status and not be subject to the new cost-per-visit caps. Medicare also must have received the CMS-855A or PECOS application prior to December 31, 2020.

Requires that RHCs that obtain grandfathered status continue to be owned by hospitals with fewer than 50 beds. If the parent hospital were to exceed 50 beds in the future, the RHC would lose grandfathered status and be subject to the caps outlined in the CAA.

The cost-per-visit caps weren't changed by H.R. 1868 and will be the following per year:

Beginning	Ending	Rate
1/1/2021	3/31/2021	$87.52
4/1/2021	12/31/2021	$100.00
1/1/2022	12/31/2022	$113.00
1/1/2023	12/31/2023	$126.00
1/1/2024	12/31/2024	$139.00
1/1/2025	12/31/2025	$152.00
1/1/2026	12/31/2026	$165.00
1/1/2027	12/31/2027	$178.00
1/1/2028	12/31/2028	$190.00
1/1/2029	12/31/2029	$190.00 + MEI

We know that this legislation comes as a benefit to some and a cost to many others. We are working with legislators across the nation to see if there is a legislative 'fix' that can loosen the cap on provider-based payments, as we recognize the great tool that this is for off-loading hospital costs to the more favorable RHC reimbursement model.

If we can be of help to your clinic in better understanding how this legislation will affect you, please contact Ryan Kelly at 601.898.3001 (ext 3) or ryan.kelly@mississippirural.org.

MISSISSIPPI RURAL HEALTH ASSOCIATION

RURAL HEALTH CLINIC CONFERENCE

May 21, 2021
Virtual Conference

The Rural Health Clinic Conference is a special meeting designed specifically for the rural health clinic members of the Mississippi Rural Health Association. Sessions include:

- **Leveraging Wireless Technologies**
- **Spotlight on Patient Access in HIPAA and other regulations**
- **The Importance of SBIRT Training**
- **Advanced Analytics Platform in MS**
- **Patient Centered Medical Home Advantages with Mississippi Medicaid**
- **When to admit and transfer care?**
- **New Data Governance Request App**
- **RHC Provider Relief Funds and Cost Reports**
- **Emergency Preparedness and planning, RHC Program Evaluations**

A new low price has been established for this conference to help our RHCs receive the information they need in the easiest and least prohibitive manner possible. Register today at msrha.org/events.

EXPERT: STATE'S HEALTH CARE SYSTEM STARTING TO 'CRUMBLE' FROM PANDEMIC, OTHER FACTORS

By C.J. LeMaster, WLBT

Two years after a 3 On Your Side investigation highlighted the struggles of getting emergency care in Mississippi's rural counties, an expert on the subject says the state's health care system has started to crumble from the coronavirus pandemic and other factors, like a decline in nurses.

At the same time, some factors affecting emergency medical technicians, like road and bridge closures, have improved statewide.

In 2019, our joint 3 On Your Side investigation with Mississippi Today uncovered holes in the fabric of our state's health care system, pockets where people don't get adequate ambulance coverage and can't even get emergency care in their own county.

"Where you live affects your health outcomes," said Ryan Kelly, who served as chairman of Mississippi's Rural Health Task Force under Gov. Phil Bryant. "It is a sad truth."

Kelly now works as executive director of the Mississippi Rural Health Association.

Our 2019 investigation showed how EMTs in particular are affected because of a shortage of ambulances and a patchwork of emergency rooms and hospitals in many areas of Mississippi.

"For us to continue to provide care and leave another county, my primary county, uncovered for four to six hours to me, it's unacceptable," Rural Rapid Response owner Tyler Blalock told WLBT in 2019.

Some of those barriers to emergency service were actual barriers.

Our 2019 investigation revealed more than 500 bridges across the state had been shut down, deemed unsafe to use.

Two years later, nearly 150 bridges have reopened, improving ambulance response time when navigating those rural roads.

In a handful of counties, the problem's actually gotten worse, however.

A 3 On Your Side analysis finds Holmes, Humphreys and Yazoo counties have seen bridge closures increase by more than 40 percent in two years.

In fact, the number of bridges shut down in Yazoo County spiked 163 percent in that timeframe, from 8 in 2019 to 21 closures now.

"If you are only able to access a hospital or a clinic based on very limited thoroughfares in our counties, those become degraded," Kelly said earlier this month. "That's a tremendous access problem, whereas you may go from a 15 or 20 minute drive to a one hour drive to access care."

Those critical minutes are also affected by how many emergency rooms and hospitals are available across the state.

In 2019, we found 14 counties didn't have emergency rooms in Mississippi, a statistic that

remains the same.

For some facilities, Kelly said the workforce itself is also affected.

Nurses are leaving Mississippi in larger numbers to other states that pay more.

"It's kind of hard to blame them. If you make $100 an hour in Mississippi, you can make $160 somewhere else," Kelly said. "It's really hard to justify staying here when you could go do that."

Kelly says COVID-19 has accelerated the crumbling of our health care infrastructure in recent months.

At the height of the pandemic, Mississippi's hospitals buckled under the pressure of dealing with an avalanche of patients and finite resources to handle them.

Even now, the state remains on the list for being at most critical risk of hospital closures.

"I'm afraid we're at the point where if one person gets sick for more than a few weeks, and the bills don't go out, that hospital, it may be the difference in them being open and not being open," Kelly said. "So we have some that are that close, to where they're not taking vacations, because there's no one else that can do that job. And if that job isn't done, there's no hospital anymore."

Despite additional hospital closures in the South in recent years, Mississippi has not had a hospital shut down since Quitman County Hospital in Marks closed its doors in September 2016, according to data from the Sheps Center for Health Services Research.

Kelly said broadband advances across the state will eventually bring telehealth to some of those places without emergency care, but it's still a long way off.

"This is great news for us, but it's not there yet. I mean, you see trucks down the road that are laying line, but it may take years for this to really fully expand into our rural areas," Kelly said.

This story is part of a series of reports collectively addressing the nation's great health divide, part of a partnership between Gray Television and Google.

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HYDE-SMITH ELECTED AS A MEMBER OF THE SENATE RURAL HEALTH CAUCUS

US Senator Cindy Hyde-Smith was recently elected as a member of the Senate Rural Health Caucus, a section of legislators dedicated toward supporting rural health issues in the United States Senate. Hyde-Smith has been a great supporter of rural health issues in the US Senate, including a focus on financial reimbursement and compliance issues for Mississippi's rural hospitals and rural health clinics as well as a strong focus on telehealth and broadband expansion and support of the 340(b) program.

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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.

INDEPENDENT PRIMARY CARE DOCS MORE FINANCIALLY STABLE, BUT FED UP WITH VACCINE EXCLUSION

By: Rebecca Pifer, HealthCareDive

The U.S. has grappled with the coronavirus pandemic for one year now, a year that saw major health systems and community physicians alike scrambling to ramp up operations to care for the growing tide of COVID-19 patients.

But unlike large hospitals, which have remained on relatively stable footing, the competition for scarce supplies and federal aid paired with a catastrophic plummet in patient visits early in the year left independent primary care practices — many already operating on razor-thin margins — wheezing.

Now, the financial situation has improved for the private practices that survived 2020. But even as volumes recover, front-line doctors are still facing fresh challenges, including rising frustration that they've been excluded from the vaccine distribution process and worries about downstream effects from delayed care.

SIGH OF RELIEF AS VOLUMES BOUNCE BACK

After a year of COVID-19 and months of struggling to make ends meet, many independent practices report they're no longer facing an immediate financial cliff.

Although expenses, including pricey personal protective equipment, are still high, volumes are almost entirely back to normal, aided in large part by telehealth, primary care physicians say.

Autumn Road Family Practice in Little Rock, Arkansas, had to lay off 12 employees in March following plummeting patient visits, and was facing an extremely precarious financial future. Now, the independent practice is at 85% to 90% of normal visit volumes, with more than a third of visits conducted virtually.

Autumn Road has been able to rehire every employee who wanted to return, and even added a new provider, thanks to strict cost control measures and congressional COVID-19 aid, practice administrator Tabitha Childers said.

Numerous small providers that survived the worst of the pandemic's financial effects are reporting solidifying volumes and, having cut unnecessary costs and lobbied for loans, are even using the extra cash to grow, adding more providers or value-adds to their offices.

Additionally, practices operating in the direct primary care model, where patients pay a subscription fee to a practice for a wide swath of primary care services and insurance isn't accepted, say they've seen rising demand from people in their communities wanting to sign up.

Michael Ciampi, who operates a family practice in South Portland, Maine, has seen a lot of interest in his DPC office, which currently has about 675 members. "My waiting list is four to six months," said Ciampi, who's been spacing out in-person visits for patient peace of mind and filling in the extra time with telehealth.

BOTTOM OF FORM

Family Medicine of Malta, a primary care practice in Saratoga County, New York, had to cut expenses and halt overtime early in the pandemic. Now, it's "completely fine," Marc Price, a physician at the practice, said, partially thanks to a new COVID-19 testing machine that's helped bring in some additional revenue. "We're back to decent volume, but it's still not as busy as it has been. But we're not facing an immediate threat of closure. If we have to maintain long term at this volume, we can."

Despite the optimism, however, independent

practices are still very much in a holding pattern following months of depressed revenue and sky-high expenses. A study published in Health Affairs estimates U.S. primary care practices could have lost more than $15 billion in 2020.

And though data is spotty on medical closures during the pandemic, a late September survey of primary care practices conducted by the Larry A. Green Center and Primary Care Collaborative found 7% didn't think they could keep their doors open past December. Another survey conducted by the Physicians Foundation estimates 8% of all physician practices nationwide, independently-owned or otherwise, have closed due to COVID-19. In addition, the Physicians Foundation survey found 72% of physicians said their income plummeted, 43% had to cut staff and 16% had already changed jobs or planned to within a year.

Professional Medical Associates in Enterprise, Alabama, had a 75% patient no-show rate last March that resulted in huge dings to its topline. A lot of that pressure had abated by July, but "we really are still in that holding pattern," PMA physician Beverly Jordan said, noting winter is normally her practice's busiest time of year, but volumes are sitting at about 80% of normal levels. "It was a rough year," she said.

'OUR BIGGEST STRUGGLE:' EXCLUDED FROM VACCINE DISTRIBUTION

Despite rising economic stability, primary care doctors report mounting frustration from being left out of the vaccine rollout. The push has ramped up in recent weeks but faced criticism for being disjointed, with states and localities having widely varying strategies. However, most are excluding family physicians — especially those unaffiliated with a larger hospital or system.

Many say they registered with their state and local health departments first thing to disseminate the shots and simply haven't heard back, despite repeated efforts to get in touch and dozens of calls a day from patients desperate to get the vaccine.
Jeff Gold, who operates a primary care practice in Marblehead, Massachusetts, said he signed up with the state's public health agency to be an immunization site in December. But "we still haven't heard a damn thing. It's just a complete debacle," Gold said.

In lieu of primary care physicians, who often have relationships with patients spanning years if not decades, most state officials are focusing on massive vaccination sites, including stadiums or hospitals, along with major drugstore chains like CVS or Walgreens. Currently, large retail pharmacies are the only sites allowed shipments directly from the federal government.

"It's like instead of the first resort, which is what we should be, we end up being the last resort," Gold said. Primary care doctors say the exclusion is illogical, as their offices administer roughly half of all adult vaccinations in the U.S. The country has given emergency authorization to two efficacious vaccines, Moderna's and Johnson & Johnson's, which don't require special freezers like the Pfizer-BioNTech shot, and which even small offices could easily store and administer.

Almost 90% of primary care clinicians want their practices to be a vaccination site, but only 22% are considered one by their health department or local health system, according to a survey conducted mid-February by Larry A. Green Center and PCC. Autumn Road, open for half a century, registered the first day possible in Arkansas and hasn't heard back about when it might receive doses, if at all.
"Our biggest struggle right now is our patients are angry because we can't get the COVID vaccine," Childers said, noting the practice fields about 10 to 20 calls a day from patients about the shot. "Many of our patients have said we're not going to get it until we can get it from y'all."

Many practices are keeping an updated list of their highest-risk patients to contact and a plan to pivot to vaccine administration once they hear a shipment is on the way. Forty percent of PCC respondents said they had already invested significant time into trying to find a vaccine for their most vulnerable patients, even if they themselves aren't distributing it.

"We've been applying to get the vaccine since day one ... Patients are calling constantly. When should I get it? Where should I get it? Should I get it? We get dozens of calls a day," Family Medicine of Malta's Price said, noting he's filled out informational surveys from New York's health department about his ability to distribute the vaccine, but isn't sure

that means they'll ever get it. "It's more onus on us, and we still can't give it out," Price said.

Though the U.S. is now averaging more than 2 million shots a day, a number of high-risk and elderly Americans have yet to receive a coronavirus vaccine. Fewer than a third of seniors have been fully inoculated, despite accounting for four-fifths of all coronavirus-related deaths in the country, according to the CDC.

And it's nigh impossible for primary care physicians to keep track of which of their patients have been vaccinated and which haven't, because distribution sites — whether a retail pharmacy chain, a hospital or other location — don't notify them. That's left doctors almost entirely out of the loop on a key aspect of their patients' health.

"Unless a patient tells us, we don't know who's been vaccinated, which is really unfortunate," Ciampi said, noting he estimates about 10% to 20% of his patients have been vaccinated — but just isn't sure. "You'd think they could have one more person send us an email or fax to the primary care provider's office, but that hasn't been part of their modus operandi at this point," he said.

A YEAR'S WORTH OF STRESS

Vaccine quagmire aside, primary care physicians are also airing concerns about the ramifications of medical care delayed during COVID-19, saying they're already seeing some detrimental effects crop up. Mental health needs in particular have seen the greatest near-term rise, and front-line physicians themselves aren't immune following months of acute stress.

One in five U.S. adults report pushing off medical care during the pandemic, according to a research study conducted by Harvard T.H. Chan School of Public Health and the Robert Wood Johnson Foundation. Of that group, more than half said they experienced negative health consequences as a result.

"We've had a lot of increased complaints for anxiety and depression," and patients with chronic conditions — "people we'd normally see regularly — it took six, nine months to get them back in the office and it took a lot of convincing," Childers said.

Independent primary care physicians are reporting a similar emotional toll, as they've for a year now continued to deliver healthcare while facing grave financial pressure and little-to-no direct federal aid. On top of that, the doctors have had to combat rampant misinformation and educate their patients around thorny issues like testing, masks and now vaccinations — often to intense pushback.

"You can see the toll that a year's worth of stress has taken on people," Jordan said, noting the difficulty of keeping confused and fearful patients abreast with shifting public health guidelines and conflicting messaging, especially as the virus has been politicized. "Our physicians and staff feel we can do no right. No matter what they say or do, there's always someone with a different opinion who has a lot of distrust in medicine who's on the attack."

Despite the frustration and fatigue, primary care physicians are in a prime spot to address vaccine hesitancy. Eight out of 10 people are likely to rely on a doctor, nurse or other provider's advice when deciding whether or not to get a shot, according to the Kaiser Family Foundation, and three-fourths of primary care clinicians surveyed by Larry A. Green said their relationships with patients have been integral to addressing hesitancy.

A glimmer of hope is President Joe Biden's American Rescue Plan, which explicitly calls out the need to leverage primary care workers moving forward. But primary care doctors say they're fed up of being the last line of defense against COVID-19, when they should have been the linchpin of the U.S.'s pandemic response from the start.

"We're all suffering from COVID fatigue in some way. Everybody is. Everybody's frustrated, I totally get it," Gold said. "But the pattern of what I've seen during this whole thing just proves that primary care is devalued, in the grand scheme of things. We're made to not matter."

HELPING HEALTHCARE FACILITIES GUIDE PATIENTS TO QUIT USING TOBACCO

Tobacco dependence is a chronic condition driven by addiction to nicotine. No amount of tobacco use is safe. Treatment of tobacco use and dependence often requires multiple interventions and long-term support. Effective clinical interventions are available to help tobacco dependent patients to quit.

Key considerations for treating tobacco dependence:

- Behavioral counseling can benefit all patients.
- Medication can help patients quit and can be used with most patients, though special considerations may apply for some individuals.
- Combining behavioral counseling and medication is more effective than either treatment alone.
- Follow-up is key to monitoring patients for treatment adherence, side effects, and efficacy, along with providing support and continued assistance.

Simple steps and suggested language that you can use to briefly (3 to 5 minutes) intervene with patients who use tobacco are available to you. These steps can be integrated into the routine clinical workflow and can be delivered by the entire clinical care team.

These are the 5 A's for Tobacco Cessation Brief Clinical Intervention steps listed below:

1. **Ask** about current tobacco use. Provide a message of prevention if recently quit (last 1 to 12 months), assess challenges, confidence, and need for support.
2. **Advise** to quit.
   Reference the Mississippi Quitline
3. **Assess** willingness to make an attempt to quit tobacco use. If the patient is not willing at this time, provide a brief motivational message, set expectations, and leave the door open to future conversations.
4. **Assist** the quit attempt by doing the following:
   - Brief counseling
   - Medication, if appropriate
   - Refer to additional resources such as the Mississippi Tobacco Quitline at 1-800-QUIT NOW or the Mississippi Department of Health, Office of Tobacco Control at Tobacco Control -Mississippi State Department of Health (ms.gov)
5. **Arrange** a follow-up appointment (in person or by telephone)

For more information on clinical tobacco prevention resources and clinical training opportunities AT NO COST, please contact Lorrie Davis at lorrie.davis@mississippirural.org with the Mississippi Rural Health Association at 601.898.3001 or msrha.org

HHS ANNOUNCES NEARLY $1 BILLION FROM AMERICAN RESCUE PLAN FOR RURAL COVID-19 RESPONSE

On May 4, 2021, The US Department of Health and Human Services announced additional funding targeted to rural health clinics. The funding is intended to do the following:

- Provide up to $100,000 to each of more than 4,600 Rural Health Clinics (RHCs) across the country through the Rural Health Clinic COVID-19 Testing and Mitigation Program, which follows the success of the Rural Health Clinic COVID-19 Testing Program. Send questions about the Rural Health Clinic COVID-19 Testing and Mitigation Program to RHCCOVID-19Testing@hrsa.gov.
- Further expand COVID-19 testing in approximately 1,730 small rural hospitals – Critical Access Hospitals and other rural hospitals with fewer than 50 beds – with up to $230,000 each through the Small Rural Hospital Improvement Program (SHIP). Hospitals that are interested should contact their state's SHIP grantee.
- Invite RHCs to join the new Rural Health Clinic COVID-19 Vaccine Distribution Program – a joint effort with the Centers for Disease Control and Prevention to increase COVID-19 vaccine supply in rural communities. Send questions about the Rural Health Clinic COVID-19 Vaccine Distribution Program to ruralpolicy@hrsa.gov with RHC Vaccine Distribution in the subject line.
- Make nearly $100 million available in grants through the Rural Health Clinic Vaccine Confidence (RHCVC) Program. HRSA will fund all eligible RHCs that apply. Rural Health Clinics participating in the RHCVC program will be able to use the funds to increase patient and community confidence in COVID-19 vaccination and to address equity gaps by bolstering patient literacy on the benefits of broader vaccination for other infectious diseases.

Send questions about the Rural Health Clinic Vaccine Confidence Program to RHCVaxconfidence@hrsa.gov.

NO TIME TO MAKE OUR SPECIAL IN-SERVICE TRAINING ON TOBACCO AND VAPING PREVENTION?

View the On-Demand Version Instead!
1.0 hours of nursing CE available

The Mississippi Rural Health Association, in partnership with the Mississippi State Department of Health, Office of Tobacco Control, is offering a special one (1) hour in-service training for rural health clinic staff.

If your rural health clinic is interested in participating in this training at no cost, contact Ryan Kelly at 601.898.3001 or ryan.kelly@mississippirural.org

If you are low on time but still want to participate, consider registering for our special On-Demand Course at www.msrha.org/events.

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The Mississippi Rural Health Association is pleased to have these valued partners on-board as a valued asset to our members. We encourage all members to use these vendors as a preferred source for your rural health needs. Learn more about these partners at www.msrha.org/sponsors

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