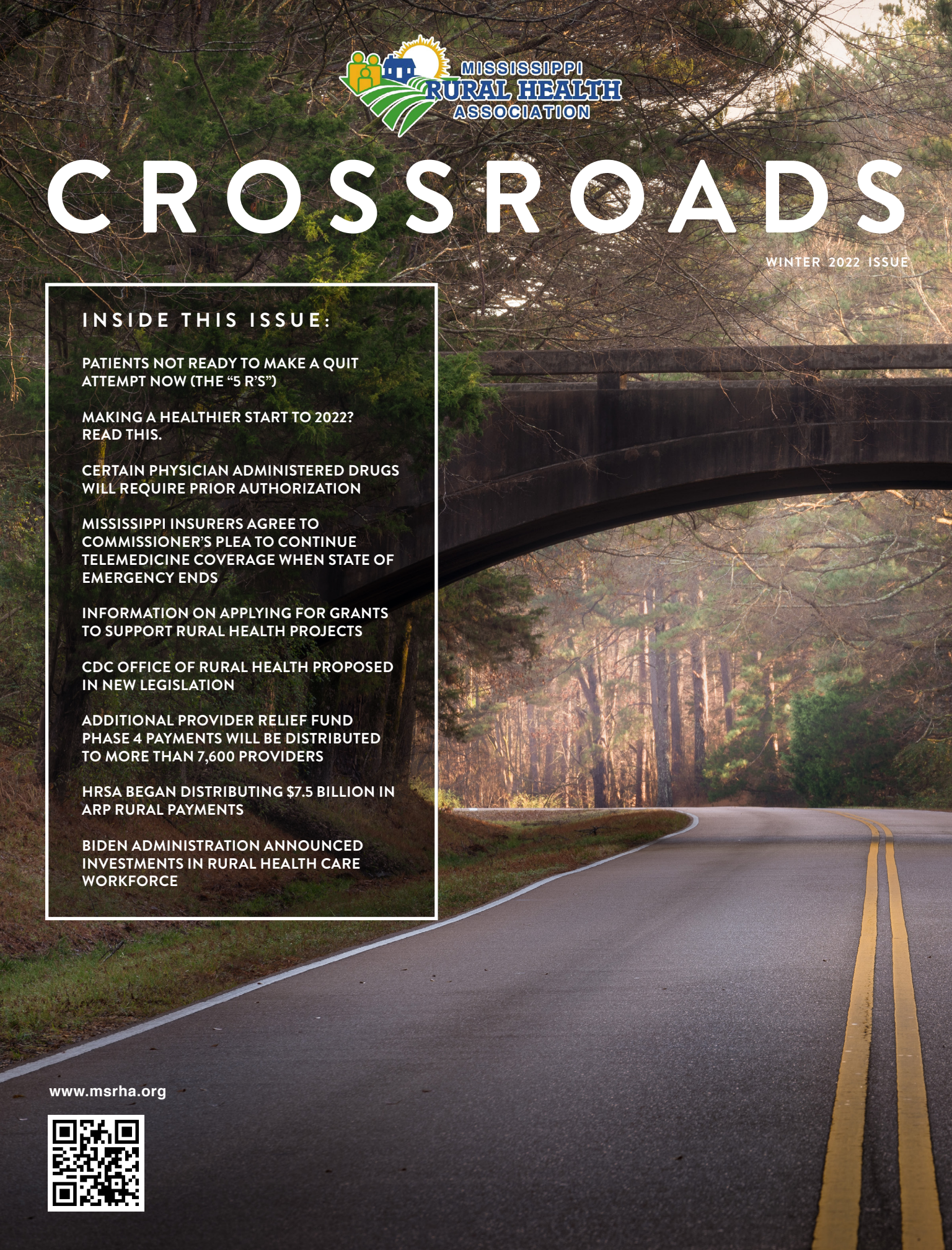

MISSISSIPPI RURAL HEALTH ASSOCIATION

CROSSROADS

WINTER 2022 ISSUE

INSIDE THIS ISSUE:

www.msrha.org

CROSSROADS MAGAZINE

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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.

ASSOCIATION

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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.

MRHA JOB BOARD

MSRHA.ORG/JOB-BOARD

The Mississippi Rural Health Association is pleased to host a job board for rural health professionals. Click **here** to view and access current listings. Additionally, any job in the rural health sector is now being accepted on the job board.

PATIENTS NOT READY TO MAKE A QUIT ATTEMPT NOW (THE "5 R'S")

Patients not ready to make a quit attempt may respond to a motivational intervention. The clinician can motivate patients to consider a quit attempt with the "5 R's": Relevance, Risks, Rewards, Roadblocks, and Repetition.

- **Relevance** - Encourage the patient to indicate why quitting is personally relevant.
- **Risks** - Ask the patient to identify potential negative consequences of tobacco use.
- **Rewards** - Ask the patient to identify potential benefits of stopping tobacco use.
- **Roadblocks** - Ask the patient to identify barriers or impediments to quitting.
- **Repetition** - The motivational intervention should be repeated every time an unmotivated patient has an interaction with a clinician. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful.

MAKING A HEALTHIER START TO 2022? READ THIS.

By Ryan Kelly

Like so many, you may have planned the new year with a new attitude toward eating right and exercising. I applaud you if you made this commitment this year!

As healthcare professionals, we should stand as the example for others to follow when it comes to taking care of ourselves. Something you may not know about me, I have exercised for 5-6 days per week every week since I was nine years old. My wife and I actually used to teach group fitness classes, and we work hard to eat healthy and set a good example for our kids. Now, that certainly doesn't mean that we don't love the occasional hamburger or slice of chocolate cake. But, it does mean that we have developed a lifestyle of discipline and routine fitness that helps to give us a positive start to each day.

The keyword to any good fitness plan is 'routine.' You must enable a sustainable and enjoyable routine of fitness and nutrition that you can do without dread or inconvenience. I have grown to love grilled chicken and salads, and I am miserable if I don't get a workout in each day. This is not because I was born to love these things, but rather because I have developed a daily pattern of doing them. You must make a decision that you will engage in a new or adjusted lifestyle that is not determinant on an outcome or an end-date. This is a decision that you should be willing to carry out for the rest of your life.

This decision can certainly be very daunting, and it's the reason why more than two-thirds of those that make a New Year's Resolution to live healthier end up breaking it within a month. It's often too large of a goal without the foundation to support it.

As healthcare professionals, we should stand as the example for others to follow when it comes to taking care of ourselves.

You can search for hundreds of crash diets, crazy workout programs, and gadgets and gizmos to help you along your path. I would recommend that you place most of this aside, though, and do what you feel will best help you to your goal. If you like bread and don't think that you can live without it (like me), don't go on a Keto diet. If you hate running, don't commit to running 4-5 times per week. You must love what you do in order to want to continue to do it! The Lord created each of us different from one another, and it means that we should all approach the goal of living healthier in a way that is unique to each of us.

As I said earlier, we must set the example as healthcare professionals and live our lives the way that we know is best for our patients. They are looking to us to be the example for them to follow. If you made this commitment for a healthier lifestyle in 2022, we are all in your corner cheering you on! If you ever have a question about fitness or nutrition, feel free to call me anytime and I am happy to help as I can. I care about each of you and want the very best for you. You've got this!

CERTAIN PHYSICIAN ADMINISTERED DRUGS WILL REQUIRE PRIOR AUTHORIZATION

Effective Feb. 14, 2022, the Mississippi Division of Medicaid will require prior authorization (PA) of an additional 63 Physician Administered Drugs (PADs). To learn more about these changes, please read the attached notice and share through any of your appropriate channels.

MISSISSIPPI INSURERS AGREE TO COMMISSIONER'S PLEA TO CONTINUE TELEMEDICINE COVERAGE WHEN STATE OF EMERGENCY ENDS

By Julie Whitehead

Mississippi Insurance Commissioner Mike Chaney has secured crucial support from Blue Cross & Blue Shield of Mississippi, the largest health insurer in the state, to continue covering telehealth visits at the same rate as in-person visits. Telehealth, also called telemedicine, includes consulting with a health professional online or over the phone. Recently, Chaney's office issued a bulletin alerting health insurers in the state that Gov. Tate Reeves' decision to end Mississippi's state of emergency on Nov. 20 means the Insurance Department will be withdrawing the emergency authorization of insurance coverage of telemedicine during the COVID-19 pandemic. He appealed to the insurance companies to continue the coverage until the Legislature can resolve the issue. Blue Cross & Blue Shield of Mississippi on Tuesday became one of the companies responding positively to Chaney's appeal. In a statement to Chaney's office, BCBS general counsel Cheri D. Green said, "Blue Cross & Blue Shield of Mississippi had previously determined to continue its approved Novel Coronavirus (COVID-19) Pandemic Telemedicine Policy after the Governor's declared state of emergency expired." Vantage Health also has agreed to continue coverage.

While the widespread use of telehealth came to Mississippi on an emergency basis because of the pandemic, state leaders have made a case for health insurance companies to continue covering it because of cost savings, ease of service, and better access to specialists that came about in healthcare arena.

Telehealth made its debut in Mississippi in 2016, when the University of Mississippi Medical Center pioneered the concept to provide services to much of the state's rural population. But much of the use, particularly in mental health coverage, came after the Mississippi Insurance Department, the Mississippi Department of Human Services and the Centers for Medicare and Medicaid had come together to issue emergency rules that allowed health practitioners to be paid for both video- and audio-based services at the same rate as in-person visits.

"The use of telemedicine during the pandemic has been an outstanding and effective method of providing consistent healthcare to Mississippians and has shielded many from unnecessary exposure to the coronavirus," Chaney noted in his newly issued bulletin. "Many elderly or rural residents have received consultations with their medical providers by the use of phones or computers. People in need of mental health services have received immediate, thorough, and consistent treatment, especially children and teenagers who have needed these types of services. The benefits of telemedicine are too great to be ignored or discontinued."

Julie Seawright of Tupelo says that having telehealth access paid for by her children's insurance during the first of the pandemic was wonderful. "During the pandemic, we used telehealth for our Advanced Psychiatric Mental Health Nurse Practitioner visit with RightTrack in Tupelo, Amy Thomas."

Seawright says she and her two sons have attention deficit hyperactive disorder and that she also has depression, anxiety, and obsessive-compulsive disorder. Her children no longer had to miss school for their ADHD appointments, Seawright said. "I really enjoyed being able to transition from doing online school with the boys to them not technically leaving school. They were able to pause their work and pop on screen to have their visit with her." Seawright was able to receive therapy for her depression after her boys were treated. Not having to leave the house for therapy was convenient for other reasons as well. It made going to therapy less stressful. Her favorite part of telehealth, Seawright says, was "not having to find shoes for every visit for two growing boys!"

Dr. Finn Perkins, a psychiatrist at the Mississippi State Hospital in Whitfield, noted the numbers on telehealth in testimony before a joint meeting of the House and Senate Insurance committees in late September. Perkins, testifying in his role as Mississippi Psychiatric Association public affairs chairman, noted that telehealth resulted in treatment of this vulnerable population at a much higher rate than was true pre-pandemic. "Our members have quickly adapted to telemedicine. They note that no-show rates have significantly decreased, with patients no longer having to leave their homes or consider travel to access care — some even report a no-show rate of 0 percent," Perkins said. "These changes have also allowed many clinics and practices to stay open when they may otherwise have been forced to close."

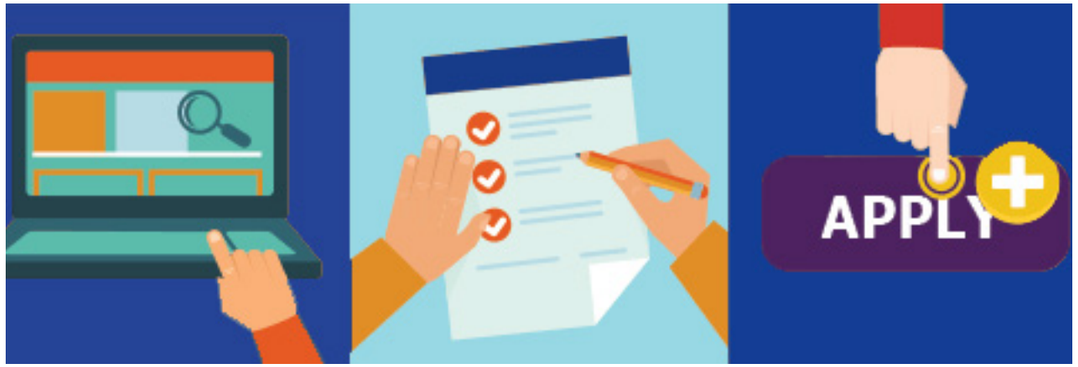
State Employee Health Insurance Plan administrator Dr. Cindy Bradshaw of the Department of Finance and Administration said the rate of participation in mental illness-related telehealth services totaled 34,000 visits for behavioral health and 17,000 psychiatric encounters. Those numbers refer to patients seen in telehealth during the pandemic, according to Marcy Scoggins, communications director for DFA. All in all, Bradshaw noted to legislators in her testimony before the committee that the plan had saved around $700,000 by using telehealth for a wide array of services. Scoggins confirmed this sum was a total savings since the advent of telehealth in Mississippi in 2016.

Chaney noted his bulletin did not apply to the state employee plan but that the board governing the state employee health plan (of which he is a member) had bypassed BCBS in its role as a third-party administrator to offer telemedicine to its members in the first place.

The insurance committees in the House and Senate let bills die last session that would have codified the role of telemedicine in the state of Mississippi. Republican Sen. Nichole Boyd of Oxford said both chambers passed separate telehealth bills and could not come to an agreement on the bills' language.

"The bill broke down last year because some of what the House offered to us in the Senate would have limited Medicaid." Boyd said.

The late September joint hearing listened to testimony on these issues from a variety of interested groups. Perkins noted that passing legislation to make telemedicine an option for all patients in the state would serve the state's mentally ill population particularly well. "MPA asks that you support continued access to telemedicine services by codifying many of these temporary changes," Perkins said. "Without telehealth coverage and payment parity for Medicaid and commercial insurance Mississippi health plans can reimburse providers at unsustainably low rates or choose not to cover services at all, stifling flexible access and investments in virtual technologies that have been rapidly adopted and accepted this year," Perkins said.



INFORMATION ON APPLYING FOR GRANTS TO SUPPORT RURAL HEALTH PROJECTS

From the Rural Health Information HUB

Rural America includes vibrant communities that find innovative solutions to unique health challenges. Nonprofit organizations and healthcare providers in rural areas rely on government and state funders as well as foundations, businesses, and individual donors to help bring new projects to life or sustain crucial, existing services.

Getting a grant is hard work, and can involve numerous, time-intensive steps. Many funders hold competitive cycles for grant programs in which rural organizations must compete alongside well-funded, well-prepared organizations with dedicated and experienced grant writing teams. Organizations in rural areas are less likely to have staff members strictly dedicated to grant writing. Staff, board members, or even community members who have the most writing or business experience may be chosen by necessity to be responsible for securing funds.

Rural organizations face many barriers when seeking grant funding, as identified in the National Committee for Responsive Philanthropy's 2007 report Rural Philanthropy: Building Dialogue from Within, including:

- Lack of major foundations located in rural areas, leading to fewer networking opportunities
- Foundations and state/federal grant-makers without knowledge of rural issues
- The inability to show potential impact to funders when serving less densely populated areas
- Perception that rural projects are less sustainable and organized
- Smaller local nonprofit infrastructure

In addition to those barriers, the amount of funding allocated to rural organizations is significantly smaller per capita when compared to urban counterparts. A 2015 USDA report, Foundation Grants to Rural Areas from 2005 to 2010: Trends and Patterns, compares the average value of grants from large foundations given from 2005 to 2010. The report states that organizations based in nonmetro counties received less than half the amount per capita compared to organizations in metro counties.

The purpose of a grant proposal isn't just to request funding. Successful grant applications should be thought of as one of the first steps to building sustainable, long-term programs that will increase the health of rural communities. This guide can serve as a starting point for those who need assistance to begin the grant writing process. It will cover tips on searching for rural-specific funding, grant proposal preparation, building successful funding relationships, and planning for program sustainability.

CDC OFFICE OF RURAL HEALTH PROPOSED IN NEW LEGISLATION

Representative McEachin and Senator Merkley led a bicameral introduction of the Rural Health Equity Act (H.R. 5848/S. 3149) to establish an Office of Rural Health within the Centers for Disease Control and Prevention (CDC). Their legislation would ensure the nation's premiere health promotion, prevention, and preparedness agency prioritizes addressing the unique health care challenges and inequities faced by rural communities across America. The Office of Rural Health must serve as the primary point of contact within the CDC on rural health matters, coordinate public health research on issues affecting rural populations, and carry out related activities.

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.

ADDITIONAL PROVIDER RELIEF FUND

PHASE 4 PAYMENTS WILL BE DISTRIBUTED TO MORE THAN 7,600 PROVIDERS

Through the Health Resources and Services Administration (HRSA), the U.S. Department of Health and Human Services (HHS) is making over $2 billion to PRF Phase 4 General Distribution payments to 7,600 providers across the nation this week. Over $18 billion will have been distributed from the PRF and the ARPR provider funding in the last 3 months and approximately 82 percent of all Phase 4 applications have now been processed. NRHA will continue to monitor the rollout of this funding and ensure rural providers are adequately represented.

"Provider Relief Fund payments have served as a lifeline for our nation's heroic health care providers throughout the pandemic, helping them to continue to recruit and retain staff and deliver care to their communities," said Health and Human Services Secretary Xavier Becerra. "This funding is just the latest example of the Biden-Harris administration's dedication to ensuring that providers continue to have the resources they need to meet the evolving challenges presented by COVID-19 and keep providing critical services to the American people."

Provider Relief Fund payments have been critical in helping health care providers prevent, prepare for, and respond to coronavirus. Providers have used the funds to remain in operation and to continue supporting patient care by covering a variety of costs including personnel, recruitment and retention initiatives, medical supplies, information technology, and many other functions.

"The COVID-19 pandemic is an unprecedented challenge for health care providers and the communities they serve," noted HRSA Administrator Carole Johnson. "The Provider Relief Fund remains an important tool in helping to sustain the critical health care services communities need and support the health care workforce that is delivering on the frontlines every day."

Phase 4 payments have an increased focus on equity, including reimbursing a higher percentage of losses for smaller providers and incorporating "bonus" payments for providers who serve Medicaid, Children's Health Insurance Program (CHIP), and Medicare beneficiaries. Approximately 82 percent of all Phase 4 applications have now been processed.

HRSA BEGAN DISTRIBUTING $7.5 BILLION IN ARP RURAL PAYMENTS.

The Health Resources and Services Administration (HRSA) began distributing $7.5 billion in American Rescue Plan (ARP) Rural payments to providers and suppliers who serve rural Medicaid, Children's Health Insurance Program (CHIP), and Medicare beneficiaries. Throughout the last 18 months, NRHA has worked with Congress and both the Trump and Biden Administration's to ensure rural providers were adequately represented in the Provider Relief Fund (PRF) allocations. This spring, NRHA worked closely with Senator Joe Manchin (D-WV) to ensure additional funding was set aside for rural providers in the American Rescue Plan Act of 2021. NRHA applauds the Administration for getting funding out to rural providers who continue to be disproportionately impacted by COVID-19. The average payment being announced is approximately $170,700, with payments ranging from $500 to approximately $43 million. More than 40,000 providers in all 50 states, Washington, D.C., and six territories will receive ARP Rural payments.

"Health care providers in rural communities have been hit hard by the COVID-19 pandemic, and they continue to experience significant financial hardships," said HHS Secretary Xavier Becerra. "The infusion of these funds will be critical to ensuring rural communities maintain access to high-quality health care and addressing urgent needs like workforce recruitment and retention." Rural providers play an integral role in the Administration's focus on addressing health equity. Research has found that 47 percent of rural providers were operating in the red pre-pandemic, and this Administration has heard from providers on the ground that the pandemic worsened this reality. To help mitigate some of these pandemic-related financial losses, providers were invited to begin applying for this ARP Rural relief funding starting September 29, 2021, and asked to complete their applications by November 3, 2021. In just three weeks, HRSA processed nearly 96 percent of the more than 55,000 ARP Rural applications submitted. Many ARP Rural payment recipients will also be eligible for additional funding through the $17 billion Provider Relief Fund (PRF) Phase 4 opportunity that was also made available during the same time period. Providers could apply for both opportunities through a single application.

To streamline the application and payment process as much as possible, ARP Rural payments are based on Medicare, Medicaid, and CHIP claims for services to rural beneficiaries from January 1, 2019, through September 30, 2020. This period was chosen as it represents the most recent comprehensive data available to HHS and takes into account both pre-pandemic and pandemic operations. Rural providers serve a disproportionate number of Medicaid and CHIP patients who often have more complex medical needs. To provide equitable relief to these providers, ARP Rural payment calculations were generally based on Medicare reimbursement rates, regardless of whether the service was provided to a Medicare, Medicaid, or CHIP patient. Every eligible provider that serves at least one rural Medicare, Medicaid, or CHIP beneficiary will receive funding.

This funding will help health care providers keep their doors open, address workforce challenges, and make up for the lost revenues and increased expenses caused by the pandemic. Specifically, providers can use these funds for salaries, recruitment, or retention; supplies such as N95 or surgical masks; equipment like ventilators or improved filtration systems; capital investments; information technology; and other expenses related to prevent, prepare for, or respond to COVID-19. In the coming weeks, HHS plans to announce the first wave of PRF Phase 4 payments, and will continue processing the remaining ARP Rural applications, some of which require more extensive review to ensure program integrity.

"HRSA has a deep and longstanding commitment to supporting health providers in rural communities," said HRSA Acting Administrator Diana Espinosa. "The billions of dollars of funding we are distributing today will provide vital support to rural communities on the front lines of this pandemic."

BIDEN ADMINISTRATION ANNOUNCED INVESTMENTS IN RURAL HEALTH CARE WORKFORCE

The Biden-Harris Administration announced they have awarded the largest field strength in history for its health workforce loan repayment and scholarship programs thanks to a new $1.5 billion investment, including $1 billion in supplemental American Rescue Plan (ARP) funding and other mandatory and annual appropriations. HRSA Acting Administrator Diana Espinosa notes that, "[the awards] which represent a more than 27 percent increase in scholarship and loan repayment awards, support current and future providers who are committed to working in vulnerable communities." The awards were made in direct response to the recommendations in the final report of the Presidential COVID-19 Health Equity Task Force.

As Vice President Harris announced **earlier** today, the Biden-Harris Administration has awarded the largest field strength in history for its health workforce loan repayment and scholarship programs thanks to a new $1.5 billion investment, including $1 billion in supplemental American Rescue Plan (ARP) funding and other mandatory and annual appropriations. More than 22,700 primary care clinicians now serve in the nation's underserved tribal, rural and urban communities, including nearly 20,000 National Health Service Corps (NHSC) members, more than 2,500 Nurse Corps nurses, and approximately 250 awardees under a new program, the Substance Use Disorder Treatment and Recovery Loan Repayment Program. The U.S. Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA) oversees these critical programs.

"Thanks to the American Rescue Plan, we now have a record number of doctors, dentists, nurses and behavioral health providers treating more than 23.6 million patients in underserved communities," said Health and Human Services Secretary Xavier Becerra. "This demonstrates the Biden-Harris Administration's commitment to advance health equity and ensure access to critical care across the country. We will continue to invest in our health workforce to make life-saving support within everyone's reach."

During the pandemic, thousands of NHSC and Nurse Corps health care providers have served in community health centers and hospitals across the country, caring for COVID-19 patients, supporting the mental health of their communities, administering COVID-19 tests and lifesaving treatments, and putting shots in arms.

Connecting Skilled Providers with Communities in Need

HRSA's workforce programs directly improve the nation's health equity by connecting skilled, committed providers with communities in need of care. National Health Service Corps, Nurse Corps, and Substance Use Disorder Treatment and Recovery Loan Repayment Program members work in disciplines urgently needed in underserved tribal, rural and urban communities.

"Today's awards, which represent a more than 27 percent increase in scholarship and loan repayment awards, support current and future providers who are committed to working in vulnerable communities," said HRSA Acting Administrator Diana Espinosa. "These awards also provide critical support for health care sites that need to recruit and retain clinicians to meet increasing demand."

- Today's field strength includes more than 11,900 members working in behavioral health disciplines, including psychiatrists, substance use disorder (SUD) counselors and psychiatric nurse practitioners.
- Nurses represent the largest proportion of the field strength, numbering more than 8,000 across all scholarship and loan repayment programs. National Health Service Corps nurse practitioners make up its largest discipline at approximately 5,400 and fill a critical need for primary care where shortages exist throughout the country.
- Currently, one-third of HRSA's health workforce serves in a rural community where health care access may be especially limited or require patients to travel long distances to receive treatment.
- More than half of all National Health Service Corps members serve in a community health center where patients are seen regardless of their ability to pay.

Providing Treatment and Care to Patients with Substance Use Disorders

Through dedicated funding for substance use disorder (SUD) professionals, HRSA is now supporting more than 4,500 providers treating opioid and other substance use disorder (SUD) issues in hard-hit communities. The Substance Use Disorder Treatment and Recovery Loan Repayment Program was launched in FY 2021 to create loan repayment opportunities for several new disciplines that support HHS' comprehensive response to the opioid crisis, including clinical support staff and allied health professionals. In addition, this year's NHSC awards include 1,500 substance use disorder (SUD) clinicians at approved treatment sites through the NHSC's Substance Use Disorder and Rural Community loan repayment programs.

Investing in the Future Health Workforce

Through scholarship programs, HRSA is investing in the next generation of providers committed to working in communities most in need. The American Rescue Plan supplemental funding announced today allowed HRSA to award almost 1,200 scholarships -- a four-fold increase -- in the National Health Service Corps and nearly doubled the number of Nurse Corps scholarship awards to 544. In addition, new awards to 136 nurse faculty are supporting training for the future nursing workforce. This year's scholarship recipients join 2,500 current National Health Service Corps medical, dental, and health professions students and residents and approximately 900 current Nurse Corps scholars preparing to serve in high-need communities across the country.

ASSOCIATION PARTNERS

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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REGISTER FOR ALL EVENTS ONLINE AT MSRHA.ORG/EVENTS

The Mississippi Rural Health Association conducts workshops, conferences, receptions, webinars and a variety of other opportunities for healthcare professionals to gain valuable education and networking opportunities throughout the year.

COST SAVINGS, INCREASING MARGINS, & EXCEEDING INDUSTRY BENCHMARKS FOR HEALTHCARE ORGANIZATIONS:
Gallagher Introduction
February 23, 2022 I Virtual

E&M GUIDELINES UPDATE
May 18, 2022 I Virtual

2022 RURAL HEALTH CLINIC CONFERENCE
May 27, 2022 I Virtual